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**UNITED STATES OF AMERICA**
**BEFORE THE FEDERAL TRADE COMMISSION**

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| In the Matter of | ) | |
| | ) | |
| PROMEDICA HEALTH SYSTEM, INC. | ) | Docket No. 9346 |
| a corporation. | ) | **PUBLIC** |
| | ) | |

**RESPONDENT PROMEDICA HEALTH SYSTEM, INC.'S**

**POST-TRIAL REPLY BRIEF**

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## I. INTRODUCTION

To prevail on a Clayton Act Section 7 claim Complaint Counsel must prove, by a preponderance of the evidence, that St. Luke's Hospital's ("St. Luke's") joinder with ProMedica Health System, Inc. ("ProMedica") is reasonably likely to result in a *substantial* lessening of competition. *United States v. Penn-Olin Chem. Co.*, 378 U.S. 158, 171 (1964); *FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1051 (8th Cir. 1999); *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 142 (E.D.N.Y. 1997). Complaint Counsel, who have built their case on sound bites and excerpts of documents taken out of context, market shares, biased or unfounded and speculative testimony, and flawed economic analysis, have not met their burden. Moreover, this case involves a consummated transaction with actual evidence of post-closing conduct and effects, and there is no evidence that St. Luke's joinder with ProMedica has or will likely harm competition in any relevant market in the future, notwithstanding Complaint Counsel's speculation to the contrary. Accordingly, this Court should dismiss the Complaint and deny Complaint Counsel their requested relief.

Complaint Counsel rely heavily on pre-joinder statements by St. Luke's employees to show that St. Luke's motivation for the joinder is evidence of the anticompetitive effects that will result.[1] *See, e.g.*, CCBR at 1, 49-50, 52-53.[2] There is good reason why neither motivation nor intent appear within the text of Clayton Act Section 7. 15 U.S.C. § 18. That is because only by examining the "structure, history, and probably future" of the Lucas County marketplace can the

[1] Throughout Complaint Counsel's initial brief, Complaint Counsel misleadingly refer to St. Luke's as the Respondent. To be clear, the Respondent is ProMedica, not St. Luke's, and statements made by St. Luke's employees prior to the consummation of the joinder are *not* admissions by ProMedica, as this Court has recognized. (Final Pre-Trial Conference, Tr. 51) (May 31, 2011) ("I am not convinced that the rule regarding admission to the party includes statements made by an individual who was not an employee of the party at the time the statements were made."). Moreover, no evidence exists in the record demonstrating that ProMedica entered the joinder with St. Luke's with any intent to raise rates.

[2] Citations to Complaint Counsel's initial brief are abbreviated "CCBR."

ALJ determine whether St. Luke's joinder with ProMedica provides it with ability to raise rates above competitive levels for a prolonged period, which is the proper test for determining the legality of this transaction. *United States v. Gen. Dynamics Corp.*, 415 U.S. 486, 498 (1974); *United States v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1282-83 (7th Cir. 1990); *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 135 (E.D.N.Y. 1997). The extensive record developed over eight weeks of trial in this case reveals why St. Luke's joinder with ProMedica is not likely to enhance or facilitate any ability by ProMedica to raise rates above competitive levels.

Complaint Counsel cite to percentages and percentage differences in their discussion of market shares and rely on "constructed averages" when they discuss prices, all to obscure and deflect attention from the real numbers of patients at issue. CCBR at 30-36, 51-56. St. Luke's only treats about ten commercially insured patients per day, of which about one is a commercially insured mother delivering a child. (RPF 1147; RX-71(A) at 000201, *in camera*). St. Luke's offers no acute care services that inpatients cannot otherwise receive from other hospitals in Lucas County. (RPF 1149). Nevertheless, Complaint Counsel would have the ALJ believe that the addition of St. Luke's ten commercially insured patients per day represents the tipping point that will enable ProMedica to name its price from managed care organizations ("MCOs"), the commercial health insurance companies who negotiate contracts to buy a variety of services, including general acute care inpatient services, from hospitals. The record evidence demonstrates why this is not true.

If St. Luke's were as valuable or critical to MCOs as Complaint Counsel claim, it stands to reason that MCOs would not have pushed St. Luke's to the brink of financial failure by paying St. Luke's *less than its total cost* to treat their patients despite St. Luke's pleas to the contrary.

Indeed, when the joinder closed, St. Luke's earnings per adjusted discharge showed that on average it lost money on every commercially insured patient it treated. (RPF 1771). This is but one inconsistency in Complaint Counsel's theory of harm.

With that in mind, the ALJ should view as suspect the self-serving testimony of MCOs, including national and regional MCOs with millions of covered lives, who claim they will be powerless to resist any future rate demands by ProMedica as a result of the joinder.[3] *Compare* CCBR at 53-54 *with Tenet Health Care Corp.*, 186 F.3d at 1054 (holding that testimony contrary to an MCO's economic interest is suspect, especially when large, sophisticated MCOs can and do resist price increases). This testimony is especially suspect when the Court examines the history of provider contracting by MCOs in Lucas County, Ohio, which shows that they have successfully served their members with hospital networks that did not include ProMedica or St. Luke's. (RPF 709-717). While Complaint Counsel argue that a network consisting of Mercy and UTMC would not be marketable, no credible evidence exists showing that, competitively priced, it would not be successful. CCBR at 54-55. The fact that ProMedica and Mercy are each other's closest competitor – a fact that the MCOs and Complaint Counsel's own economic expert concede – means that MCOs in the future, as they have in the past, can substitute Mercy for ProMedica and still serve their members. (Town, Tr. 4058; RPF 713, 1110, *in camera*, 1112, *in camera*, 1119, *in camera*, 1316-1319).

In the face of these market facts, Complaint Counsel rely upon the novel and flawed theories of their economic expert, Professor Town, to claim that the joinder will enable ProMedica to raise rates to MCOs for its legacy hospitals and St. Luke's by anywhere from 11 to 56 percent over an unspecified time period. CCBR at 55-56. Professor Town's stylized, never

[3] These MCOs, of course, also compete with ProMedica's health insurance arm, Paramount Healthcare, further biasing their testimony.

before court-accepted model, however, fails to capture real world influences on the rates that MCOs and hospitals negotiate. (RPF 1097-1104). And, after incorporating a few corrections suggested in the economic literature by economists *employed by the FTC*, his model predicts post-joinder price changes that may not differ from zero. (RPF 1564-1580). The ALJ should accord Complaint Counsel's economic evidence no weight. *Brooke Group Ltd. v. Brown & Williamson Tobacco Corp.*, 509 U.S. 209, 242 (1993) (holding that "when indisputable record facts contradict or otherwise render the [expert's] opinion unreasonable, it cannot support a jury's verdict").

While Respondent prevails if Complaint Counsel fail to meet their burden, the market facts demonstrate affirmatively that the joinder will not enable ProMedica to raise rates above competitive levels. Indeed, MCOs can use the excess capacity that exists among Lucas County hospitals to their advantage by creating networks that serve their members without necessarily including ProMedica and St. Luke's. (RPF 1316-1319). Also, Mercy and UTMC are not standing still, but responding to the joinder by repositioning their resources to direct more inpatient referrals to their existing hospitals which, contrary to Complaint Counsel's position, the *Horizontal Merger Guidelines* analyze like entry. (RPF 1169-1182, *in camera*, 1183-1186, 1187-1188, *in camera*, 1189-1196; United States Dep't of Justice and Fed. Trade Comm'n, *Horizontal Merger Guidelines*, § 6.1 (2010) ("*Horizontal Merger Guidelines*"). And, even "the threat of entry can stimulate competition in a concentrated market, regardless of whether entry ever occurs." *United States v. Baker Hughes, Inc.*, 908 F.2d 981, 988 (D.C. Cir. 1991). Employers are also taking steps to lower their healthcare costs, including creating financial incentives for their employees to use only certain favored hospitals over others. (RPF 1279-1284 *in camera*; 1285, 1286-1290, *in camera*, 1291, 1292-1293, *in camera*, 1294-1305). Finally,

physicians in the Toledo area tend to have privileges and practice at multiple competing hospitals. This allows them to maintain their relationship with those patients who prefer a particular hospital or whose health insurance coverage creates a financial incentive or requires the patient to use a specific hospital to maximize their benefits. (RPF 1204-1206, 1207-1209, *in camera*).

Thus, a "rigorous analysis of actual market dynamics" reveals that Complaint Counsel are wrong on facts. *See Baker Hughes, Inc.*, 908 F.2d at 983-85. Complaint Counsel are also wrong on the law. Complaint Counsel's position, based upon the implications of Professor Town's bargaining leverage theory, is that *any* post-joinder price increase, including one from *below-cost* pre-merger rates, establishes a Clayton Act Section 7 violation. The law requires that Complaint Counsel show – as they have not – that St. Luke's joinder with ProMedica will enable ProMedica to raise rates *above* competitive levels for a prolonged period. *United States v. Rockford Mem'l Corp.*, 898 F.2d at 1282-83; *Long Island Jewish Med. Ctr.*, 983 F. Supp. at 135.

Notwithstanding the evidence to the contrary, if the ALJ concludes that St. Luke's joinder with ProMedica violates Clayton Act Section 7, it should still reject Complaint Counsel's proposed remedy. Complaint Counsel's proposed remedy ignores a ready alternative that would preserve the joinder's community benefits while, at the same time, preventing its perceived potential ills. That remedy, separate negotiating teams for the ProMedica legacy hospitals and St. Luke's, is one that the Commission has previously ordered in lieu of divestiture in another consummated hospital merger case. *In re Evanston Nw. Healthcare Corp.*, No. 9315, 2007 FTC LEXIS 210 (F.T.C. Aug. 6, 2007). Even if the Court rejects this proposed alternative remedy, it should also reject Complaint Counsel's proposed order as drafted because it is overbroad,

provides St. Luke's with a competitive advantage that it did not have prior to the joinder, and imposes an unwarranted financial penalty on ProMedica.

## II. THE RELEVANT MARKET IN WHICH TO ANALYZE THE EFFECTS OF ST. LUKE'S JOINDER WITH PROMEDICA IS GENERAL ACUTE CARE INPATIENT SERVICES AVAILABLE TO COMMERCIALLY INSURED PATIENTS

Complaint Counsel have not proven that any relevant product market exists other than for general acute care inpatient hospital services available to commercially insured patients. Even as to general acute care inpatient hospital services, however, Complaint Counsel improperly narrow the scope of the relevant market, first by focusing exclusively on supply-side – rather than demand-side – market characteristics and, second, even as to that narrower cluster of services, by excluding services that both ProMedica and St. Luke's offered, but may not have provided, to a commercially insured patient.[4] Moreover, Complaint Counsel also have no principled factual or legal basis for carving inpatient OB services out of the cluster market of general acute care inpatient services.

### A. Complaint Counsel Improperly Seek To Narrow the General Acute Care Inpatient Services Product Market

Complaint Counsel ask the ALJ to ignore the settled hospital merger caselaw and the principles of market definition articulated in the *Horizontal Merger Guidelines* and define the relevant product market as only those services that both St. Luke's and ProMedica actually *supplied* (rather than those they offered and therefore competed to provide) to commercially insured patients. CCBR at 11-15. It is well established, however, that market definition "focuses solely on demand substitution factors." *Horizontal Merger Guidelines* § 4 (defining a market by "customers' ability and willingness to substitute away from one product to another in

[4] Complaint Counsel's product market definition would exclude services that both ProMedica and St. Luke's provided to Medicare, Medicaid, or charity care patients, but only one of them provided to commercially insured patients. (Guerin-Calvert, Tr. 7199-7201, 7205, 7214-7215; RX-71(A) at 000017, *in camera;* RX-2072).

response to a price increase or a corresponding non-price change"); *Brown Shoe*, 370 U.S. at 325 (stating the "outer boundaries of a product market are determined by the reasonable interchangeability of use or the cross-elasticity of demand between the product itself and substitutes for it").[5]

Complaint Counsel would have the ALJ narrow the market to only those services that both St. Luke's and ProMedica actually provided to commercially insured patients. The limited subset of services that St. Luke's supplied to commercially insured patients is not what MCOs or self-insured employers, the consumers of inpatient services, demand or contract to purchase from ProMedica, Mercy, or UTMC. (RX-71(A) at 000017, *in camera*). By limiting the relevant product market to just those services that St. Luke's actually provided to commercially insured patients, Complaint Counsel exaggerate St. Luke's relative competitive importance in Lucas County. In particular, they ignore significant competition that occurs between Mercy, ProMedica, and UTMC for services that St. Luke's did not provide, *but could have*. (RX-71(A) at 000015-000018, *in camera*).[6]

Moreover, it makes no sense to exclude from the market services that either ProMedica or St. Luke's, but not both, provided to MCOs' patients. Under Complaint Counsel's theory, a shop offering a product that no customers buy does not compete with the shop next door that offers the same product, which customers do buy. Similarly confounding is Complaint

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[5] Complaint Counsel suggest that a cluster market is appropriate where "market shares and entry conditions are similar" for general acute care inpatient services that are not interchangeable or substitutable for each other. CCBR at 8. That is not the proper method of defining a cluster market. Instead a cluster market includes services that involve demands for the same kinds of facilities and resources. *In re Evanston*, 2007 FTC LEXIS 210, at *149 (explaining that "the treatments offered to patients within this cluster of services are not substitutes for one another . . . the services and resources that hospitals provide tend to be similar across a wide range of primary, secondary, and tertiary inpatient services") (citing *California v. Sutter Health Sys.*, 130 F. Supp. 2d 1109, 1119 (N.D. Cal. 2001)).

[6] For general acute care inpatient services that ProMedica provided to commercially insured patients, the *Horizontal Merger Guidelines* would treat St. Luke's as a competitor of ProMedica, and "market participant," if St. Luke's offered or provided those same services to Medicare, Medicaid or charity care patients, but not to commercially insured patients. *Horizontal Merger Guidelines* 5.1.

Counsel's argument that just because patients are willing to travel farther to get certain tertiary services that both ProMedica and St. Luke's provided to commercially insured patients, those products do not belong in the relevant product market. While it may be that the relevant geographic market for those tertiary services is broader than Lucas County, Complaint Counsel have offered no factual justification or legal basis for excluding those services from the relevant product market.

Complaint Counsel's legal citations do not support their product market definition. As an initial matter, Complaint Counsel's reliance on Judge Katz's decision on the Commission's request for a preliminary injunction is misplaced because that ruling has no precedential effect in this proceeding. (Town, Tr. 4337-4338 ("Judge Chappell: What [District Court Judge Katz] did or didn't do is not relevant")); *see also In re R.R. Donnelley & Sons Co.*, No. 9243, 1995 FTC LEXIS 215, at *17 (F.T.C. July 21, 1995) (citing *Univ. of Tex. v. Camenisch*, 451 U.S. 390, 394-95 (1981)). In addition, the relevant product market was not a contested issue – and thus not analyzed – in some of the cases on which Complaint Counsel rely. *FTC v. Tenet Healthcare Corp.*, 17 F. Supp. 2d 937, 942 (E.D. Mo. 1998) (stating only that the parties agreed to the relevant product market and not deciding on the propriety of that agreement), *rev'd*, 186 F.3d 1045 (8th Cir. 1999); *United States v. Mercy Health Servs.*, 902 F. Supp. 968, 976 (N.D. Iowa 1995) (stating only that the parties *agreed* to limit the relevant product market to services that Mercy and Finley offered and not deciding on the propriety of that agreement), *vacated*, 107 F.3d 632 (8th Cir. 1997).

*Little Rock Cardiology Clinic, P.A. v. Baptist Health*, 573 F. Supp. 2d 1125 (E.D. Ark. 2008), *aff'd*, 591 F.3d 591 (8th Cir. 2009), which did not involve a hospital merger, is also distinguishable. In that case, the court disregarded plaintiffs' alleged relevant product market

because the services plaintiff sought to include were not substitutes for one another. *Id.* at 1144. Finally, *United States v. Long Island Jewish Medical Center* does not stand for the proposition that services for which patients are willing to travel further do not belong in the same *product* market; it simply holds that different product markets may have different geographic markets. 983 F. Supp. 121, 141-42. The court there held that the government failed to meet its burden of establishing a market limited to primary and secondary services at anchor hospitals, and that even if it had met its burden, it must include all of the hospitals located in the wider geographic market. *Id.* at 140.

In defining the relevant product market based on consumer or MCO demands, as the law requires, it is apparent that the appropriate relevant product market is all general acute care inpatient services available to commercially insured patients, excluding quaternary services. MCOs and self-insured employers contract for broad array of primary, secondary, and tertiary inpatient services from hospitals together in a single negotiated transaction. (RPF 585, 1010). Conversely, the prices that MCOs negotiate for quaternary inpatient services, psychiatric and substance abuse services, and outpatient[7] services are distinct from the prices for general acute care inpatient services. (RPF 1013-1015). Complaint Counsel admit that including all inpatient DRGs does not materially affect "the market structure, market shares, or strength of the presumption of anticompetitive harm." CCBR at 15, n.4. Accordingly, the proper relevant product market in which to evaluate the competitive effects of the joinder between ProMedica

[7] Although ProMedica agrees that outpatient services are not part of the relevant product market, the testimony of both hospital and MCO witnesses confirmed that rates for outpatient services are negotiated together with those for inpatient, physician, and ancillary services. (RPF 1071, 1081). Additionally, Toledo is experiencing a shift from inpatient to outpatient services, such that an increasing percentage of services that previously were delivered on an inpatient basis are now rendered on an outpatient basis. (RPF 37). Lucas County hospitals consider outpatient services to be effective substitutes for many medical conditions that currently require hospital admissions, including certain primary- and secondary-level services. (RPF 38).

and St. Luke's is general acute care (primary, secondary, and tertiary) inpatient services available to commercial health plans.

