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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

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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"). Over 60 of the SAMG physicians provide primary care services. *See Exhibit 2028.* 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. Plaintiff Treasure Valley Hospital Limited Partnership, doing business as Treasure Valley Hospital ("TVH"), is a nine-bed, physician-owned, for-profit hospital in Boise, largely used for outpatient surgeries. *Dkt. 63 (Saint Alphonsus/TVH Am. Compl.) ¶ 9; Transcript at 989:21-990:5 (N. Genna).* [redacted]

3. Partnership between Saint Alphonsus and Treasure Valley Hospital

10. In the fall of 2012, Saint Alphonsus and TVH jointly opened a new outpatient surgery center in Nampa called the Treasure Valley Surgery Center ("TVSC"). [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].[2] *Dkt. 397 (S. Jeffcoat Dep.) at 66:14-22, 68:1-4; 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. Scale is also necessary for the integrated delivery system to support risk-based arrangements. *Transcript at 398:2-4 (J. Crouch); 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. A two-person group could not possibly bear the financial risk of loss that would come with a full risk-sharing contract, and scale is required to assume both upside and downside risk. *Transcript at 397:23-398:4 (J. Crouch).* "[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*), [redacted] It is also negotiating with PacificSource to form a risk product for the new health insurance exchange opened pursuant to the Affordable Care Act. *Dkt. 322 (S. Drake Dep.) at 107:5-9, 21-24*.

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*) and other payors like Regence and Blue Cross beginning to develop new products to compete with SelectHealth. *Exhibit 2165; Transcript at 1262:11-1263:11 (B. Petersen).*

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. Saint Alphonsus employs approximately 200 physicians, [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 [redacted]

[redacted]

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.* The MHPN includes only 25 percent of the area physicians. *Transcript at 2906:7-10 (D. Argue).* [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. Dr. Argue also demonstrated that when Micron implemented its new plan, Micron employees in Nampa did not merely switch providers, they switched from providers *in* Nampa to providers *outside* of Nampa. Before the implementation of the Micron health plan, Nampa pediatricians accounted for 48 percent of pediatric visits by Micron employees in Nampa. After the Micron health plan was established, and the Saltzer pediatricians were excluded from the MHPN, visits to Nampa pediatricians by Micron employees in Nampa dropped from 48 percent to 7 percent. *Transcript at 2948:16-25 (D. Argue); Exhibit 2577.*

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).*

Indeed, plaintiffs cite evidence relating to Saltzer's negotiations with Regence in Nampa as evidence that Saltzer had market power *before* the transaction with St. Luke's. *See, e.g., Transcript at 1489:11-1490:7 (D. Haas-Wilson).*[7] 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

[7] The Court addresses the evidence concerning Saltzer's negotiations with Regence below. *Infra* at ¶ 283.

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. For example, Blue Cross of Idaho is the largest insurer in Idaho. *Transcript at 305:14-15 (J. Crouch).* It insures more than one quarter of Idaho's entire population—twice as many commercial members in Idaho as does its next

largest competitor, Regence Blue Shield of Idaho. *Transcript at 305:12-13 (J. Crouch); Dkt. 373 (G. Sonnenberg Dep.) at 38:8-39:2.* 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. Recently, St. Luke's succeeded in getting IPN to increase the amounts paid to the Magic Valley physicians, but that increase merely brings their reimbursement from being below the statewide fee schedule up to the level of the statewide fee schedule. *Transcript at 493:20-495:2, 503:19-23 (L. Duer).*

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]

However, the Court gives these reports little weight, primarily for three reasons.

297. First, the reports were heavily redacted, and St. Luke's was not provided with all of the underlying data (such as data for the hospitals state-wide against which St. Luke's is being compared) in order to fully examine the reports and their methodology. *See Exhibit 1300; Transcript at 343:17-344:4 (J. Crouch).*

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] However, when Blue Cross chose to present information from these reports to St. Luke's during contract negotiations, Blue Cross chose to present information from the *weighted average* columns of the spreadsheet. *Exhibit 1299; Transcript at 2981:2-7 (D. Argue).* The weighted averages account for the different sizes of the hospitals being compared. *Transcript at 339:13-22 (J. Crouch).* [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][9]

303. [redacted]

[9] [redacted] Thus, the relevant question, which the Court has addressed above, is whether the total reimbursements to St. Luke's change in a way that reflects an exercise of market power. As the Court has explained, they did not.

[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.

iii. "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

nondiscrimination provisions, and treat all patients regardless of their ability to pay. 42 CFR § 413.65(d), (g).

309. St. Luke's has met the regulatory requirements and has incurred significant costs converting certain previously-independent sites to outpatient hospital departments, and therefore engages in provider-based billing for services performed at those sites. St. Luke's is not alone in receiving payments from Medicare for provider-based billing. *See Transcript at 815:9-11 (N. Powell).*

310. Provider-based billing for treatment of Medicare beneficiaries is not a function of, and in no way connected to, market power. Instead, a hospital provider's ability to engage in provider-based billing for services furnished in a facility acquired by the hospital turns solely on whether the provider complies with the requirements set forth by CMS in federal regulations. Therefore, neither St. Luke's past practice of provider-basing facilities in accordance with federal regulations nor the possibility that it will seek to provider-base Saltzer under those regulations in any way supports the antitrust claims in this case. *Transcript at 1349:7-16 (D. Dranove); Transcript at 2461:15-21 (J. Kaiser).*

311. St. Luke's compliance with federal regulations for provider-basing its facilities does not compel any commercial payor to increase *its* payments to St. Luke's for care provided at those facilities. To the contrary, the amounts that commercial payors pay St. Luke's are determined through negotiations. [redacted]

iv. The Grant Thornton documents do not reflect any expectation that commercial reimbursements will increase.

312. Plaintiffs claim that the fair market value opinions that St. Luke's received from Grant Thornton show that St. Luke's and Saltzer contemplated that the transaction would increase compensation to the Saltzer physicians above market norms and would pay for that compensation increase through price increases to commercial insurers. Neither the fair market value opinions nor the deposition testimony concerning these documents supports plaintiffs' argument.

313. Initially, plaintiffs ignore the fact that the Grant Thornton fair market value opinions found that the compensation offered to Saltzer was *consistent* with fair market value, concluding that the "compensation model results in reasonable compensation." *See, e.g., Exhibit 6 at 7.* [redacted]

314. Contrary to plaintiffs' characterization of these documents, nowhere did Grant Thornton conclude that the *compensation* offered to the Saltzer physicians was above market norms; rather, Grant Thornton opined that the level of the *increases* proposed for the primary care physicians was above the typical percentage increase offered to physicians in the market. This is significant, and fully supports the testimony from St. Luke's witnesses that in its compensation analyses it determined that Saltzer had been significantly underpaying its primary care physicians relative to St. Luke's other primary care providers in the Treasure Valley. *Transcript at 2249:2-18 (C. Roth).* In other words, where physicians are underpaid relative to the market, bringing those physicians up to market norms will result in a larger than normal

percentage increase in compensation, even where the resulting compensation is within market norms. *Id.*

315. The undisputed testimony on this topic evidences the fact that the level of compensation for the Saltzer physicians under the St. Luke's transaction was set to be consistent with the compensation that St. Luke's pays its physicians in the same specialties throughout the Treasure Valley. *Transcript at 2249:2-2250:7 (C. Roth).* Indeed, Grant Thornton itself recognized in its fair market value opinion that the compensation offered to the family practice physicians, for example, was "in line with the compensation model offered to other SLHS family practice physicians." *Exhibit 2575 at 10.*

316. [redacted]

317. Thus, the fact that there was the potential for an increase in compensation to Saltzer primary care physicians, pediatricians, and other physicians under the St. Luke's agreement reflects that these physicians were under-compensated at Saltzer relative to their peers at Saint Alphonsus or St. Luke's.

318. The fair market value opinions also suggest that the increased compensation for these physicians were further "justified due to the facts and circumstances of the contract" because, in part, the "Saltzer physicians' charge rates are being adjusted to the SLHS rates, which results in a corresponding increase in the rates collected." *See, e.g., Exhibit 6 at 7.* Plaintiffs read this language to suggest that the parties contemplated that Saltzer's charge rates and collections from *commercial* payors would increase as part of the transaction. However, the

documents make no mention of commercial payors, and no one who testified concerning the import of this language agreed with that interpretation. *Transcript at 2341:14-2342:6 (C. Roth); see also Dkt. 288 (P. LaFleur Dep.) at 319:21-320:4, 320:5-14* (making clear that assumptions regarding increased reimbursement rates for Saltzer physicians related only to Medicare reimbursement rates, and that "commercial reimbursement rates changes were not included in the . . . assumptions that would result in overall higher reimbursement"). Rather, the language reflects the understanding of both parties that, if Saltzer's operations were modified consistent with federal regulations, St. Luke's would be entitled under federal law to increased reimbursements for services provided to patients covered by the Medicare program, a fact of Medicare reimbursement referred to, as noted above, as "provider-basing." *Id.*

319. The expectation of increased reimbursement through "provider-basing" Saltzer does not in any way suggest that St. Luke's or Saltzer anticipated exercising market power, as the increase in Medicare reimbursement is a function of federal law, not negotiating leverage.

[redacted]

320. Thus, the Court concludes that the Grant Thornton opinions cited by plaintiffs do not support a finding that the parties to the Saltzer Transaction expected or anticipated that the Saltzer physicians would be compensated at rates above market norms or that prices to commercial payors would be increased to pay for any such compensation increases.

v. The financial modeling performed by St. Luke's consultant does not reflect any expectation of increased reimbursement from commercial payors.

321. Plaintiffs claim that a number of documents that reflect financial modeling of the Saltzer Transaction by outside consultant Peter LaFleur provide evidence that St. Luke's and

Saltzer fully expected that commercial reimbursement rates for Saltzer's services would increase following their transaction. However, the documents and the testimony about them refute plaintiffs' interpretation.

322. As would be expected, St. Luke's sought to understand the revenues and costs associated with integrating Saltzer into St. Luke's delivery system. For that purpose, St. Luke's turned to Mr. LaFleur, a health care consultant with many years of experience. *Exhibit 54 (P. LaFleur Dep.) at 50:1-9.*

323. With respect to the Saltzer Transaction's impact on the revenues generated by Saltzer's services, Mr. LaFleur explained to both St. Luke's and Saltzer that the only changes in revenues that could be counted on were related to increased payments from Medicare, provided St. Luke's invested the resources to bring Saltzer's operations into compliance with federal provider-basing regulations. *Id. at 284:2-8; Dkt. 288 (P. LaFleur Dep.) at 332:3-13.*

324. For completeness, Mr. LaFleur also modeled the revenues that would be generated from Saltzer's services if commercial payors were to reimburse for those services at St. Luke's contracted rates. However, this modeling of commercial reimbursements does not support plaintiffs' "pay more charge more" argument for several reasons.

[redacted] He made clear in giving his presentations that the parties to the transaction could not count on realizing these changes in reimbursement. *Id. at 284:2-8; Dkt. 288 (P. LaFleur Dep.) at 319:21-320:4, 320:6-14, 332:3-13.* [redacted]

[redacted]

326. Mr. LaFleur's analysis of changes in commercial reimbursements for Saltzer's services played no role in determining the level of compensation paid to the Saltzer physicians. *Exhibit 54 (P. LaFleur Dep.) at 72:21-24.* Nor was the financial modeling used in any way in determining the amount St. Luke's paid for Saltzer's assets. *Id. at 72:25-73:2.* [redacted]

327. The documents relied upon by plaintiffs do not support their pay-more-charge-more argument for an additional reason. [redacted]

328. [redacted] However,

plaintiffs have made no argument, nor presented any evidence that would suggest, that the Saltzer Transaction will result in St. Luke's gaining market power in the market for laboratory, imaging, or other ancillary services. In the absence of market power in those markets, even assuming that the Court agreed that the documents cited by plaintiffs evidenced a plan by St. Luke's to charge supracompetitive prices to commercial payors for Saltzer's ancillary services, the Court would have to conclude that the plan would have come to naught.

329. In sum, the Court finds that none of the purported evidence supports plaintiffs' contention that St. Luke's planned to pay for higher compensation to the Saltzer physicians by raising prices to commercial insurers.

b. Plaintiffs' claims that St. Luke's will resist price competition

330. Plaintiffs have also referred to statements by St. Luke's employees to the effect that St. Luke's does not want to get into "bidding wars." *Transcript at 225:19-226:19 (J. Crouch); Transcript at 584:11-25 (P. Otte); Transcript at 1520:16-1521:11 (D. Haas-Wilson).* Plaintiffs suggest that what this means is that St. Luke's does not want to compete on price, and to the extent that the Saltzer Transaction increases St. Luke's bargaining leverage, St. Luke's will succeed in avoiding "bidding wars."

331. It is clear from the context of the statements cited by plaintiffs that what St. Luke's is referring to is not some blanket opposition to providing "discounts." Rather, St. Luke's has sought to shift the payment paradigm from one in which providers compete to provide fee-for-service medicine at discounted rates to a "population management" model of reimbursement in which providers bear the overall risk for managing the health of a patient population. *Dkt. 321 (R. Billings Dep.) at 140:5-16.* Thus, St. Luke's has made proposals to BCI and Micron, for example, for more comprehensive population management-based reimbursement as an alternative to the traditional payment paradigm in which two providers

simply bid against each other for discounted fee for service payment. *Transcript at 405:5-16 (J. Crouch); Transcript at 584:11-25 (P. Otte).*

332. For example, Jeffrey Crouch testified that St. Luke's rejected BCI's proposal to participate in a new BCI product called "ConnectedCare," and that Randy Billings of St. Luke's told him that St. Luke's did not want to take part in ConnnectedCare because it did not want to compete over price with Saint Alphonsus. *Transcript at 194:22-195:3, 401:11-14 (J. Crouch).* However, Mr. Crouch later testified that St. Luke's rejected the ConnectedCare product because it wanted a much *broader* risk-based arrangement with BCI, under which a majority of St. Luke's compensation would be risk-based by 2017—rather than the ConnectedCare fee-for-service product. *Transcript at 402:21-24 (J. Crouch); Exhibit 2587.* Mr. Crouch also acknowledged that St. Luke's has stated on several occasions its desire to move to a more population management-based and risk-based arrangement instead of continuing to perpetuate the traditional fee-for-service paradigm. *Transcript at 405:7-12 (J. Crouch).*

4. There are available alternative to St. Luke's and Saltzer PCPs in Nampa.

333. Another reason that the Saltzer Transaction is not likely to have anticompetitive effects—even if Nampa were the relevant geographic market for adult PCP services—is that Nampa residents have alternatives to St. Luke's and Saltzer PCPs in Nampa. *Transcript at 2946:4-14, 2954:20-23 (D. Argue).* Entry of new providers or expansion of existing providers in a market can ameliorate the potentially adverse effects of a merger. *See Transcript at 2986:19-21 (D. Argue); Merger Guidelines § 9.*

a. There is sufficient existing slack capacity in Nampa for patients who want to stay in Nampa.

334. Non-St. Luke's/Saltzer providers have ample slack capacity in the market to defeat a price increase. *Transcript at 2990:20-2991:2 (D. Argue).*

335. Dr. Argue calculated slack capacity using the average number of visits to Saltzer primary care physicians in Nampa as a benchmark. *Transcript at 2987:15-2988:1 (D. Argue); Exhibit 2457.* [redacted]

336. Plaintiffs have focused their arguments on the difficulty of recruiting sufficient PCPs to Nampa to replace all of the Saltzer PCPs, but under the Merger Guidelines, "for entry or expansion to be sufficient, it must replace at least the scale and strength of *one* of the merging firms in order to replace the lost competition from the Acquisition." *FTC v. ProMedica Health Sys., Inc.*, No. 11-cv-47, 2011 WL 1219281, at *31-34 (N.D. Ohio Mar. 29, 2011) (quoted in FTC Opening Statement) (emphasis added). Here, the merging parties are Saltzer and the Mercy Physicians Group physicians, who are the St. Luke's employed PCPs in Nampa. *Transcript at 2990:4-17 (D. Argue).* Thus, only the scale and strength of the Mercy Physicians Group physicians need to be replaced for entry or expansion to be sufficient. [redacted]

337. Testimonial evidence supports Dr. Argue's conclusions that there is ample slack capacity in Nampa. Eight of SAMG's PCPs in Nampa, including the three primary care physicians that SAMG recruited in 2012, are at approximately the 25th percentile for productivity compared to national averages. *Transcript at 715:15-18 (N. Powell).*

338. The fact that the non-St. Luke's/Saltzer PCPs in Nampa have significant capacity to treat additional patients means that they are a viable outside option for payors looking to

include PCPs in Nampa in their network. *Transcript at 792:12-15 (N. Powell); Transcript at 2990:18-2991:2 (D. Argue).*

b. Other Nampa providers are close substitutes for St. Luke's.

339. Professor Dranove performed a "diversion analysis," which "identifies which firms most closely substitute for one another." Using this analysis, Professor Dranove determined that Saltzer is St. Luke's closest competitor in the market, and St. Luke's is Saltzer's next closest competitor. *Transcript at 1349:21-1352:3, 1352:25-1353:7 (D. Dranove).*

340. According to Professor Dranove's diversion analysis, if St. Luke's Nampa location were unavailable, half of the St. Luke's patients at that location would switch to Saltzer. *Transcript at 1352:4-19 (D. Dranove).* However, according to that same analysis, roughly 65 percent of the patients of Saltzer physicians in Nampa would switch to providers *outside* of Nampa in the event Saltzer physicians were unavailable, even if there were alternative providers available in Nampa. *See Transcript at 1410:1-9 (D. Dranove).*

341. Moreover, as Dr. Argue explained, if one focuses on the "Nampa market" that Dr. Dranove contends is the appropriate market, his own diversion analysis shows that as between St. Luke's providers in Nampa and Saint Alphonsus's providers in Nampa, the diversion percentages are 15 percent and 12.3 percent, respectively—a difference that is not significant. *Transcript at 2956:6-10 (D. Argue).*

342. In other words, the analysis shows that if Saltzer physicians in Nampa were unavailable, the percentage of patients who would choose a Saint Alphonsus provider as their next alternative is roughly the same as the percentage who would choose a St. Luke's provider as their next alternative. Saint Alphonsus primary care physicians in Nampa and St. Luke's primary care physicians in Nampa are "virtually indistinguishable" and very close substitutes for Saltzer patients who would seek to continue to receive care in Nampa. *Transcript at 2956:10-13*

(D. Argue). St. Luke's, therefore, is not the only close substitute to Saltzer. *Transcript at 2956:10-13 (D. Argue).*

343. Even if St. Luke's and Saltzer are each other's closest substitutes and a network without either would be less attractive, as Professor Dranove suggests, health plans can still construct narrow networks that offer fewer providers, but at a lower price. Through various network designs, health plans can attract a spectrum of patients. *Transcript at 3016:17-3017:21 (D. Argue).*

c. Nampa residents who already travel for work have even more alternatives.

344. Thirty-four percent (34%) of Nampa residents who commute out of Nampa for work currently receive primary care physician services in Nampa. Those patients would not have to travel for the purpose of seeing a PCP; they are already traveling outside of Nampa for work. *Transcript at 2943:21-2946:3 (D. Argue); see also Exhibit 1793.* Accordingly, even if Nampa residents who wanted to avoid a price increase had to travel in order to change physicians—and because of the ample availability of SAMG and Primary Health PCPs, they do not—a significant number are traveling already for work.

5. If St. Luke's attempts to increase prices, it is likely to lose revenues in excess of the critical loss.

345. The evidence set forth above establishes that patients do react to changes in the price of physician services, and that health plans and employers have reacted in the past, and can react going forward, to price increases by incentivizing employees to use lower-cost providers.

346. In addition to the evidence regarding patient sensitivity to price increases and the use of financial incentives to override patient preference, survey data regarding patient loyalty indicate that enough patients would switch to providers with excess capacity that the Critical Loss would be exceeded. These data indicate that anywhere between 10 to 25 percent of patients

do not have a primary care physician or usual source of care. If only some of those patients who do not have an established relationship with a primary care physician switch, the Critical Loss would be exceeded. *Transcript at 2992:1-9 (D. Argue).*

347. Further, 10 to 15 percent of patients are not satisfied with or are likely to switch their primary care physician. Those percentages are also sufficient to exceed the Critical Loss. *Transcript at 2992:10-18 (D. Argue).*

348. Finally, there are sufficient alternative providers in Nampa, including the SAMG providers – who are essentially viewed as equal substitutes to St. Luke's – for Nampa residents who would want to stay in Nampa but see another provider. There are likewise numerous providers available in communities outside of Nampa—communities to which 34 percent of Nampa residents currently travel for work—in the event that Saltzer and St. Luke's attempted to implement an anticompetitive price increase.

349. Dr. Argue determined that the Critical Loss for a 5 percent increase is 1.5 percent when taking into account complementary services, and he concluded that the actual loss is likely to exceed that amount. The Court agrees.

6. Recruitment serves as a further check on St. Luke's ability to raise prices.

350. The Court has already found that there is sufficient capacity among the non-St. Luke's and Saltzer PCPs to constrain a price increase. However, even if there were not sufficient capacity, the Court finds that plaintiffs have likely overstated the difficulties of recruiting PCPs to Nampa.