B. Complaint Counsel Have Not Proven That Inpatient Obstetric Services Qualify as a Distinct Relevant Product Market

In their post-trial brief, Complaint Counsel explained precisely why the cluster market of all general acute care inpatient services is the relevant product market used in hospital merger cases: "Because there are hundreds of inpatient medical and surgical services offered by general acute-care hospitals, it is analytically convenient, appropriate, and efficient to group these services in a single cluster market where 'market shares and entry conditions are similar for each.'" CCBR at 8. Remarkably, Complaint Counsel still argue that inpatient obstetric ("OB") services are a separate product market because they are not substitutable with any other general acute care inpatient services even as they acknowledge that "other individual services in the GAC cluster are not substitutable for any other GAC service." CCBR at 16. Of course, no one would suggest that a caesarean delivery could be substituted for an appendectomy, or that either is reasonably interchangeable with a hip replacement, even though hospitals offer all three services on an inpatient basis; that is the purpose behind a cluster market. Complaint Counsel's assertion that inpatient OB services are not substitutable for other general acute care inpatient services is equally applicable to inpatient knee surgery and inpatient gastro-intestinal services, both of which Complaint Counsel include in their general acute care inpatient services market. *See Sutter Health Sys.*, 130 F. Supp. 2d at 1119. Yet Complaint Counsel fail to credibly explain

why inpatient OB services are somehow different from any of the other services they include in their general acute care inpatient services market.[8]

Complaint Counsel's alternative justification for defining a separate inpatient OB services product market – that "the market participants and market structure for OB services differ significantly from the other GAC services" (CCBR 16-18) – is neither intellectually honest nor persuasive. First, not all hospitals in Lucas County provide all of the services that Complaint Counsel include in their general acute care inpatient services market. (Guerin-Calvert, Tr. 7234-7236; Town, Tr. 3966-3967; RX-2073). Second, the real reason that Complaint Counsel want to define a separate product market for inpatient OB services is to be able to argue that the joinder represents a "merger to duopoly." But the undisputed testimony established that St. Luke's provides only low-risk OB services; with respect to higher-risk or complex inpatient OB services, there have always been and continue to be only two hospital providers – ProMedica and Mercy – and the joinder does not change that. (RPF 1022).

No legal authority supports carving inpatient OB services out from the general acute care inpatient hospital services cluster market. Complaint Counsel did not cite a single case in which the court defined an inpatient hospital OB services market separate from other general acute care inpatient hospital services. CCBR at 17-18 (citing cases involving separate markets for adult cardiac surgery physician services and anesthesiologists' services).

The record evidence fails to establish that inpatient OB services are somehow unique and should be treated differently than other general acute care inpatient services. For example, Complaint Counsel argue that OB is a separate relevant market because market participants

[8] If, as Complaint Counsel suggest, services that St. Luke's does not provide should be excluded from the relevant product market, then there must be two separate inpatient OB markets, because it is undisputed that St. Luke's does not offer the high-risk inpatient OB services that both ProMedica and Mercy do. (RPF 122).

separately track market shares for general acute care inpatient services and OB services. CCBR at 18. However, St. Luke's and ProMedica analyze their market shares for a variety of services, of which OB is just one example. (Response to RFA at ¶ 5; PX01077 at 004 (also tracking cardiac cases); PX00009 at 022 (tracking heart, orthopedics, and cancer services)). Complaint Counsel do not segregate those services from their general acute care inpatient services market.

In addition, the evidence shows that negotiations between hospital providers and MCOs for inpatient services cover the full range of services that an MCO's members may need, including inpatient OB services. (RPF 1020). Complaint Counsel offered no evidence that hospitals can or do price discriminate for inpatient OB services as required to delineate a separate inpatient OB services market by the *Horizontal Merger Guidelines*, § 4.1.4. ("*If* a hypothetical monopolist could profitably target a subset of customers for price increases, the Agencies may identify relevant markets defined around those targeted customers, to whom a hypothetical monopolist would profitably and separately impose at least a [small but significant and non-transitory increase in price].") (emphasis added). That is because hospitals contract with MCOs to provide inpatient OB services in conjunction with all other services, and the negotiated terms and conditions are very similar. (RPF 1021, 1025). No representative of an MCO testified that they negotiated separate rates for inpatient OB services; rather, they testified that they negotiate for the full range of general acute care inpatient services, including OB services. (RPF 1010, 1021, 1025, 1071-1072). In addition, contracts with the largest MCOs do not { } (RPF 1026, *in camera*). For example, { } agreement with ProMedica does not carve out inpatient OB rates from general acute inpatient care rates for any ProMedica hospital. (RPF 1026, *in camera*). To the extent that inpatient OB rates may be listed separately in a contract

between a hospital and a MCO, that is the result of a request by the MCO, not ProMedica. (Wachsman, Tr. 5158, *in camera*).

In sum, Complaint Counsel have not met their burden of proving that a separate relevant product market exists for inpatient OB services. Accordingly, the ALJ should dismiss the Complaint's allegations that the joinder violated Clayton Act Section 7 as to the alleged inpatient OB services market.

## III. THE RELEVANT GEOGRAPHIC MARKET IN WHICH TO ANALYZE THE EFFECTS OF ST. LUKE'S JOINDER WITH PROMEDICA IS LUCAS COUNTY, OHIO, NOT ST. LUKE'S CORE SERVICE AREA

The purpose of relevant geographic market definition is to identify the geographic area in which consumers can reasonably turn to an alternative supplier if one competitor attempts to raise prices for the relevant product above competitive levels. *See Long Island Jewish*, 983 F. Supp. at 140; *Mercy Health Servs.*, 902 F. Supp. at 975-976. Complaint Counsel and Respondent agree that for general acute care inpatient services, the relevant geographic market is properly defined to be Lucas County, Ohio because that is where ProMedica, St. Luke's, and their primary competitors, Mercy and UTMC, provide those services. (RPF 1028-1030). Despite this agreement, Complaint Counsel devote an inordinate amount of attention to the locations of the hospitals in Lucas County, the origin of those hospitals' inpatients, and the time and distances those inpatients travel to get their inpatient care. CCBR at 22-28. Complaint Counsel also fixate on St. Luke's self-defined "core service area," as if it is somehow relevant to the analysis of the competitive effects of the joinder, which it is not because there is no evidence that any hospital provider can price discriminate against residents of that area who need general acute care inpatient services. (RPF 1036, 1038). Objectively viewed, hospital location is not as important to patients as Complaint Counsel suggest.

Patient origin analysis reveals that patients are willing to travel across the metropolitan Toledo area, and even across county lines, to receive general acute care inpatient services in Lucas County. (RPF 1482). In fact, patient origin and drive time analysis reveal that hospital inpatients do not necessarily go to the closest or next closest hospital to them. (RPF 1218, 1483). For example, most patients who reside in the zip codes immediately surrounding St. Luke's drive past it to seek inpatient services from hospitals located further away from their homes. (RPF 224, 1480-1481). That is likely because patients usually rank availability of the service, access to a particular physician, and coverage by their insurance company ahead of geographic location when they choose a hospital. (RPF 1484). Even avoidance of out-of-pocket expenses is more important to a patient's selection of a hospital than travel time. (RPF 1485).

Hospital location is not important in this case because Toledo is a small area, not densely populated, and the Lucas County hospitals are all located near one another. Professor Town estimated that Lucas County residents' average drive time for general acute care inpatient services is only about twelve minutes. CCBR at 23. The evidence shows that the drive time from any given set of zip codes is not materially different to one hospital than to another competing hospital. (RPF 219). Respondent's economic expert's drive time analysis illustrated that hospitals in Toledo are all located conveniently to patients, the overall drive time to reach hospitals in Toledo is short, and the incremental drive time between them is minimal (RPF 1210), which explains why patients are willing to travel to more distant hospitals than their closest available hospital for both general acute care inpatient services and inpatient OB services. (RPF 1218). In short, location is not a material factor to patients' choice of a hospital.

Complaint Counsel cite MCO testimony for the proposition that patients prefer and use the hospital closest to their homes. But not one MCO witness testified to having performed any

recent analyses to test their belief that travel time to, or the geographic proximity of, a hospital are important to their insureds. (RX-71(A) at 000021, n. 22, *in camera*). Indeed, those same MCO witnesses uniformly testified that they have not conducted any market studies to determine how far their members do or would travel for general acute care inpatient services. (RPF 1261-1262, 1264-1265, 1268, *in camera*, 1269-1270). And not one of Complaint Counsel's MCO witnesses could testify to the number of their insureds who received inpatient care at St. Luke's (or any other Lucas County hospital), let alone where those insureds lived.

Complaint Counsel's focus on St. Luke's "core service area" is similarly misplaced. It is undisputed that the relevant geographic market in this case is Lucas County, not St. Luke's core service area, which includes zip codes inside and outside Lucas County. Nor have Complaint Counsel offered a shred of evidence to suggest that hospitals can somehow charge higher prices – that is, price discriminate – for inpatient services provided to patients who live near St. Luke's. (RPF 1038). Accordingly, Complaint Counsel's repeated recitation of the Lucas County hospitals' supposed "market shares" in St. Luke's core service area are irrelevant to an analysis of the competitive effects of ProMedica's joinder with St. Luke's. Instead, the relevant geographic market in which to analyze the competitive effects of the joinder is Lucas County, Ohio, as the parties have agreed.

## IV. COMPLAINT COUNSEL HAVE NOT MET THEIR BURDEN OF SHOWING THE JOINDER OF PROMEDICA AND ST. LUKE'S HAS CAUSED OR IS LIKELY TO RESULT IN A SUBSTANTIAL LESSENING OF COMPETITION IN THE RELEVANT MARKET BY ENABLING PROMEDICA TO RAISE RATES ABOVE COMPETITIVE LEVELS

### A. Market Shares and Market Concentration Are Only the Beginning of the Competitive Effects Analysis

In their initial brief, Complaint Counsel rely on their calculation of market shares and market concentration to argue that St. Luke's joinder with ProMedica is presumptively unlawful.

CCBR at 30-36. However, the case law teaches that market shares and market concentration statistics are just the beginning, not the end, of the analysis of a transaction's potential competitive effects. *Gen. Dynamics,* 415 U.S. at 498 (ruling market concentration statistics "were not conclusive indicators of anticompetitive effects"); *Baker Hughes,* 908 F.2d at 984 ("Evidence of market concentration simply provides a convenient starting point for a broader inquiry into future competitiveness."); *United States v. Oracle Corp.*, 331 F. Supp. 2d 1098, 1111 (N.D. Cal. 2004) ("determining the existence or threat of anticompetitive effects has not stopped at calculation of market shares."). Indeed, the *Horizontal Merger Guidelines* caution that "[m]arket shares may not fully reflect the competitive significance of firms in the market or the impact of a merger." *Horizontal Merger Guidelines,* § 5.3.

It would be inappropriate for the ALJ to conclude that ProMedica's joinder with St. Luke's will result in anticompetitive effects based solely on market shares and market concentration statistics. First, a court should proceed cautiously when relying on market shares to presume a transaction will likely lead to anticompetitive effects when the transaction involves differentiated products, which, there is no dispute, general acute care inpatient hospital services are. (Town, Tr. 4157; Guerin-Calvert, Tr. 7266); *Oracle Corp.*, 331 F. Supp. 2d at 1122 ("a strong presumption of anticompetitive effects based on market concentration is especially problematic in a differentiated products unilateral effects context."). That is because "in differentiated product markets, some measure of market power is inherent," in part due to "the many non-price dimensions in which sellers in such markets compete." *Oracle Corp.*, 331 F. Supp. 2d at 1121. Moreover, merger analysis is concerned primarily with "determining whether the merger would enhance market power, not whether market power currently exists." *Id.* For that reason, Complaint Counsel's references to ProMedica's *pre-joinder* shares are beside the

point when evaluating this transaction. *See, e.g.*, CCBR at 31 (". . . ProMedica' market share already was significantly higher than Mercy's even before ProMedica's acquisition of St. Luke's.").[9]

The second reason why this Court should decline Complaint Counsel's invitation to leap to conclusions about the joinder's competitive effects based on market shares and market concentration statistics alone is that it is undisputed that before it began discussing any possible collaboration with ProMedica, St. Luke's pursued the possibility of affiliating with either Mercy or UTMC. But an affiliation of St. Luke's with either of Complaint Counsel's suggested alternative partners, Mercy and UTMC, also would result in a presumptively unlawful *Horizontal Merger Guidelines* violation in a highly concentrated market.[10] *Compare* CCBR at 102 ("St. Luke's had two willing alternatives to ProMedica right in front of it.") *with* CCBR at 32 (showing market shares for Lucas County hospitals). St. Luke's itself recognized this fact as it deliberated which partner to select during its affiliation process. (PX01030 at 017, *in camera*) (calculating HHIs for affiliations with Mercy, UTMC, and ProMedica).

The ALJ should resist the temptation to blindly rely on market share computations and engage in a more meaningful analysis of the "structure, history, and probable future" of the Lucas County hospital landscape to assess the joinder's prospective impact on competition. When it does, the ALJ will conclude that Respondent has rebutted any presumption of

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[9] The document Complaint Counsel cite, PX00270, presents market shares based on data that is several years old, dating from 2004 to 2006. (PX00270 at 025). Moreover, Complaint Counsel ignore testimony that ProMedica's market share has decreased since then. (RX-203 (Oostra, Dep. at 112-113)) ("again, as we've talked previously, we were declining in market share.").

[10] Based on Complaint Counsel's own market shares for general acute-care inpatient services, a Mercy-St. Luke's merger would result in a post-merger HHI of 3,975. CCBR at 32, Table 1 ((28.7% + 11.5%)², for Mercy and St. Luke's, + (46.8%)², for ProMedica, + (13.0%)² for UTMC, = 3,975). Likewise, a UTMC-St. Luke's merger would result in a post-merger HHI of 3,614. CCBR at 32, Table 1((13.0% + 11.5%)², for UTMC and St. Luke's, + (46.8%)², for ProMedica, + (28.7%)², for Mercy, = 3,614). Both alternative mergers would result in highly concentrated markets as measured by HHI. *Horizontal Merger Guidelines*, § 5.3 (HHI above 2,500 considered highly concentrated).

anticompetitive effects stemming from static market concentration statistics that do not accurately capture the dynamics of competition between the Lucas County hospitals. *Gen. Dynamics*, 415 U.S. 486, 498 (1974).

### B. ProMedica's Closest Competitor Was and Continues To Be Mercy, Not St. Luke's

Complaint Counsel assert the remarkable and untenable proposition that St. Luke's, a standalone community hospital located in "southwest Toledo," and ProMedica, with three hospitals – including a major tertiary hospital – in Lucas County and none situated in "southwest Toledo," are each other's closest substitute and competitor. CCBR at 2, 36-40. A cursory examination of the evidence refutes Complaint Counsel's contention and undercuts the necessary factual predicate for their theory that the joinder will result in ProMedica's anticompetitive unilateral exercise of market power. *Horizontal Merger Guidelines*, § 6.1 ("[t]he extent of direct competition between the products sold by the merging parties is *central* to the evaluation of unilateral price effects.") (emphasis added).

Complaint Counsel conclude that ProMedica and St. Luke's are each other's closest substitute and competitor principally based on "market" shares for "southwest Toledo" or the zip codes comprising St. Luke's core service area. CCBR at 36-40. They claim that, because ProMedica and St. Luke's have the highest and next-highest shares in "southwest Toledo," it follows that ProMedica and St. Luke's are close competitors. CCBR at 38-39. Complaint Counsel's narrow focus on that portion of the relevant market closest to St. Luke's is wrong as a matter of law and their conclusion is contradicted by the market facts. Proper merger analysis requires a review of the "structure, history, and probable future" of the relevant market, not blind reliance on "shares" in a piece of it. *Gen. Dynamics*, 415 U.S. at 498.

As an initial matter, "southwest Toledo" is neither the relevant geographic market alleged in the Complaint nor the one Complaint Counsel advance now. *Compare* Compl. ¶¶ 16-19 *with* CCBR at 22 ("The relevant geographic market . . . is Lucas County, Ohio"). An analysis of "market" shares just within St. Luke's core service area only captures about 60 percent of St. Luke's discharges. (RPF 1037). No evidence even insinuates, let alone proves, that any hospital can price discriminate against the residents of St. Luke's core service area by charging them higher or lower rates simply based on their zip code of residence. (RPF 1038). Moreover, the data shows that residents of St. Luke's core service area, like other Lucas County residents, use all eight hospitals located in Lucas County, rendering any examination of "market" shares within "southwest Toledo" meaningless. (RPF 1041).

What is relevant are the actions of MCOs, the purchasers of general acute-care inpatient hospital services. Here, MCOs uniformly recognize the similarities among the ProMedica and Mercy systems, and agree that ProMedica and Mercy, not St. Luke's, are each other's primary competitor. (RPF 1110, *in camera*, RPF 1113-1114; PX02443 at 002 ("In the Toledo market there are 2 major hospital systems")). { } experience configuring its network over time is particularly revealing. {

} (RPF 1112, *in camera*),

because it believed Mercy and ProMedica were similar in location, types of services offered, and acuity of care provided. (RPF 1114). Indeed, no MCO believes it could substitute St. Luke's for ProMedica within its network, a fact that even Complaint Counsel's economic expert conceded. *Compare* (RX-204 (Pugliese, Dep. at 11-12); RX-205 (Radzialowski, Dep. at 10-11); RX-23 (Pirc, Dep. at 16)) *with* (Town, Tr. 4057, 4081). MCOs, instead, believe that because of their

{

} (RPF 1119, *in camera*).

Not surprisingly, top executives at ProMedica and Mercy echo those views and consider each other to be its closest competitor. For example, Ronald Wachsman, ProMedica's Senior Vice President for Managed Care, Reimbursement and Revenue Cycle Management, testified:

> Q. Why do you consider Mercy to be ProMedica's primary competitor?
>
> A. Mercy is similar to ProMedica in a few important ways. They are also able to – like ProMedica, they're able to provide a geographic network of providers to be able to meet a payer's needs on their own. They also have employed physician relationships or aligned physician relationships, so they provide for the most part the same continuum of services that ProMedica provides. So from a provider standpoint and a geographic standpoint, they compete very closely with our system, whereas the other stand-alone hospitals really don't provide, you know, those two, those two capabilities.")

(Wachsman, Tr. 4833, 4866-4867). Likewise, Mercy's Senior Vice President for Business Development and Advocacy, Scott Shook, responded {

} (Shook, Tr. 1091-1092, *in camera*) ({

}).

Aside from the subjective views of ProMedica's and Mercy's executives, the data confirm ProMedica and Mercy to be each other's closest substitutes. For example, when {

}

contrary to what Complaint Counsel would predict. (RPF 1135). Likewise, St. Luke's analyzed patient discharge data from 2000 to 2007 and concluded that UTMC, not ProMedica, gained most of the patient volume that St. Luke's lost when it did not participate in the Paramount and

Anthem networks. (RX-2162 at 000001) ("I have been crunching some numbers to assess the shift in patients away from St. Luke's to other providers due to our exclusion from the Paramount and Anthem BCBS networks. *As expected, the main beneficiary of this exclusion was the University of Toledo.*") (emphasis added). When the joinder closed, St. Luke's re-joined Paramount's network, and St. Luke's believes that most of its new Paramount inpatient volume has come at { }, not from the other ProMedica hospitals. (Wakeman, Tr. 3025, *in camera*) {

}.

A diversion analysis of 2009 data conducted by Respondent's economic expert also predicts that if ProMedica were not available, {

}, contrary to what one would expect if ProMedica and St. Luke's really were close substitutes. (RPF 1129, *in camera*). Similarly, if St. Luke's were unavailable, {

} (RPF 1128, *in camera*). The results are similar {

} (RPF 1130, *in camera*). For example, for {

} (RPF 1132, *in camera*). Nevertheless, Complaint Counsel argue that Professor Town concluded the opposite based on his examination of data for five MCOs in Lucas County other than MMO. CCBR at 40-41. But MMO alone {

} (RX-71(A) at 000191-000193, *in camera*).

In the face of all this evidence, even Complaint Counsel's economic expert conceded on cross-examination that "Mercy is ProMedica's closest substitute." (Town, Tr. 4058). In sum, Complaint Counsel have no legal, economic, or factual support for their claim that ProMedica and St. Luke's are each other's closest competitor.

C. Complaint Counsel Overstate St. Luke's Competitive Significance

Because their unilateral effects theory depends upon St. Luke's relative importance as a competitor in the relevant market, but the facts demonstrate that Mercy, not St. Luke's, is ProMedica's closest competitor and that St. Luke's deteriorating financial condition jeopardized even its short-term viability as an independent competitor, Complaint Counsel have no choice but to overstate St. Luke's competitive significance, which they do. The record evidence demonstrates, however, that St. Luke's lacked the competitive significance Complaint Counsel attribute to it.

Complaint Counsel first claim that St. Luke's treated a "large number of commercial patients in Lucas County," stating, "St. Luke's served the third-largest number of patients in the market based on total (i.e., commercial, government, and self-pay) discharges and outpatients visits." CCBR at 41. Of course, that characterization ignores the undisputed fact that government insured and self-pay patients are not in the relevant product market, which is limited to commercially insured patients. (*Compare* RPF 1001 ("The relevant product market is general acute care inpatient hospital services available to commercially insured patients") *with* CCBR at 7 ("The first relevant service market is inpatient general acute-care services sold to commercial health plans") *and* CCBR at 16 ("The second relevant service market is inpatient obstetrical services sold to commercial health plans.")). Besides improperly including inpatients who are

outside the markets at issue, Complaint Counsel inappropriately add outpatient visits, which the parties also agree are not part of the relevant market, with inpatient discharges to conclude that St. Luke's treats the third highest volume of patients of any Lucas County hospital. (*Compare* RPF 1013 (". . . outpatient and quaternary services are excluded from this relevant product market because they are often excluded or contracted for separately.") *with* CCBR at 10 ("As Respondent admits, outpatient services are not included in the inpatient GAC market.")). Regardless of how St. Luke's patient volume is computed, it is undisputed that St. Luke's only treated approximately ten commercially insured inpatients (including just one expectant mother) per day. (RPF 1147). And, given the excess capacity available in the market and the relatively low acuity of care that St. Luke's provides, it is not surprising that {

} (PX02288 at 003, *in camera*).

Complaint Counsel then argue that St. Luke's was located in a "geographically desirable and strategically important part of Lucas County," suggesting that its location made it important for MCOs to include St. Luke's within their networks to improve their marketability.[11] CCBR at 41-42 (citing Pirc, Tr. 2266-2267, *in camera*) {

}. Despite MCOs' trial testimony about their need for St. Luke's, history teaches that MCOs like Anthem and Paramount have thrived with provider networks that did not include St. Luke's. Anthem successfully marketed a hospital network consisting only of ProMedica and UTMC until 2008. (RPF 725-728). Throughout, Anthem's membership remained stable, indicating that it was not at a competitive disadvantage relative to

[11] To the extent St. Luke's is located in a "geographically desirable and strategically important" part of Lucas County, Complaint Counsel cannot pretend that its competitors will not seek to increase their presence there as well. Indeed, this is the motivation behind { } See Section V.E. *infra*.

other MCOs that had broad networks. (RPF 728). Similarly, Paramount has always offered a limited hospital network and been successful in the market.[12] (RPF 779-783). The evidence also shows that employers who have selected Paramount instead of other MCOs since the joinder did so, in part, because Paramount was a lower cost option.[13] (Randolph, Tr. 7010-7015).

The "natural experiment" that Anthem and Paramount represent refute Complaint Counsel's claim that MCOs must have St. Luke's in their networks. MCOs' actions speak louder than their words, and St. Luke's alleged geographic advantage apparently did not prevent MCOs from reimbursing the hospital at levels below its costs of treating their patients. (RPF 1796, *in camera*; RPF 1842, *in camera*). Even Professor Town contradicted Complaint Counsel's position about St. Luke's importance to MCOs when he testified that St. Luke's is *not* a "must have" hospital. (Town, Tr. 4093). That is because, all else equal, the more valuable a product or service is, the more willing someone is to pay for it. (Town, Tr. 4098-4099). MCOs' unwillingness to reimburse St. Luke's at rates sufficient to cover its costs establishes that St. Luke's is less valuable to MCOs than other hospitals in Lucas County. (Town, Tr. 4099-4100). In sum, and as {

} (PX02288 at 003, *in camera*) (emphasis added).

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[12] Complaint Counsel misleadingly cite PX00040 for the proposition that "adding St. Luke's to the Paramount network could net Paramount as many as { } new members." CCBR at 42 (citing PX00040 at 008, *in camera*). ProMedica did estimate that {

} (PX00040 at 008, *in camera*). But, the document Complaint Counsel cite does not end there; it goes on to say: "The more likely scenario" is that {

} (PX00040 at 008, *in camera*). Moreover, Paramount's additional membership estimate also included { } who would enroll in Paramount's government insurance products. (PX00040 at 008, *in camera*).

[13] Mr. Randolph also testified that the addition of St. Luke's has not had a "significant impact" on Paramount, and Paramount would expect to see a bigger increase in Medicare patients than commercially insured patients due to the addition of St. Luke's. (Randolph, Tr. 7013).

Nevertheless, Complaint Counsel insist that ProMedica's pre-joinder *estimates* of how St. Luke's might impact ProMedica's hospitals once it re-joined the Paramount network support the notion that an independent St. Luke's posed a "direct threat to ProMedica's bottom line." CCBR at 43-44. Complaint Counsel again overstate and mischaracterize the record evidence. Paramount's hospital network, of course, does not include the Mercy hospitals. (Randolph, Tr. 6933). This means that the addition of any new hospital to Paramount's network will impact the ProMedica hospitals disproportionally as compared to if it had a broader network. Regardless, St. Luke's CEO Dan Wakeman testified at trial that he believes most of the new Paramount patient activity at St. Luke's since the joinder has come from UTMC, not the other ProMedica hospitals, based upon monthly Hospital Council of Northwest Ohio reports that show UTMC's *actual* admissions have decreased while *actual* admissions at ProMedica's hospitals have either increased or remained stable. (Wakeman, Tr. 3025, *in camera*; 3045-3046, 3049-3051). In other words, what has transpired in the marketplace since the joinder rebuts Complaint Counsel's speculation as to what might occur as a result of the joinder, again undermining their unilateral effects theory.

Complaint Counsel also seize on ProMedica's and Paramount's past contracting practices as evidence of the purported "formerly strong-competition between ProMedica and St. Luke's." CCBR at 45-48. They first argue that ProMedica exercised its "leverage to have St. Luke's excluded from Anthem's network for four and a half years, between 2005 and July 2009." CCBR at 45. The trial testimony established, however, that Anthem's "fair and competitive" negotiations with ProMedica resulted in a contract that was mutually agreeable and executed by both parties. *Compare* (Pugliese, Tr. 1554, 1610) *with* (RPF 751). At trial, Anthem testified that it {

} (Pugliese, Tr. 1588-1592, *in camera*). That is a procompetitive, not anticompetitive, result.

Complaint Counsel would also have the Court ignore perhaps the single most significant aspect of ProMedica's negotiations with Anthem in connection with that 2005 contract – that is, the agreement to exclude Mercy from Anthem's hospital network. (RPF 739). To obtain that greater exclusivity (and the corresponding expectation of a higher volume of patients), ProMedica agreed to reduce its rates by an additional { } (RX-208 (Wachsman, Dep. at 41, *in camera*)). When Anthem sought to add Mercy to its hospital provider network in 2008, Anthem and ProMedica negotiated a new contract with adjusted rates to reflect the addition of Mercy's hospitals into Anthem's network. (RPF 752). To compensate ProMedica for its reduced exclusivity and potential loss of patients to Mercy, Anthem agreed to increase its rates to ProMedica by approximately { }[14] (Wachsman, Tr. 4976-4977, *in camera*; RX-208 (Wachsman, Dep. at 41-42, *in camera*)). In contrast, when Anthem sought to add St. Luke's to its network, Anthem and ProMedica agreed to increase ProMedica's rates by just { } (RPF 773, *in camera*). The difference between ProMedica's change in rates when Mercy and St. Luke's entered Anthem's hospital network {

} (RPF 776, *in camera*). Thus, applying Complaint Counsel's favorite

[14] Anthem's new contract with ProMedica also included a most favored nations clause (at Anthem's request) to ensure that Anthem would receive at least as favorable a rate as ProMedica agreed to accept from any other third-party MCO. (RPF 754).

comparative metric, Anthem and ProMedica agreed that Mercy represented { } more potential lost Anthem business for ProMedica than St. Luke's. (RPF 776, *in camera*). This further corroborates the fact that Mercy, not St. Luke's, is ProMedica's closest competitor.

Complaint Counsel also highlight Anthem's proposal during the negotiations to exclude St. Luke's for only {

} CCBR at 45 (citing PX00231, *in camera*; PX02244, *in camera*; Pugliese, Tr. 1493-1497, *in camera*). Left undisclosed by Complaint Counsel, however, is that ProMedica initially sought an {

} but Anthem and ProMedica *compromised* and agreed to an { }[15] (RPF 771, *in camera*). Put in context, ProMedica's negotiations with Anthem do not compel the conclusion that the joinder has foreclosed "formerly strong competition."[16]

Nor does Paramount's experience with St. Luke's prove that the joinder extinguishes "formerly strong competition." Complaint Counsel imply that ProMedica engaged in unlawful exclusionary conduct by claiming, without citation, that it "refused to allow Paramount to contract with St. Luke's." CCBR at 47. However, the antitrust laws do not obligate ProMedica to help St. Luke's. *Verizon Commc'ns. Inc. v. Law Offices of Curtis V. Trinko, L.L.P.*, 540 U.S. 398, 408 (2004) (holding no duty exists to aid competitors). Moreover, the trial record reveals that Complaint Counsel again have mischaracterized past events.

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[15] Moreover, Complaint Counsel mischaracterize PX00295. ProMedica's managed care contracting team had recommended agreeing to { .} (Wachsman, Tr. 5005, 5240-5241, *in camera*; PX00333 at 002, *in camera*).

[16] In fact, trading discounts for greater exclusivity is common and not unique to ProMedica. For example, MMO increased Mercy's reimbursement simply for the right to negotiate with ProMedica to join its hospital network. (RPF 733). {

} (RPF 735, *in camera*).

Prior to the joinder, St. Luke's had participated in Paramount's network until January 1, 2001. (RPF 784). Before then, St. Luke's and Paramount tried to negotiate a new contract, but those talks broke down for a variety of reasons. (RPF 785). At that time, St. Luke's was keenly aware of and concerned with ProMedica's property at nearby Arrowhead Park. (RPF 786-787). St. Luke's senior management feared that signing a contract with Paramount might lead ProMedica to build a new hospital at Arrowhead and then cancel Paramount's contract with St. Luke's, as it believed ProMedica and Paramount had done with Mercy St. Charles in connection with ProMedica's construction of Bay Park. (RPF 787-789). In addition, St. Luke's objected to a proposed Paramount contract term that would have required St. Luke's to offer Paramount insurance to St. Luke's employees if Paramount insureds grew to be 20 percent or more of St. Luke's payor mix. (RPF 790).

For its part, Paramount was dissatisfied with St. Luke's rate proposals. Paramount had purchased a small health plan, Medical Value Plan ("MVP"), just prior to its negotiations with St. Luke's about a new contract. (RPF 791). Through the purchase, Paramount discovered that St. Luke's was giving a greater discount to MVP than to Paramount, despite Paramount representing a much larger proportion of St. Luke's patients. (RPF 792). During their negotiations, Paramount asked St. Luke's to extend its MVP discounts to Paramount; St. Luke's refused, proposing that Paramount's higher rates apply to the MVP patients. (RPF 793-794). When St. Luke's decided that the rates Paramount offered were too low, the parties mutually agreed to terminate their contract. (RPF 795-96). Interestingly, the loss of St. Luke's as a hospital provider had a minimal impact on Paramount's membership, a result that is consistent with the conclusion that St. Luke's is not ProMedica's next closest competitor. (Randolph, Tr.

7003) ("Q. Did the loss of St. Luke's from Paramount's hospital provider network in 2000 affect Paramount's membership? A. No. Actually, it had a very minimal effect on our membership.").

Complaint Counsel also claim that, eight years later, ProMedica overruled Paramount's desire to bring St. Luke's back into its network. CCBR at 47-48. Again, that mischaracterizes the facts.

When new CEO Dan Wakeman arrived at St. Luke's, he reached out to Paramount about rejoining its network, and even submitted rate proposals to Paramount as part of that dialogue. (RPF 799). While Paramount did contemplate adding St. Luke's back into its network before Anthem would in 2009 (Randolph Tr. 7083-7084), it only sought to do so at cost effective rates, which St. Luke's never proposed. (Randolph, Tr. 7017) ("[St. Luke's rate proposals] were better than historically had been the case," but they "certainly were not adequate to have [Paramount] . . . include them as a network hospital."). Thus, as Paramount's President testified, St. Luke's unwillingness to offer acceptable rates made any concerns voiced by other ProMedica employees about St. Luke's *potential* impact on the ProMedica hospitals immaterial. (Randolph, Tr. 7084) ("Well, for Paramount, to the extent we could add St. Luke's at a cost-effective rate that did not impede our ability to be cost-effective, then yes, it was important. We never got to that point because they never did, so, therefore, the issue of it being important to anyone else is kind of a moot point."). More importantly, St. Luke's itself believed that its re-entry into Paramount's network would impact *UTMC* more than it would impact the ProMedica hospitals. (Wakeman, Tr. 2831) ("A. At that time, it appeared that the University of Toledo Medical Center would be the one most affected by the inpatient traffic and activity if we were to come back into the Paramount programs"). And, that is what has happened since St. Luke's rejoined Paramount in September 2010. (Wakeman, Tr. 3025, *in camera*; 3045-3046, 3049-3051) (monthly Hospital

Council of Northwest Ohio reports show that UTMC's admissions have decreased while admissions at ProMedica's hospitals have either increased or remained stable since St. Luke's has rejoined Paramount). Thus, the history of Paramount's relationship with St. Luke's also fails to support Complaint Counsel's claim that the joinder will eliminate "formerly strong competition."