351. Canyon County is a fast growing market. As one Saint Alphonsus internal assessment explained, "Canyon County consistently ranks as one of the fastest growing counties in the Nation with a 42% growth rate from 2000-2009. Nampa has exploded with an 83%

growth rate between 1990 and 2000. This growth is expected to continue in the market." *Exhibit 2079; Exhibit 2087.*

352. The anticipated growth of the market in Canyon County is reflected in the fact that both Saint Alphonsus and St. Luke's are expanding operations there. In July 2012, St. Luke's opened a free-standing emergency room in Nampa. *See Transcript at 2235:18-23 (C. Roth); Transcript at 2369:4-6 (J. Kaiser).* Saint Alphonsus also has committed to investing over $33 million to expand in Nampa. It recently opened the Treasure Valley Surgery Center, an ambulatory surgery facility in Nampa. *Transcript at 945:11-17, 973:14-17 (L. Checketts); Exhibit 2087; Dkt. 372 (J. Hessing Dep.) at 36:21-37:1.*

353. SAMG currently has four different PCP clinics in Nampa and at least 14 primary care physicians in Nampa. *Exhibit 1115 at slide 6; Transcript at 712:15-19, 790:19-791:5 (N. Powell).* In 2012 alone, Saint Alphonsus Medical Group recruited three primary care physicians into its Nampa practices. *Transcript at 715:8-11, 792:20-24 (N. Powell).*

354. To the extent that Saint Alphonsus has not been as successful as it would like in recruiting or retaining PCPs in Nampa, the evidence indicates that that problem may be self-inflicted. For example, Saint Alphonsus includes covenants not to compete in its physician employment contracts. *Transcript at 3348:19-23 (H. Kunz).* [redacted]

355. PHMG also has succeeded in expanding its capacity in Nampa. [redacted]

[redacted] PHMG estimates that its new clinic will draw patients not only from Nampa, but from the outlying areas of Canyon County. *Transcript at 1204:23-1205:19 (D. Peterman).*

7. The involvement of St. Luke's Board of Directors further tempers concerns about St. Luke's raising prices above competitive levels.

356. While the Court is persuaded by the aforementioned evidence that the Saltzer Transaction is not likely to have anticompetitive effects, the active involvement and oversight of the Board of Directors of St. Luke's Health System provides the Court with some additional level of comfort that the transaction is not intended or likely to raise prices.

357. The Court heard testimony from Skip Oppenheimer, a member of the St. Luke's Health System Board and the chairman and CEO of Oppenheimer Companies, Inc., which employs approximately 60 people in Idaho. *Transcript at 2756:2-2757:10 (A. Oppenheimer).* The System Board includes representatives of several other significant employers, including J.R. Simplot, Clear Springs, and Albertsons, and the former president of Boise Cascade. *Transcript at 2757:22-2758:22 (A. Oppenheimer).*

358. Board members are not paid for their services. *Transcript at 2759:10-13 (A. Oppenheimer).* However, Mr. Oppenheimer testified, they serve because of a strong commitment to St. Luke's and its mission to change the way that health care is delivered. *Transcript at 2759:14-2760:24, 2784:22-25, 2785:16-22 (A. Oppenheimer); see also Transcript at 1611:3-8, 1628:11-12 (D. Pate).*

359. Concerning the Saltzer Transaction, the System Board considered three factors: (1) the transaction would give St. Luke's a presence in Canyon County and provide more convenient care to the approximately 22 percent of St. Luke's patients that were traveling outside of Canyon County to receive care at St. Luke's; (2) Saltzer and St. Luke's were aligned in their

vision of where health care was going; and (3) the transaction would allow St. Luke's to obtain the critical mass necessary to transition to a risk- and value-based system, which the board views as "potentially transformational in terms of where health care is going in this country." *Transcript at 2766:19-2767:22 (A. Oppenheimer).*

360. Mr. Oppenheimer testified that the ability to have increased leverage with payors as a result of an acquisition is not something the board considers and that it played no role in the decision to approve the Saltzer Transaction. *Transcript at 2764:13-18, 2767:23-2768:1 (A. Oppenheimer).* He explained that St. Luke's is "a nonprofit, community-based, charitable institution" that has "no interest in raising prices in terms of anything above competitive levels." *Transcript at 2768:13-2769:1 (A. Oppenheimer).*

361. Additionally, Mr. Oppenheimer testified that, because the board is "made up of a lot of employers who pay premiums for their employees," there is a "built-in check" because those employers would learn if there was any pricing above competition. *Transcript at 2769:16-25 (A. Oppenheimer).*

362. Mr. Oppenheimer testified that "if there was anything above competitive levels, we, as board members, would see it firsthand, and it would affect us directly." *Transcript at 2769:16-2770:2 (A. Oppenheimer); see also Transcript at 1645:10-17, 1646:10-12 (D. Pate).* He further explained that the board would challenge any price increase above competitive levels and would not allow such an increase. *Transcript at 2770:3-9 (A. Oppenheimer).*

363. Because the board's goal is not to maximize revenue, but rather is "100 percent behind" St. Luke's mission to achieve the Triple Aim and transform health care to a value-based system, holding down prices is consistent with the board's fiduciary duty. *See Transcript at 2770:10-2772:11, 2785:20-23 (A. Oppenheimer).*

364. For all of the foregoing reasons, the Court finds that the Government Plaintiffs have failed to prove their claims.

VII. The Private Plaintiffs Have Failed To Prove That The Saltzer Transaction Is Likely To Have Anticompetitive Effects In the Markets for Pediatric Services, Inpatient Hospital Services, or Outpatient Hospital Services.

365. The Private Plaintiffs (but not the Government Plaintiffs) allege anticompetitive effects in four markets in addition to the adult PCP market: (1) general pediatric physician services sold to commercial payors in Nampa; (2) general acute care inpatient hospital services in Ada and Canyon Counties, (3) neurosurgery and orthopedic ("neuro+ortho") outpatient surgical facility services in Ada and Canyon Counties, and (4) general surgery outpatient surgical facility services in Ada and Canyon Counties.

366. Defendants do not dispute the product or geographic market definitions for these four additional markets. However, defendants argue that the Saltzer Transaction is not likely to result in anticompetitive effects in those markets. For the reasons set forth below, the Court agrees.

A. Relevant Background

1. Vertical foreclosure vs. horizontal foreclosure

367. St. Luke's does not employ any pediatricians in Nampa. Thus, as Professor Haas-Wilson conceded, the Saltzer Transaction is not alleged to have any horizontal effects on the market for pediatric primary care services. *Transcript at 1537:5-21 (D. Haas-Wilson).* Likewise, because Saltzer is not a participant in the alleged markets for inpatient or outpatient facility services, the Saltzer Transaction will not result in horizontal competitive effects in those markets either.

368. The Private Plaintiffs' claims are instead based on a theory of vertical foreclosure—that is, plaintiffs allege that the Saltzer physicians will "steer" referrals of patients

for inpatient and outpatient facility services from the Private Plaintiffs to St. Luke's. Accordingly, the Private Plaintiffs contend, the Saltzer Transaction will deprive them of access to patient referrals from the Saltzer primary care physicians, which plaintiffs characterize as a "necessary input" for inpatient and outpatient facility services. *Transcript at 1494:8-15, 1554:4-7 (D. Haas-Wilson).*

2. Harm to competitors must be distinguished from harm to competition.

369. The Private Plaintiffs' economic expert, Professor Deborah Haas-Wilson, defines foreclosure as "impeding a rival or rivals from access to a necessary input." *Transcript at 1494:8-15 (D. Haas-Wilson).* In this case, she continued, "that necessary input is the patients." *Id.* Moreover, Professor Haas-Wilson equates harm to Saint Alphonsus and TVH—competitors of St. Luke's—with harm to *competition*, testifying: "In this case, harm to a competitor and harm to competition are one and the same." *Transcript at 1542:18-1543:3 (D. Haas-Wilson).*

370. Competitors are frequently harmed as part of the normal competitive process. As Dr. Argue testified, foreclosure occurs any time that a rival is excluded from access to an input. However, foreclosure is of no concern under the antitrust laws—*i.e.*, it is not anticompetitive—unless it either (a) eliminates competitors from the market, or (b) diminishes substantially the competitive constraint that those competitors place on St. Luke's. *See* 2A Phillip E. Areeda *et al., Antitrust Law* ¶ 570b1 (2013); *Transcript at 2993:16-2994:6 (D. Argue).*

371. Whether foreclosure is anticompetitive depends on whether the challenged transaction forecloses access to a sufficient portion of the overall market. *See, e.g., Omega Envtl., Inc. v. Gilbarco, Inc.*, 127 F.3d 1157, 1162 (9th Cir. 1997); 2A Phillip E. Areeda *et al., Antitrust Law* ¶ 570b1 (2013) ("The foreclosure effect, if any, depends on the market share involved. The relevant market for this purpose includes the full range of selling opportunities

reasonably open to rivals, namely all the product and geographic sales they may readily compete for, using easily convertible plants and marketing organizations."). "In short, the threatened foreclosure of competition must be in relation to the market affected." *Tampa Elec. Co. v. Nashville Coal Co.*, 365 U.S. 320, 327 (1961).

372. What this means is that determining whether there is anticompetitive foreclosure from the alleged loss of "Saltzer referrals" requires analysis not merely of the extent to which "Saltzer referrals" are likely to change as a result of the transaction, but also of what portion of the total available referrals of patients in Ada and Canyon Counties (plaintiffs' defined geographic market) the Saltzer referrals account for. Even if the transaction would eliminate "Saltzer referrals" to the Private Plaintiffs, that could be competitively significant only if there was not a sufficient volume of alternatives for referrals in the market for which plaintiffs could compete. *Transcript at 2993:16-2994:6 (D. Argue).*

373. As explained below, the Private Plaintiffs have failed to produce evidence on which the Court could conclude that the Saltzer Transaction is likely to result in anticompetitive foreclosure in the inpatient or outpatient facility services markets.

B. Plaintiffs Have Failed To Prove Anticompetitive Effects In The Market for Pediatric Services.

374. St. Luke's does not employ any pediatricians in Nampa. Accordingly, the transaction will not result in any horizontal combination (*i.e.*, increase in market share) of pediatricians. *Transcript at 1537:11-21 (D. Haas-Wilson).* In other words, a combined St. Luke's and Saltzer employs the same number of pediatricians after the transaction as Saltzer, standing alone, did before.

375. Professor Haas-Wilson contends that the affiliation of Saltzer pediatricians with St. Luke's "will affect how competition works in the market for inpatient and outpatient

services." *Transcript at 1485:25-1486:4 (D. Haas-Wilson).* In other words, Professor Haas-Wilson is opining that as a result of their employment by St. Luke's, Saltzer pediatricians will shift referrals for inpatient and outpatient facility services to St. Luke's. While that could conceivably establish anticompetitive effects in the inpatient or outpatient services markets (an issue addressed below), that would not establish that the transaction is likely to have anticompetitive effects in the market for *pediatric* PCP services.

376. A combined St. Luke's/Saltzer will have no more "market power" in the market for pediatric services after the transaction than before. The Court therefore finds that the Saltzer Transaction will not result in any anticompetitive effect in the market for pediatric services.

C. The Saltzer Transaction Is Not Likely To Have Anticompetitive Effects In The Inpatient or Outpatient Hospital Services Markets.

1. Treasure Valley Hospital is not likely to suffer competitive harm from the Saltzer Transaction.

a. TVH has not proven that it is likely to suffer anticompetitive foreclosure from referrals.

377. Nicholas Genna, TVH's Chief Executive Officer, testified that he is concerned that the Saltzer Transaction is likely to harm TVH by depriving it of referrals from Saltzer physicians, which could impact the financial success of TVH and its ability to attract new investors. *Transcript at 1063:18-1064:7 (N. Genna).*

378. Mr. Genna presented evidence that after Boise Orthopedic Clinic ("BOC") surgeons affiliated with St. Luke's, their volume of surgeries at TVH decreased from 490 in 2009, to 60 in 2010, to zero by 2011. *Exhibit 1961; Transcript at 1015:8-1016:8, 1016:25-1017:2 (N. Genna).* Mr. Genna also testified that the volume of surgeries done by the Saltzer surgeons at TVH has dropped significantly since the fall of 2012. *Transcript at 1047:11-13 (N. Genna).*

379. A closer examination of the evidence belies TVH's claim that it has suffered anticompetitive foreclosure in the past, or is likely to suffer anticompetitive foreclosure as a result of the Saltzer Transaction.

380. Exhibits 2641 and 2642 show surgical case counts for TVH and TVSC for 2008 through August 2013. It is appropriate to consider the volumes of TVH and TVSC together, for several reasons. [redacted] Second, ample evidence demonstrates that decreases in TVH's volumes, especially from the Saltzer surgeons, are attributable in part to the opening of the TVSC in Nampa. For example:

a) The number of procedures at TVH done by Dr. Steven Williams, a TVH shareholder, began decreasing significantly starting in September 2012. *Transcript at 1050:2-20 (N. Genna).* However, Dr. Williams is also a shareholder in TVSC, which opened in August 2012. *Transcript at 2519:6-2520:4 (S. Williams).* Dr. Williams testified that once the TVSC opened, he began taking at least as many (if not more) cases to TVSC than he took to TVH. *Transcript at 2520:5-11 (S. Williams).*

b) Dr. Andrew Curran, another former Saltzer surgeon now employed by Saint Alphonsus (and a TVH shareholder) testified that he used to take 90 percent of his outpatient cases to TVH, but that since the TVSC opened, he now takes 45 percent of his outpatient cases to TVH and 45 percent of his outpatient cases to the Treasure Valley Surgery Center. *Dkt. 393 (A. Curran Dep.) at 48:5-20, 113:23-114:25.*

c) [redacted]

381. [redacted]

382. [redacted]

[redacted]

383. [redacted]

384. [redacted]

385. [redacted]

386. Taken together, these data show that there has been no anticompetitive foreclosure of patients from TVH.

b. TVH's financial information confirms that it is not likely to experience competitive harm.

387. Trial Exhibit 2645 presents financial information produced by TVH concerning its EBITDA—earnings before interest, taxes, depreciation and amortization. EBITDA is one of the key metrics that TVH tracks as a measure of its financial health. *Exhibit 2645; Transcript at 1103:16-1104:10 (N. Genna).*

388. [redacted]

389. [redacted]

390. [redacted]

[redacted]The fact that TVH can attract new investors likely explains in part why it has continued to be successful notwithstanding the decrease in surgeries by BOC and Saltzer surgeons. Several witnesses—including TVH's Medical Director, Dr. Jeffrey Hessing—conceded that having an ownership interest in a medical facility provides physicians with a financial incentive to do surgeries at that facility. *Transcript at 1072:5-8 (N. Genna); Transcript at 2517:16-2518:7 (S. Williams); Dkt. 361 (R. Reider Dep.) at 72:5-20; Dkt. 372 (J. Hessing Dep.) at 51:20-25; Dkt. 397 (S. Jeffcoat Dep.) at 165:9-17*[redacted]

392. TVH continues to be a lucrative investment for its shareholders. *Dkt. 372 (J. Hessing Dep.) at 97:14-17.* [redacted] Thus, no evidence has been presented to support the fear that TVH is in danger of losing investors or not being able to attract new investors such that it will go out of business or be significantly weakened as a competitor.

393. In sum, the financial data, like the case count information, do not support a conclusion that TVH is likely to be driven from the market or weakened as a competitive constraint on St. Luke's as a result of the Saltzer Transaction. To the contrary, the evidence demonstrates that TVH is financially as strong as it has ever been, [redacted]

394. For the foregoing reasons, the Court finds that TVH has failed to prove that it is likely to suffer anticompetitive foreclosure as a result of the Saltzer Transaction. Defendants are therefore entitled to judgment on TVH's claims.

2. Saint Alphonsus Has Failed To Demonstrate That It Is Likely To Suffer Anticompetitive Foreclosure.

a. Professor Haas-Wilson's "steering" analyses do not demonstrate a likelihood of anticompetitive foreclosure.

395. Like TVH, Saint Alphonsus bases its foreclosure claim primarily on evidence that after certain physicians affiliated with St. Luke's, their admissions to Saint Alphonsus decreased. Professor Haas-Wilson opines that when St. Luke's acquires a physician practice, those physicians "steer" patients to St. Luke's facilities. *Transcript at 1499:6-12 (D. Haas-Wilson).* She further opines that as a result of the Saltzer Transaction, the Saltzer PCPs are likely to direct referrals to St. Luke's specialists, who will in turn admit patients to St. Luke's, rather than Saint Alphonsus.

396. Professor Haas-Wilson relies primarily on an analysis she conducted of admissions to Saint Alphonsus by five specialty practices acquired by St. Luke's: Boise Orthopedic Clinic, Idaho Cardiothoracic and Vascular Associates ("CVA"), Idaho Pulmonary Associates ("IPA"), Idaho Cardiology Associates ("ICA"), and Intermountain Orthopedics. Her

analysis shows that after physicians with these groups affiliated with St. Luke's, they essentially ceased admitting patients to Saint Alphonsus. *Exhibit 1705.*[11]

397. As discussed in the following sections, there are at least three major problems with concluding, based on Professor Haas-Wilson's analyses, that the Saltzer Transaction is likely to result in anticompetitive foreclosure of Saint Alphonsus. First, Professor Haas-Wilson's analysis of past acquisitions by St. Luke's does not actually demonstrate that any past transactions caused anticompetitive foreclosure because it does not demonstrate that there was any net loss or financial impact to Saint Alphonsus resulting from these prior acquisitions. Indeed, other evidence the Court will discuss below indicates there was no such impact because, like TVH, Saint Alphonsus was able to offset the lost admissions from the St. Luke's physicians with admissions by other doctors.

398. The second problem with Professor Haas-Wilson's analysis is that even if one assumes that the Saltzer Transaction will result in a virtual cessation of admissions to Saint Alphonsus by Saltzer physicians, Saint Alphonsus provided no information on which the Court could conclude that Saint Alphonsus would be foreclosed from a competitively significant portion of the markets alleged by Saint Alphonsus—*i.e.*, referrals for inpatient and outpatient facility services throughout all of Ada and Canyon Counties.

399. The third problem with relying on Professor Haas-Wilson's analyses of specialty practice acquisitions is that the Saltzer Transaction involves mainly primary care physicians, not specialists. Defendants' expert, Dr. Argue, has examined prior acquisitions of PCP practices by

[11] According to Professor Haas-Wilson, one of the groups, Intermountain Orthopedics, actually increased the percentage of admissions to Saint Alphonsus after it was acquired by St. Luke's. *Exhibit 1705.* Intermountain Orthopedics admitted 0 percent of its patients to Saint Alphonsus in the pre-acquisition period, and 1 percent of its patients to Saint Alphonsus in the post-acquisition period. *Id.*

St. Luke's and his analyses provide further support for the conclusion that Saint Alphonsus has failed to prove that it will suffer anticompetitive foreclosure as a result of the Saltzer Transaction.

vi. Professor Haas-Wilson's analyses of admissions by specialists do not show any net decrease in admissions.

400. Professor Haas-Wilson's analysis shows that admissions to Saint Alphonsus by the specialists of CVA, ICA, and IPA decreased after they joined St. Luke's. However, as Professor Haas-Wilson conceded, a decrease in admissions *by certain physicians* does not mean that total admissions at Saint Alphonsus actually decreased. *Transcript at 1563:17-1565:3 (D. Haas-Wilson).*

401. For example, Professor Haas-Wilson's analysis shows that after CVA affiliated with St. Luke's, admissions to Saint Alphonsus *by CVA-affiliated surgeons* decreased from 34 percent of their volume in the year prior to the transaction to 0 percent in the year after the transaction. But Professor Haas-Wilson failed to examine whether the decrease in admissions by those particular surgeons was offset by an increase in cardiothoracic and vascular surgeries at Saint Alphonsus by other surgeons. *Transcript at 1561:20-1563:11 (D. Haas-Wilson).*

402. Dr. Scott Huerd of CVA testified that while the volume of surgeries he does at Saint Alphonsus has decreased since he affiliated with St. Luke's, the volume of surgeries he does at St. Luke's has not changed. Dr. Huerd explained that after he affiliated with St. Luke's, the volume of referrals he received from Saint Alphonsus physicians decreased substantially. *Transcript at 2359:18-2361:5 (S. Huerd).* Thus. Dr. Huerd did not "shift" cases from Saint

Alphonsus to St. Luke's—he simply lost that volume of work because Saint Alphonsus stopped referring any cases to him. *Transcript at 2361:3-16 (S. Huerd).*[12]

403. Saint Alphonsus's CEO Sally Jeffcoat testified that [redacted] Saint Alphonsus recruited replacement surgeons whose "patient count has exceeded those of the acquired physicians they were intended to replace." *Dkt. 397 (S. Jeffcoat Dep.) at 182:5-22, 184:18-23; Exhibit 2231 at 4.* Indeed, within hours of a replacement cardiothoracic surgeon that Saint Alphonsus had recruited being granted privileges at Saint Alphonsus, Dr. Huerd received a text message dismissing him from Saint Alphonsus's service. *Transcript at 2357:16-20 (S. Huerd).*

404. This evidence demonstrates that the decrease in admissions to Saint Alphonsus by CVA surgeons did not result in anticompetitive foreclosure. Saint Alphonsus doctors simply began referring cases they used to refer to CVA to other surgeons who continued to admit patients to Saint Alphonsus, including to those surgeons that Saint Alphonsus recruited to replace the CVA surgeons.

405. Evidence relating to the other practices that are the subject of Professor Haas-Wilson's analysis likewise undermines any inference that these prior acquisitions resulted in anticompetitive foreclosure. For example, Dr. Marshall Priest of ICA testified that at the same time that 12 of the ICA cardiologists joined St. Luke's, 4 ICA cardiologists joined Saint Alphonsus. *Transcript at 1826:20-24, 1827:9-15 (M. Priest).* The ICA cardiologists who joined

[12] Dr. Roberto Baressi of Boise Surgical Group, another practice that affiliated with St. Luke's, testified to an experience similar to Dr. Huerd's. After he became employed by St. Luke's, Dr. Baressi's referrals from Saint Alphonsus "effectively dried up." *Dkt. 370 (R. Baressi Dep.) at 112:21-113:10.* Dr. Baressi testified that his practice has not "shifted" to St. Luke's so much as developed new sources of referral that have grown to replace his old practice. *Id. at 114:13-115:2.*

St. Luke's continued to maintain privileges and cover call at Saint Alphonsus "to support the four physicians who were in ICA who moved to Saint Alphonsus and became employed until they could begin to increase the numbers in their group." *Transcript at 1827:16-22, 1851:4-7 (M. Priest).*

406. By the Spring of 2008, ICA experienced a decline in business at Saint Alphonsus, which Dr. Priest attributed to the fact that Saint Alphonsus physicians were supporting the ICA physicians who joined Saint Alphonsus. *Transcript at 1827:23-1828:3, 1851:8-12 (M. Priest).* In May of 2008, Dr. Priest and the ICA physicians who had become employed at St. Luke's withdrew privileges from Saint Alphonsus. *Transcript at 1828:4-8 (M. Priest).* At the same time, the former ICA physicians who had become employed at Saint Alphonsus withdrew their privileges from St. Luke's. *Transcript at 1828:4-8, 1851:12-13 (M. Priest).* Since that time, the group of cardiologists at Saint Alphonsus that consisted initially of the four former ICA cardiologists has grown to at least 12 members. *Transcript at 1828:16-21 (M. Priest).* Again, the evidence does not show that the affiliation of certain ICA physicians with St. Luke's resulted in any net loss of cardiology procedures to Saint Alphonsus.