Complaint Counsel also contend that St. Luke's knew that it was a target of ProMedica's competitive efforts and feared "retaliation" from ProMedica as it became a stronger competitor and if it chose to affiliate with another Lucas County partner.[17] CCBR at 48-50.. Complaint Counsel argue that, rather than continuing to compete against ProMedica, St. Luke's chose to affiliate with it, primarily to access ProMedica's MCO reimbursement rates. CCBR at 49-50. Both of these contentions misrepresent the record.

Contrary to Complaint Counsel's claims, St. Luke's primary motivation to seek a joinder with ProMedica was not access to ProMedica's rates. (RPF 937). Instead, St. Luke's CEO, Dan Wakeman, testified that St. Luke's board was most concerned with {

} (Wakeman, Tr. 2961, *in camera*). St. Luke's Board Chair, James Black, echoed those concerns in his testimony:

{

[17] Complaint Counsel take pains to point out that St. Luke's considered filing an antitrust suit against ProMedica in the past. CCBR at 48. However, St. Luke's also contemplated filing an antitrust suit against Anthem. Of course, St. Luke's never did file an antitrust suit against ProMedica. (PX01207 at 003).

}

(Black, Tr. 5650, *in camera*). Indeed, Mr. Wakeman recommended that the board approve the pursuit of exclusive partnership discussions with ProMedica based on his evaluation of several factors, including:

- {

.}

(Wakeman, Tr. 2996–2997, *in camera*). To the extent it considered MCO rates in the context of an affiliation, that was because St. Luke's largest MCOs were paying it rates below the hospital's costs of treating their insureds. (*See, e.g.*, RPF 1804, *in camera* {

}; Sheridan, Tr. 6650-6651, *in camera* {

}). It is undisputed that {

.} (Wakeman, Tr. 2995-2996, *in camera*). Moreover, St. Luke's believed that an affiliation with {a } given its below-cost reimbursement situation. (PX01016 at 203-024, *in camera*) {

}

Furthermore, no evidence exists to even suggest that ProMedica approached the St. Luke's joinder with any thought of seeking higher rates from MCOs for either St. Luke's or ProMedica's legacy hospitals. During the course of joinder discussions with St. Luke's, ProMedica did not discuss the potential for increasing commercial payor rates at St. Luke's, The Toledo Hospital ("TTH"), Bay Park, or Flower. (Hanley, Tr. 4544-4545). And, {

.} (Oostra, Tr. 5881, *in camera*). Likewise, when ProMedica formulated its turnaround plan to restore St. Luke's to profitability, it { } (RPF 989, *in camera*). The reason was simple: {

.} (Hanley, Tr. 4666-4667, *in camera*). Instead, ProMedica focuses on what it can control – { } (Hanley, Tr. 4666-4667, *in camera*).

Complaint Counsel claim that another motivation for St. Luke's joinder with ProMedica was St. Luke's purported fear that ProMedica would "retaliate" if St. Luke's affiliated with either Mercy or UTMC. CCBR at 50. The very documents Complaint Counsel cite undercut that proposition and reveal that St. Luke's also {

} (PX01030 at 021, *in camera*). Indeed, it appears St. Luke's apprehension was well-founded, { }[18] *See* Section V.E. *infra*. Moreover, St. Luke's fear of a competitive response to an affiliation with *either* ProMedica or Mercy belies Complaint Counsel's argument that St. Luke's did not anticipate any entry or expansion by the disfavored competitor into southwest Toledo. CCBR at 84-87.

D. The Joinder Does Not Enable ProMedica To Raise Rates above Competitive Levels

Complaint Counsel must prove that, as a result of the joinder, there is a "reasonable probability" of a substantial lessening of competition *in the future* for general acute care inpatient services, or inpatient OB services, in Lucas County. *See Long Island Jewish Med. Ctr.*, 983 F. Supp. at 135; *Oracle Corp.*, 331 F. Supp. 2d at 1121 (stating that merger analysis is concerned primarily with "determining whether the merger would enhance market power, not whether market power currently exists."). To prove anticompetitive effects, Complaint Counsel cannot "simply [make] conclusory allegations that . . . the merger will significantly limit competition without any evidence." *Advocacy Org. v. Mercy Health Servs.*, 987 F. Supp. 967, 974 (E.D. Mich. 1997). Rather, they must show "anticompetitive effects . . . that will result from the merger." *Id.* "[A]ntitrust theory and speculation cannot trump facts." *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 116-17 (D.D.C. 2004).

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[18] St. Luke's believed that an affiliation with { } (PX01030 at 021, *in camera*; Wakeman, Tr. 2701, *in camera*) {

}

Complaint Counsel's reliance on ProMedica's high market share, their economic expert's "merger simulation model" of constructed, not real prices, and unfounded, speculative testimony from MCO witnesses about future prices, while ignoring actual evidence presented in this case that reflects competition in the relevant market prior to and following the joinder, is insufficient to meet their burden of proof. *See Arch Coal, Inc.*, 329 F. Supp. 2d at 130 (citing *Gen. Dynamics*, 415 U.S. at 498) (cautioning that "statistics concerning market share and concentration . . . were 'not conclusive indicators of anticompetitive effects'")). Similarly misplaced is any claimed correlation of market shares with prices, because with differentiated products, like hospital services, there is no automatic correlation between market share and anticompetitive effects, which in the hospital context means supracompetitive prices. *See Oracle Corp.*, 331 F.Supp.2d at 1122 ("a strong presumption of anticompetitive effects based on market concentration is especially problematic in a differentiated products unilateral effects context."); *see also Long Island Jewish Med. Ctr.*, 983 F. Supp. at 135; *Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic*, 65 F.3d 1406, 1411-12 (7th Cir. 1995) ("when dealing with a heterogeneous product or service, such as the full range of medical care, a reasonable fact finder cannot infer monopoly power just from higher prices"). In addition, and contrary to the *Horizontal Merger Guidelines*, Complaint Counsel misdirect their attention on St. Luke's and its ability to constrain ProMedica, when all of the evidence shows that Mercy is ProMedica's closest competitor and competitive constraint. *See Horizontal Merger Guidelines*, § 6.1 ("[t]he extent of direct competition between the products sold by the merging parties is *central* to the evaluation of unilateral price effects.") (emphasis added).

1. Complaint Counsel's Economic Expert's Price and Econometric Analyses Are Fatally Flawed

In their initial brief, Complaint Counsel argue that St. Luke's joinder with ProMedica is presumptively unlawful based upon an analysis of the parties' market shares. CCBR at 50-52. They go on to contend that because ProMedica's market share, as computed by their economic expert, is the highest compared to the other hospitals in Lucas County, ProMedica has market power which it has exercised to obtain the highest (aggregated, constructed) prices of all the competitors in the market. CCBR at 51. Even Complaint Counsel's economic expert agrees, however, that high prices are not necessarily indicative of anticompetitive conduct. (Town, Tr. 4200-4201). Indeed, there is no automatic correlation between market share and price, particularly in markets characterized by differentiated products, as the market for general acute care inpatient services in Lucas County is. *Oracle Corp.*, 331 F.Supp.2d at 1122. Where, as the evidence shows to be the case in Toledo, market shares are not an accurate predictor of future competitive effects, they are no substitute for a rigorous analysis of actual market dynamics. *See Baker Hughes, Inc.*, 908 F.2d at 983-85.

Fundamentally, the market shares that Complaint Counsel's economic expert calculated are flawed because they are not based upon the relevant product markets the Complaint alleges in this case. And a manipulated market definition cannot serve as the basis for valid market share calculations. *See Oracle Corp.*, 331 F. Supp. 2d at 1171-72 (holding that a "gerrymandered" market definition taints any market statistics based on that definition). Professor Town's manipulation of the inpatient dataset on which he calculates his market shares resulted in shares that understate the competitive significance of Mercy, ProMedica and UTMC in Lucas County, but overstate St. Luke's competitiveness. He achieves that result by using less than one year of data, (PX02148 at 143, *in camera*) ("Based on hospital discharges with commercial insurance from July 2009 through March 2010"), and then limiting the "market" for

which he computes the competitors' shares to only those general acute care inpatient services (identified as "diagnostic related groups" or "DRGs") that both ProMedica and St. Luke's provided to at least three commercially-insured patients. (RPF 1491). That initial "filter" has the effect of eliminating many services for which ProMedica, Mercy, and UTMC have considerable discharges. (RPF 1489-1493, 1504, 1510, *in camera*). Additionally, Professor Town inappropriately excluded from the market for which he computed the parties' shares overlapping St. Luke's and ProMedica DRGs for which St. Luke's and ProMedica compete with hospitals outside of Lucas County (RPF 1494-1495), and DRGs with a case weight index, which reflects complexity of care, greater than two. (RPF 1496). Ironically, Professor Town included within his relevant market (at least for market share computation purposes) some DRGs with case weights higher than four, thereby capturing some services that could be classified as tertiary or quaternary, which Complaint Counsel claim do not belong in the product markets alleged in the Complaint. (RPF 1500).

Professor Town's market share calculations for the alleged inpatient OB services product suffers from similar defects. He bases his share calculations for that market on less than one year of data, and excludes OB services that are not offered by both St. Luke's and ProMedica, or where the case weight was greater than two, outmigration was greater than 15 percent, and more than 20 discharges occurred. (RPF 1501, PX02148 at 143, *in camera*).

Once Professor Town finished applying his numerical filters to his dataset, he calculated competitors' market shares based on a market definition that captures only about 30 percent of the commercial discharges from Lucas County hospitals, and only 34 percent of ProMedica's total commercial discharges. (RPF 1505). And that market definition does not conform to the relevant market alleged in the Complaint.

A more appropriate measure of market shares in this case would be based upon billed charges, which reflect the fact that many DRGs and service lines require care that costs hospitals more to provide, result in longer hospital stays, and generate higher revenues. When market shares for general acute care inpatient services, inclusive of inpatient OB services, are calculated using billed charges, {

} combined have a higher share than ProMedica in Lucas County. (RX-71(A) at 000036-000037, 000162, *in camera*). Looking only at {

} based on billed charges in Lucas County. The numerical filtering that Complaint Counsel's economic expert performs before computing the competitors' shares in both the alleged general acute care inpatient services market and the separate inpatient OB services market improperly bias the results so as to overstate St. Luke's competitive significance and prevent an objective evaluation of the nature of competition in any alleged relevant market. (RPF 1510, *in camera*); *see Gen. Dynamics*, 415 U.S. at 498 (requiring an examination of the structure, history and probable future of the market). Simply put, Complaint Counsel's market shares neither accurately reflect the competitive dynamics of the general acute care inpatient services market in Lucas County nor can they serve as a reliable predictor of future competitive effects. *See Baker Hughes, Inc.*, 908 F.2d at 983-85.

Complaint Counsel also inappropriately rely on their economic expert's pre-joinder constructed prices to conclude that high prices are the direct result of high market shares. CCBR at 51. The most egregious flaw with this argument is that Professor Town's constructed prices are inconsistent with and unsupported by the evidence adduced at trial – a sufficient reason, in itself, for the ALJ to disregard them. *See Tenet*, 186 F.3d at 1054 n.13 ("When an expert opinion is not supported by sufficient facts to validate it in the eyes of the law, . . . it cannot support a

decision."). Moreover, as Professor Town conceded, higher prices can be a result of other, competitively benign factors, including cost or quality. (RPF 1522). *See Blue Cross & Blue Shield,* 65 F.3d at 1412 (noting that quality can affect prices). But Professor Town's case-mix-adjusted price estimates do not account for any other possible competitively benign explanations for the price difference he finds across Lucas County hospitals, including the complexity of the bargaining process between hospitals and MCOs. (RPF 1521). And Professor Town agrees that the presence of price differences alone are not sufficient to determine the exercise of market power. (RPF 1515, *in camera*).

Professor Town's constructed prices are inconsistent with MCO trial testimony. For example, while {

} (RPF 1350, 1527, *in camera*), Professor Town's case-mix-adjusted price calculations show Mercy's prices to be higher than ProMedica's. (RPF 1527). {

} (RPF 1528, *in camera*). Similarly, although {

} (RPF 1402, *in camera*), Professor Town's constructed price estimates do not take this factor into account. Nor does his analysis conform to testimony from Mr. Pirc of MMO, who testified that, {

} (Pirc, Tr. 2315-2316, *in camera*). {

.} (Pirc, Tr. 2316, *in camera*). This wealth of real world evidence undermines Professor Town's analysis based on constructed prices to the point where the ALJ should disregard it entirely. *See Brooke Group Ltd.*, 509 U.S. at 242 (ruling that "when indisputable record facts contradict or otherwise render the [expert's] opinion unreasonable, it cannot support a jury's verdict").

Moreover, documentary evidence demonstrates that hospital reimbursement rates in Lucas County are linked to their costs of providing care. (PX01016 at 009, *in camera*). For example, ordinary course of business documents show that {

.} (PX01016 at 009, *in camera*). The document also shows that, on a disaggregated basis, {

.} (PX01016 at 009, *in camera*).

In fact, a review of Professor Town's estimated case-mix-adjusted prices, disaggregated by hospital and MCO, corroborates the fact that ProMedica's prices are not higher than all other hospitals in Lucas County. (RPF 1531). For example, for Aetna, Professor Town's case weight adjusted price for St. Vincent is the highest of all Aetna's Toledo area hospitals, and ProMedica's system price is lower than Mercy's system price. (RPF 1532). Similarly, for Anthem, each of the Mercy hospitals' case weight adjusted prices is higher than TTH and about the same as Bay Park, though lower than Flower; St. Luke's has the lowest adjusted price. For Anthem, the estimated system price for Mercy is higher than the system price for ProMedica. (RPF 1533). For Blue Cross Blue Shield of Michigan ("BCBS of Michigan"), St. Vincent's price is higher than that of TTH. (RPF 1534). For FrontPath, St. Anne's price is higher than TTH's, St. Vincent's, UTMC's, and Flower's. (RPF 1535). Because Professor Town's model

reflects neither the real world competitive dynamics either before or after the joinder nor the evidence presented at trial, the Court should reject it as a basis for predicting the joinder's potential competitive effects. *See FTC v. CCC Holdings Inc.*, 605 F. Supp. 2d 26, 70-72 (D.D.C. 2009) (dismissing an expert's model because "the data and predictions cannot reasonably be confirmed by the evidence.").

2. Pre- and Post-Joinder Contracting Is the Best Evidence of a Lack of Competitive Harm

To attempt to meet its burden and prove that the joinder will increase prices post joinder, Complaint Counsel offer unsubstantiated speculation from sophisticated MCOs, a non-peer reviewed merger simulation model that no court has ever accepted, and St. Luke's hope and speculation that it may receive higher commercial reimbursement rates if it joined with ProMedica in lieu of actual pre- and post-joinder price-related evidence, which they dismiss as "manipulated." *Lektro-Vend Corp. v. Vendo Co.*, 660 F.2d 255, 276(7th Cir. 1981) (stating "post-acquisition evidence favorable to a defendant can be an important indicator of the probability of anticompetitive effects"). But the record reflects that prior to the joinder, St. Luke's received below-market commercial reimbursement rates from the same MCOs that testified at trial in opposition to this transaction and that, subsequent to the joinder, the rates that ProMedica has negotiated on behalf of St. Luke's are competitive and comparable to the rates that St. Luke's had previously negotiated with those same MCOs.

First, Complaint Counsel base their case on unsubstantiated, speculative testimony from MCOs. But as the court in *Tenet* held, this type of testimony, particularly from large, sophisticated buyers, is suspect. *Tenet Health Care Corp.*, 186 F.3d at 1054 (stating that MCOs' testimony that they would unhesitatingly accept a price increase was contrary to their economic interests and, therefore suspect). For example, Complaint Counsel rely on the testimony of the

representative from Humana, an MCO that insured less than one inpatient discharged per day from St. Luke's. (RPF 405). Complaint Counsel also presented testimony from {

} (RPF 1792, *in camera,* 1793, 1794-1804, *in camera,* 1823-1826, 1827, *in camera,* 1828, 1829-1842, *in camera*). Despite their claims that the joinder would result in increased rates and that they would not be able to offer alternative networks post-joinder, no MCO presented any rigorous studies showing that ProMedica would raise rates after the joinder, nor any studies to support their statements that patients are unwilling to travel to another hospital in Lucas County for general acute care inpatient services. (RPF 1261-1265, 1267, 1269-1271).

Second, Complaint Counsel rely on a non-peer reviewed merger simulation model that has never been accepted in any court as evidence that the joinder will substantially lessen competition. (RPF 1583-1585; RX-71(A) at 000076, *in camera*). But only variants of the basic model Professor Town uses to estimate the predicted price effects in this case have been published in peer-reviewed economics literature. (RX-71(A) at 000076, *in camera*). Complaint Counsel's implication that Professor Town's model has been peer-reviewed and validated for use in analyzing specific hospital mergers is misleading and incorrect. (RX-71(A) at 000076, *in camera*). In fact, there are no peer-reviewed articles that validate his model's predictions against the outcomes of actual mergers and, therefore, no way to judge the accuracy of the model's predictions. (RPF 1585; RX-71(A) at 000076, *in camera*).