407. The Court also heard testimony from Dr. James Souza of IPA, another group that is the subject of Professor Haas-Wilson's analysis. Dr. Souza testified that at the same time that some IPA physicians joined St. Luke's, four joined Saint Alphonsus. *Transcript at 2050:24-2051:8 (J. Souza).* He explained that there was a mutual decision among all of the members of IPA upon splitting that they would drop privileges at the other hospital in May 2010—which they did. *Transcript at 2053:8-2054:12 (J. Souza).* Since that time, Dr. Souza no longer receives any referrals from Saint Alphonsus. *Transcript at 2055:14-17 (J. Souza).*

408. Dr. Souza testified that he asks his patient their preference in making a referral. If no preference is stated, he tends to refer internally based on his "fundamental belief" that a clinically-integrated practice using a single health record system provides the best patient care. *Dkt. 290 (J. Souza Dep.) at 100:3-17.* However, Dr. Souza testified that he "believe[s] so fundamentally in the power of an integrated system" that he routinely sends patients who have a Saint Alphonsus PCP to a Saint Alphonsus pulmonary care specialist. *Id. at 92:18-25.* Moreover, Dr. Souza continues to refer patients to specialists—such as neurologists—who are affiliated with Saint Alphonsus and no longer have privileges at St. Luke's. *Id. at 101:6-18.*

409. Professor Haas-Wilson's analysis focuses only on admissions to Saint Alphonsus by the IPA physicians who affiliated with St. Luke's—ignoring what happened to the volume of admissions to Saint Alphonsus by the IPA physicians who affiliated with Saint Alphonsus (and who dropped their privileges at St. Luke's). Again, absent any information about what happened to the overall level of pulmonology services provided at Saint Alphonsus, the Court is unable to conclude that the evidence presented by Professor Haas-Wilson reflects anticompetitive foreclosure.

410. Analyses done by Dr. Argue confirm what Dr. Huerd, Dr. Priest, Dr. Souza, and Dr. Baressi testified—*i.e.*, that once an independent specialist affiliates with St. Luke's, Saint Alphonsus physicians' referrals to those specialists decrease dramatically:

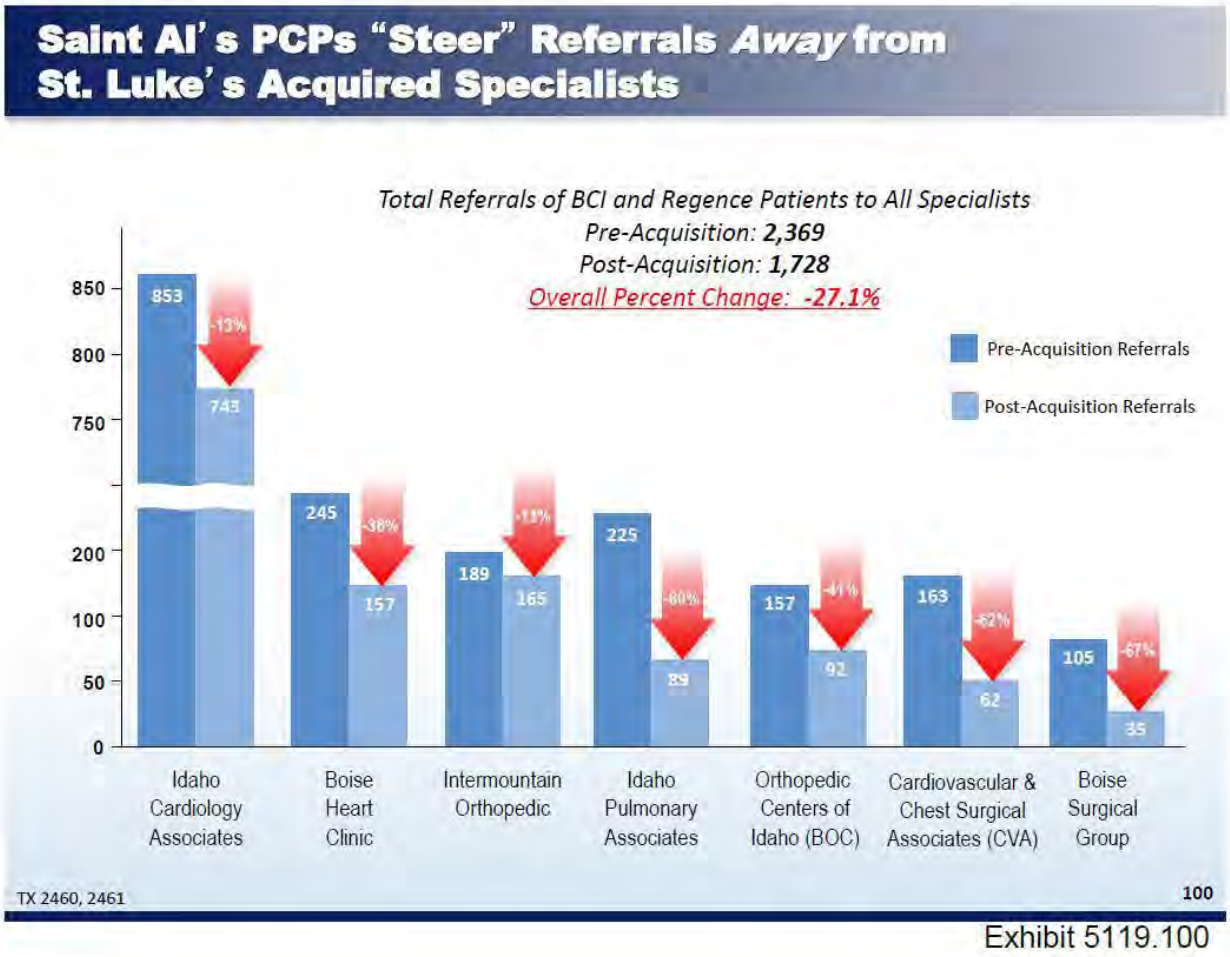

Exhibit 5119.100

Exhibit 2460; Exhibit 2461; Transcript at 2998:19-3004:12 (D. Argue).

411. As Dr. Argue testified, those lost referrals cannot be explained by patients suddenly no longer requiring specialty services. The only logical inference is that those referrals are simply being redirected to *other* (non-St. Luke's) physicians who are admitting those patients to Saint Alphonsus. *Transcript at 3000:8-17 (D. Argue).* The facts concerning the CVA practice support that inference.

412. Professor Haas-Wilson concedes that she has not attempted to ascertain whether there has actually been any change in total procedures performed at Saint Alphonsus following the acquisitions that are the subject of her analysis. *Transcript at 1563:17-1565:3 (D. Haas-Wilson).* Accordingly, the Court concludes that her analysis fails to demonstrate that previous

acquisitions by St. Luke's have resulted in anticompetitive foreclosure. It likewise provides no support for a finding that the Saltzer Transaction is likely to result in anticompetitive foreclosure.

vii. Saint Alphonsus has not provided basic market information from which conclusions about the foreclosure effects of the Saltzer Transaction can be drawn.

413. Saint Alphonsus contends that the Saltzer Transaction will result in anticompetitive foreclosure of referrals of patients for inpatient and outpatient facility services in the geographic market consisting of all of Ada and Canyon Counties. Professor Haas-Wilson concedes that one cannot reach conclusions about foreclosure without an understanding of the overall size of the market, and the portion of that market that is comprised of referrals from Saltzer physicians. *Transcript at 1554:17-24 (D. Haas-Wilson).*

414. Professor Haas-Wilson asserted that the Saltzer physicians comprise a large number of the independent physicians in the "Nampa/Canyon County" area. *Transcript at 1555:7-11 (D. Haas-Wilson).* The Court has not been presented with data to substantiate that assertion, but in any event, the market that plaintiffs have defined is not limited to Nampa/Canyon County, it includes *all* of Ada and Canyon Counties. Thus, in order to determine whether foreclosure from all referrals by Saltzer PCPs would constitute foreclosure from a competitively significant portion of the market, the Court would have to first know the size of the market—*i.e.*, the volume of "available" referrals in the markets defined by the plaintiffs, meaning the total number of referrals for inpatient and outpatient facility services by non-St. Luke's physicians in Ada and Canyon Counties.

415. Saint Alphonsus has produced no such evidence. Professor Haas-Wilson testified that she was unable to identify, even approximately, what percentage of referrals for inpatient and outpatient facility services come from independent physicians. *Transcript at 1554:25-*

1557:1 (D. Haas-Wilson). Without knowing what portion referrals from Saltzer physicians constitute of the overall available referrals—whether, for example, it is 1 percent or 90 percent—the Court cannot find that the loss of "Saltzer referrals" would result in anticompetitive foreclosure to Saint Alphonsus.

viii. Analyses of referral practices by other primary care practices acquired by St. Luke's do not support plaintiffs' foreclosure claims.

416. Professor Haas-Wilson's conclusions are based on her analysis of *admissions* to Saint Alphonsus by certain *specialists* who have affiliated with St. Luke's. However, the Saltzer Transaction involves mainly primary care physicians—not specialists. Thus, the extent to which the analysis of admissions by specialists is pertinent to the Saltzer Transaction depends in large part on the extent to which the reasons for changes in admission patterns by specialists apply to PCPs as well.

417. Unlike specialists, PCPs tend not to admit patients to the hospital themselves, instead referring patients to specialists or hospitalists. *Dkt. 249 (M. Johnson Dep.) at 132:21-133:2.* Thus, focusing on admissions attributed to PCPs may not accurately reflect the volume of activity at a hospital that is attributable to a PCP.

418. A number of specialists who affiliated with St. Luke's testified that they relinquished privileges at Saint Alphonsus in order to reduce the burdens they faced in covering call at multiple hospitals. *Transcript at 2053:15-2054:2 (J. Souza); Transcript at 2356:7-2357:20 (S. Huerd); Transcript at 3173:6-15 (L. Ahern).* Without privileges at a hospital, a hospital-based specialist, such as an interventional cardiologist (*e.g.*, Dr. Priest) or cardiothoracic surgeon (*e.g.*, Dr. Huerd) cannot perform procedures at that hospital. *Transcript at 872:18-873:1 (K. Keeler).*

419. PCPs, by contrast, need not maintain privileges at a hospital in order to have their patients admitted to the hospital, because Saint Alphonsus and St. Luke's operate "hospitalist" programs. *Transcript at 872:18-873:1 (K. Keeler).* When a PCP sends a patient to the hospital to be admitted through a hospitalist, this most often occurs through the physician instructing the patient to go to the emergency room, and then the patient being admitted through the ER by a hospitalist. *Transcript at 975:25-976:4 (L. Checketts).*

420. In Saint Alphonsus's records, the hospitalist is recorded as the admitting physician. *Transcript at 901:16-902:4 (K. Keeler); Transcript at 935:17-21, 974:14-17 (L. Checketts).* This recordation of the admitting physician does not provide data about which physician, specifically which PCP, referred a patient to the Saint Alphonsus-Nampa hospital. *Transcript at 901:22-902:4 (K. Keeler).*

421. Dr. Argue analyzed that data produced by Blue Cross of Idaho and Regence to determine whether they support plaintiffs' claim that there are significant changes in referral patterns by PCPs who affiliate with St. Luke's. Dr. Argue studied admissions to Saint Alphonsus in the year before and year after acquisition by five of the largest primary care groups that joined St. Luke's between 2007 and 2012:[13]

[13] Dr. Argue used a three month "buffer" on either side of the acquisition in order to eliminate from the analysis situations in which a physician might have referred a patient for admission *prior* to the acquisition, but the admission did not occur until *after* the acquisition. *Transcript at 3005:21-3006:6 (D. Argue).*

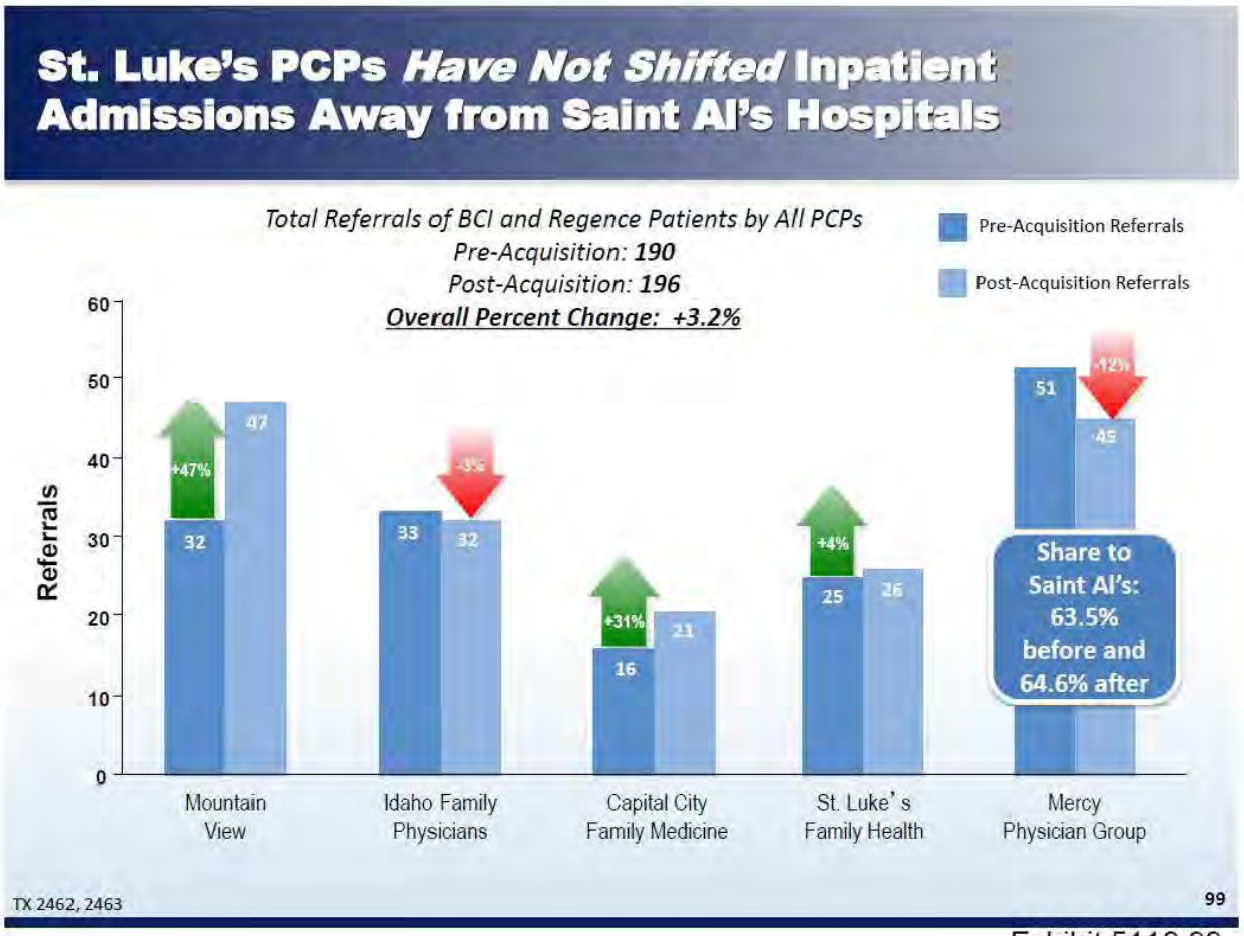

Exhibit 5119.99

Exhibit 2462; Exhibit 2463.

422. Dr. Argue's analysis shows that there is no systematic decrease (indeed, no net decrease at all) in admissions to Saint Alphonsus by primary care groups affiliated with St. Luke's. While admissions by two groups, including the Mercy Physicians Group in Nampa, decreased following acquisition, Dr. Argue explained that the decrease reflects the fact that the total number of admissions for the group decreased, rather than any "shifting" of admissions from Saint Alphonsus to St. Luke's. Mercy Physicians Group physicians admitted virtually the same percentage of their patients to Saint Alphonsus in the before period as in the after period. *Transcript at 3011:23-3012:21 (D. Argue).*

423. Dr. Argue also studied whether PCPs who affiliate with St. Luke's change their patterns of referrals to specialists after the affiliation:

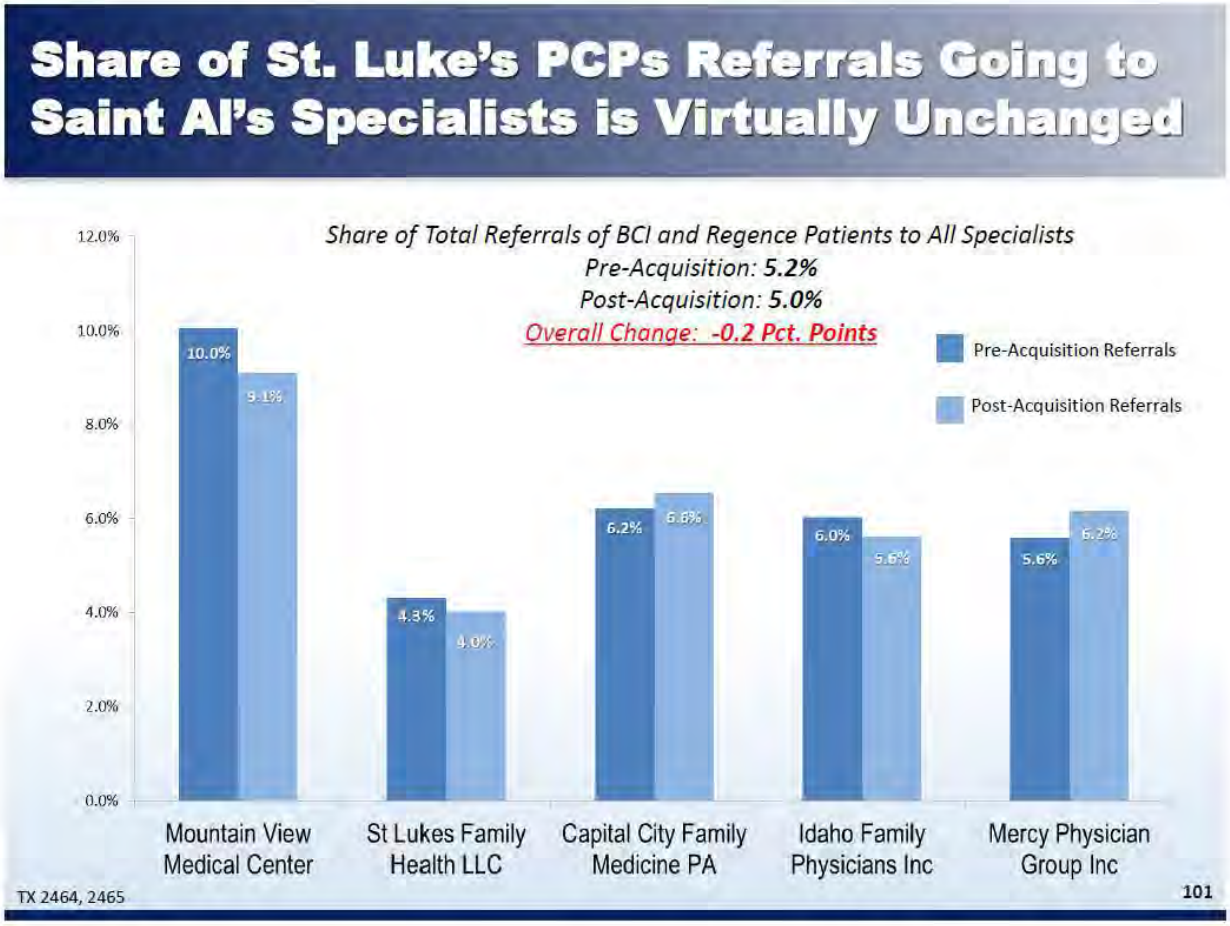

Exhibit 2464; Exhibit 2465.