Moreover, Professor Town's merger simulation model mistakenly predicts substantially higher price changes post-joinder because he omitted key explanatory variables (RPF 1333, 1574-1575), including variables that economists agree should be used in hospital merger

simulations. (RPF 1581). When these variables are incorporated into Professor Town's model, his predicted post-joinder price effect *cannot be statistically distinguished from zero*, making the results of his model unreliable. (Guerin-Calvert, Tr. 7520 ("[W]hen you include in . . . these explanatory variables, you come to the assessment that you cannot accept the conclusion that the post-joinder effect due to bargaining power bears a relationship or has explanatory power or is any different than zero"); *see also* RPF 1580, RX-71(A) at 000081, *in camera*). In other words, Complaint Counsel is asking this Court to rely on an untested, unverified, and unreliable economic model to substantiate Complaint Counsel's claim that this joinder will substantially lessen competition when the documents and testimony suggest otherwise.

Third, St. Luke's speculation that its commercial reimbursement rates would increase regardless of which Lucas County hospital it joined does not meet Complaint Counsel's burden to show that commercial reimbursement rates will increase to supracompetitive levels as a result of St. Luke's joinder with ProMedica. St. Luke's thought its rates would increase regardless of who it joined, since it was being paid below its costs.[19] (RPF 1783-1786, *in camera*). However, St. Luke's had no direct knowledge of any other hospital's rates at the time it decided to join with ProMedica. (*See* PX01016 at 023 (pros for joining with Mercy "favorable insurance contracts"); PX01030 at 013 (both Mercy and UTMC shown as having favorable managed care contracts); Wakeman, Tr. 2691-2693, *in camera* ({

[19] To the extent Complaint Counsel purport to use St. Luke's documents prepared before September 1, 2010, as party admissions, Respondent notes that any such documents were prepared prior to St. Luke's becoming part of the Respondent, and therefore do not constitute party admissions. *See Champagne Metals v. Ken-Mac Metals, Inc.*, No. CIV-02-528-C, 2004 U.S. Dist. LEXIS 27313, at *25 (W.D. Okla. June 15, 2004) (holding that "statements made by a predecessor-in-interest or employees of a predecessor are not admissible [as admissions by a party-opponent under the Federal Rules of Evidence]."); *see also* (Final PreTrial Conference, Tr. 51) (May 31, 2011) ("I am not convinced that the rule regarding admission to the party includes statements made by an individual who was not an employee of the party at the time the statements were made." ).

}); Black, Tr. 5651, *in camera* ({t

}}). Furthermore, ProMedica never discussed reimbursement rates with St. Luke's prior to the joinder nor did ProMedica's management {r

.} (RPF 940, 948, 949-950, *in camera*). ProMedica's turnaround plan for St. Luke's did not include {

.} (RPF 990, *in camera*).

There is no evidence in this case that ProMedica joined with St. Luke's to increase its bargaining leverage, market power or commercial reimbursement rates. Despite Complaint Counsel's claim, based on one draft of a document, that ProMedica touted its bargaining leverage with MCOs as an affiliation benefit, Mr. Oostra unequivocally testified that the draft of the document was never disclosed or sent to anyone outside of ProMedica and never presented to any potential affiliation partners, including St. Luke's. (Oostra, Tr. 6201-6226). Complaint Counsel have done nothing more than make conclusory statements and offer unsupported speculation about documents that are contradicted by other evidence, all of which this Court should disregard. *Advocacy Org.*, 987 F. Supp. at 974 (requiring more than conclusory statements to prove a violation).

Finally, Complaint Counsel ignore all of the pre- and post-joinder evidence that contradicts their theory that the joinder will substantially lessen competition. The record evidence reflects that St. Luke's post-joinder prices are comparable to prices St. Luke's would

have received had it remained independent. For example, prior to the joinder, St. Luke's negotiated a contract with { } (RPF 1872-1876, *in camera*). In comparison, the contract ProMedica negotiated on behalf of St. Luke's with { } after the joinder projected an eventual cost coverage ratio of only { } (RPF 1385, *in camera*).

Post acquisition evidence is only entitled to little weight *if it is subject to manipulation. Hosp. Corp. of Am. v. FTC*, 807 F.2d 1381, 1384 (7th Cir. 1986) (Posner, J.). Here, despite Complaint Counsel's protests to the contrary, there is no reason to discount the post-joinder evidence. The contracts that were negotiated subsequent to the joinder will be in place long after this case is over. (*See, e.g.*, RPF 1382, *in camera* ({ }); RX-333 at 000017-000018, *in camera* ({ })). Thus, ProMedica will have to live with the rates it negotiated until the contract is up for renewal. Moreover, the competitiveness of the post-joinder contracts is corroborated by comparison to contracts negotiated prior to the joinder. *See* RBR at 85-89.[20] Although Complaint Counsel suggest that the post-joinder contracts were manipulated, they present no support for that claim.

Nor have Complaint Counsel presented any evidence that ProMedica "can easily exercise its bargaining leverage by insisting on higher rates for OB and contracting for these rates separately." CCBR at 58. Instead, MCOs have testified that they approach negotiations with a view toward the overall cost for inpatient, outpatient and all other services for their entire patient base at a particular hospital or hospital system. (RPF 585). Thus, to the extent ProMedica might try to increase OB rates, payors would demand decreases in other rates. (RPF 587). There has

[20] RBR refers to Respondent's Post-Trial Brief, filed on September 13, 2011.

also been no evidence suggesting that when ProMedica and Mercy were the sole providers of OB services in Anthem's and MMO's networks, respectively, either hospital charged higher prices of OB services than it otherwise would have. (*See* Guerin-Calvert, Tr. 7230-7231).

Complaint Counsel argue that ProMedica seeks "the highest rates possible from commercial health plans," to support their claim that ProMedica will in fact extract higher rates from MCOs. CCBR 58. However, this argument ignores other testimony that all hospitals seek to maximize the reimbursement they receive from MCOs in order to cover their total cost of caring for their patients, which tends to increase over time, and yield an operating margin to fund capital expenditures, expansion, and maintain a strong balance sheet. (RPF 482). The evidence explains that hospitals seek higher reimbursement rates from MCOs to cover not only the cost of treating the MCO's members, but also the cost of treating government-insured and charity care patients.[21] (RPF 475-476). Hospitals need to generate a positive operating margin to fulfill that objective. (RPF 481). Complaint Counsel's argument also ignores the ALJ's own observation that he "wouldn't expect [hospitals] to negotiate the lowest rates. It's a business." (Opening Statements, Tr. 169). On the other side of the negotiating table, MCOs seek the lowest rate possible, but in any event want to pay similar rates as their competitors. (RPF 559). Ultimately, the evidence established that the rates ProMedica negotiated with MCOs after the joinder were the result of fair and competitive negotiations, and the trial record shows that ProMedica will pursue the same contracting philosophy after the joinder as it did before. (*See, e.g.*, RPF 778, *in camera*, 1383, *in camera*).

[21] Regarding Complaint Counsel's statement that the yearly bonuses Mr. Wachsman and his direct reports receive from ProMedica are based in part on the rates obtained in negotiations with health plans, Mr. Wachsman noted that his salary is based on a set of goals, a small fraction of which is based on whether he is able to negotiate contracts that are within ProMedica's cost coverage goals. (Wachsman, Tr. 5098-5099).

### 3. Ownership of Paramount, the Only MCO without a Broad Network, Does Not Permit ProMedica To Raise Rates above Competitive Levels

Complaint Counsel suggest, again without proof, that owning Paramount gives ProMedica the ability to raise rates above competitive levels. CCBR 59-60. Complaint Counsel rely upon testimony from Paramount's competitors to support their theory that ProMedica could "win either way" if ProMedica walks away from an MCO's network. CCBR at 60 (relying on testimony from Mr. Radzialowski of Aetna).[22] This testimony is based on nothing except unfounded apprehensions, and "unsubstantiated customer apprehensions do not substitute for hard evidence." *Oracle*, 331 F. Supp. 2d at 1131. It also ignores the very real possibility that if ProMedica ceases to be an in-network provider with one "open network" MCO, like MMO, that MCO's members would switch to another open network MCO (such as Anthem, Aetna, FrontPath, or United) instead of Paramount.

Complaint Counsel also disregard the fact that United walked away from ProMedica in 2005 and did not lose members. (RPF 359). Furthermore, Complaint Counsel contradict their own contention that narrow networks, such as a Mercy-UTMC network, will not succeed because patients want broad networks when they claim that patients who lose access to ProMedica would turn to Paramount, the only narrow network in Lucas County. Ironically, Complaint Counsel's argument supports the conclusion that limited networks can be successful and attract patients, which would make a competitively-priced Mercy-UTMC network marketable.

[22] Mr. Randolph noted that because Paramount cannot compete based on the size of its hospital network (it does not include Mercy), it must make sure it is attractive from a cost perspective. (Randolph, Tr. 6935-6936).

E. No Evidence Exists To Show that the Joinder Has Harmed or Will Harm Hospital Quality

Complaint Counsel assert that the joinder will harm hospital quality, but this argument ignores recent quality data demonstrating that St. Luke's quality lags behind ProMedica in several categories and evidence that the joinder will positively impact quality at St. Luke's and ProMedica's legacy hospitals. (RPF 1466, 2241-2255). In fact, Complaint Counsel's expert testified that he has not seen any economic evidence that the joinder has reduced the quality of patient care. (Town, Tr. 4348). Professor Town also disclaimed testifying that St. Luke's quality would decrease after the joinder. (Town, Tr. 4351).

The evidence revealed that St. Luke's quality ratings were not as high as they believed they were and that its ratings have slipped recently (suggesting that St. Luke's deteriorating finances, cutbacks in capital expenditures, and reduced payroll expenses were beginning to affect patient satisfaction if not patient care). Prior to the joinder, some patients {

} (RPF 1454, *in camera*). That same document identified {

} (RPF 1455, *in camera*). St. Luke's fared no better under recent quality metrics, which ranked St. Luke's lower than the legacy ProMedica hospitals for quality. (RPF 1466 (CMS reporting data through fourth quarter of 2010)). In fact, during the first three quarters of 2010, {

} (RPF 1462, *in camera*). Although he was initially surprised by these scores, {

} (RPF 1464, *in camera*). At the same time, ProMedica hospitals {

} (RPF 1463, *in camera*).

Moreover, ProMedica has historically performed better than St. Luke's in certain quality measures. For example, the American College of Cardiology ("ACC") data through the third quarter of 2010 ranked TTH higher than St. Luke's for cardiology services. (RPF 1465). TTH also outperformed St. Luke's with regard to heart services on two outcome-validated measures, issued by the Society of Thoracic Surgeons and the ACC. (RPF 1468). For critical care, ProMedica ranks in the top decile under the APACHE measurements. (RPF 1472). ProMedica received 32 awards from Healthgrades for clinical quality, including 18 or 19 at TTH alone. (Oostra, Tr. 5775). In addition, Navigant determined {

} (PX01221 at 068, *in camera*).

Navigant also determined in its study that {

} (RPF 1474-1477, *in camera*).

Complaint Counsel mischaracterize ProMedica documents and testimony regarding its quality initiatives. For example, ProMedica strives to achieve the top decile or reach the 100-percent rankings in its quality programs; anything less is not sufficient. (Oostra, tr. 5933-5934 ("subpar" meaning less than the top decile for quality scores)). ProMedica's CEO also explained that "any [health] executive in this country ... will say they need to improve their quality" (Oostra, Tr. 5998-5999), but that does not mean that their quality is not good. Indeed, all Lucas County hospitals are quality institutions. (RPF 1446). Lucas County residents and physicians perceive the quality of care at Lucas County hospitals to be comparable with one another. (RPF 1447-1448).

Complaint Counsel also overstate St. Luke's concerns about ProMedica's quality of care prior to the joinder. St. Luke's CEO, Dan Wakeman, testified that he recommended to the St. Luke's board that St. Luke's should pursue an affiliation with ProMedica for several reasons, including their plan to improve quality and satisfaction scores through an incentive program to management and employees. (Wakeman, Tr. 2996-2997). Whatever questions St. Luke's may have had about ProMedica's quality of care (or commitment to it) at the time the parties first began their discussions, they were resolved by the time St. Luke's board voted to approve the joinder.

Although Complaint Counsel suggest that quality is an important factor in an MCO's decision to include a hospital in its network, the reality is that MCOs were unwilling to increase St. Luke's rates in recognition of its allegedly superior quality. (RPF 1456-1460). { } representative testified that its members neither select a hospital based on its quality nor understand what it takes to be a quality provider. (RPF 1438, *in camera*).

Thus, there is no evidence that the joinder will harm quality at St. Luke's. To the contrary, the joinder will enable St. Luke's to gain access to life-saving technologies it did not have on its own, including eICU and smart pump. (RPF 2245, 2246, *in camera*, 2247-2252, 2253, *in camera*). As a result, St. Luke's patients and the community will benefit from quality improvements because of the joinder.

F. Complaint Counsel's Employer Evidence about the Impact of the Joinder Lacks any Foundation and the ALJ Should Disregard It

Complaint Counsel rely on testimony from "local employers" to argue the joinder will harm Lucas County employers and their employees.[23] Their testimony lacks any valid foundation, and the ALJ should, therefore, disregard it.

All the employers who testified lacked even the most basic knowledge of the local healthcare landscape in Lucas County. They did not know what services the different hospitals offered, which MCOs competed in Lucas County, or even which hospitals were in the various MCO networks. (Buehrer, Tr. 3089-3090, 3093; Neal, Tr. 2148, 2150-2152). None has ever negotiated with a hospital or had any exposure to MCO-hospital contracting. (Neal, Tr. 2144; Buehrer, Tr. 3089-3091; Lortz, Tr. 1732; Caumartin, Tr. 1872). Not one employer worked directly with MCOs to negotiate healthcare benefits for his or her employees. (Neal, Tr. 2092, 2144; Buehrer, Tr. 3089; Lortz, Tr. 1731-1732). Instead, they relied upon third-party consultants and brokers to handle those matters. (Neal, Tr. 2092; Buehrer, Tr. 3089; Caumartin, Tr. 1856).

Amazingly, although called to testify about the impact of the joinder on their employees, not one employer witness had any idea about their employees' healthcare usage. Ms. Neal, for example, has never visited any Lucas County hospital and, despite the vast resources of a large company like Chrysler, has not studied which hospitals Chrysler's employees use or whether they are willing to travel for care. (Neal, Tr. 2151, 2155). She is not alone in her ignorance. None of the employers had conducted any studies of their employees' healthcare utilization patterns. (Buehrer, Tr. 3088-3089; Lortz, Tr. 1738). Nor did they know the proportion of their healthcare expenses represented by general acute-care inpatient services as opposed to other

[23] The employers who testified barely merit the label "local." Most do not live within the relevant geographic market, and one employer's organization does not even operate there. (Lortz, Tr. 1715 (lives outside Lucas County); Neal, Tr. 2127-2128 (Michigan); Caumartin, Tr. 1833-1835 (Bowling Green, OH)). Mr. Caumartin worked as Superintendent of Bowling Green Schools and vice-chairman of the Wood County Schools Health Consortium, neither of which ever operated in Lucas County. (Caumartin, Tr. 1833-1835 (Bowling Green, OH)).

health services (though they acknowledged that their employees' demographic characteristics, as well as their use of other healthcare services (e.g., physicians, drugs, ancillary services), contribute significantly to their overall healthcare premium costs). (Neal, Tr. 2141, 2147; Buehrer, Tr. 3087-3089; Lortz, Tr. 1733-1734; Caumartin, Tr. 1872 ).

If Complaint Counsel's employer witnesses had studied their employees' healthcare usage more carefully, they would have learned that general acute care inpatient hospital services comprise just a small fraction of their total healthcare costs and that only six percent of all commercially insured persons – one in every 17 persons – actually require general acute care inpatient services each year. (RPF 441).

Given the employer witnesses' ignorance about the impact of the joinder on their employees, one is left to wonder what motivated these witnesses to testify when Complaint Counsel contacted them. After all, many in the community, like the { } and the { }, strongly support the joinder. (RPF 2257, *in camera*). For Mr. Lortz, the bad blood between the UAW and ProMedica, which has long resisted unionization, strongly suggests that his testimony was motivated by bias against ProMedica. (Lortz, Tr. 1726-1727). Mr. Lortz has close ties to the unionized Mercy hospitals. (Lortz, Tr. 1717-1718). Indeed, he first learned of the joinder from Mercy and later asked the Ohio Attorney General to investigate the joinder. (Lortz, Tr. 1713-1715). In contrast, neither Ms. Neal nor Mr. Buehrer had any knowledge of the joinder or concern about its impact until Complaint Counsel started dialing for witnesses. (Neal, Tr. 2126-2127; Buehrer, Tr. 3080-3081). Mr. Buehrer's lack of concern was especially startling. (Buehrer, Tr. 3080 ("...it happened to be a day when I wasn't under a lot of pressure, because if it was a typical day, I probably would have said 'I don't have time'.")).

Complaint Counsel cannot demonstrate any significant impact on consumers as a result of the joinder. No employees testified in this matter and the employers on which Complaint Counsel rely lack any knowledge of the Lucas County healthcare market, their employees' usage patterns and preferences, and the proportion of employees' healthcare costs generated by the relevant product in this case. Their testimony is without foundation and should be disregarded.