424. That analysis shows that the volume of referrals to Saint Alphonsus specialists by PCPs who affiliate with St. Luke's is virtually unchanged before and after the affiliation. *Transcript at 3011:23-3015:5 (D. Argue).*

425. Dr. Argue's findings are corroborated by the analysis done by defendants' other expert witness, Lisa Ahern. While Dr. Argue focused on payor data, Ms. Ahern conducted her analysis using Saint Alphonsus admissions data. After reviewing the data and the deposition testimony, Ms. Ahern determined that the "admitting physician" field is not a reliable indicator

of activity associated with PCPs. Several physicians testified that when they refer a patient to Saint Alphonsus-Nampa, their name is not reflected in the "Admitting" physician field. *Transcript at 2198:2-2199:2, 2219:16-25 (A. Crownson); Transcript at 3168:8-3169:4 (L. Ahern).* [redacted]

426. Ms. Ahern concluded that the field in the Saint Alphonsus data that is most relevant to examining the extent to which affiliation of a PCP group with St. Luke's results in a loss of activity at Saint Alphonsus is the field in the Saint Alphonsus data identifying the patient's PCP. *Transcript at 3170:7-13 (L. Ahern).* Several Saint Alphonsus executives confirmed that the PCP field is the most accurate field in the Saint Alphonsus data for identifying activity associated with a PCP. *Transcript at 900:16-902:4 (K. Keeler); Dkt. 362 (B. Petersen Dep.) at 144:12-145:1, 147:8-16.* Saint Alphonsus-Nampa itself relies on the information in the PCP field in identifying which physician should get copies of the patient's records of services provided at Saint Alphonsus, which provides a further measure of its reliability. *Transcript at 976:17-22 (L. Checketts); Transcript at 3170:14-23 (L. Ahern).*

427. Ms. Ahern's analysis of Saint Alphonsus's data does not support the conclusion that the acquisition of a PCP group by St. Luke's results in any sudden or dramatic decrease in admissions activity by the affiliated PCPs. For the three groups she examined—Mountain View

Medical and Idaho Family Physicians in Boise, and Mercy Physicians Group in Nampa—Ms. Ahern calculated a decrease in activity at Saint Alphonsus attributable to those physicians ranging from 9 percent to 23 percent over a full year period. *Exhibit 2350; Transcript at 3181:10-3182:1 (L. Ahern).*

428. The decreases in activity that Ms. Ahern measured do not necessarily reflect any net loss of patients or activity at Saint Alphonsus. As Dr. Argue demonstrated, practices acquired by St. Luke's tend to lose patients following the affiliation. *Transcript at 3006:25-3008:23 (D. Argue).* For example, Dr. Adebayo Crownson of Mercy Physicians Group testified that his group lost about a third of its patients when they switched from being employees of Saint Alphonsus to being employees of St. Luke's. *Transcript at 2199:24-2200:7 (A. Crownson).*

429. While Ms. Ahern's analysis shows a decrease in the number of instances in which physicians with the acquired PCP groups are identified as the "Admitting" physician in Saint Alphonsus data, that information is not significant. Two of the physicians with Mercy Physicians Group worked as hospitalists when they were employed by Saint Alphonsus, but stopped working as hospitalists after they went to work for St. Luke's. *Transcript at 2197:22-2198:1, 2198:21-2199:2 (A. Crownson).* The fact that they admitted patients directly when they worked as hospitalists, but themselves relied exclusively on hospitalists after they became employed by St. Luke's, explains the decrease in "admitting physician" records. *Transcript at 2198:2-2199:2, 2219:16-25 (A. Crownson).* Similarly, Dr. Mark Johnson of Mountain View Medical testified that the focus on "Admitting" physician data was misleading because it simply reflected the transition of his personal practice from one in which he admitted patients in his own name to relying exclusively on hospitalists. Dr. Johnson testified that he sends dozens and dozens of patients to Saint Alphonsus, and the Saint Alphonsus admissions data do not reflect

this fact. *Dkt. 249 (M. Johnson Dep.) at 130:4-131:15.* He explained that due to the hospitalist program, he does not directly admit his patients to Saint Alphonsus—that is done by sending them to a hospitalist for admission. *Id. at 132:21-133:2.*

430. Moreover, as noted above, any decrease in *admissions* to Saint Alphonsus is relevant to foreclosure only to the extent that the alleged loss of referrals excludes Saint Alphonsus from a sufficient volume of customers in the relevant market. *Transcript at 2993:16-2994:6 (D. Argue).* Even if it is the case that continued admissions to Saint Alphonsus of patients of PCPs affiliated with St. Luke's occurs because those patients had a previous relationship with Saint Alphonsus or Saint Alphonsus specialists—something plaintiffs have not demonstrated—the important fact for the foreclosure analysis is that there is no large scale "steering" of patients affiliated with St. Luke's primary care physicians away from Saint Alphonsus. As explained below, Saint Alphonsus's claim that it will be seriously harmed by the Saltzer Transaction hinges substantially on an assumption that the Saltzer Transaction will result in an immediate and virtually complete cessation of all referrals from Saltzer physicians—an assumption that is simply not supported by the analyses described above. *Transcript at 3165:1-3166:7 (L. Ahern).*

431. The analyses by Dr. Argue and Ms. Ahern are also significant because of Professor Haas-Wilson's testimony that her opinion that the Saltzer Transaction is likely to have anticompetitive effects in the hospital services markets is based on her conclusion that the transaction will result in a loss of referrals of at least 30 percent. *Transcript at 1544:8-1545:5 (D. Haas-Wilson).* If, as analyses by defendants' experts demonstrate, any loss of referrals is

likely to be less than 30 percent, then Professor Haas-Wilson testified she is not able to offer an opinion about the likely anticompetitive effects of the Saltzer Transaction on Saint Alphonsus.[14]

432. Professor Haas-Wilson also included an analysis showing a decrease in certain diagnostic imaging procedures ordered by the physicians of the Mercy Physicians Group at Saint Alphonsus after that group affiliated with St. Luke's. However, Professor Haas-Wilson did not demonstrate any net change in such procedures at Saint Alphonsus, let alone measure anticompetitive foreclosure. *Transcript at 1573:22-1574:2 (D. Haas-Wilson).* She admitted that one explanation for the decrease she measured is that a new imaging facility opened in Nampa that would be a more convenient location than Saint Alphonsus-Nampa for some number of patients. *Transcript at 1573:22-1574:2 (D. Haas-Wilson).* Indeed, Dr. Crownson testified that St. Luke's opened a diagnostic imaging facility in North Nampa, and that many patients now choose the St. Luke's facility in North Nampa because of its more convenient location and the fact that imaging results there are integrated into the patients' St. Luke's medical record. *Transcript at 2203:23-2204:9 (A. Crownson).*

b. Saint Alphonsus's "Impact Analysis" does not demonstrate a likelihood of anticompetitive harm.

433. Lannie Checketts, the CFO of Saint Alphonsus-Nampa, offered an analysis of the potential impact of the Saltzer Transaction on Saint Alphonsus-Nampa (the "Impact Analysis").

[redacted] For

[14] Professor Haas-Wilson did not undertake to study whether the Saltzer Transaction is likely to result in any procompetitive benefits. *Transcript at 1536:17-19 (D. Haas-Wilson).* Accordingly, by her own admission, she does not offer any opinions concerning the net competitive impact of the Saltzer Transaction. *Transcript at 1536:17-19 (D. Haas-Wilson).*

the reasons set forth below, the Court concludes that the Impact Analysis does not demonstrate that the Saltzer Transaction is likely to result in anticompetitive foreclosure.

434. [redacted]

435. Neither Mr. Checketts, nor any other Saint Alphonsus executive, cited any analysis or data supporting the assumptions about referral losses in the Impact Analysis. *Transcript at 898:10-16, 899:16-19 (K. Keeler); Transcript at 975:3-6 (L. Checketts).*

436. Dr. Argue's analysis shows that PCPs who affiliate with St. Luke's have not shifted inpatient admissions away from Saint Alphonsus hospitals. *Supra* at ¶¶ 410-411. He further demonstrated that the share of St. Luke's primary care referrals going to Saint Alphonsus specialists is virtually unchanged after different primary groups have joined St. Luke's when

compared to each group's share of patients being referred to Saint Alphonsus prior to joining St. Luke's. *Transcript at 3011:23-3015:5 (D. Argue).*

437. [redacted]

438. Furthermore, as explained above in the discussion of TVH, since becoming employed by Saint Alphonsus, the former Saltzer surgeons have not seen a significant drop in their productivity, despite the fact that their referrals from Saltzer physicians have decreased. *Transcript at 782:5-15 (N. Powell); Dkt. 393 (A. Curran Dep.) at 196:7-20.* [redacted]

439. Additional evidence and testimony from a number of St. Luke's witnesses calls into serious question the referral assumptions on which the Impact Analysis is based.

a) The PSA between Saltzer and St. Luke's contains an express statement providing 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).* This was a provision that the Saltzer physicians

specifically requested be included in the contract due to their desire to continue referring patients where they deemed most appropriate. *Transcript at 2242:2-2243:11 (C. Roth)*; *Transcript at 3325:16-3326:12 (T. Patterson)*.

b) Dr. Pate, St. Luke's CEO, testified that St. Luke's has never had a practice of directing physicians on where to refer patients. *Transcript at 1649:2-12 (D. Pate)*.

c) Dr. Crownson of the Mercy Physicians Group testified that St. Luke's has never put any pressure on the Mercy Physicians Group doctors to change their referral practices in any way. *Transcript at 2208:23-2209:2 (A. Crownson)*.

d) Chris Roth, the CEO of St. Luke's Treasure Valley testified that no purpose of the affiliation with Saltzer was to affect Saltzer physicians' referral patterns. *Transcript at 2241:5-8 (C. Roth)*.

e) Dr. Patterson, a Saltzer physician who specializes in pediatrics testified that St. Luke's has never sought to influence his admission patterns to hospitals in any way. *Transcript at 3325:13-15 (T. Patterson)*. He has admitting privileges at Saint Alphonsus-Nampa, and his admissions practices have not changed since the Saltzer Affiliation; indeed, he testified that he sends most of his patients to Saint Alphonsus-Nampa. *Transcript at 3324:4-10, 3324:20-3325:12 (T. Patterson)*.

f) Dr. Kunz, a family medicine physician at Saltzer, testified that, in making the decision of where to refer a patient, he considers first where the patient will be provided with the best care; he also seeks a patient's preference. *Transcript at 3350:22-3351:6, 3352:12-21 (H. Kunz)*. He similarly testified that St. Luke's has never indicated in any way that it wants to direct how he refers his patients and to

whom, and St. Luke's has never done anything to discourage referrals to Saint Alphonsus-Nampa. *Transcript at 3351:7-20, 3352:22-3353:7, 3353:14-16 (H. Kunz).* Dr. Kunz testified that his referral patterns have not changed in any significant way since the Saltzer Transaction, and he continues to refer to Saint Alphonsus, including Saint Alphonsus-Nampa, "frequently." *Transcript at 3351:21-3352:6, 3353:8-10 (H. Kunz).*

440. The Court finds that the key assumption on which the Impact Analysis is based—that the Saltzer Transaction will result in the immediate, complete, and sustained loss of all Saltzer referrals—is not reasonable.

441. [redacted]

442. [redacted]

443. [redacted]

[redacted]

444. For the foregoing reasons, the Impact Analysis does not support a conclusion that the Saltzer Transaction is likely to result in anticompetitive foreclosure of Saint Alphonsus-Nampa, let alone Saint Alphonsus as a whole.

c. Any competitive harm that Saint Alphonsus may suffer if St. Luke's builds a hospital in Nampa is not relevant to the antitrust analysis.

445. Plaintiffs introduced evidence that St. Luke's has plans to construct a new hospital in Nampa, and that the Saltzer physicians have indicated that they would support such a hospital. *Dkt. 323 (J. Kaiser Dep.) at 98:18-24.* Plaintiffs cited this as evidence that the Saltzer physicians intend to shift their referrals to St. Luke's. *Id. at 97:18-20, 97:23-98:7, 98:18-24*; *see also Transcript at 2321:4-11, 2340:2-17 (C. Roth).*

446. It may be that at some point in the future, if St. Luke's actually does build a hospital in Nampa, Saltzer physicians will choose to send patients to that facility rather than to Saint Alphonsus-Nampa. It is possible that that may cause Saint Alphonsus-Nampa to lose revenue. Karl Keeler, the CEO of Saint Alphonsus-Nampa, testified that construction of a competing hospital by St. Luke's in Nampa—where Saint Alphonsus currently has the only hospital—would be "devastating" to Saint Alphonsus and that he believes the Saltzer Transaction will enable St. Luke's to move forward with a new hospital in Nampa more quickly than it otherwise would be able to. *Transcript at 888:23-889:20 (K. Keeler).* Similarly, Nancy Powell, Chief Administrative Officer of SAMG, testified that "[o]f course" it was concerning to Saint Alphonsus that St. Luke's might build a hospital facility in Nampa. *Transcript at 812:11-20 (N. Powell).*

447. The Court does not view any harm that Saint Alphonsus might suffer as a result of the creation of competition for hospital services in Nampa as anticompetitive.

d. Plaintiffs' "network competition" argument does not warrant a finding that the Saltzer Transaction is likely to be anticompetitive.

448. The Private Plaintiffs also contend that the Saltzer Transaction is anticompetitive because of its impact on what Professor Haas-Wilson calls "network competition." By this, Professor Haas-Wilson appears to be referring to the need for payors to offer provider networks that include a full range of providers, including PCPs, hospital inpatient and outpatient services, and ancillary services. *Transcript at 1486:19-1487:17 (D. Haas-Wilson).*

449. Plaintiffs have not alleged or analyzed a market for "network services" separate and apart from any of the physician services or hospital facility services markets. *Transcript at 1488:15-21, 1567:2-1568:10 (D. Haas-Wilson).* Rather, Professor Haas-Wilson contends that "network competition" is something that "impacts" competition in the specific markets that plaintiffs have defined. *Transcript at 1488:15-21, 1551:24-1552:3 (D. Haas-Wilson).*

450. Plaintiffs complain that St. Luke's ultimately plans to remove St. Luke's providers from competitors' networks. Except as it relates specifically to the Saltzer physicians, that complaint is outside the scope of this case.

451. Moreover, even if the Saltzer physicians are withdrawn from competing networks, that is not anticompetitive. Health plans like Blue Cross, and companies that rent provider networks to health plans or employers like IPN or the Saint Alphonsus Health Alliance, compete for business by trying to make their network look more attractive to purchasers than their competitors' networks. *Transcript at 1553:7-19 (D. Haas-Wilson); Transcript at 3016:17-3017:21 (D. Argue).* That is the essence of competition. The fact that competing networks may

be less attractive without Saltzer than they would be if they included Saltzer provides no basis for a finding of liability in this case.

452. [redacted]

453. [redacted]

454. [redacted]

[redacted]

455. In order to determine whether the withdrawal of Saltzer physicians from competing networks raises competitive concerns, one has to engage in the same analysis the Court has already conducted above with regard to the adult PCP services market. If the Saltzer Transaction will not create or enhance market power in the market for adult PCP services (or the other specific product markets alleged by the plaintiffs), then, by definition, there are sufficient alternative providers ("outside options," in Dr. Dranove's terms) for competing networks to offer complete networks. *Transcript at 3017:18-3018:4 (D. Argue).*

456. The Court's conclusion that the Saltzer Transaction is not likely to create or enhance market power in the markets for adult or pediatric PCP services, or inpatient or outpatient hospital facility services, necessarily means that the Saltzer Transaction will not impede "network competition." Competing networks—whether offered by Saint Alphonsus, IPN, Blue Cross, Micron, or others—can construct viable networks without Saltzer.

457. [redacted]

458. Here again, Micron is informative. At the time the Micron plan was formed, St. Luke's felt that its participation was important for the plan's success. As Steven Drake testified, "That was not true, ultimately." *Dkt. 322 (S. Drake Dep.) at 206:16-21, 206:23-207:1; see also Dkt. 318 (J. Butterbaugh Dep.) at 138:1-6.*

459. Likewise, Nancy Powell thought there would be an "uprising" if Saltzer were not included in the MHPN, but as far as she was aware, there was not an uprising in response to the MHPN launching without Saltzer being in-network. *Transcript at 803:18-804:9 (N. Powell).*

460. The Micron plan has succeeded, both in terms of saving money and steering patients to network providers, even though it has excluded St. Luke's since its inception and for three years it excluded both St. Luke's and Saltzer, notwithstanding the fact that Micron had a substantial number of employees in the Treasure Valley. *Transcript at 545:9-11 (P. Otte).*

461. [redacted] This provides yet another reason to be cautious about claims that competing networks cannot survive without Saltzer.

462. For the foregoing reasons, the Court finds that Saint Alphonsus has failed to prove that it is likely to suffer anticompetitive foreclosure as a result of the Saltzer Transaction. Defendants are therefore entitled to judgment on Saint Alphonsus's claims.

VIII. The Saltzer Transaction Will Promote Benefits of Integrated Care That Could Not Be Achieved Through a Looser Affiliation.

463. The Court has already concluded that neither the Government Plaintiffs nor the Private Plaintiffs have proven that the Saltzer Transaction is likely to result in anticompetitive effects. For the reasons explained below, the Court also finds that to the extent there is any

likelihood of anticompetitive effects, it is outweighed by the significant procompetitive benefits that are likely to result from the transaction.

A. The Saltzer Transaction Will Provide Benefits of Integrated Care for the Population of Canyon County.

1. The Saltzer Transaction will enhance care by facilitating shared use of St. Luke's health information technology.

464. By affiliating with St. Luke's, Saltzer will gain the ability to make full use of St. Luke's Epic system. *Transcript at 3315:23-3316:2 (T. Patterson).* Several witnesses testified that moving to Epic would represent a significant improvement over Saltzer's current health information technology, the eClinicalWorks system. *Transcript at 2802:19-2903:9 (M. Chasin)*; *see also Transcript at 3316:3-15 (T. Patterson)*; *Transcript at 2043:24-2044:7, 2115:4-24 (J. Souza); Transcript at 2043:24-2044:7 (S. Williams).*

465. eClinicalWorks provides much less in the way of tools supporting integrated care than does St. Luke's health information technology. For instance, eClinicalWorks does not offer the practice tools—such as practice reminders and automated order sets—that St. Luke's Epic system does. *Transcript at 2381:5-18 (J. Kaiser).* eClinicalWorks also limits the ability of the Saltzer physicians to communicate with physicians beyond the walls of Saltzer. *Transcript at 2507:18-2508:6 (S. Williams); Transcript at 2381:19-2382:6 (J. Kaiser).*

466. Saltzer and St. Luke's are not likely to achieve the benefits of St. Luke's health information technology if the transaction is unwound. For one thing, Saltzer's eClinicalWorks and St. Luke's Epic system cannot simply be made to work together. While St. Luke's currently is able to—after investment of substantial time and resources—extract some information from Saltzer's eClinicalWorks system, eClinicalWorks is not presently interoperable with Epic and does not easily interface with Epic. *Transcript at 1941:21-1942:13, 1960:7-13 (J. Kee); Transcript at 2800:7-13 (M. Chasin).* Users of one system cannot seamlessly and accurately

share data and medical information with users of the other. *Transcript at 2805:18-24, 2810:7-2811:4 (M. Chasin).* At best, eClinicalWorks allows physicians to send faxes and scans back and forth, but does not allow physicians to "shar[e] discrete data elements." *Transcript at 1960:7-13 (J. Kee).* Physicians on Epic have to manually call up in eClinicalWorks the notes from each particular physician encounter a patient has had, and there is no way to automatically prompt the physician on Epic about what to look for. *Transcript at 2806:4-2807:8 (M. Chasin).*

467. Additionally, Saltzer will not likely have the ability to upgrade its own technology to match the functionality of Epic if the transaction is unwound. Saltzer could not afford to upgrade its technological infrastructure before the transaction, and, as a small group, could not independently acquire the Epic system. *Transcript at 3344:5-17 (H. Kunz); Transcript at 743:16-19, 789:5-8 (N. Powell).* As John Kaiser testified, if this transaction is unwound, then given the dire financial situation Saltzer is likely to be in, it is even less likely to spend money to buy a new EMR system or upgrade the one it has. *Transcript at 2407:7-17 (J. Kaiser).*

468. St. Luke's "affiliate EMR" program is also not likely to provide Saltzer with the benefits of St. Luke's Epic system. The affiliate EMR program is intended to make Epic available to independent physicians. *Transcript at 2819:15-2820:5 (M. Chasin).* However, the affiliate EMR program is still in the planning stage, and St. Luke's does not expect that it will be widely available until at least 2015. *Transcript at 2824:5-12 (M. Chasin).*

469. Furthermore, the affiliate EMR program requires independent practices to make a substantial financial investment. While St. Luke's expects to subsidize a significant portion of the costs in accordance with applicable laws, the estimated per-physician cost to an independent practice for Epic through the affiliate EMR program is still $20,000 per physician *after* taking into account St. Luke's subsidy. *Transcript at 2823:3-17 (M. Chasin).* That means that Saltzer

would have to invest approximately $800,000 just to have the system installed—in addition to costs associated with hardware, maintenance, and lost productivity from training on the new system, which St. Luke's cannot subsidize. *Transcript at 2823:18-2824:4 (M. Chasin)*. As Dr. Kaiser testified, that is not an investment that an unwound Saltzer is likely to make. *Transcript at 2383:23-2384:10 (J. Kaiser).*

470. The Idaho Health Data Exchange ("IHDE") also does not offer Saltzer or St. Luke's the same integration or functionality as Epic. The IHDE is a repository of health information, not an electronic medical record. *Transcript at 2812:18-20 (M. Chasin); Dkt. 366 (S. Brown Dep.) at 121:13-23*. For those physicians who participate, the IHDE makes available some of a patient's demographic information, administrative information, and medical information like allergies, health problems, and medications. *Transcript at 2814:14-21 (M. Chasin)*. The repository does not include physicians' notes, radiological or lab work, or health maintenance information. *Transcript at 2814:22-2815:1 (M. Chasin).*

471. Nor does the IHDE allow providers to integrate information from the IHDE into their own medical records systems. *Dkt. 361 (R. Reider Dep.) at 139:5-10*; *Transcript at 2815:18-1816:8 (M. Chasin)*. Instead, the IHDE is a static tool: It merely allows a physician to review medical information that has previously been entered by other participating providers; that information may or may not be up to date, does not include information from non-participating providers, and the reviewing physician is unable to work with the information by, for example, making notes on previously entered records. *Transcript at 2815:16-2816:16, 2818:12-24 (M. Chasin)*. Saint Alphonsus itself does not pull any data into its electronic medical records systems from the IHDE. *Dkt. 361 (R. Reider Dep.) at 139:5-10.* Moreover, Saltzer did

not participate in the IHDE as an independent practice. *Transcript at 2379:11-12 (J. Kaiser); Transcript at 2814:1-3 (M. Chasin).*

472. The IHDE does not currently have a self-sustaining funding model. *Transcript at 2818:25-2819:9 (M. Chasin).* As Dr. Chasin, a member of the IHDE's Board, testified, the IHDE is scheduled to run out of funding in March 2014. *Transcript at 2818:25-2819:9 (M. Chasin).*

473. Saint Alphonsus has itself recognized the benefits of having providers on a single electronic health record. Nancy Powell, the Chief Administrative Officer of Saint Alphonsus Medical Group, testified that her biggest concern in developing a clinically integrated organization was getting all of SAMG on the same electronic medical record. *Transcript at 789:9-13 (N. Powell); Exhibit 2212.* She testified that a shared system would provide benefits in pursuing clinical integration. *Transcript at 789:14-17 (N. Powell).* [redacted]

474. [redacted]. Dr. Polk, the Chief Quality Officer of Saint Alphonsus, testified that Saint Alphonsus is now investing in an electronic records system that it hopes to make available to independent physicians. *Transcript at 2630:11-13 (J. Polk).* However, that system is not yet in use by any physician practice. *Transcript at 3633:17-20 (J. Polk).* [redacted]

[redacted]

475. If not for the affiliation with St. Luke's, Saltzer would also have no access to the data analytics capabilities and practice improvement tools offered by WhiteCloud. Saltzer's eClinicalWorks does not permit Saltzer physicians to gauge how their patient care tracks evidence-based standards and best practices, as WhiteCloud does. *Transcript at 3359:1-24 (T. Patterson); Transcript at 2392:22-2393:13 (J. Kaiser).*

476. Access to St. Luke's WhiteCloud tools since the affiliation has already begun to change Saltzer physicians' approach to care. *Transcript at 3359:1-3360:14 (T. Patterson); Transcript at 2393:6-13 (J. Kaiser).* For example, Dr. Patterson explained that use of WhiteCloud had enabled him to substantially improve the quality of care he could give to his diabetic patients because he could see, for the first time, which patients would benefit from further care. *Transcript at 3360:1-14 (T. Patterson).*

477. Plaintiffs' expert, Dr. Kizer, stated that he had seen no evidence that WhiteCloud had provided "any benefits with regard to patient care for Saltzer." *Transcript at 3540:16-21 (K. Kizer).* However, Dr. Kizer simply failed to address the contrary testimony of the Saltzer physicians, who had firsthand experience of WhiteCloud's effect on the quality of their patient care.

478. Like the Saltzer physicians, other previously independent physicians who have affiliated with St. Luke's have emphasized that access to WhiteCloud allows them to offer materially better care than they could in the independent practice setting. Dr. Mark Johnson of Mountain View Medical Center, which affiliated with St. Luke's in 2008, described WhiteCloud

as an "unbelievable tool . . . that I never would have imagined having in independent private practice." *Transcript at 1866:16-18 (M. Johnson).*

479. St. Luke's has invested substantial resources to gather some information from Saltzer's eClinicalWorks system for analysis by WhiteCloud, and continued communication between eClinicalWorks and WhiteCloud would require ongoing costs. *Transcript at 1941:9-1942:13 (J. Kee).* This is another investment that Dr. Kaiser testified an independent Saltzer would be unlikely to incur. *Transcript at 2383:23-2384:10 (J. Kaiser).* Dr. Brian Fortuin corroborated this testimony, stating that independent physicians are unlikely to recognize the return on investment of using WhiteCloud without fully implementing it, if they can afford the product at all. *Transcript at 2157:11-21, 2183:7-2184:11 (B. Fortuin).*

480. Apart from the cost, independent physicians may be less willing to participate in projects that would force them to track metrics selected by St. Luke's physicians and that reveals their results to St. Luke's employed physicians. *Transcript at 2183:7-2184:11 (B. Fortuin).* Dr. Kaiser confirmed that this was true for Saltzer, explaining, "as an independent group, you're always a bit skeptical about providing data and how much data you provide and what it looks like." *Transcript at 2399:24-2400:9 (J. Kaiser).* Saltzer, he said, would not have been "all gung ho about trying to provide all the data elements as much as we could if we were staying independent." *Id.*

481. Plaintiffs' expert, Dr. Kizer, agreed that if the transaction provided Saltzer with access to improved health information technology, that would be a benefit. *Transcript at 3580:22-3581:4 (K. Kizer).* However, he opined that "the health IT tools that are needed—electronic health records, data analytic tools … —are already available to Saltzer." *Transcript at 3540:11-14 (K. Kizer).*

482. Notably, Dr. Kizer had no familiarity with Saltzer's actual health information technology. He was unfamiliar with Saltzer's implementation of eClinicalWorks. *Transcript at 3576:12-3578:5 (K. Kizer).* Specifically, he did not know whether Saltzer's system provided clinical support tools such as practice reminders and automated support tools (*Transcript at 3577:14-3578:5 (K. Kizer)*) or whether Saltzer tracked its clinical performance through that system (*Transcript at 3574:22-3577:1 (K. Kizer)*).

483. Dr. Kizer also had no familiarity with the facts necessary to determine whether Saltzer could access St. Luke's health information technology if the transaction were unwound. Dr. Kizer testified that he was unfamiliar with Saltzer's financial status, and "had no way of knowing" whether Saltzer would or would not spend the money to obtain access to Epic. *Transcript at 3580:14-21 (K. Kizer).* He further testified that he did not know "the cost in time, money, and disruption" that Saltzer would experience if it attempted to obtain access to WhiteCloud as an independent practice. *Transcript at 3584:1-6 (K. Kizer).*

2. The Saltzer Transaction will facilitate aligned incentives.

a. The Saltzer Transaction will accelerate the shift to value-based compensation.

484. The Saltzer Transaction will also facilitate the ability of Saltzer physicians to transition to value-based, rather than volume-based, compensation. As noted above, the PSA provides for compensation based on a fixed salary with some additional compensation if the physicians exceed certain productivity levels. However, the PSA also provides that ultimately 20 percent of Saltzer physicians' compensation will be at risk based on compliance with quality and outcome measures. *Exhibit 2624; Transcript at 3327:11-17 (T. Patterson).* Both parties agreed that payment for value is "the direction that [they] want to go." *Transcript at 2252:13-16 (C. Roth); Transcript at 3326:19-3327:3 (T. Patterson).*

485. St. Luke's has presented evidence that other physicians whose practices were acquired, including cardiologists, pulmonologists, and internal medicine physicians, were initially compensated on a strict salary or productivity basis, but have moved to a more value-based compensation system as the tools necessary to implement such a system (such as Epic and WhiteCloud) have become available. *See supra at Sec. III.B.5.* The same is expected with family practice physicians. *Transcript at 1869:9-16 (M. Johnson)*

486. Plaintiffs' expert, Dr. Kizer, opined that the transaction "does not align incentives to provide quality care." *Transcript at 3558:19-20 (K. Kizer).* While the Saltzer physicians' compensation does not currently include a quality component, as noted above, all parties expect that it soon will—and that expectation is supported by St. Luke's experience in transitioning its other physician groups to value-based compensation.

487. Moreover, the financial alignment of Saltzer and St. Luke's has already resulted in other benefits. For example, as part of St. Luke's, Saltzer physicians are no longer compensated in any way based on the volume of ancillary services they order. *Transcript at 2028:24-2029:6 (J. Kee); Transcript at 2396:1-2398:7 (J. Kaiser); see also Transcript at 3327:22-3328:3 (T. Patterson).*

b. The Saltzer Transaction is improving access for uninsured and Medicaid patients.

488. Another benefit of the financial integration is that as part of St. Luke's, the Saltzer physicians' pay is no longer affected in any way by the insurance status of their patients. *Transcript at 3082:12-21 (W. Savage).* As an independent practice compensated on a FFS basis, Saltzer physicians had to limit the number of new patients they accepted who were insured by "lower reimbursement" payors like Medicare, Medicaid, and TRICARE as their practices matured. *Transcript at 788:2-10 (N. Powell); Transcript at 2370:12-2371:2 (J. Kaiser).* Saltzer

physicians would not typically treat uninsured patients unless they were referred to a Saltzer on-call physician from an emergency room. *Transcript at 2371:3-8 (J. Kaiser).*

489. Since the transaction closed in December of 2012, Saltzer physicians have increased the number of Medicare, Medicaid, and uninsured patients they treat, expanding access for that subset of the population. *Transcript 3082:22-25 (W. Savage).* Saltzer physicians no longer need to consider insurance type at all when determining whether to accept the patient. *Transcript at 3321: 22-3323-25 (T. Patterson); see also Dkt. 269 (M. Djernes Dep.) at 81:15-82:4; Transcript at 2398:8-17 (J. Kaiser); Transcript at 3358:11-25 (H. Kunz).*

490. If the transaction were unwound, the Saltzer physicians would have to revert to their prior method of considering insurance type when treating patients. *Transcript at 3329:9-3330:5 (T. Patterson).* This is especially problematic in an area like Nampa where there are more uninsured individuals and people on Medicaid as compared to Meridian and Boise. *Transcript at 852:8-14 (K. Keeler).* As Richard Armstrong of the Idaho Department of Health and Welfare testified, the availability of care for all patients regardless of their ability to pay is highly desirable. *Transcript at 2277:1-11 (R. Armstrong).*

c. The Saltzer Transaction is facilitating enhanced community outreach and evidence-based wellness efforts.

491. Community outreach and evidence-based wellness efforts are also increasing because Saltzer physicians are no longer compensated on a FFS model. *Transcript at 3320:6-21, 3321:9-21 (T Patterson).* As independent physicians, the Saltzer physicians viewed such efforts as a financial loss because that time out of the office equated to less patient volume and less serious patient treatments. *Id.*

492. Similarly, Saltzer is now able to offer particular patient services that it could not before. For example, deaf patients of Saltzer now have access to sign language interpreters,

which Saltzer could not afford to provide as an independent group. *Transcript at 2392:8-21 (J. Kaiser).* Saltzer has also begun offering a diabetic education and management program, run by diabetes educators, made possible by St. Luke's assistance. *Transcript at 2393:14-24 (J. Kaiser).* Although Saltzer had previously employed a diabetes educator years earlier, it had to let the educator go because the relationship was not profitable to Saltzer's independent practice. *Transcript at 2393:24-2394:1 (J. Kaiser).*

493. These types of benefits would not be achievable to the same degree, if at all, with a looser affiliation. Chris Roth of St. Luke's offered an example of why this would be the case based on a previous attempt by Saltzer and St. Luke's to work together on cardiology services. St. Luke's and Saltzer partnered together to provide cardiac services in a Saltzer clinic. *Transcript at 2237:6-9 (C. Roth).* Mr. Roth testified that while the partnership and shared goals were a "good start" to clinical integration, the fact that St. Luke's and Saltzer remained on separate medical records, had separate billing processes, and had separate registration processes made it impossible for the two to offer seamless, fully coordinated care to cardiac patients. *Transcript at 2237:9-14 (C. Roth).*

494. Dr. Patterson of Saltzer also testified that Saltzer's attempts at joint ventures in the past "d[id] nothing to push [Saltzer] forward towards [its] [clinical integration] goals," and that such an arrangement "wouldn't have the scope of the needed things that [Saltzer] would need to [provide value-based care]." *Transcript at 3318:14-22 (T. Patterson).* For example, when independent physicians were asked to participate in a statewide pediatric immunization initiative—the purpose of which was to improve outcomes related to childhood immunizations—only two of Saltzer's pediatricians chose to do so. *Transcript at 3337:4-19, 3338:7-9 (T. Patterson).* Dr. Patterson explained that time and money constraints inevitably influence

independent physicians' willingness and ability to participate in such efforts. *Id.* Under the FFS model, without any control over how physicians are compensated, physicians are compelled not to spend time on efforts other than fee-generating office visits, but instead to "keep [their] office clicking and patients going in order to make payroll and pay the expenses." *Transcript at 1632:25-1633:2 (D. Pate).*

3. The Saltzer Transaction will enhance Saltzer's ability to provide outcomes-based care to a regional population.

495. The affiliation with St. Luke's also has significantly enhanced Saltzer's ability to provide evidence-based, accountable care—*i.e.*, care under which the Saltzer physicians, as part of St. Luke's, accept risk for their patients' outcomes—to the population of Canyon County. Without St. Luke's, Saltzer was "not nearly large enough to assume that type of risk and develop that type of systems and lay out that kind of capital." *Dkt. 253 (W. Savage Dep.) at 67:22-68:8; Transcript at 2374:22-2375:16 (J. Kaiser); see also Transcript at 826:20-827:3 (N. Powell).*

496. Prior to the affiliation, Saltzer had entered into only one contract that involved any kind of value-based reimbursement, and that provided merely a modest sharing of gains for certain Medicare Advantage patients. *Transcript at 2376:23-2377:10 (J. Kaiser).* However, Saltzer's involvement in that Medicare Advantage contract did not facilitate any improvements in cost or quality of care, because there was no sharing of data among the involved providers; thus, Saltzer physicians had no way of knowing whether they would obtain cost savings in any particular year, and if so, how those savings were achieved, much less how further savings could be achieved in the future. *Transcript at 2378:5-15 (J. Kaiser).*

497. Although Saltzer attempted to enter into gain-sharing contracts with commercial payors, it had little success in doing so. Nancy Powell testified, for example, that prior to its affiliation with St. Luke's, Saltzer tried repeatedly to enter into contracts with Blue Cross that

contained elements of gain-sharing, but Blue Cross refused to agree to such arrangements in their commercial contracts because it wanted to keep profits for itself. *Transcript at 793:22-794:19 (N. Powell).*

498. As Dr. Kaiser testified, Saltzer's current infrastructure will not permit it to increase its acceptance of risk for patient outcomes if it is divested from St. Luke's. *Transcript at 2378:16-2379:7 (J. Kaiser).*

B. The Saltzer Transaction Will Enhance St. Luke's Transition to An Integrated Delivery System.

1. Saltzer offers a base of culturally aligned primary care providers in Canyon County.

499. Integration with Saltzer through the PSA will enhance St. Luke's ability 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).*

500. St. Luke's previously had few employed or closely affiliated physicians in Canyon County—yet approximately 22 percent of St. Luke's patients were traveling from Canyon County to receive care at St. Luke's. *Transcript at 2766:19-2767:7 (A. Oppenheimer).*

501. Maintaining a nucleus of employed or closely affiliated physicians in the region will improve St. Luke's ability to achieve the benefits of accountable, coordinated, and integrated care there. *Dkt. 254 (G. Swanson Dep.) at 69:19-71:9, 113:25-114:25, 116:3-24.* In particular, close affiliation with PCPs will more effectively advance St. Luke's goals of providing integrated care and population health management in Canyon County. *Id.*; *see also Transcript at 2640:1-2641:3 (A. Enthoven).* Closely affiliated physicians, with guaranteed minimum compensation, are not subjected to the competing and perverse incentives of FFS medicine, as independent Saltzer physicians would be. *Transcript at 2640:21-2641:3 (A.*

Enthoven). Moreover, their close affiliation enables Saltzer physicians to contribute to St. Luke's efforts to innovate and improve evidence-based care. *Transcript at 2641:10-2642:6 (A. Enthoven)*.

502. The Saltzer physicians offer St. Luke's such a nucleus. *Transcript at 2640:1-2642:6 (A. Enthoven); Transcript at 1638:21-1639:8 (D. Pate)*. Saltzer's physicians are geographically dispersed throughout Canyon County. *Transcript at 2230:16-19 (C. Roth)*. And, as described above, Saltzer physicians are committed to the goals of the Triple Aim, just as St. Luke's is. *See supra at Sec. V.C.*

2. The Saltzer Transaction enhances St. Luke's ability to engage in risk-based contracts.

503. St. Luke's ability to develop capitated, risk-based contracts like the one it has developed with SelectHealth is also enhanced by its close affiliation with Saltzer. As both Richard Armstrong of the Idaho Department of Health and Welfare and Jeffrey Crouch of Blue Cross testified, risk-based contracts depend upon a significant number of patients in a population in order to stabilize the per capita health care costs for the populations served and absorb the disproportionate costs of outliers. *Transcript at 397:23-398:4 (J. Crouch); Transcript at 2269:18-2270:11 (R. Armstrong)*. Patricia Richards also testified that SelectHealth views it as "very important" to have a "broad geographic coverage for a network . . . close to both where people work and where people live." *Transcript at 1750:16-1751:4 (P. Richards)*.

504. St. Luke's close affiliation with a substantial number of primary physicians in Canyon County supports St. Luke's acceptance of risk for residents of Canyon County. As noted in the section above, the financial integration between St. Luke's and Saltzer already has enhanced Saltzer physicians' ability to provide high-value care. Working with physicians providing such high-value care improves St. Luke's ability to succeed in taking on risk, because

it enhances its ability to control costs. *Transcript at 1621:17-1622:19 (D. Pate); Transcript at 1744:20-1745:25 (P. Richards).* Thus, St. Luke's close affiliation with Saltzer enhances its ability to take on risk because it gives it a "solid base of primary care doctors who can fit into the model they're trying to implement in Canyon County." *Transcript at 2642:22-2643:10 (A. Enthoven).*

C. The Procompetitive Benefits of the Saltzer Transaction Would Not Result from Any Hypothetical Looser Affiliation with the Saltzer Physicians.

505. Although the plaintiffs generally contend that the same benefits could be achieved if Saltzer remained independent and participated in a clinically integrated network, the plaintiffs have not identified any concrete action Saltzer could take to achieve the same procompetitive benefits that its affiliation with St. Luke's will bring about within any reasonable timeframe.

506. Initially, plaintiffs' expert, Dr. Kizer, expressly declined to opine on the availability of any contract that Saltzer could enter into with St. Luke's, or with any other clinically integrated network, to achieve the benefits of providing clinically integrated, value-based care. *Transcript at 3596:17-3597:24 (K. Kizer).* While Dr. Kizer and other witnesses pointed to certain gains that clinically integrated networks have made outside of Idaho, plaintiffs offered no evidence that such clinically integrated networks currently exist in Idaho or will exist in Idaho in the near future. Nor did plaintiffs offer evidence that a divested Saltzer could participate in such a network.

507. Dr. Kizer, for example, cites Advocate, a health system in Illinois, as an example of a system structure "that has achieved attention for its success in incorporating both independent physicians and a smaller number of employed physicians . . . to improve quality of care." *Transcript at 3531:2-18 (K. Kizer).* Relying almost exclusively on this example, he suggests that the financial affiliation between St. Luke's and Saltzer is not necessary for either

party to provide integrated care in equal measure to that anticipated as a result of the transaction. *Transcript at 3534:19-24 (K. Kizer).* Dr. Kizer omits to mention that Advocate employs over 950 physicians, nearly twice the number employed by St. Luke's, and, unlike the nascent attempts to create clinically integrated networks in Idaho, Advocate has been developing its clinically integrated network since the 1980s. *Dkt. 321 (R. Billings Dep.) at 13:25-14:7, 131:4-18.* Moreover, based on his description of Advocate's model—"where physicians align with [a] hospital[] and may align with them either in an employment or nonemployment relationship," (*Transcript at 3531:2-7 (K. Kizer)*)—there exists no basis on which to distinguish Advocate from systems like Geisinger or, indeed, from the system that St. Luke's has designed.

508. Dr. Kizer also offers no specifics, in the form of initiatives or data, supporting the assertion that Advocate has improved quality of care or explaining the extent to which it has done so. *Transcript at 3531:2-18 (K. Kizer).*

509. Even if Advocate has achieved quality and utilization gains, Dr. Kizer also omits from his testimony any explanation of how it has structured its contracts with independent physicians to engender that result. He states simply that, under the Advocate model, the system would pay physicians "for their performance." *Transcript at 3531:8-11 (K. Kizer).* He offers no guidance on how St. Luke's could replicate Advocate's putative success with Saltzer or what entity, in lieu of St. Luke's, could establish an Advocate-like affiliation with Saltzer to the same end. He, thus, provides no evidence that the Advocate-model—as it is vaguely described by Dr. Kizer—could garner equal success in Idaho or that the clinical integration gains possible through St. Luke's affiliation with Saltzer can be achieved without financial integration.

510. Plaintiffs' expert, Dr. David Dranove, offered no further details on why Advocate might offer a model that Saltzer could follow. *Transcript at 1370:15-1371:10, 1428:21-1430:1*

(D. Dranove). He describes Advocate as having "about the same number of independent physicians as they have employed physicians" (*Transcript at 1370:22-1371:1 (D. Dranove)*), and, therefore, as "showing that a mixed model is certainly very viable where some doctors are employed and some doctors remain independent." *Transcript at 1371:5-7 (D. Dranove)*. Like Dr. Kizer, Dr. Dranove offers no evidence to meaningfully distinguish Advocate from St. Luke's, to quantify the former's success in terms of improving the quality and value of care, or to support a conclusion that the Advocate "model" could be replicated with Saltzer in Idaho. *Transcript at 1370:22-1371:1, 1428:21-1430:1 (D. Dranove)*. Indeed, he admits that St. Luke's is also already a "mixed model" system. *Transcript at 1429:9-10 (D. Dranove)*.

511. Plaintiffs' argument that the Saint Alphonsus Health Alliance network poses a fully-formed, equally viable alternative to St. Luke's affiliation with Saltzer proves similarly unfounded. Saint Alphonsus itself has admitted that its Alliance is not clinically integrated. *Transcript at 3655:12-18 (J. Polk); Dkt. 366 (S. Brown Dep.) at 130:7-19*. To date, the Alliance has not demonstrated any ability to coordinate care amongst its members. *Transcript at 1219:22-1220:5 (D. Peterman)*. Nor has it demonstrated any progress in combating FFS medicine. [redacted] *Dkt. 366 (S. Brown Dep.) at 222:17-223:16.* Explorys, the data analytics system that Saint Alphonsus intends to use with the Alliance, will not begin implementation until December 2013, the scheduled implementation has already experienced delays (*Transcript at 3656:2-9 (J. Polk)*), and there is no evidence to suggest that Explorys will successfully be implemented at the offices of the independent physicians in the Alliance.