## V. MARKET FACTS AND NATURAL EXPERIMENTS PROVE THAT PROMEDICA WILL NOT BE ABLE TO RAISE RATES ABOVE COMPETITIVE LEVELS

### A. Excess Capacity and Competitive Responses by Rivals Are Another Reason Why the Joinder Will Not Give ProMedica the Ability To Raise Rates above Competitive Levels

Complaint Counsel claim that there are no competitive constraints on ProMedica in this market. Respondent is not asserting that Toledo hospitals should be exempt from the antitrust laws, but that an analysis of the structure, history and probably future of the market demonstrate that Complaint Counsel have not met their burden of proving that the joinder has a reasonable likelihood of resulting in a substantial lessening of competition in the future. *See Gen. Dynamics*, 415 U.S. at 498; *Long Island Jewish Med. Ctr.*, 983 F. Supp. at 135. There is no evidence that since the joinder ProMedica has raised either St. Luke's or its legacy hospitals' rates for general acute care inpatient services above competitive levels. Indeed, the evidence shows that, while ProMedica has negotiated new contracts for St. Luke's at rates higher than they were before the joinder, the newly negotiated rates are consistent with ProMedica's pre-joinder managed care contracting philosophy and remain at competitive levels.

Merging parties are constrained from increasing prices to supracompetitive levels if other firms can enter the relevant markets. *Id.* That can occur if new firms enter the relevant markets, or if existing firms expand their current capacity or "[expand] into new regions of the market." *FTC v. Cardinal Health, Inc.*, 12 F. Supp. 2d 34, 55 (D.D.C. 1998). *See also Baker Hughes*, 908

F.2d at 989 n.8. The *Horizontal Merger Guidelines* also evaluate "repositioning" like new entry. *Horizontal Merger Guidelines*, § 6.1; *see also In re Evanston*, 2007 FTC LEXIS 210, at *159 (quoting IV Phillip E. Areeda, Herbert Hovenkamp & John L. Solow, *Antitrust Law* ¶ 914a, at 67 (3d ed. 2009) ("The degree to which a merger in a product-differentiated market might facilitate a unilateral price increase depends on . . . the relative inability of other firms to redesign their products to make them close to the output of the merging firms.")). Even perceived entry or expansion can constrain a possible anticompetitive price increase. *See Baker Hughes*, 908 F.2d at 988.

Here, because there is excess capacity, competitive responses by Mercy and UTMC will constrain ProMedica's ability to increase rates above competitive levels. Although Complaint Counsel assert that the number of inpatient hospital beds in Toledo is not unusual, they miss the point that excess capacity – which represents the ability of competitors to expand – does not need to be "unusual;" it just has to exist, or be perceived to exist, to constrain any attempts by ProMedica to raise rates to an anticompetitive level. *Id.*

There is virtually no dispute that excess capacity exists in Lucas County and the evidence establishes that it will constrain ProMedica's prices to MCOs. While Complaint Counsel cite just one witness who testified that the number of hospitals in the Toledo area was not out of line (Radzialowski, Tr. 651-652), they fail to point out that Mr. Radzialowski, who neither lives nor works in Lucas County, did not say that there was not excess capacity. Several other witnesses, who actually do live and work at the hospitals located in Lucas County, testified that Lucas County has excess capacity for general acute care inpatient services. For example, Mr. Shook of Mercy testified that he believed there is excess bed capacity in the Toledo area for general acute care services. (Shook, Tr. 1032, 1037, 1041; PX02288 at 003, *in camera*). More specifically, he

said that Mercy has the capacity, right now, to accommodate an additional ten patients per day at its Toledo-area hospitals. (Shook, Tr. 1042). In other words, Mercy alone can treat all of St. Luke's commercially insured patients. (RPF 1147). It is little wonder that {

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(PX02288 at 003, *in camera*; Shook, Tr. 1112, *in camera*). Similarly, Dr. Gold of UTMC testified that northwestern Ohio has more inpatient acute care beds than needed. (Gold, Tr. 257; PX02206 at 001). He also has referred to the Toledo area as "overbedded" and believes that there is a high degree of duplication of services in the community. (Gold, Tr. 340; PX02206 at 001). In fact, most days, UTMC could provide general acute care inpatient services to additional patients, if needed, by utilizing more of its staffed beds or staffing more of its registered beds that are currently unstaffed. (Gold, Tr. 256, 283). Finally, {

.} (Nolan, Tr. 6313, *in camera*).

Complaint Counsel's argument that Mercy cannot constrain ProMedica in southwest Lucas County because Mercy offers no direct counterpart there is misleading. First, it ignores the fact that, prior to the joinder, ProMedica did not have a hospital in the southwest Lucas County quadrant but, according to Complaint Counsel, was still a "must have" for the MCO networks. Second, a hospital system does not need a physical presence in the southwest quadrant of Lucas County to effectively compete against ProMedica there (just as ProMedica did not have to have a hospital there to compete for patients in that section of Lucas County prior to the joinder).

Thus, whether Mercy has a hospital in southwest Lucas County is irrelevant to the question of whether Mercy and UTMC, through their own competitive responses, can effectively

constrain any attempts by ProMedica to raise general acute care inpatient services rates to supracompetitive levels. And they can do that without constructing a new hospital in southwest Lucas County.

### B. The History of MCO Networks Demonstrates Why a Mercy-UTMC Network Can Constrain ProMedica's Rates Post-Joinder

A relevant question for the analysis of ProMedica's joinder with St. Luke's is what alternative hospitals are available to MCOs and patients in the event ProMedica tries to impose an anticompetitive rate increase. *See Tenet*, 186 F.3d at 1054; *Oracle*, 331 F. Supp. 2d at 1131. The *Horizontal Merger Guidelines* note that "natural experiments" are informative when evaluating a merger's possible competitive effects. *Horizontal Merger Guidelines*, § 2.1.1. Here, there is a natural experiment concerning the viability and marketability of narrow networks, which Complaint Counsel ignore.

MCOs could offer their members a competitively-priced network comprised of Mercy and UTMC as an alternative to ProMedica. Narrow networks were the norm in Lucas County until as recently as 2008. (RPF 709-717, 1252). MMO and Anthem, the two largest MCOs in Lucas County, offered hospital provider networks that excluded ProMedica and Mercy, respectively, until 2008. (RPF 709-714, 263, 283). Even now, Paramount offers a narrow network that competes on price with the other major MCOs in Lucas County. (RPF 314; Randolph, Tr. 6935-6936 (noting that because Paramount cannot compete based on the size of its provider network, it must be attractive from a cost perspective)). MMO, Anthem, and Paramount competed with each other and with broad access networks, and were able to maintain a steady membership and serve their members well. (RPF 719-720, 728, 317). The excess hospital bed capacity in Lucas County allowed MCOs like MMO and Anthem to serve their members with less than all hospitals in their networks. (RPF 719-720, 728, 256). Of course,

from 2001 until the joinder in September 2010, Paramount was able to serve its members without St. Luke's in its network. (RPF 317).

Second, history shows that MCOs are able to play ProMedica and Mercy against each other to the MCOs' advantage in narrow networks. United was able to substitute Mercy for ProMedica when ProMedica exited United's network in 2005, and United continued its presence in Lucas County. (RPF 359). { } parlayed Mercy and ProMedica's fears that { } would align exclusively with the other system if they refused { } demand for significant rate discounts. (RPF 1257, *in camera*). { } received a double digit rate discount from { } in exchange for leaving { } out of its network. (RPF 740-741, *in camera*). Similarly, { } received a significant discount from { } in exchange for leaving { } out of its network. (RPF 730-732, *in camera*, 1253).

Finally, despite MCOs' testimony that a Mercy-UTMC network would not be marketable, no MCO has even tried to market it, nor have any presented any studies to support their speculation that a Mercy-UTMC network would not be marketable. (RPF 1250). Even Complaint Counsel's economic expert admitted that MCOs have not tried to market a Mercy-UTMC network. (Town, Tr. 4311). Complaint Counsel simply assume that because it has not been tried before, a Mercy-UTMC network could not succeed in the future. If MCOs can successfully market a ProMedica-UTMC only network, as the evidence shows they have, they can also offer a Mercy-UTMC network by substituting Mercy for ProMedica, just as United did in 2006.

### C. MCOs, Employers, and Physicians All Have the Means To Defeat Any Attempt by ProMedica To Raise Rates above Competitive Levels

Complaint Counsel focus their attention on "hard steering" by MCOs. However, this ignores evidence that MCOs, employers and physicians all have the means to adjust their current

practices to defeat any attempt by ProMedica to raise rates above a competitive level. As the *Tenet* court noted, steering can successfully change patient behavior. *Tenet*, 186 F.3d at 1049. These alternatives are not theoretical; in fact, MCOs and employers in Lucas County, including some of the county's largest employers, are already employing tactics to incentivize members and employees to use lower cost options. (RPF 1285, 1295, 1300).

MCOs may use multiple tools to steer insureds to utilize certain healthcare providers, including affirmative financial or other incentives. (RPF 1272). Aetna is piloting a program in Lucas County to steer members to lower cost hospitals. (RPF 1308-1310). If Aetna did not believe that program would work – in Lucas County where there is high unemployment and presumably concerns about healthcare costs – it would not have wasted resources testing it. MCOs also are not prohibited from providing the relative cost of care among hospitals or between, for example an HMO product or a PPO product. (RPF 1276). Ultimately, MCOs can walk away from ProMedica if it attempts to raise rates above a competitive level. *See supra* Section V.B.

Complaint Counsel ignore the fact that three sizable employers in Lucas County are already steering their employees to lower cost alternatives. (RPF 1285, 1295, 1300). ProMedica has no ability to stop employers from changing their benefit designs to favor networks with certain, lower cost, hospitals. (RPF 1292, *in camera*). The Lucas County government changed its benefit design such that it contributed a greater percentage to its employees' healthcare costs if they chose to enroll with Physicians Health Collaborative ("PHC") instead of Paramount or FrontPath. (RPF 1285). This, in effect, steered its employees away from ProMedica because ProMedica is not in the PHC network. (Randolph, Tr. 7065). Similarly, the Catholic Diocese of Toledo worked with United to develop a benefit design that included only the Mercy system

hospitals. (RPF 1294-1295). For this narrow network, United and Mercy negotiated lower rates for Diocese members because Mercy was now guaranteed that business. (RPF 1296). Finally, Mercy devised a health plan for its employees that puts its provider hospitals into three tiers, with tier one being the preferred (less expensive) tier and including only Mercy hospitals. (RPF 1300-1301). Mercy employees who choose to go to ProMedica hospitals incur higher out-of-pocket expenses. (RPF 1300-1301).

Physicians also offer a competitive constraint on ProMedica. Contrary to Complaint Counsel's argument, physicians do consider which hospitals are in-network providers in a patient's MCO, and they can and do make referrals accordingly. (RPF 680, 682-683). In order to admit and treat patients in their in-network hospital, a physician must have privileges there. For example, when St. Luke's was no longer a preferred provider under Mercy's health plan, Dr. Marlowe sought privileges at St. Vincent to better serve Mercy employees who would get lower in-network rates at Mercy hospitals. (Marlowe, Tr. 2427-2428).

Physicians will also change referrals based on patient requests. (RPF 680). Complaint Counsel's assumption that patients prefer to remain close to home and, therefore, would not prefer a more distant but perhaps less expensive hospital, is unfounded. The data show that patients do travel. Even with broad access networks, a significant number of patients are driving past hospitals that are closer to them, indicating that location is not a material factor when patients choose a hospital. (RPF 1215-1218). Moreover, patients consider other factors, such as their doctors' preferences, quality, and previous experience, in choosing a hospital. (RPF 43-45). Having the ability to admit patients to various hospitals is how physicians can facilitate switching and provide a competitive check on ProMedica. *See Sutter Health Sys.*, 130 F. Supp.

2d at 1132 (using actual physician overlapping privileges data to counter MCOs' testimony that patients would not switch hospitals in the face of a price increase).

An analysis of physician overlap shows that many doctors with admitting privileges at St. Luke's have privileges elsewhere, allowing them to refer patients to other hospitals. This is true even if a physician is employed by a hospital. Employed physicians have no restrictions on where they can refer patients. (RPF 324, 677, 686-693). {

.} (RPF 695, *in camera*). {

.} (RPF 704, *in camera*).

{

.} (RPF 708, *in camera*). This evidence of informative, natural experiments that are occurring today in Lucas County reflects the structure, history and probable future of the market, and show that, despite unfounded fears by third parties, the joinder will not substantially lessen competition. *See Gen. Dynamics*, 415 U.S. at 498; *Oracle Corp.*, 331 F. Supp. 2d at 1109; *Horizontal Merger Guidelines*, § 2.1.1.

D. Competitive Responses by Rivals Will Also Constrain ProMedica

Competitive responses by rivals such as { ,} which has a well-conceived plan to attract additional patients from southwest Toledo, also will constrain ProMedica's ability to raise rates above competitive levels. Complaint Counsel incorrectly focus on the need for *de novo* entry to constrain ProMedica post-joinder. CCBR at 84-87. That approach is incorrect as a

matter of law and fact, particularly given the number and location of competing hospitals and the excess inpatient bed capacity extant in Lucas County.

Contrary to Complaint Counsel's contention, repositioning by rivals is hardly a "novel 'quasi-entry' argument." CCBR at 86. Indeed, the *Horizontal Merger Guidelines* state "[r]epositioning is a supply-side response that is evaluated much like entry." *Horizontal Merger Guidelines*, § 6.1. They recognize that "non-merging parties may be able to reposition their products to offer close substitutes for the products offered by the merging firms." *Id.* Complaint Counsel, therefore, have no basis for their position that Respondent must show that *de novo* entry (i.e., by a new inpatient hospital) is likely to occur in order to argue that entry can prevent any post-joinder anticompetitive effects. Instead, as the *Horizontal Merger Guidelines* make clear, repositioning by rivals can defeat anticompetitive effects. *See also Baker Hughes, Inc.*, 908 F.2d at 988-89 (the presence of existing firms "poised for future expansion" supported the conclusion that the merger at issue would not likely cause anticompetitive effects).

That conclusion is reinforced here because, as Mercy and UTMC both agree, the Toledo area is characterized by excess capacity, (Shook, Tr. 1032, 1037, 1041; Gold, Tr. 257, 340), which provides these rivals the incentive and ability to respond competitively to St. Luke's joinder with ProMedica. (Guerin-Calvert, Tr. 7286-7287). Indeed, MCOs have previously taken advantage of the Lucas County hospitals' excess capacity to market limited hospital networks that satisfied their members' needs effectively. (Guerin-Calvert, Tr. 7291-7293).

The existence of excess capacity also explains why *de novo* entry is not necessary to constrain any attempt by ProMedica to raise rates above competitive levels. Indeed, {

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(PX01940 (Shook, Dep. at 45, *in camera*)). That is because the {

} and advances in technology will continue to erode the need for lengthy inpatient stays and, therefore, inpatient beds. (PX01940 (Shook, Dep. at 14, *in camera*); Shook, Tr. 967).

That also explains the motivation for {

.} (Shook, Tr. 971, 981-982, *in camera*, 1056). {

.} (Shook, Tr. 973, *in camera*, 982-985, *in camera*). Thus, { } satisfies the *Horizontal Merger Guidelines*' requirements that the entry or repositioning be likely and timely. *Horizontal Merger Guidelines*, §§ 9.1-9.2.

{

.} (Shook, Tr. 983, *in camera*). {

}

(Shook, Tr. 982, *in camera*, 1115, *in camera*). As Respondent's expert economist testified,

{

.} (Guerin-Calvert, Tr. 7390-7392, *in camera*). For these reasons, { } also satisfies the *Horizontal Merger Guidelines*' requirement that the entry or repositioning be sufficient to defeat anticompetitive effects. *Horizontal Merger Guidelines*, 9.3. Indeed, prior to the joinder, St. Luke's not only feared "retaliation" from ProMedica if it affiliated with Mercy, but also believed that {

.} (PX01030 at 021, *in camera*; PX01018 at 014, *in camera*) {

)} Likewise, ProMedica believes that { } will not stand idly by and will respond competitively. (Oostra, Tr. 5807-5808; RX-475 at 000001). To the extent Complaint Counsel are correct that St. Luke's is located in a "geographically desirable and strategically important part of Lucas County," that can only serve as additional motivation for rivals to increase their presence in St. Luke's backyard. CCBR at 41. Both St. Luke's and ProMedica's beliefs as to { } are significant because even "the threat of entry can stimulate competition in a concentrated market, regardless of whether entry ever occurs."[24] *Baker Hughes, Inc.*, 908 F.2d at 988. Therefore, competitive responses by St. Luke's and ProMedica's rivals can constrain ProMedica's ability in the future to raise prices above competitive levels.

E. St. Luke's Financial Condition Was Not Indicative of a Resurgent Competitor

Complaint Counsel stands alone in its belief that St. Luke's was a financially strong competitor. St. Luke's management, board, documents, credit rating agency, and bond insurer

[24] Aside from { ,} UTMC is also seeking to develop additional outreach clinics with the hope of gaining additional inpatient referrals. (Gold, Tr. 264-265).

all disagree. Even the ALJ recognized on the first day of this proceeding that a monthly "profit" of $7,000 on $36 million of revenue is a "rounding error." (Opening Statements, Tr. 88). To support their delusion, Complaint Counsel misleadingly focus on total inpatient and outpatient volume, revenue, and market share. Yet they ignore the expenses, operational losses, and potential service cuts that accompanied these metrics at St. Luke's. They anoint St. Luke's CEO Dan Wakeman as a turn-around guru, but ignore him when he judged that the three-year plan failed financially and carefully, reluctantly, but rationally concluded that a joinder with ProMedica was the best way for St. Luke's to continue serving the community in the future. To counter the views of St. Luke's rating agency and bond insurer who confirm St. Luke's self-assessment, Complaint Counsel put forth Mr. Errol Brick as an expert to "re-interpret" these views; yet he does not himself evaluate the underlying facts.

Complaint Counsel forget that this assessment concerns a hospital operating in a healthcare industry that is highly regulated, where for-profit and not-for-profit participants' financial performance is closely scrutinized and compared. They ignore benchmarks with comparable hospitals on operating profit, operating margin, earnings before interest, taxes, depreciation and amortization ("EBITDA"), age of plant, percentage of private beds, and reimbursement rates that all show St. Luke's lagging significantly behind peer hospitals. Yet Complaint Counsel persist in comparing St. Luke's pension funding with the likes of Exxon and CBS. They minimize the substantial regulatory burdens faced by St. Luke's and other hospitals. Yet sixty percent of St. Luke's patients are non-negotiated, fixed-rate Medicare or Medicaid patients, and that number is increasing. St. Luke's faces more than $20 million in new capital expenditures for new electronic medical record ("EMR") systems lest it be severely penalized, and federal healthcare legislation is shifting the risk for the cost of patient treatment to hospitals.

Hospitals are uniquely capital intensive, yet Complaint Counsel focus on a measure for cash flow, EBITDA, that excludes capital expenditures.

1. St. Luke's Financial Condition Was Deteriorating Before The Joinder

"Activity, yes. Financial, no." This testimony from Mr. Wakeman, when asked whether St. Luke's had improved, succinctly describes St. Luke's financial predicament leading up to the joinder. (Wakeman, Tr. 2608). Complaint Counsel are correct that the number of patients at St. Luke's had increased, but neglect to mention that on average St. Luke's lost money on each patient who walked through its doors. Complaint Counsel are also correct that St. Luke's revenues had increased, but deliberately ignore the other side of the ledger which showed that its costs had increased even more. Complaint Counsel are also correct that St. Luke's market share had grown, but neglect to state that St. Luke's remained unprofitable.

Mr. Wakeman's statement also illuminates a major flaw in Complaint Counsel's argument – they focus on the first half, "activity, yes", but ignore the second, "financial, no." Complaint Counsel's conclusion that Mr. Wakeman's three-year plan turned St. Luke's around epitomizes this flaw. (*See, e.g.,* CCBR at 90). To support this conclusion, Complaint Counsel cite numerous documents, statistics, and testimony all of which support a point with which Respondent agrees – St. Luke's total patient volume, revenues, and market share improved during Mr. Wakeman's tenure. For example, in support of their conclusion that the three-year plan was a success, Complaint Counsel include a list describing improvements in the following metrics (CCBR at 90-91):

- Inpatient revenue
- Outpatient revenue
- Inpatient market share in St. Luke's core service area
- Acute inpatient admissions

- Inpatient volume
- Outpatient visits
- Patient days
- Cases treated
- Occupancy rate

However, all these show improvements in volume, and none reflect profits.

Most egregiously, Complaint Counsel explain that Mr. Wakeman's three year plan "consisted of five strategic pillars, including pillars for Growth' and 'Finance/Corporate.'" (CCBR at 90). Complaint Counsel then state that St. Luke's "achieved four of the five pillars in the Three-Year Plan," quoting Mr. Wakeman, who wrote, "I guess that growth thing worked...we did a great job in 4 of the 5 pillars." (CCBR at 90). However, Complaint Counsel glaringly omit the fifth pillar which St. Luke's did *not* achieve – the "Finance/Corporate" pillar. They ignore Mr. Wakeman's testimony explaining how, before the joinder, St. Luke's did not achieve the financial pillar or any of the financial metrics that were outlined in those financial goals (RPF 1942-1949):

- St. Luke's did not accomplish the three-year plan goal of having "a break even margin by the end of 2009." (RPF 1943) St. Luke's did not even achieve a break even margin by the end of 2010. (RPF 1944).
- St. Luke's did not accomplish the three-year plan goal of "[w]ithin three years, systematically convert[ing] all St. Luke's double-bed patient rooms to single-bed patient rooms." (RPF 1948). In fact, at the time of the joinder, only { } percent of St. Luke's rooms were single-bed rooms. (RPF 2222, *in camera*).
- St. Luke's did not accomplish the three-year plan goal to "Maintain St. Luke's "A" rating with Moody's." (RPF 1945). St. Luke's was downgraded twice during Mr. Wakeman's tenure and at the time of the joinder St. Luke's rating with Moody's was Baa2 and its outlook was negative. (RPF 1981-1983). As Mr. Wakeman described, the Baa2 rating { } (RPF 1984, *in camera*).
- St. Luke's did not accomplish the three-year plan goal to "Achieve an average age of plant consistent with Moody's "A" rated hospitals." (RPF 1947). {

.} (RPF 1918, *in camera*).

- St. Luke's did not accomplish the three-year plan goal to maintain a "Debt Service Coverage Ratio of 2.0." (RPF 1946). St. Luke's debt coverage ratio dropped to negative 2.9 in 2009 and was 0.5 in 2008. (RPF 2009; RPF 2011).

Complaint Counsel also highlight St. Luke's capacity constraints in the months leading up to the joinder as a sign of St. Luke's improvement. (*See, e.g.*, CCBR at 92). But reduced capacity is just another measure of volume increases and says nothing about profitability. Moreover, St. Luke's capacity constraints were a sign of its financial weakness and competitive limitations, not a sign of financial strength as Complaint Counsel imply. St. Luke's capital freeze had prevented it from making important investments in expansion and private rooms prior to the joinder. (RPF 1949, 1961, 2113-2114). In addition, its hiring freeze made it more difficult for St. Luke's to serve its growing numbers of patients with its existing staff. (RPF 1919-1933, 1934-1935, *in camera*).

In the rare instances when Complaint Counsel and their financial expert, Mr. Dagen, do focus on measures of profitability rather than volume, they limit their analysis to a very short time period, typically the first eight months of 2010. Mr. Dagen testified that the most important time period in analyzing St. Luke's financial viability is from 2008 when Mr. Wakeman arrived, through 2010 when the joinder occurred. (Dagen, Tr. 3337-3338). However, he repeatedly ignores his own recommendation, as do Complaint Counsel. When they talk about a "positive trend" they invariably mean only the first eight months of 2010. For example, Mr. Dagen testified that in the first eight months of 2010, St. Luke's operating loss was less than the operating loss that occurred in 2009, and this was "a positive trend." (Dagen, Tr. 3413-3414). That is misleading because St. Luke's parent, OhioCare's operational losses in the first eight

months of 2010 were large, $7.7 million. The table below shows OhioCare's and St. Luke's operating losses and negative operating margin from 2007 through the first eight months of 2010. OhioCare is the more relevant entity because it incorporates St. Luke's physician practice acquisitions (a key component of St. Luke's three-year plan) and their related financials.

**Table 1**

| *($ millions)* | 2007 | 2008 | 2009 | 8/31/10 |
|---|---|---|---|---|
| Operating Loss (OhioCare) | ($8.163) | ($12.673) | ($20.246) | ($7.745) |
| *Margin (OhioCare)* | *-6.2%* | *-9.1%* | *-13.0%* | *-6.9%* |
| Operating Loss (St. Luke's) | ($7.698) | ($8.976) | ($15.167) | ($2.702) |
| *Margin (St. Luke's)* | *-5.9%* | *-6.6%* | *-10.3%* | *-2.6%* |

(RX-56 at 000006). Indeed, in the short paragraph in Complaint Counsel's initial brief that claims that "St. Luke's increased its profitability," they include three statistics and one quotation all of which are limited to improvements in St. Luke's in the first eight months of 2010. (CCBR at 91).

Complaint Counsel's focus on EBITDA as a measure of St. Luke's financial viability is also inaccurate and misleading. (*See, e.g.*, CCBR at 89). Hospitals are capital intensive and EBITDA ignores cash spent on capital. (RPF 1622). Relying on his extensive experience with hospitals, Respondent's expert Mr. Den Uyl appropriately looks at Operating Cash Flow Less Capital Expenditures to evaluate St. Luke's level of available cash. (RPF 1629). {

.} (RPF 1633, *in camera*). Such ongoing cash flow losses are not sustainable and demonstrate St. Luke's inability to fund its operations and cover its capital needs. (RX-56 at 000008). Moreover, even OhioCare's EBITDA was negative from 2008 through the time of the joinder (RPF 1625), which Mr. Den Uyl described as very unusual for a hospital. (RPF 1626).

This case is not the first time Complaint Counsel have sought to use EBITDA to distract a reviewing court from the true financial condition of a merging party. In *Arch Coal*, the FTC also asserted that EBITDA indicated that the selling firm there was a financially strong competitor. The district court saw through the FTC's ruse there and this Court should do the same here. *Arch Coal, Inc.*, 329 F. Supp. 2d at 155 (ruling that a "company with a positive EBITDA but a negative net income is not sustainable for the long term.").

Not surprisingly, Complaint Counsel's Post Trial Brief ignores the central reason that St. Luke's financials did not improve despite volume increases – St. Luke's was being {u

.} (RPF 1792-1860, *in camera*). It was being paid {

.} (RPF 1789-1791, *in camera*). As a result, St. Luke's commercial payments did not make up for its large losses on Medicare and Medicaid patients. (RPF 1775-1777, *in camera*). Its overall cost coverage ratio was below 1.0, meaning that for the average patient that walked through the door, St. Luke's lost money. (RPF 1763-1764, *in camera*, RPF 1777, *in camera*; Den Uyl, Tr. 6423). This was not sustainable. (RPF 1782, *in camera*). As Mr. Wakeman lamented, {

}. (Wakeman, Tr. 2942-2943, *in camera*; PX01283 at 002, *in camera*).

Complaint Counsel's extensive exposition of Dan Wakeman's September 24, 2010, monthly report encapsulates the flaws in their assessment of St. Luke's financial condition. (CCBR at 92-93; PX00170). Five out of the seven quotations chosen by Complaint Counsel focus on volume improvements ("declining activity to near capacity"; "volume increase"; "inpatient and outpatient activity...running hot all month"; "increased activity"; "if there was

one pillar where we attained a high level of success...it would be growth."). (CCBR at 92-93; PX00170). And, the one quotation that concerns profits highlights the very small positive margin that occurred the *one month* before the joinder, $7,000 on $36 million in revenues in August 2010, an extreme example of Complaint Counsel's consistent extrapolation of "trends" out of short time frames. (CCBR at 92-93; PX00170). As Mr. Wakeman testified, "This was not a trend. This was one month." (Wakeman, Tr. 2606). In reality, OhioCare had lost $7.7 million year to date by the end of August 2010, despite increasing volume. (RPF 1616; PX02147 at 028-029).

2. St. Luke's Defined Benefit Pension Plan Funding Was A Burden

St. Luke's obligation under federal law to contribute millions of dollars annually to restore its pension fund to full funding is a significant financial burden. (RPF 1664). St. Luke's has had to contribute millions of dollars to the pension fund during the past three years. First, it {[redacted]} in pension fund credit balance reserves in 2008 and 2009. (RPF 1677; PX01602 at 015, *in camera*). Still coming up short, St. Luke's {[redacted]} in 2009 and 2010 to cover continuing shortfalls. (RPF 1676, 1682, *in camera*). Despite over $12 million in contributions over three years, St. Luke's was barely able to remain above 80 percent funded. (Arjani, Tr. 6741). If assumptions made at the start of the year hold true, St. Luke's {[redacted]} to restore the plan to full funding. (Arjani, Tr. 6765, *in camera*). Only the joinder with ProMedica has provided St. Luke's with some relief from this obligation. (RPF 2134, 2135-2136, *in camera*).

Rather than discussing St. Luke's payments and obligations, Complaint Counsel focus on the market value of St. Luke's pension fund assets. In reality, St. Luke's return on assets from January to August 2010 was only {[redacted]}, which was {[redacted]} below expectations. (Arjani, Tr. 6745, *in camera*). Even by the end of 2010, after the stock market had improved

considerably, St. Luke's pension fund finished the year {

}. (RX-214 at 000011-000012, *in camera*).

Complaint Counsel's references to current payments to pensioners and St. Luke's switch to a defined contribution plan are irrelevant. (CCBR at 93-94). Neither have an effect on St. Luke's obligation to restore the defined benefits plan to full funding. (RPF 1664-1665).

Finally, Complaint Counsel argue there is nothing unusual about being underfunded by comparing St. Luke's to ExxonMobil and CBS. (CCBR at 93-94). Comparing a small, community hospital to giant international corporations in the energy and media sectors is absurd. It also violates the Supreme Court's mandate that a company's financial and competitive significance should be evaluated in the context of its own industry. *Gen. Dynamics*, 415 U.S. at 498. Complaint Counsel's comparison with Exxon and CBS is particularly ironic given that Complaint Counsel consistently ignore Respondents' benchmarks with comparable *hospitals* on multiple metrics including operating profit, operating margin, EBITDA, age of plant, private beds and reimbursement rates, all showing St. Luke's falling behind.

3. St. Luke's Violated Covenants On Its Outstanding Bond Debt

AMBAC's independent assessment of St. Luke's in 2010 confirmed what St. Luke's management and board had already determined – St. Luke's was in serious financial trouble. Mr. Gordon, AMBAC's Vice-President at the time, who made that assessment, has twenty-two years experience assessing hospital credit risk, including fourteen years at Moody's. (Gordon, Tr. 6788, 6789). At trial, he confirmed that his interest in the proceedings was "neutral and independent" and he even refused counsel's offer to prepare him for trial. (Gordon, Tr. 6789, 6848).

First, Complaint Counsel try to mitigate the significance of AMBAC's independent assessment by emphasizing and obfuscating the bond insurance term "technical default." While

it is true that AMBAC refers to most bond defaults as technical defaults, Complaint Counsel ignore the very {i

.} (RPF 2002-2004). St. Luke's was a { .} (RPF 2005, *in camera*). St. Luke's debt coverage service ratio was 0.5 in 2008 and *negative* 2.9 in 2009, well below the required 1.3 threshold. (RPF 2008-2009, 2011). Mr. Wakeman, St. Luke's CEO, considered this default to be { }. (Wakeman, Tr. 3009, *in camera*). He understood that AMBAC {

} (Wakeman, Tr. 3009, *in camera*).

In its analysis, AMBAC highlighted that {

'} (RPF 1997, 1999, *in camera*). AMBAC believed there was {

.} (RPF 2023, *in camera*).

{ .} {RPF 2025, *in camera,* 2043, 2044, *in camera,* 2045-2047). {

.} (RPF 2042, *in camera*, 2048, *in camera*).

Second, Complaint Counsel try to hide the importance of AMBAC's independent assessment by pointing to the relatively small size of St. Luke's debt. However, the relatively small amount owed by St. Luke's actually highlights the seriousness of St. Luke's financial distress. (RPF 1993, *in camera*). AMBAC (and Moody's) downgraded St. Luke's, and

AMBAC sought to impose serious remedies despite St. Luke's relatively small debt burden. (RPF 1993, *in camera*, 2000-2001, 2021, *in camera*, 2023, *in camera*).

Finally, Complaint Counsel point out that St. Luke's "could" have repaid the full amount of the debt. However, Complaint Counsel ignore testimony by Mr. Gordon and Mr. Den Uyl explaining that it {

.} (RPF 2024, *in camera*, 2027-2028, *in camera*). Paying back the debt would have worsened St. Luke's financial condition. As a result, St. Luke's concluded that { } (Wakeman, Tr. 3009, *in camera*).

4. St. Luke's Credit Rating Dropped Twice

Moody's independent downgrades of St. Luke's bonds in November of 2008 and February of 2010 speak for themselves, literally. For example, in February 2010, Moody's explained that two primary reasons it downgraded St. Luke's were (1) St. Luke's "[t]hird consecutive year of large operating losses" and (2) "[c]urrently unfavorable commercial contracts and ongoing challenges with negotiating higher commercial reimbursement rates with SLH's two largest commercial payors, who account for approximately 22 percent of SLH's gross revenues." (PX01372 at 001). Moody's downgraded St. Luke's to Baa2 which Mr. Wakeman described as {"} (RPF 1984, *in camera*). In addition, Moody's maintained a "negative outlook" for St. Luke's, meaning it was more likely that Moody's would further downgrade St. Luke's. (PX01372 at 001; Den Uyl, Tr. 6463). Moreover, Moody's made this assessment despite the potential positive factors that Complaint

Counsel emphasized in their brief. (*See, e.g.*, CCBR at 97). For example, Moody's downgraded St. Luke's despite St. Luke's relatively small debt burden. (PX01372 at 001-002).

Despite the clarity of Moody's independent assessment, Complaint Counsel hired its own expert, Mr. Brick, to put his own spin on these reports. However, Mr. Brick did not independently assess the underlying data and documents that formed the basis for Moody's analysis or Respondent's defense. (Brick, Tr. 3474, 3511-3557). He relied solely on the reports themselves and the conclusions of Mr. Dagen, Complaint Counsel's financial expert. (Brick, Tr. 3474, 3511-3557).

Finally, Complaint Counsel's characterization of Ms. Hanley's testimony is inaccurate and misleading. Mr. Hanley actually testified that the Moody's downgrade in February 2010 did not have a practical effect only *at that specific point in time* as St. Luke's was not borrowing in February 2010. (Hanley, Tr. 4707). She added that she expected the downgrade would affect St. Luke's ability to borrow in the future: "You look at a company for the future sustainability." She noted that the downgrade would constrain St. Luke's ability to access debt and affect St. Luke's "potential for future funding." (Hanley, Tr. 4706-4707).