512. Plaintiffs' claims regarding the various quality and utilization gains that Saint Alphonsus hopes to achieve with its Alliance network in the future are, therefore, no more than aspirational and are not substantiated by plaintiffs' evidence. For instance, Dr. Polk testified that he did not anticipate any greater "resistance" to the Alliance's clinical integration efforts by independent physicians than by Saint Alphonsus's employed physicians (*Transcript at 3618:4-24 (J. Polk)*), based on Saint Alphonsus's positive experiences working with independent physicians on the 100,000 Lives Campaign and the Surgical Care Improvement Project. *Transcript at 3613:25-3614:8, 3615:7-11, 3615:16-3616:12 (J. Polk).* However, both the 100,000 Lives Campaign and the Surgical Care Improvement Project targeted hospital-based care, with a particular focus on surgical outcomes. *Transcript at 3614:5-21, 3654:13-3655:5 (J. Polk).* Regardless of any quality improvements they may have generated, Dr. Polk's examples had no application to the potential for clinical integration of primary care physicians, nor did they prove that their achieved gains equaled or exceeded those possible through financial integration.

513. Furthermore, neither Dr. Polk nor any other witness explained how or whether a divested Saltzer would be able to participate in any Alliance efforts to achieve clinical integration in the future. Plaintiffs introduced no evidence on the contractual structures or terms that would facilitate such a partnership between the Alliance and Saltzer. Instead, they indicated that clinical integration would result from the mere fact that "[m]ost physicians want to do the right thing" and "want to see good outcomes in their patients." *Transcript at 3618:9-12 (J. Polk).*

514. However, a number of witnesses testified that past efforts to create clinically integrated networks in Idaho, absent financial integration, failed. John Kee, for example,

testified that when he was employed by the Magic Valley Regional Medical Center (MVRMC), he worked actively to restructure the practice's approach to the delivery of health care. He instituted principles, referred to as STEEEP, that prioritized safe, timely, effective, efficient, equitable, and patient-centered care. *Transcript at 1892:5-1893:7 (J. Kee)*. MVRMC soon realized, however, that it was not achieving the success that it could were it to affiliate with a health system. *Transcript at 1897:14-16, 1904:21-1905:16 (J. Kee)*. Close affiliation provided the "best opportunity to create a regionally organized integrated health system." *Transcript at 1905:2-9 (J. Kee)*. Moreover, the Magic Valley physicians realized that financial affiliation with a health system would afford them sufficient capital to replace the aging hospital facility, a financial risk that MVRMC was unable to assume on its own. *Transcript at 1905:10-13 (J. Kee); see also Transcript at 1886:10-23 (J. Kee)*.

515. Dr. Souza similarly testified that his practice, Idaho Pulmonary Associates, viewed affiliation as critical to its continued viability as a practice. As an independent practice, IPA struggled to recruit a sufficient number of new physicians to meet the medical needs of the community. *Transcript at 2109:18-23 (J. Souza)*. New physicians "coming out of training knew that the old model was unsustainable, and they wanted to be employed with a health system." *Transcript at 2049:12-15 (J. Souza)*. IPA's physicians agreed, concluding that the practice's financial stability and opportunities would slow if they continued to remain unaffiliated. *Transcript at 2049:16-21 (J. Souza)*.

516. Boise Surgical Group chose to affiliate with St. Luke's for the same reason. As Dr. Baressi testified, BSG physicians were concerned about the viability of their practice "given the uncertainty . . . of the future of medicine with accountable care organizations and the new health care act." *Dkt. 370 (R. Baressi Dep.) at 22:6-9*.

517. Dr. Dranove also suggested that Saltzer could form its own ACO rather than join a larger health system. *Transcript at 3454:16-21 (D. Dranove).* However, he did not explain how Saltzer could accomplish this. To date, St. Luke's remains the first and only federally designated accountable care organization in Idaho. *Transcript at 1626:22-23 (D. Pate).* Saint Alphonsus, indisputably larger than Saltzer in terms of geographic coverage, human and technological capital, and scale rejected becoming an ACO [redacted]. *Dkt. 366 (S. Brown Dep.) at 52:13-22, 53:5-20.* Dr. Dranove did not explain how Saltzer could better manage these requirements than a large hospital system like Saint Alphonsus. And, in any event, Saltzer physician Dr. Kunz testified that Saltzer had independently concluded that it could not spearhead formation of an ACO. *Transcript at 3367:17-20 (H. Kunz).*

IX. Even if the Saltzer Affiliation Were Held to Be Anticompetitive, Divestiture Would Not Be An Appropriate Remedy.

A. Saltzer's Ability to Survive as a Going Concern Would be Significantly and Negatively Affected as the Departure of the Surgeons and Other Physicians Would Create a "Destabilizing Effect" on an Unwound Saltzer.

1. The expert testimony of Lisa Ahern establishes the significantly decreased compensation physicians in an unwound Saltzer would be expected to earn.

518. Lisa Ahern is a Managing Director of AlixPartners, LLP, in Chicago, Illinois, whose work frequently focuses on advising health care clients; in particular, her practice focuses on analyses of health care organizations joining together in potential transactions. *Transcript at 3145:24-3146:11 (L. Ahern).* She has extensive experience analyzing historical and projected financial data, for hospitals, health systems, as well as for physician practices, and frequently analyzes departmental staffing along with plans for physician recruiting and acquisition. *Transcript at 3145:24-3146:24 (L. Ahern); Exhibit 2374.*

519. Ms. Ahern conducted an analysis that measures the change in compensation (physician salary and retirement) for those physicians who would remain with Saltzer should the Court order divestiture of Saltzer ("the Unwind Analysis"). *Transcript at 3150:9-12 (L. Ahern).* To perform the Unwind Analysis, Ms. Ahern compared the compensation that the physicians earned in Fiscal Year 2012 ("FY12") (the last fiscal year before the Saltzer Affiliation) to the compensation that they would earn if the Saltzer Affiliation is unwound. *Transcript at 3217:15-22, 3218:19-3219:3 (L. Ahern).*

520. Because there were a net 12 physicians who departed from Saltzer during or after fiscal year 2012, Ms. Ahern's Unwind Analysis reallocates certain costs and revenues associated with those departed physicians across the remaining physicians in the event of an unwind. *Transcript at 3218:19-3219:1 (L. Ahern).*

521. The physicians who departed Saltzer include six of the top ten earners at Saltzer, which means a significant portion of Saltzer's income departed the practice, and a significant amount of overhead expenses would be required to be reallocated across the remaining Saltzer physicians. *Transcript at 3235:14-21 (L. Ahern).*

522. The departed physicians include the seven surgeons who were part of Saltzer in FY12, but left in October and November 2012 (after FY12) to practice at Saint Alphonsus. These seven surgeons included five Orthopedic Surgeons (Dr. Shane Andrew, Dr. Andrew Curran, Dr. Keith Holley, Dr. Miers Johnson, and Dr. Tildon Clark Robinson), one General Surgeon (Dr. Steven Williams), and one ENT Surgeon (Dr. Donald Beasley). *Transcript at 3219:4-13 (L. Ahern).* The departed physicians also include seven physicians who were part of Saltzer in fiscal year 2012, but either passed away, retired, or left for employment elsewhere

during either fiscal year 2012 or fiscal year 2013. *Transcript at 3219:13-17, 3221:1-5 (L. Ahern).* Two other departed physicians were part of the practice in FY12, but retired in 2013.

523. The departed physicians constituted approximately 25 percent of the head count of physicians in FY12. *Transcript at 3219:18-21 (L. Ahern).*

524. Two additional physicians, Dr. Dahlke, a pediatrician, and Dr. Affleck, an ENT surgeon, were not part of Saltzer in FY12, but joined the practice in FY13. *Transcript at 3220:6-16 (L. Ahern).*

525. The importance of these physician departures (and limited additions) is that Saltzer physicians share overhead expenses and ancillary revenue. When new physicians arrive at Saltzer, they absorb a portion of the allocated costs, and compensation increases. However, when physicians leave the Saltzer practice, regardless of the reason, their share of those costs is reallocated to the remaining physicians, causing the profitability of the practice to decline and the corresponding compensation paid to the remaining physicians to fall. *Transcript at 3217:7-14, 3220:18-25 (L. Ahern).*

526. Certain costs, like facility costs (*e.g.*, rent, maintenance, utilities) are allocated to the Saltzer physicians on an equal share basis. *Transcript at 3224:1-13, 3225:3-13 (L. Ahern).* Indirect overhead costs (*e.g.*, salary and benefits of non-revenue-generating departmental employees) are allocated based on a proportion of income generated by a physician. *Transcript at 3225:14-3226:13 (L. Ahern).* As a result, if a high-earning physician departs Saltzer versus a low-earning physician, there are more indirect overhead costs left behind to allocate over the remaining physicians. *Transcript at 3226:14-21 (L. Ahern).* The third category of Saltzer's overhead is ancillary revenue, which is income generated by ancillary departments and is distributed back to the physicians as a positive impact to their compensation. *Transcript at*

3226:22-3227:15 (L. Ahern). These revenues were significantly diminished by the departure of the Saltzer surgeons. *Transcript at 3233:10-20 (L. Ahern).*

527. Ms. Ahern's Unwind Analysis assumes that if the Court determines that the Saltzer Affiliation should be unwound, then 41 physicians will make up the unwound Saltzer. The Unwind Analysis estimates the incremental burden to be borne by the 41 physicians that will remain at Saltzer following the unwind based on a reallocation to them of facility costs, indirect overhead, and ancillary income formerly borne or contributed by the departed physicians. *Transcript at 3228:13-3229:7 (L. Ahern).*

528. [redacted]

529. When Saltzer compensation following an unwind is compared to compensation benchmarks for each relevant practice area from the Medical Group Management Association ("MGMA")—which benchmarks are generally recognized as the premier physician compensation data available—the percentage of Saltzer physicians receiving compensation at or above median levels would drop from 52 percent [redacted]. *Transcript at 3234:3-18 (L. Ahern); Transcript at 2385:22-24 (J. Kaiser).* [redacted]

530. In addition, the compensation Saltzer physicians would earn in the event of an unwind is significantly lower than the offers that were made by both St. Luke's and Saint Alphonsus to those physicians. *Transcript at 3234:19-3235:2 (L. Ahern).*

531. The results of the Unwind Analysis demonstrate that the loss of the departed physicians will negatively and significantly affect the financial status of the practice and corresponding compensation of the remaining physicians should Saltzer be unwound from St. Luke's, making compensation levels far less competitive. *Transcript at 3235:22-3236:3 (L. Ahern).*

532. Ms. Ahern opined that the level of decreased compensation will likely affect whether physicians remain with Saltzer or opt to associate elsewhere in an effort to obtain increased compensation. *Transcript at 3236:21-3237:6 (L. Ahern).* Ms. Ahern further testified that the decreased compensation levels will likely negatively affect future recruiting efforts as post-unwind Saltzer physician compensation is even less when compared to regional medians than it was prior to the Saltzer Transaction, making Saltzer a less competitive employer than it would have been before the departed physicians left Saltzer. *Transcript at 3237:7-12 (L. Ahern).*

533. Plaintiffs did not present any expert or fact testimony contrary to Ms. Ahern's opinions. The Court accepts the opinions of Ms. Ahern as reasonable and appropriate, as further confirmed by the testimony and evidence presented during trial.

2. The testimony of Saltzer personnel confirms that an unwound Saltzer will have difficulty surviving.

534. Throughout its history, Saltzer has never lost anywhere close to 25 percent of its physician workforce over such a short amount of time. *Transcript at 3083:12-21 (W. Savage).*

535. Over the last 10 years, Saltzer has never lost more than four physicians in any year. *Transcript at 3083:18-21 (W. Savage).* Saltzer has never lost a significant group of its

highest producing physicians in one year. Indeed, often when physicians depart, it is after only a short period of time of employment with Saltzer. *Transcript at 3083:22-3083:5 (W. Savage).*

536. Additionally, over the last ten years Saltzer has never recruited more than a single surgeon in any given year. *Transcript at 3083:12-17 (W. Savage).*

537. Saltzer is currently recruiting various physicians, including for orthopedics, obstetrics, dermatology, and pediatrics. *Transcript at 3084:6-9 (W. Savage).* Saltzer is looking to fill three orthopedic positions, which is less than the five orthopedic surgeons it lost to Saint Alphonsus-Nampa, because Saltzer is still unsure of the market for its services, given that the former Saltzer surgeons are still in the market. *Transcript at 3084:10-22 (W. Savage).*

538. Saltzer has not had much success in recruiting physicians to Saltzer over the last eight months, even with St. Luke's assistance. *Transcript at 3088:4-10 (W. Savage).*

539. The Private Plaintiffs elicited testimony from Nancy Powell that she did not believe it would be difficult for Saltzer to recruit replacement surgeons. *Transcript at 753:2-14 (N. Powell).* Ms. Powell's testimony conflicts with that of Mr. Savage, who testified that recruiting orthopedic surgeons to replace those who departed Saltzer will not be easy. *Transcript at 3084:23-3085:7 (W. Savage).* And Ms. Powell admitted that Mr. Savage was "predominantly responsible for recruiting" and that her involvement was limited to meeting with certain recruits to go over financial aspects of the recruitment. *Transcript at 815:14-20 (N. Powell).*

540. Additionally, aside from citing the fact that Saltzer had a strong primary care base, Ms. Powell did not provide any basis for her belief that recruiting replacement surgeons would not be difficult. *Transcript at 753:2-14 (N. Powell).* Ms. Powell also had not been employed at Saltzer, nor had she seen any Saltzer financial statements, for nearly two years at the time of her trial testimony. *Transcript at 706:12-15, 822:12-24 (N. Powell).*

541. Ms. Powell did not provide any testimony contradicting the fact, as testified to by Mr. Savage, that Saltzer had not been able to recruit more than a single surgeon in any given year over the past decade. She also testified that it took Saltzer roughly twelve months to recruit any type of physician, surgeon or otherwise. *Transcript at 816:3-6 (N. Powell).*

542. In contrast to Ms. Powell, Mr. Savage provided extensive testimony supporting his belief that Saltzer will have great difficulty recruiting replacement surgeons in the event of a divestiture.

543. First, even with the assistance of St. Luke's, since January 2013, Saltzer has recruited only one surgeon, Dr. Affleck, an ENT. *Transcript at 3099:15-22 (W. Savage).* Mr. Savage does not believe that Saltzer would have been able to recruit Dr. Affleck without the assistance from St. Luke's, as Saltzer could not have funded *even the new physician's guarantee*, let alone his compensation. *Transcript at 3099:23-3100:2 (W. Savage).*

544. [redacted]

545. Second, even before Saltzer's affiliation with St. Luke's, Saltzer was experiencing difficulty recruiting physicians, particularly specialists, because the demand for these physicians is very high and the guarantees required to secure recruits and the output of money to recruit physicians has increased significantly. *Transcript at 3084:23-3085:7 (W. Savage); Dkt. 393 (A. Curran Dep.) at 43:20-44:11.*

546. Dr. Williams, a surgeon formerly employed by Saltzer now at Saint Alphonsus, similarly testified that he did not feel very threatened, nor did the other surgeons, that St. Luke's

would be able to recruit other surgeons to Canyon County to compete if the Saltzer surgeons accepted the non-exclusive offers from St. Luke's, because of the difficulties in recruiting specialists into Nampa. *Dkt. 396 (S. Williams Dep.) at 97:18-98:18.*

547. Mr. Savage explained that Saltzer would have even greater difficulty recruiting today as an independent, freestanding group, should it be unwound, than it had in the past, in part because physicians coming out of residency today are very attuned to the current state of health care and are looking to work for health systems. *Transcript at 3088:19-3089:4 (W. Savage).*

548. Moreover, even if Saltzer is able to recruit any replacement surgeons, it will take time for them to build a practice and they could not rely exclusively on internal referrals to do so. *Transcript at 3087:14-19 (W. Savage).*

549. Saltzer physicians testified that with the increased amount of overhead burden they will be forced to shoulder, the significantly decreased compensation they would receive, and the expected difficulty in recruiting replacement physicians—particularly specialists—to replace the production of the departed physicians, they would consider leaving the group, and perhaps the community, in the event Saltzer is divested from St. Luke's. *Transcript at 2401:10-22 (J. Kaiser); Transcript at 3328:12-3329:23 (T. Patterson); Transcript at 3365:4-3366:13, 3367:21-3368:4 (H. Kunz); Dkt. 269 (M. Djernes Dep.) at 71:10-15.*

3. Even if Saltzer were to survive an unwind, its divestiture would not inject a strong competitive force into the market and the procompetitive benefits of the affiliation would be lost.

550. Because an unwound Saltzer Medical Group will face financial difficulties as a result of reduced physician compensation and practice profitability, caused by the departure of 14 (net 12) physicians at Saltzer relative to fiscal year 2012, even if it survives a divestiture from St. Luke's, it will be in a significantly weaker state than prior to its affiliation with St. Luke's. *Transcript at 3216:19-3217:6 (L. Ahern).*

551. Dr. Thomas Patterson, a Saltzer pediatrician, testified regarding his concerns that an unwound Saltzer would be able to survive given the loss of its specialists in particular. Even if it were to survive, however, he testified that Saltzer would be "fighting so hard to survive" it would be "in a different setting. We are not the Saltzer from pre-affiliation anymore. We're a completely different group" that would not be able to compete effectively, and would have a much harder time recruiting new physicians. *Transcript at 3328:12-3329:15 (T. Patterson).*

552. Dr. Patterson also testified that he believed Saltzer would lose the ability to seek a value-based delivery model, the ability to support a patient-centered medical home, and that Saltzer physicians would have to cut back on their community outreach. *Transcript at 3329:9-3329:18 (T. Patterson).*

553. Dr. Harold Kunz, a Saltzer family medicine physician, testified that if Saltzer were forced to be divested from St. Luke's, the physicians would lose the time and effort spent in creating a vision of where they believe Saltzer needs to go and the type of health care system it needs to develop, and would be forced to go back to practicing high volume, fee-for-service health care that he does not believe is the best way to go, and that he does not believe is sustainable. *Transcript at 3364:7-23 (H. Kunz).* In the event of a divestiture, given the inability to practice medicine the way they believe is best, and with the increased overhead burden to be shared by the remaining physicians, Dr. Kunz testified that he and his partners would have to give serious thought to whether they could stay open and viable. *Transcript at 3365:4-8 (H. Kunz).*

554. Dr. Kunz further testified that, in the event of a divestiture, Saltzer would not have sufficient funds even to recruit physicians or to pay salaries in the range the remaining

physicians had historically made, so the outreach programs that Saltzer had put in place would have to be abandoned. *Transcript at 3365:18-3366:1 (H. Kunz).*

555. Dr. John Kaiser, the President of Saltzer, testified the reason that Saltzer decided to affiliate with St. Luke's is the Saltzer physicians made a decision that they did not think the independent model was the right model moving forward given where health care is going, and "[a]s a result of that, through conversations with partners, I believe that we would have partners, perhaps even departments, that would simply say, 'I don't think this is right, I don't wish to stay in this model, and I'm going to leave.' And the group would be at significant financial harm." *Transcript at 2401:10-22 (J. Kaiser).*

556. Dr. Kaiser testified that Saltzer would not invest in anything that it did not believe would increase its revenue stream, which would preclude upgrading its electronic health record to interoperate with other systems. *Transcript at 2407:7-17 (J. Kaiser).*

557. Similarly, Drs. Patterson, Kunz, and Kaiser testified that Saltzer would have to cut back on the number of Medicare, Medicaid, and TriCare patients its physicians could treat. *Transcript at 3329:19-3330:5 (T. Patterson); see also Transcript at 2407:23-2408:12 (J. Kaiser); Transcript at 3366:2-13 (H. Kunz).*

558. Moreover, Saltzer as an independent group would not be able to enter into insurance contracts involving downside risk—as confirmed by Saltzer's former CFO, Nancy Powell, and its current President, Dr. John Kaiser. *Transcript at 826:20-827:3 (N. Powell); Transcript at 2374:22-2375:15 (J. Kaiser).*

4. Saint Alphonsus witnesses and documents further confirm the anticipated result of St. Luke's being ordered to divest Saltzer.

559. [redacted]

[redacted]

[redacted]

560. Further, a text message exchange between Drs. Curran and Williams (two of the departed Saltzer surgeons) on August 13, 2012, predicts that the practice overhead burden for the remaining Saltzer providers will be substantial. The exchange reads: "Honestly if we all quit &then FTC DOES hold up or unwind deal, Saltzrs ovrhed will b thru roof without us &Kaisr wil finally get his due." [*sic*] *Exhibit 2020 at 4; see also Transcript at 3236:17-20 (L. Ahern).*

561. Nancy Powell also testified that, before she left Saltzer for Saint Alphonsus Medical Group, she performed an analysis of the effect on Saltzer if the surgeons were to leave the group. She concluded, and informed Mr. Savage and Dr. Kaiser, that it would be difficult (perhaps "very" difficult) for the group to survive if the surgeons left. *Transcript at 782:22-783:11 (N. Powell).* And her analysis did not even consider the additive effects of losing seven *other* Saltzer physicians in addition to the surgeons.

5. The Court's conclusion that divestiture is an inappropriate remedy is not based on deterioration of Saltzer following the denial of the preliminary injunction.

562. During trial, plaintiffs objected on several occasions to defendants presenting evidence that Saltzer would be in a dire financial condition in the event this Court orders St. Luke's to divest Saltzer. Plaintiffs argued that such arguments were contrary to representations made at the preliminary injunction hearing by defendants. *Transcript at 53:6-12 (Opening Statement of D. Ettinger).* What defendants argued at the preliminary injunction hearing was that "we have said we will not in any way claim that it [the transaction] cannot be undone. We may

oppose divestiture as a remedy, but we will never say that it cannot be done." *Dkt. 49 (Transcript of December 14, 2012 Hearing) at 148:2-5.*

563. Indeed, during the hearing on the preliminary injunction motion, defendants made the same essential arguments that they made at trial as to why Saltzer would be severely weakened, and have great difficulty surviving, as an independent group. Defendants argued: "If Your Honor grants preliminary injunction… I think there is a high likelihood that there won't even be a trial because there won't be a Saltzer to affiliate with. And the problem here arises from the departure of seven surgeons after the announcement of the planned affiliation with St. Luke's. The facts here were summarized in Mr. Savage's declaration at paragraphs 13 and 14. Here is what he says: 'The departure of seven surgeons has significantly impacted Saltzer's finances… Losing these surgeons has left us with $2 million in overhead expenses, including costs for leases, the IT and billing departments, and other administrative outlays that prior to their leaving would have been covered by revenues generated by their practice…. Were our deal with St. Luke's to fall through, Saltzer would have to pursue serious cost-cutting measures to defray our $2 million exposure and survive as a practice. One option is to force our remaining physicians to endure an estimated 30 percent pay cut, which could compensate them at a rate significantly below market value. Another option is to scale back the number of low-income patients we treat or stop seeing such patients entirely. Likely, our financial position would necessitate some combination of both options. If our compensation or services drop in this manner, we likely will see additional physicians leaving Saltzer to join other practices or to form discrete groups… More departures will exacerbate our financial instability and foster patient migration, creating a downward spiral that threatens Saltzer's existence.'" *Id. at 140:6-141:19.*

564. The Court does not understand defendants to have made any different argument at trial. The Court does not understand defendants to argue that divestiture today would be more difficult to accomplish than it would have been in December of 2012. Nor does the Court understand defendants to contend that Saltzer would be worse off financially if divested today as a result of having been partially integrated into St. Luke's operations than they would have been in December 2012 had the Court enjoined the transaction from proceeding. (Even if that were defendants' argument, however, the Court has not considered any such difficulties in reaching its conclusion that divestiture would not be an appropriate remedy in these circumstances, even if the transaction were found likely to lead to anticompetitive effects.) Indeed, defendants' expert, Lisa Ahern, testified that her opinion as to the financial difficulties facing an independent Saltzer would have been virtually identical at the time of the preliminary injunction hearing. She testified that the compensation decrease likely to occur for the Saltzer physicians would have been roughly the same "regardless of whether or not there was a St. Luke's affiliation" that had actually been allowed to proceed. *Transcript at 3218:4-18 (L. Ahern).* The only difference between Saltzer's prospects as an independent group today and what they would have been on December 15, 2012, is that four additional physicians have left Saltzer and two additional physicians have been recruited given the passage of time. *Transcript at 3221:19-3222:4 (L. Ahern).*

565. Accordingly, the Court does not find that defendants' presentation of facts and expert opinion regarding the financial difficulties that would face Saltzer in the event of a divestiture is in any way inconsistent with defendants' arguments and representations at the preliminary injunction hearing.

B. Other Remedies Will Protect Competition

566. To the extent the concern with St. Luke's affiliation with Saltzer is that joint negotiation of contracts by St. Luke's and Saltzer will result in higher prices, the Court can order Saltzer and St. Luke's to negotiate fee-for-service contracts independently.

567. A conduct remedy that requires separate negotiation of fee-for-service contracts will address any concern that the transaction will allow St. Luke's to engage in supracompetitive pricing.

568. In these circumstances, Saltzer would be solely responsible for negotiating such contracts with payors, and would be free to enter into agreements with payors that do not contract with St. Luke's.

569. By limiting any such remedy to fee-for-service contracts—as opposed to risk-based contracts—the Court can ensure that St. Luke's will retain the panel of physicians necessary to accept risk under such a contract.

570. Payors and employers who do not wish to engage in risk-based contracting with St. Luke's and Saltzer will be presented with the same contracting choices that they had prior to the transaction. No payor would have to agree to St. Luke's contract terms to gain access to the Saltzer physicians, nor would any payor have to agree to Saltzer's contract terms in order to gain access to St. Luke's inpatient, outpatient, or physician services.

571. Moreover, as compared to divestiture, a conduct remedy will offer consumers more choices and better care at lower cost. By ensuring that Saltzer will participate in its risk-based contracts, St. Luke's will be able to offer payors and employers alternatives to fee-for-service contracting, and St. Luke's will also be able to move forward with and expand its risk-based agreement with SelectHealth.

CONCLUSIONS OF LAW

572. All plaintiffs challenge the Saltzer Transaction under § 7 of the Clayton Act, 15 U.S.C. § 18, and the analogous Idaho state law, Idaho Code Ann. § 48-106. *Dkt. 63 (Saint Alphonsus/TVH Am. Compl.) ¶¶ 131-52; Dkt. 98 (Gov't Pl. Compl.) ¶ 66.* The Private Plaintiffs also challenge the transaction under § 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.*

573. The Idaho antitrust laws are to be "construed in harmony with federal judicial interpretations of comparable federal antitrust statutes." Idaho Code Ann. § 48-102. Accordingly, the Court's discussion of the parties' claims will focus on federal antitrust laws, but the analysis applies equally to plaintiffs' state law claims.

574. As the Private Plaintiffs have agreed (*Dkt. 22-27 at 5 n.2*), claims under both Clayton Act § 7 and Sherman Act § 1 are generally adjudicated according to the same standards. *See, e.g., United States v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1283 (7th Cir. 1990). Accordingly, the Court will address the Private Plaintiffs' Sherman Act claim alongside its other claims.

575. The Court has jurisdiction over all plaintiffs' federal claims under 28 U.S.C. §§ 1331 and 1337. It further has jurisdiction over the FTC's federal claim under 28 U.S.C. § 1345. It has supplemental jurisdiction over all plaintiffs' state law claims under 28 U.S.C. § 1367.

I. The Parties' Burdens

576. To prevail in this case, the plaintiffs must establish that the Saltzer Transaction is likely, on balance, to cause anticompetitive effects. *United States v. Penn-Olin Chem. Co.*, 378 U.S. 158, 171 (1964). Although § 7 is designed to "curb[] in their incipiency" anticompetitive

trends, *Brown Shoe Co. v. United States*, 370 U.S. 294, 346 (1962), the statute deals with "probabilities" and not "ephemeral possibilities" of anticompetitive effects. *Id.* at 323; *United States v. Marine Bancorporation, Inc.*, 418 U.S. 602, 622–23 (1974) (rejecting claim that was "considerably closer to 'ephemeral possibilities' than to 'probabilities'"). Accordingly, plaintiffs bear the burden to show that it is likely—not merely possible—that the challenged transaction will harm consumers.

577. Although the burden of persuasion always remains firmly on the plaintiffs in a § 7 case, the burden of production shifts based on the plaintiffs' and defendants' showings. *See, e.g.*, *United States v. Citizens & S. Nat'l Bank*, 422 U.S. 86, 120 (1975); *United States v. Baker Hughes, Inc.*, 908 F.2d 981, 982-83 (D.C. Cir. 1990).

578. First, the plaintiffs must make a *prima facie* showing that the transaction will lead to undue concentration in the market for a particular product in a particular area, establishing a presumption that the transaction will substantially lessen competition. *Baker Hughes*, 907 F.2d at 982.

579. St. Luke's may then rebut this presumption by producing evidence showing that the plaintiffs' market-share statistics inaccurately depict the likely competitive effects. *Citizens & S. Nat'l Bank*, 422 U.S. at 86; *Baker Hughes*, 908 F.2d at 991.

580. This Court ultimately applies a "totality of the circumstances" test and weighs all relevant factors to determine the transaction's overall effect on competition. *Baker Hughes*, 908 F.2d at 984 ("Evidence of market concentration simply provides a convenient starting point for a broader inquiry into future competitiveness."); *see also United States v. Gen. Dynamics Corp.*, 415 U.S. 486, 498 (1974) (market share and concentration statistics, while significant, are not conclusive indicators of anticompetitive effects); *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*,

429 U.S. 477, 487 (1977); *Copperweld Corp. v. Independence Tube Co.*, 467 U.S. 752, 768 (1984).

II. Plaintiffs Have Not Made Out a Prima Facie Case That The Transaction Is Likely to Produce Anticompetitive Effects.

581. Both the Government and Private Plaintiffs assert that the Saltzer Transaction creates too great of concentration in the market for primary care physician services in Nampa, and gives St. Luke's market power.[15] However, the Government and Private Plaintiffs advance significantly different theories as to how the increase in market concentration from the transaction will supposedly lead to harm to competition. The two sets of claims are thus separately analyzed below.

A. Government Plaintiffs' Claims

582. The basic theory of the Government Plaintiffs is that the Saltzer Transaction will enable St. Luke's to exercise market power to raise prices above competitive levels—to the detriment of commercial payors.

1. Standard for Assessing the Likelihood of Anticompetitive Effects

583. The Government Plaintiffs' *prima facie* case relies heavily on market concentration statistics and an analysis of the HHI figures for the challenged transaction.

584. Thus, for example, the Government Plaintiffs have repeatedly cited the Supreme Court's 1963 decision in *United States v. Philadelphia National Bank*, 374 U.S. 321 (1963), which set forth a presumption of unlawfulness based on market concentration alone. *See Dkt. 196 (Pl. Pretrial Br.)* (citing *Philadelphia National Bank* some eight times); *Transcript at 18:1-3, 18:9-10, 30:21-25, 35:8-10 (FTC Opening Statement)* (citing *Philadelphia National Bank* an additional four times).

[15] As discussed further below, the Private Plaintiffs also allege additional product markets.

585. However, the myopic focus on market concentration reflected in *Philadelphia National Bank*, a decision that counsel for the FTC conceded was "somewhat old" *(Transcript at 18:1-3 (FTC Opening Statement)),* falls far short of showing a complete picture of the likely effects of a transaction on competition.

586. Numerous courts, including the Supreme Court, have moved away from *Philadelphia National Bank* in the fifty years since that case was decided. *See Baker Hughes*, 908 F.2d at 990 ("Although the Supreme Court has not overruled these section 7 precedents [including *Philadelphia National Bank* and decisions of the same time period], it has cut them back sharply.").

587. Courts have consistently and repeatedly explained that market concentration statistics are insufficient, standing alone, to demonstrate the likelihood of anticompetitive effects. *Baker Hughes*, 908 F.2d at 984, 991-92 ("[e]vidence of market concentration simply provides a convenient starting point for a broader inquiry into future competitiveness"; "[t]he Herfindahl-Hirschman Index cannot guarantee litigation victories"); *see also Gen. Dynamics*, 415 U.S. at 498 (market share and concentration statistics, while significant, are not conclusive indicators of anticompetitive effects).

588. Indeed, one of the current FTC Commissioners, Joshua D. Wright, recently advocated that the FTC should seek to "bring[] modern merger review more closely in line with economic thinking" by "urging courts to abandon the decades-old and economically misguided *Philadelphia National Bank* presumption." Remarks of Joshua D. Wright, Commissioner, "The FTC's Role in Shaping Antitrust Doctrine: Recent Successes and Future Targets," at 15 (Sept. 24, 2013) ("Wright Remarks"), online at ftc.gov/speeches/wright/130924globalantitrustsymposium.pdf.

589. As Commissioner Wright explained, a presumption of unlawfulness based solely on market concentration "is far too sensitive to the market definition exercise," and ignores "the critical lesson of the modern economic approach to mergers … that post-merger changes in pricing incentives and competitive effects analysis are what matter." Wright Remarks at 17-18.

590. Commissioner Wright further observed that the influence of *Philadelphia National Bank*'s presumption based on market concentration "has eroded somewhat," but it is still used as a "convenient litigation tool" by "the antitrust agencies and private plaintiffs." Wright Remarks at 16-17. Any such reliance on *Philadelphia National Bank*, however, is misplaced. In the words of Commissioner Wright:

> [T]he structural presumption endorsed by *Philadelphia National Bank* does not make economic sense. Modern economic learning and empirical evidence does not support the notion that mergers that generate a post-merger firm with greater than 30 percent share are systematically more likely to be anticompetitive. Of course, the presumption is a convenient litigation tool—and one that confers some valuable advantages to the antitrust agencies and private plaintiffs in their litigation efforts—to shift the burden to defendants when courts are not otherwise persuaded by a competitive effects story. But the lodestar of the antitrust laws is not litigation victories—it is consumer welfare. If the economic foundation of the structural presumption is no longer supported by sound economics, and it is not and has not been for quite some time, the Commission would do well to encourage courts to abandon its use.

Id. at 17.

591. Commissioner Wright is not alone in criticizing undue reliance on market concentration. For example, a leading antitrust treatise explains that "the reliance on concentration information in these cases"—including *Philadelphia National Bank* and similar cases of the time period—"seems quite unfocused and ad hoc. Further, the Court clearly found cause for concern and even alarm at concentration ratios that today are found to be quite

modest." Phillip E. Areeda & Herbert Hovenkamp, *Antitrust Law: An Analysis of Antitrust Principles and Their Application* ¶ 926b (3d ed. 2010) (hereinafter "Areeda").

592. Such undue reliance on market concentration statistics has a particularly grave potential for harm in a case like this one, where the defendants contend that the transaction will produce substantial procompetitive benefits: "The most serious consequence of an overly broad prohibitory rule is its interference with mergers that would yield procompetitive or other economic benefits." Areeda ¶ 905d.

593. Nonetheless, the Government Plaintiffs have repeatedly and expressly asked the Court to hold the Saltzer Transaction presumptively unlawful on the ground that the market concentration, in the market as defined by the Government Plaintiffs, exceeds the level declared presumptively unlawful in *Philadelphia National Bank*. *See Dkt. 196 (Pl. Pretrial Br.) at 12* (arguing that the challenged transaction is presumptively unlawful because "the Supreme Court in *Philadelphia National Bank* found that a post-merger market share of only *30 percent* with many remaining competitors violated the Clayton Act") (emphasis in original); *Transcript at 35:8-10 (FTC Opening Statement)* ("And then just let me put this … briefly in context, Your Honor. *Philadelphia National Bank*, this was 30 percent share. This was enjoined.").

594. Contrary to the litigation strategy adopted by the Government Plaintiffs in this case, however, Commissioner Wright has urged that "the Commission should take an active approach—most significantly in the way it drafts its own complaints and briefs—to encouraging courts to move away from the structural presumption." Wright Remarks at 18.

595. In view of the case law and authorities undermining the approach in *Philadelphia National Bank* and criticizing an undue reliance on market concentration statistics, the Court

rejects any contention that the Saltzer Transaction is presumptively unlawful merely as a result of market concentration statistics.

596. Instead, the Court will thoroughly analyze the full scope of the evidence to determine the likelihood that the transaction will result in anticompetitive effects. Market concentration is no more than a "convenient starting point" in this analysis. *Baker Hughes*, 908 F.2d at 984.

2. Market definition

597. To establish their *prima facie* claim, the Government Plaintiffs must prove that the transaction is likely to lead to a significant and non-transitory increase in prices, to supracompetitive levels, in a properly defined market for a particular product in a particular geographic area. *E.g.*, *Marine Bancorporation*, 418 U.S. at 618; *Baker Hughes*, 908 F.2d at 982.

598. The Government Plaintiffs contend that the relevant product market is adult primary care physician services sold to commercial payors. Defendants do not dispute that this is a relevant product market. The Court agrees that the relevant product market is adult primary care physician services sold to commercial payors.

599. The Government Plaintiffs contend that the relevant geographic market is limited to Nampa. Defendants dispute that Nampa is a properly defined geographic market. While defendants' expert, Dr. Argue, does not precisely define the outer bounds of the geographic market, he contends that it includes at least providers in Caldwell, Meridian, and West Boise. *Transcript at 2949:3-2950:3 (D. Argue).*

600. A proper geographic market is "an area of effective competition … where buyers can turn for alternate sources of supply." *Morgan, Strand v. Radiology Ltd.* 924 F.2d 1484, 1490 (9th Cir. 1991) (quotations omitted). What constitutes a proper geographic market "can be

determined only after a factual inquiry into the commercial realities faced by consumers." *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1052 (8th Cir. 1999).

601. Plaintiffs bear the burden of proving that their definition of the relevant geographic market is correct. *United States v. Conn. Nat'l Bank*, 418 U.S. 656, 669 (1974); *R.C. Dick Geothermal Corp. v. Thermogenics, Inc.*, 890 F.2d 139, 143 (9th Cir. 1989). The plaintiffs' establishment of a proper geographic market is "a necessary predicate to the finding of an antitrust violation." *Tenet Health Care*, 186 F.3d at 1051; *FTC v. Freeman Hosp.*, 69 F.3d 260, 268 (8th Cir. 1995).

602. To meet their burden of proving the relevant geographic market, the Government Plaintiffs "must present evidence on the critical question of where consumers of [the relevant product] could practicably turn for alternative services should the merger be consummated and prices become anticompetitive. *This evidence must address where consumers could practicably go, not … where they actually go.*" *Tenet Health Care*, 186 F.3d at 1052 (citations omitted; emphasis added); *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1131 (N.D. Cal. 2004) ("[T]he issue is not what solutions the customers would like or prefer … ; the issue is what they could do in the event of an anticompetitive price increase.").

603. In other words, the critical question in determining whether Nampa is a relevant market is whether or not sufficient numbers of consumers would obtain adult primary care physician services *outside* of Nampa if prices in Nampa rose above competitive levels, such that the anticompetitive price increase would not be profitable. If consumers have enough acceptable alternatives outside of Nampa such that supracompetitive pricing cannot profitably be maintained in Nampa, then Nampa cannot be a relevant geographic market. *See, e.g.*, *Coastal Fuels of P.R., Inc. v. Caribbean Petroleum Corp.*, 79 F.3d 182, 198 (1st Cir. 1996) ("The

touchstone of market definition is whether a hypothetical monopolist could raise prices."); Areeda ¶ 536.

604. The Court concludes that the Government Plaintiffs have failed to prove that Nampa is a relevant geographic market. In particular, the Government Plaintiffs have not shown that consumers would be unable or unwilling to obtain primary care physician services outside of Nampa in response to an increase in price above competitive levels. *See Bathke v. Casey's General Stores, Inc.*, 64 F.3d 340, 346 (8th Cir. 1995) (declaring "insufficient both evidence detailing where consumers actually went for services as well as evidence indicating that consumers tended to go close to home for services because the evidence did not address where they could practicably go for the products and services").

605. By contrast, defendants' expert, Dr. Argue, undertook a critical loss analysis to establish that enough consumers *would* seek primary care physician services outside of Nampa to defeat any increase of prices above competitive levels. The critical loss analysis is a methodology that is employed by the FTC in its *Horizontal Merger Guidelines* and that has been followed by multiple courts. *See Merger Guidelines* at 12; *Tenet Health Care*, 186 F.3d at 1053; *Nilavar v. Mercy Health System-Western Ohio*, 244 F. App'x 690, 698-99 (6th Cir. 2007); *California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1128 (N.D. Cal. 2001).

606. In sum, plaintiffs have failed to show that consumers could not practicably go outside of Nampa for primary care physician services if prices were raised above competitive levels. Defendants, however, have shown that consumers could defeat anticompetitive pricing by seeking care outside of Nampa. The Court therefore concludes that plaintiffs have failed to prove that Nampa is a properly defined geographic market.

607. Similarly, although Dr. Dranove suggested an alternative market of Nampa plus Caldwell, plaintiffs also failed to establish that Nampa and Caldwell consumers could not practicably seek care outside of that region in the face of supracompetitive prices. The Court therefore concludes that plaintiffs' alternate market of Nampa plus Caldwell has likewise not been shown to be a properly defined geographic market.

608. Plaintiffs' failure to establish a relevant geographic market is "fatal" to their claim that the transaction is presumptively unlawful. *See Tenet Health Care*, 186 F.3d at 1053. In particular, because plaintiffs have not established a properly defined geographic market, they have not shown that any increase in concentration in any relevant geographic market as a result of the transaction supports a presumption of unlawfulness.

3. Other Evidence of Anticompetitive Effects

609. Whether or not Nampa is a properly defined geographic market, the Court concludes that the Government Plaintiffs have failed to prove any likelihood of anticompetitive effects.

610. As described above, Dr. Dranove opined that the Saltzer Transaction would give a combined St. Luke's/Saltzer increased bargaining leverage vis-à-vis commercial payors, such that it could extract supracompetitive prices from those payors. However, Dr. Dranove further opined that *all* mergers—not merely those mergers that are prohibited by the antitrust laws—lead to increased bargaining leverage and thus harm to consumers. *Transcript at 1397:25-1398:3, 1398:17-19, 1402:23-1403:1 (D. Dranove).*

611. Dr. Dranove's theory that *all* mergers are harmful to consumers is not supported in law. Only those mergers that harm competition are unlawful. The FTC's own Merger Guidelines make clear that the agencies' purpose in enforcing the antitrust laws is to "to identify and challenge competitively harmful mergers *while avoiding unnecessary interference with*

mergers that are either competitively beneficial or neutral." *Merger Guidelines* at 1 *(emphasis added).*

612. Thus, while the challenged transaction may increase defendants' "bargaining leverage," that fact does not answer the critical question here: whether that increase in bargaining leverage will cause a combined St. Luke's/Saltzer to have market power. As summarized above, the evidence indicates that it will not.

613. The Government Plaintiffs also place substantial reliance on the testimony of Jeffrey Crouch of BCI. While it is evident that BCI opposes the transaction, the subjective opinion of a customer is of limited value in assessing anticompetitive effects. *See Oracle*, 331 F. Supp. 2d at 1131 ("[U]nsubstantiated customer apprehensions do not substitute for hard evidence."); *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 145 (D.D.C. 2004) ("[A]ntitrust authorities do not accord great weight to the subjective views of customers in the market."); Areeda ¶ 538b.

614. In sum, the Court concludes that the Government Plaintiffs have failed to prove that the transaction is likely to lead to anticompetitive effects in any properly defined, relevant market. The Government Plaintiffs have, therefore, failed to establish a *prima facie* case for antitrust liability.

B. Private Plaintiffs' claims

615. The Private Plaintiffs (but not the Government Plaintiffs) allege anticompetitive effects in four additional markets: (1) general pediatric physician services sold to commercial payors in Nampa; (2) general acute care inpatient hospital services in Ada and Canyon Counties, (3) neurosurgery and orthopedic ("neuro+ortho") outpatient surgical facility services in Ada and Canyon Counties, and (4) general surgery outpatient surgical facility services in Ada and Canyon Counties. Defendants do not dispute the product or geographic market definitions for these four

additional markets. The Court therefore agrees that the Private Plaintiffs have established that these are properly defined markets.

1. Vertical Foreclosure

616. The Private Plaintiffs' claims are primarily premised on a vertical foreclosure theory—namely, that the Saltzer physicians, as a result of the challenged transaction, will "steer" referrals of patients for inpatient and outpatient facility services from the Private Plaintiffs to St. Luke's and deprive the Private Plaintiffs of "necessary inputs" for inpatient and outpatient facility services.

a. Standard for Assessing Vertical Foreclosure

617. It is axiomatic that a transaction is unlawful only if it harms *competition*—not if it harms *competitors*. *E.g.*, *Pool Water Prods. v. Olin Corp.*, 258 F.3d 1024, 1034 (9th Cir. 2001); *see also Brunswick*, 429 U.S. at 487. Indeed, even elimination of a competitor from the market is insufficient, without more, to constitute harm to competition. *McGlinchy v. Shell Chemical Co.*, 845 F.2d 802, 812 (9th Cir. 1988). Moreover, "courts are properly skeptical of many rivals' [antitrust] suits," because "a competitor opposes efficient, aggressive, and legitimate competition by its rivals." Areeda ¶ 348a.

618. In the context of a claim of vertical foreclosure, this principle means that the plaintiffs must show that the challenged transaction "substantially forecloses competition in the relevant" market as a whole. *Tampa Elec. Co. v. Nashville Coal Co.*, 365 U.S. 320, 334 (1961). The analysis examines not how much business the plaintiff has lost, but what share of the overall market is foreclosed. *Id.*

619. Put differently, whether foreclosure is anticompetitive depends not on whether individual competitors are deprived of or even driven out of business, but on whether the challenged transaction forecloses access to a sufficient portion of the overall market that

competition is lessened. *See, e.g.*, *Omega Envtl., Inc. v. Gilbarco, Inc.*, 127 F.3d 1157, 1162 (9th Cir. 1997) ("Only those arrangements whose 'probable' effect is to 'foreclose competition in a substantial share of the line of commerce affected' violate" the antitrust laws."); Areeda ¶ 570b1 ("The foreclosure effect, if any, depends on the market share involved. The relevant market for this purpose includes the full range of selling opportunities reasonably open to rivals, namely all the product and geographic sales they may readily compete for, using easily convertible plants and marketing organizations.").

620. "In short, the threatened foreclosure of competition must be in relation to the market affected." *Tampa Elec. Co.*, 365 U.S. at 327. Even if a challenged transaction drives individual competitors out of business entirely, if "the number of firms, though reduced, remains sufficient for effective price competition," there has been no competitive harm actionable under the antitrust laws. Areeda ¶ 1010.

621. In the context of this case, the Private Plaintiffs can establish liability under their "vertical foreclosure" theory only if they succeed in showing that the transaction effects significant foreclosure in the overall market. *See* Areeda ¶¶ 1004a, 1004f ("the foreclosure theory has serious weaknesses"; the conditions necessary for harm to competition to result from a supposed foreclosure are "stringent"); *see also id.* ¶ 1004c ("Even complete self-dealing, with an absolute refusal to sell or purchase from any outsider, results in no foreclosure in a competitive market."). That is, the Private Plaintiffs must show not just that the transaction will cause them to lose referrals from Saltzer physicians, but that the Saltzer Transaction will foreclose access to a sufficient portion of the overall market to harm competition.

b. The Private Plaintiffs Have Not Shown a Likelihood of Harm to Competition

ix. Treasure Valley Hospital

622. Mr. Genna, TVH's Chief Executive Officer, testified that TVH would likely lose referrals as a result of the Saltzer Transaction because it lost referrals after another independent physician group, BOC, affiliated with St. Luke's in 2008, and because referrals from Saltzer physicians to TVH had dropped significantly since the fall of 2012. *See* ¶¶ 377-378, *supra.*

623. However, TVH's mere loss of business does not establish vertical foreclosure. Instead, TVH was required to show that it was foreclosed from a "substantial share" of the relevant line of commerce—here, surgical care. *Omega Envtl., Inc.*, 127 F.3d at 1162.

624. [redacted]

625. In short, TVH does not appear to have been foreclosed from the market for surgical services at all, much less from a "substantial share" of it, as would be required to prove its claim.

x. Saint Alphonsus

626. Like TVH, Saint Alphonsus bases its foreclosure claim primarily on evidence that after certain physicians affiliated with St. Luke's, their admissions to Saint Alphonsus decreased. Professor Haas-Wilson opines that when St. Luke's acquires a physician practice, those physicians "steer" patients to St. Luke's facilities. She further opines that as a result of the Saltzer Transaction, the Saltzer PCPs are likely to direct referrals to St. Luke's specialists, who will in turn admit patients to St. Luke's, rather than Saint Alphonsus.

627. However, Professor Haas-Wilson undertook no analysis, and offered no testimony, regarding whether Saint Alphonsus would, as a result of the transaction, be foreclosed from a *substantial share* of any of the asserted market, as controlling law requires.

628. In other words, she offered no opinion, and Saint Alphonsus offered no other evidence, on the critical question for vertical foreclosure: whether Saint Alphonsus was foreclosed from a *substantial share* of the overall market for inpatient and outpatient care. With no evidence of what share of the market is represented by referrals from Saltzer physicians—whether, for example, it is 1 percent or 90 percent—the Court cannot conclude that the loss of "Saltzer referrals" (even if it were appropriate to assume such a loss of referrals) would result in anticompetitive foreclosure to Saint Alphonsus.

629. Moreover, as explained in the Court's findings of fact above, Professor Haas-Wilson failed to support even the claim that Saint Alphonsus in fact suffered a net loss of referrals at all—much less anticompetitive harm.

630. Because Saint Alphonsus has not shown either that it is likely to be foreclosed from a substantial share of the overall patient base as a result of the transaction, or even that it is likely to suffer any net loss in referrals at all, the Court dismisses as irrelevant Saint Alphonsus's analysis of actions it would be forced to take in the "worst case scenario" that 100 percent of the Saltzer physicians' referrals were immediately diverted to St. Luke's. In any event, as set forth above, the Court finds that that "worst case scenario" analysis is unsupported by evidence. In fact, Saint Alphonsus has, since this litigation began, infused substantial resources into Nampa, belying any claim that it fears foreclosure from a substantial share of the patient base in that region.

631. Additionally, the Court dismisses as speculative the conjectures of harm Saint Alphonsus might suffer if St. Luke's were, in the future, to open a new hospital in Nampa. To the contrary, the construction of a new hospital in Nampa would only increase competition in that region for hospital services.

632. For all of these reasons, the Court concludes that Saint Alphonsus has failed to establish a *prima facie* case that vertical foreclosure is likely to occur.

c. "Steering" Referrals Does Not Effect Foreclosure

633. Finally, the Court finds that the Private Plaintiffs have failed to prove vertical foreclosure because they have not shown that Saltzer physicians' referral of patients to St. Luke's would actually *prevent* those patients from seeking care from the Private Plaintiffs. Even if the Saltzer physicians were to "steer" referrals toward St. Luke's, plaintiffs have presented no evidence to suggest that the Saltzer patients could not choose, despite their physician's referral, to obtain care from TVH or Saint Alphonsus.

634. In *Barry v. Blue Cross of California*, the Ninth Circuit assessed a claim that a vertical agreement between an insurer and physicians participating in the insurer's plan effected a vertical foreclosure because it "interfer[ed]" with nonparticipating physicians' "access to patients." 805 F.2d 866, 871 (9th Cir. 1986). Under the agreement, participating physicians were prevented from referring patients to nonparticipating physicians unless the patients consented, and patients were required to pay a higher percentage of nonparticipating physicians' fees. *Id.* at 867-68. The court rejected the claim, holding that although the vertical agreement "greatly discourage[d] patients" insured under the plan from using nonparticipating physicians, it did not "prevent patients from seeing nonparticipating physicians." *Id.* at 872. The agreement therefore did not cause "impermissible market distortions." *Id.*

635. Here, under the Private Plaintiffs' theory, Saltzer patients referred to St. Luke's would, at most, be "greatly discourage[d]"—not prevented—from obtaining care from the Private Plaintiffs. The transaction therefore does not effect a vertical foreclosure in violation of the antitrust laws.

2. The Private Plaintiffs Have Not Shown Harm to "Network Competition"

636. Finally, the Court finds that Saint Alphonsus has likewise failed to establish a *prima facie* case of harm to "network competition." Saint Alphonsus contends that the Saltzer Transaction also will harm competition if St. Luke's removes Saltzer from Saint Alphonsus's provider networks. However, as discussed above, the plaintiffs have not established a *prima facie* case that the Saltzer Transaction will create or enhance market power for a combined St. Luke's/Saltzer.

637. This conclusion applies equally to Saint Alphonsus' "network competition" theory. Just as St. Luke's lack of market power will prevent it from imposing supracompetitive prices, sponsors of competing provider networks—including Saint Alphonsus, IPN, Blue Cross, Micron, or others—can construct viable networks without St. Luke's providers. Thus, the transaction will not harm network competition.

638. For all of these reasons, the Court concludes that the Private Plaintiffs have not established a *prima facie* case that the Saltzer Transaction is likely to have anticompetitive effects.

III. Defendants Have Established The Likelihood of Transaction-Specific Procompetitive Benefits

639. As described above, defendants contend that the transaction is likely to promote substantial procompetitive benefits by enhancing the ability of both St. Luke's and Saltzer to

transition to providing integrated, value-based care. The plaintiffs do not dispute that integrated, value-based care is beneficial to consumers.

640. Plaintiffs instead contend that defendants' evidence of procompetitive effects is (a) not merger-specific, and (b) speculative. The Court rejects each of these contentions.

A. The Procompetitive Benefits Identified by Defendants Are Merger-Specific

641. The Government Plaintiffs have argued that, in offering evidence to rebut any *prima facie* showing of anticompetitive effects, St. Luke's bears a "heavy burden" to "'verify by reasonable means the likelihood and magnitude of each asserted efficiency, how and when each would be achieved (and any costs of doing so), how each would enhance the merged firm's ability and incentive to compete, and why each would be merger-specific.'" *Dkt. 160 at 3.*

642. In fact, however, a defendant must simply rebut a presumption with credible evidence that the plaintiff's evidence gives an inaccurate prediction of the acquisition's probable effect. *FTC v. Staples, Inc.*, 970 F. Supp. 1066, 1089 (D.D.C. 1997) (rejecting the FTC's position that the defendant's evidence must be "clear and convincing"); *Baker Hughes*, 908 F.2d at 991–92 (refusing to require that the defendant "clearly disprov[e] future anticompetitive effects" because "[i]mposing a heavy burden of production on a defendant would be particularly anomalous where . . . it is easy to establish a prima facie case").

643. "[E]vidence on a variety of factors can rebut a prima facie case," *Baker Hughes*, 908 F.2dat 984, including as is relevant here, evidence that the transaction will lead to "integrated delivery" of care and, ultimately, "better medical care." *Tenet Health Care*, 186 F.3d at 1054.

644. Additionally, as the FTC's Merger Guidelines indicate, procompetitive benefits are merger-specific even if those benefits might be obtained by other means, so long as the transaction causes the benefits to accrue more quickly than they otherwise would. *Merger*

Guidelines at 30 n.13 (where "a merger affects not whether but only when an efficiency would be achieved," the "timing advantage is a merger-specific efficiency").

645. Here, as set forth in the Court's findings of fact, defendants have shown that both Saltzer and St. Luke's have achieved and will continue to achieve benefits of integrated care as a result of the transaction.

646. The transaction's benefits are merger-specific because the transaction will enhance the ability of the combined St. Luke's/Saltzer to offer coordinated, patient-centered care; to support physicians in the practice of evidence-based medicine in an environment that rewards teamwork and value of care rather than volume of care; to accept risk and accountability for patients' outcomes; and to manage population health. Saltzer and St. Luke's could not achieve these benefits as effectively or as quickly by any looser affiliation or other means.

647. In short, by bringing Saltzer into the integrated delivery system that St. Luke's is working to create, the transaction enhances the ability of both to provide integrated, value-based care.

648. For the reasons set forth above, the Court concludes that defendants have established the likelihood of merger-specific procompetitive benefits.

B. The Procompetitive Benefits Identified by Defendants Are Not Speculative

649. Plaintiffs also criticize defendants' showing of procompetitive benefits of integrated care on the ground that those benefits are speculative.

650. According to plaintiffs, in offering evidence to rebut any prima facie showing of anticompetitive effects, St. Luke's bears a "heavy burden" to "'verify by reasonable means the likelihood and magnitude of each asserted efficiency, how and when each would be achieved (and any costs of doing so), how each would enhance the merged firm's ability and incentive to compete, and why each would be merger-specific.'" *Dkt. 160 at 3.*

651. The Court rejects the standard proposed by plaintiffs. In rebutting a plaintiff's *prima facie* case, the defendant cannot be required to produce evidence with "a degree of clairvoyance alien to section 7, which … deals with probabilities, not certainties." *Baker Hughes*, 907 F.2d at 987.

652. Here, defendants have demonstrated not only that St. Luke's and Saltzer have taken concrete steps toward becoming an integrated delivery system that will provide integrated, value-based care, but also that other integrated delivery systems have achieved measurable benefits in cost and quality of care as a result of taking analogous steps. Indeed, federal and state policymakers agree that moving our health system toward integrated, value-based care is the best and most effective means of achieving improvements in the cost and quality of care.

653. In these circumstances, defendants have sufficiently established the likelihood of procompetitive benefits. *See, e.g.*, *Tenet Health Care*, 186 F.3d at 1055 (reversing preliminary injunction of merger where "[t]he evidence show[ed] that the merged entity may well enhance competition"). Contrary to plaintiffs' characterization, the antitrust laws do not require that all procompetitive benefits be fully realized and measurable at the time of litigation.

IV. The Overall Effects of the Transaction Are Likely to Be Procompetitive

654. As explained above, the challenged transaction is primarily a vertical, rather than horizontal, merger. It is well-recognized that vertical mergers are generally procompetitive. Areeda ¶ 1000 (noting that "some critics have concluded that the alleged harmful effects are so implausible and efficiency gains so likely that vertical mergers should be deemed per se lawful"). Where a transaction has both horizontal and vertical effects, it may be treated as a vertical merger if it has "the potential economic advantages typically available" from a vertical merger. *Abadir & Co. v. First Miss. Corp.*, 651 F.2d 422, 427-28 (5th Cir. 1981) (declining to enjoin an agreement that had both horizontal and vertical effects).

655. Here, the procompetitive vertical effects of the transaction—enhancing the ability of the combined St. Luke's/Saltzer to provide integrated, value-based care—strongly outweigh any potential for anticompetitive horizontal effects, which are speculative at best.

656. Moreover, the Court notes that a cautious approach is called for in assessing the competitive effects of innovative measures like the ones defendants here are taking. *See United States v. Syufy Enterprises*, 903 F.2d 659, 663 (9th Cir. 1990) (if market forces can potentially "cure the perceived problem," then a court ought to exercise extreme caution because judicial intervention in a competitive situation can itself upset the balance of market forces, bringing about the very ills the antitrust laws were meant to prevent"); Frank H. Easterbrook, *The Limits of Antitrust*, 63 Tex. L. Rev. 1, 2–7 (1984) (suggesting that "wisdom lags far behind the market" and firms must be allowed to experiment with innovative practices).

657. As the Eighth Circuit ruled in the health care context in *Tenet Health Care,* "[i]n view of 'the significant changes experienced by the hospital industry in the recent past and the profound changes likely facing the industry in the near future, ... a merger, deemed anticompetitive today, could be considered procompetitive tomorrow.'" 186 F.3d at 1054-55. Simply put, antitrust law does not support the preclusion of health care transactions that will lead to procompetitive innovation. *Cf. Miller v. Cal. Pac. Med. Ctr.*, 991 F.2d 536, 545 (9th Cir. 1993) (vacating preliminary injunction requiring dissolution of merger under federal labor laws where "[u]npacking the merger might … detract from the quality of medical care CPMC provides its patients" and mean that "innovative procedures" made possible by the merger "would have to be abandoned").

658. The change that defendants seek to accomplish is tantamount to providing an entirely new product: integrated, value-based care instead of the fragmented, FFS care that

currently predominates. In such circumstances, the Supreme Court has made clear that a flexible analysis is required. *See, e.g.*, *Broad. Music, Inc. v. Columbia Broad. Sys., Inc.*, 441 U.S. 1, 9, 21-22 (1979) ("*BMI*") (declining to apply *per se* analysis to horizontal agreement among competitors to offer blanket licenses to copyrighted music, even where the competitors "literally 'fixed' a 'price,'" because "the whole [blanket license] is truly greater than the sum of its parts; it is, to some extent, a different product"). Just as the *BMI* Court did not apply a strict *per se* rule to invalidate an efficient blanket license that was viewed as a new product, this Court will not put the stop to defendants' innovation based on plaintiffs' market concentration analysis.

659. At bottom, the goal of antitrust policy is to enhance consumer welfare—not to maintain a particular HHI. *See Reiter v. Sonotone Corp.*, 442 U.S. 330, 343 (1979) (antitrust laws are "a consumer welfare prescription"); *SCFC ILC, Inc. v. Visa USA, Inc.*, 36 F.3d 958, 962 (10th Cir. 1994) (the "objective of antitrust regulation" is "to improve people's lives . . . [through] economic efficiency . . . more efficient production methods . . . [and] through increased innovation").

660. The Court concludes that the transaction is, on balance, procompetitive. Accordingly, the transaction is lawful.

V. In Any Event, Divestiture Is Not an Appropriate Remedy

661. Even if the Court were to conclude that the transaction was unlawful, it would hold that the remedy that plaintiffs seek—complete divestiture of Saltzer—is inappropriate.

662. The Court has broad discretion to fashion a remedy that is "effective to redress the antitrust violation proved." *United States v. E.I. du Pont de Nemours & Co.*, 366 U.S. 316, 323 (1961).

663. While divestiture is a common remedy, it "is not necessarily the most appropriate means for restoring competition." *FTC v. PepsiCo, Inc.*, 477 F.2d 24, 29 n.8 (2d Cir. 1973).

Indeed, "divestiture … should not be entered into lightly or without substantial evidence that the benefit outweighs the harm. Its far-reaching effects put it at the least accessible end of a spectrum of injunctive relief." *Garabet v. Autonomous Techs. Corp.*, 116 F. Supp. 2d 1159, 1172 (C.D. Cal. 2000).

664. Moreover, "just as [a] merger must be viewed in the context of the particular market involved, its structure, history, and probable future, these considerations must also be taken into account in determining the appropriate relief." *United States v. Reed Roller Bit Co.*, 274 F. Supp. 573, 585 (W.D. Okla. 1967) (quotation marks and citation omitted).

665. Here, divestiture would be inappropriate for four reasons.

666. First, divestiture would not inject competition into the market. As defendants have shown, divestiture of Saltzer is most likely to lead not to increased competition in Canyon County, but to the dissolution of Saltzer.

667. Second, divestiture would deprive Idahoans of the procompetitive benefits that the transaction offers.

668. Third, even if the transaction could lead to any anticompetitive effects, divestiture would not be necessary to "effective[ly] … redress" any such effects. *E.I. du Pont*, 366 U.S. at 323. Instead, such concerns could be effectively redressed through a conduct remedy—namely, requiring Saltzer to negotiate FFS contracts with payors independently from St. Luke's. In these circumstances, Saltzer would be solely responsible for negotiating such contracts with payors, and would be free to enter into agreements with payors that do not contract with St. Luke's. By limiting any such remedy to FFS contracts—not risk-based contracts—the Court would also ensure that St. Luke's will retain the panel of physicians necessary to accept risk under such a contract, and Saltzer will have the ability to enter into such contracts as part of St. Luke's.

669. Such a remedy would eliminate any concern that joint contracting by St. Luke's and Saltzer would enhance the combined entity's "bargaining leverage" such that it could obtain supracompetitive prices from commercial payors. Notably, the FTC has itself shown approval for a conduct remedy like this one. *See In re Evanston Northwestern Healthcare Corp.*, 2008 WL 1991995, at *3-4 (FTC Apr. 28 2008) (ordering combined hospitals to separately negotiate with payors).

670. Finally, if plaintiffs determine in the future that anticompetitive effects have resulted from the transaction, despite the Court's finding that such effects are unlikely, they may seek relief at that time. Such a claim would permit review of evidence of the actual results that have followed from the transaction—not plaintiffs' mere speculation as to potential anticompetitive effects. Moreover, the terms of the PSA allow for effective unwinding even at a later date. At a minimum, therefore, divestiture is inappropriate at this time.

671. The Court notes that its conclusion is not predicated on a failing or flailing firm defense. Indeed, the Court does not understand defendants to have asserted any such defense. The failing or flailing firm defense provides that in certain circumstances, the financial status of the acquired firm may be relevant to assessing whether the transaction is lawful. *See, e.g.*, *Arch Coal*, 329 F. Supp. 2d at 153-54. Here, defendants have not argued that the transaction is lawful as a result of Saltzer's financial status. And the Court has concluded that the transaction is lawful for reasons unrelated to Saltzer's financial status.

672. Here, the Court has considered what effect Saltzer's divestiture would have on competition not in connection with the transaction's lawfulness, but for purposes of determining whether divestiture would be an appropriate and effective remedy to ameliorate any potential

anticompetitive effects. Because Saltzer would not, in the event of divestiture, be in a position to enhance competition, divestiture is not an appropriate remedy.

673. For all of these reasons, the Court declines to order the remedy sought by plaintiffs.

VI. JUDGMENT

674. Judgment on each of Plaintiffs' claims is entered in favor of defendants.

DATED: November 4, 2013.

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on January 7, 2014, I filed the foregoing **DEFENDANTS' CORRECTED PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW** electronically through the CM/ECF system and served the foregoing on the following parties or counsel, as more fully reflected in the Notice of Electronic Filing, via electronic mail:

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