5. Healthcare Reform And The Need For Electronic Medical Records Imperiled St. Luke's Independence

Complaint Counsel make three arguments to try to minimize the significance of the regulatory challenges St. Luke's faced. First, they cherry pick a few quotations that suggest St. Luke's was "well-positioned" for healthcare reform, but ignore the balance of the evidence from St. Luke's and ProMedica's management and healthcare experts that demonstrates they were not. (CCBR at 97; RPF 926-927, 1634, 1687, 1727, *in camera*, 1732, *in camera*, 1961). Indeed, St. Luke's chose to join with ProMedica *because* it was in a strong position to *help* St. Luke's adjust to healthcare reform. Dan Wakeman explained to the board that {

*camera*). In fact, OhioCare lost more than $20 million from operations that year. (RPF 1616). Moreover, while Complaint Counsel cite a Moody's report showing that some other hospitals nationwide also reduced expenditures, they disregard Mr. Den Uyl's analysis and Ms. Hanley's due diligence that demonstrated that St. Luke's age of plant is significantly higher than other comparably rated Moody's hospitals, and this difference was rising. (RPF 982, 1916-1918, *in camera*). This age of plant comparison indicates that St. Luke's had a greater need for investments in its plant than comparably rated hospitals. Nonetheless, St. Luke's undertook these serious capital cuts.

Fourth, Complaint Counsel argue that St. Luke's capital and wage cuts were insignificant because they claim ProMedica was also making cuts. However, unlike St. Luke's, ProMedica remained profitable throughout 2009 and its credit ratings were in the A range with stable and positive outlooks. (RX-209 at 000064; RPF 117, 1981-1982). Moreover, Complaint Counsel claim without basis that "some of ProMedica's cuts were even more drastic than at St. Luke's." CCBR at 101. Complaint Counsel make no quantitative comparison on the relative size of any cost cutting undertaken by St. Luke's as compared to ProMedica or any other hospitals. CCBR at 101.

Finally, Complaint Counsel argue that St. Luke's capital and wage freeze were insignificant because they claim that in 2008 and 2009 "St. Luke's continued to make millions of dollars of strategic investments." CCBR at 102. However, as described above, St. Luke's investment spending dropped by { } in 2009 from its historical average. (RX-56 at 000024, *in camera*). Moreover, this drop occurred despite strategic investments St. Luke's was making in physician practices. This meant that St. Luke's had even less money available for ordinary capital expenditures in 2009 than it had in previous years. Also, Complaint Counsel

once again ignore St. Luke's enormous operational losses: $12.7 million in 2008, $20.3 million in 2009, and $7.7 million in the first eight months of 2010. (RPF 1616).

7. St. Luke's Had No Other Alternatives

Complaint Counsel describes St. Luke's effort to find an affiliation partner as "cursory at best." CCBR at 102. This claim contradicts overwhelming evidence. St. Luke's began partnering discussions with Mercy and UTMC in late 2008. (RPF 819, *in camera,* 841, 877). In late 2008 and 2009, St. Luke's also talked with hospital systems outside of Lucas County, such as Cleveland Clinic and the University of Michigan. (RPF 827-840). It decided to focus on the potential local partners so that it could maintain local control. (RPF 827-840). St. Luke's developed thirteen criteria to evaluate potential joinder partners (RPF 820, *in camera*) and spent almost a year evaluating how those criteria matched up with these potential partners before proceeding with exclusive discussions with ProMedica. (RPF 819-826, *in camera,* 841-861, 862, *in camera,* 863-867, 868-870, *in camera,* 871, 872, *in camera,* 873, 874, *in camera,* 875, 876, *in camera,* 877, 878, *in camera,* 879, 880-903, *in camera,* 904-910, 911-921, *in camera,* 922, 923-924, *in camera,* 925-936, 937-939, *in camera,* 940). St. Luke's hired consultants, had multiple meetings with each potential partner, and had lengthy discussions among its management and board. (RPF 819-826, *in camera,* 841-861, 862, *in camera,* 863-867, 868-870, *in camera,* 871, 872, *in camera,* 873, 874, *in camera,* 875, 876, *in camera,* 877, 878, *in camera,* 879, 880-903, *in camera,* 904-910, 911-921, *in camera,* 922, 923-924, *in camera,* 925-936, 937-939, *in camera,* 940).

The facts Complaint Counsel cite – that St. Luke's and Mercy discussed clinical consolidation as well as IT and administrative integration, that UTMC circulated drafts of terms, and that UTMC and Mercy both remained interested in joining with St. Luke's – are consistent with the thorough process that St. Luke's undertook. St. Luke's closely evaluated all of its

options and decided that ProMedica would be best. CCBR at 102; (RPF 819-826, *in camera*, 827-861, 862, *in camera*, 863-867, 868-870, *in camera*, 871, 872, *in camera*, 873, 874, *in camera*, 875, 876, *in camera*, 877, 878, *in camera*, 879, 880-903, *in camera*, 904-910, 911-921, *in camera*, 922, 923-924, *in camera*, 925-936, 937-939, *in camera*, 940).

Complaint Counsel also argue that it was an alternative for St. Luke's to stay open "for years to come." CCBR at 102. This proposition is inaccurate and Complaint Counsel's citations in support are misleading. Mr. Wakeman, St. Luke's CEO, testified that St. Luke's might be able to keep its doors open for {[redacted]}. (PX01920 (Wakeman, Dep. at 141-143)) and Mr. Wagner, as St. Luke's acting CFO, testified that St. Luke's could continue as an independent hospital for {[redacted]}. (PX01915 (Wagner, IHT at 211), *in camera*). This testimony highlights St. Luke's very serious financial problems.

Finally, Complaint Counsel argue that Mr. Wakeman would have saved St. Luke's as he had done with previous hospitals. This argument has several problems. Most notably it ignores the actions and testimony of Mr. Wakeman, the "savior" himself. First, it ignores Mr. Wakeman's extensive testimony describing how the size, demographics, financial dynamics and managed care environment of the hospitals where he worked previously were vastly different from St. Luke's and the city of Toledo. (Wakeman, Tr. 2706-2732). Second, it ignores that the three-year plan failed financially as Mr. Wakeman himself explained. (RPF 1942-1949). And finally, it ignores the fact that as a result of St. Luke's financial difficulties, it was Mr. Wakeman who initiated and led St. Luke's efforts to seek a joinder partner and recommended to the Board that it do so because he did not see another way out of St. Luke's financial distress without serious cuts in St. Luke's services. (RPF 819-826, *in camera*, 841-861, 862, *in camera*, 863-867,

868-870, *in camera*, 871, 872, *in camera*, 873, 874, *in camera*, 875, 876, *in camera*, 877, 878, *in camera*, 879, 880-903, *in camera*, 904-910, 911-921, *in camera*, 922, 923-924, *in camera*, 925-936, 937-939, *in camera*, 940).

In sum, Complaint Counsel do not rebut that St. Luke's alleged market share must be discounted by its financial weakness, which, absent the joinder with ProMedica, would have limited its ability to continue to compete effectively in the market. *See United States v. Int'l Harvester Co.*, 564 F.2d 769, 773-74 (7th Cir. 1997); *Arch Coal*, 329 F. Supp. 2d at 155-157; *Lektro-Vend Corp. v. Vendo Co.,* 660 F.2d at 275-76.

## VI. COMPLAINT COUNSEL'S PROPOSED DIVESTITURE REMEDY WILL HARM PATIENTS, IS OVERBROAD AND PUNITIVE, AND, THEREFORE, IS NOT IN THE PUBLIC INTEREST

Even if Complaint Counsel had proved that, since ProMedica's joinder with St. Luke's, competition in the markets for general acute care inpatient hospital services or inpatient OB services has been substantially lessened or is likely to be in the future – which it has not – the ALJ should reject Complaint Counsel's proposed remedy that ProMedica divest St. Luke's. This proposed remedy ignores an available alternative that would preserve the joinder's community benefits while, at the same time, preventing its perceived potential anticompetitive effects. That remedy, separate negotiating teams for the ProMedica legacy hospitals and St. Luke's, is one that the Commission has previously approved in lieu of divestiture in another consummated hospital merger case. Moreover, even if the ALJ were to reject this proposed alternative remedy, the ALJ should also reject Complaint Counsel's proposed order as drafted. The proposed order is overbroad, provides St. Luke's with a competitive advantage that it did not have (and, according to Complaint Counsel, did not need) prior to the joinder, and imposes an unwarranted financial penalty on ProMedica.

### A. Vested With Broad Discretion to Fashion an Appropriate Remedy, the ALJ Should Not Mechanically Order Divestiture

The objective of a remedy for a Clayton Act Section 7 violation is to "impose relief that is 'necessary and appropriate in the public interest to eliminate the effects of the acquisition offensive to the statute.'" *In re Evanston*, 2007 FTC LEXIS 210, at *244 (citing *United States v. E.I. Du Pont de Nemours & Co.*, 353 U.S. 586, 607 (1957)). This Court must "craft a remedy that will create a competitive environment that would have existed in the absence of the violations." *Id.* In seeking to achieve that pre-joinder competitive environment, the Court has access to a "complete array" of equitable remedies to cure the illegal conduct. *In re Ekco Prods. Co.*, No. 8122, 1964 FTC LEXIS 115, at *117, 122 (F.T.C. June 30, 1964). Remedial orders must not, however, be overbroad or punitive. *In re The Raymond Lee Org.*, No. 9045, 1978 FTC LEXIS 124, at *227-28, *337-52 (F.T.C. Nov. 1, 1978); *N. Tex. Speciality Physicians v. FTC*, 528 F.3d 346, 371 (5th Cir. 2008).

Divestiture is only one possible remedy a court may impose, and it is not an "automatic sanction, mechanically invoked in merger cases." *In re Retail Credit Co.*, No. 8920, 1978 FTC LEXIS 246, at *260 (F.T.C. July 7, 1978); *see also Ekco Prods. Co.*, 1964 FTC LEXIS 115, at *117 (stating the Commission's remedies include "divestiture *and other remedies*") (emphasis added). Indeed, divestiture is "an extremely harsh remedy." *Reynolds Metals Co. v. FTC*, 309 F.2d 223, 231 (D.C. Cir. 1962). Where equally effective remedies other than divestiture are available, "due regard should be given to the preservation of substantial efficiencies or important benefits to the consumer in the choice of an appropriate remedy." *Retail Credit Co.*, 1978 FTC LEXIS 246, at *260-61, 341; *see also Ekco Prods. Co.*, 1964 FTC LEXIS 115, at *136-37 (stating "the Commission's powers are broad and flexible" and should be "exercised in

accordance with principles of fairness and equitable treatment.") Complaint Counsel's proposed order disregards these fundamental precepts.

B. An Order that Requires ProMedica and St. Luke's To Negotiate MCO Contracts Separately Will Both Remedy the Joinder's Potential Anticompetitive Effects and Preserve Its Beneficial Impact on the Community

If the ALJ finds that the joinder violated Clayton Act Section 7 (which the evidence shows it did not), because this case involves a consummated transaction where there is no evidence that ProMedica intends to exercise whatever additional "bargaining leverage" Complaint Counsel believe its joinder with St. Luke's created, the ALJ should not reflexively order the divestiture of St. Luke's. Rather, the ALJ should impose a less draconian remedy, one that will alleviate any potential anticompetitive effect while still preserving the joinder's benefits to patients in Lucas County. In particular, the ALJ should require ProMedica to create a second team dedicated to negotiating and administering managed care contracts exclusively for St. Luke's that will be independent and firewalled from those ProMedica employees who negotiate and administer managed care contracts for all other ProMedica hospitals. This remedy, which is virtually identical to the remedy the FTC imposed in *Evanston Northwestern Healthcare* would both eliminate the potential for ProMedica to exercise any additional bargaining leverage the joinder might confer and alleviate any risk that St. Luke's will not survive as an independent community hospital if Complaint Counsel and their experts are wrong and, following a divestiture, St. Luke's financial performance does not move from red ink to black.

The Commission ordered a similar conduct remedy in *In re Evanston Northwestern Healthcare Corporation*, where the Commission found that Evanston Northwestern Healthcare's consummated merger with Highland Park Hospital violated Clayton Act Section 7 by eliminating, as Complaint Counsel claim in this case, "the pre-merger price competition between [the hospitals], as well as the MCOs' option of contracting with one hospital but not the other."

2007 FTC LEXIS 210, at *246, *249.[25] In *Evanston Northwestern Healthcare*, the Commission determined that two *non-merger specific efficiencies* – a cardiac surgery program and a medical record computer system – would not survive the divestiture and would take the acquired hospital significant time to implement on its own after divestiture. *Id.* at *247. Thus, the Commission ordered the respondent to establish separate and independent MCO negotiating teams for Evanston Hospital (and Glenbrook Hospital) and Highland Park Hospital (the acquired hospital), instead of ordering a full divestiture, noting that "[w]hile not ideal, this remedy will allow MCOs to negotiate separately again for these competing hospitals, thus re-injecting competition between them for the business of MCOs." *Id.* at *249.

While the Commission cautioned that its reasoning in *Evanston Northwestern Healthcare* might not necessarily apply to consideration of the appropriate remedy in a future challenge to a consummated merger, it recognized that divestiture may not be the appropriate remedy if it would "involve substantial costs." *Id.* at *250. Those costs include not only the financial impact of divestiture on the parties, but also the "potential effects on patient care" that might result from "swapping out complex software systems," like EMR systems, as well as any reduction of "the quality of patient care to the community" as a result of the post-divestiture elimination of clinical programs. *Id.* at *247, 249.

[25] The government has also recognized the practicality of a similar remedy outside the context of hospital mergers. The Department of Justice ("DOJ") settled litigation that it filed against Northrop Grumman Corporation ("Northrop") and TRW Inc. ("TRW") after Northrop announced that it would acquire TRW. Dep't of Justice, Final Judgment (June 10, 2003), http://www.justice.gov/atr/cases/f201000/201076.pdf). The DOJ agreed to settle its antitrust claims against the parties, despite potential harm to competition resulting from the merger, with various conditions. Dep't of Justice, Competitive Impact Statement (Dec. 23, 2002), http://www.justice.gov/atr/cases/f200600/200605.pdf. One of these conditions required Northrop to separate, by use of a firewall, the flow of information regarding each company's proprietary business information so as to preserve competition. Dep't of Justice, Final Judgment AT 10-11 (June 10, 2003), http://www.justice.gov/atr/cases/f201000/201076.pdf).

The same concerns that led the Commission to impose a conduct remedy in *Evanston Northwestern Healthcare* justify a conduct remedy in this case. Complaint Counsel baldly assert, with no explanation or factual support, that only full divestiture will restore St. Luke's to its pre-joinder competitive position. CCBR at 106-07. The gist of Complaint Counsel's case is that the joinder will enable ProMedica to extract supracompetitive rates from MCOs because St. Luke's will no longer exist as a separate hospital for inclusion in a hospital network and, therefore, MCOs will be unable to walk away from the negotiating table if ProMedica demands higher than competitive rates. CCBR at 36-60. An order that requires ProMedica to establish separate teams to negotiate and maintain contracts for St. Luke's, with appropriate information firewalls to prevent the exchange of MCO information between them,[26] would eliminate this problem. MCOs would be free to contract with St. Luke's, but not ProMedica, if they want, thereby restoring competition to the pre-joinder state where Complaint Counsel believes St. Luke's actively constrained ProMedica's prices. Additionally, an MCO that wants a single contract with ProMedica and St. Luke's together should have the opportunity to negotiate one with a third, separate negotiating team. Indeed, if anything, Respondent's proposed remedy would provide even *greater* competition than existed prior to the joinder, because an MCO would be free to negotiate with ProMedica or St. Luke's separately (as it could before), or with them collectively, an option that was not available previously.

Allowing St. Luke's to remain joined with ProMedica, but requiring ProMedica to separate and firewall the negotiation and administration of St. Luke's contracts with MCOs, serves the public's best interest because St. Luke's and its patients will continue to reap the benefits that the joinder already has begun to provide. Since St. Luke's joinder with ProMedica,

[26] ProMedica already has experience implementing and complying with internal firewalls to prevent the sharing of sensitive information between Paramount and its hospitals. (RPF 113).

patients have already benefited (or soon will) from increased capacity and additional private – as opposed to semi-private – rooms when receiving inpatient care at St. Luke's because of ProMedica's relocation of St. Luke's rehabilitation services to Flower Hospital, which freed space for the addition of 17 new, private medical/surgical beds. (RPF 2225, 2229, *in camera*, 2233-2240). St. Luke's lacked both the available space and the financial capability to pursue those initiatives on its own. (RPF 2233-2240). Additionally, St. Luke's will receive at least $20 million in additional capital contributions in 2012 and 2013, which it would lose if divested. (RPF 2115, 2117, 2118-2119, *in camera*). Those funds are to be used, for example, to: convert all existing patient rooms at St. Luke's to private rooms; update St. Luke's IT systems to meet the government's health care reform legislation meaningful use requirements; renovate St. Luke's heart center and electro-physiology lab; expand pre and post outpatient surgical areas at St. Luke's; and increase the private postpartum area and well-infant nursery at the hospital. (PX00058 at 056). Similarly, St. Luke's could lose the benefits of its provider contract with Paramount, which ProMedica likely would re-evaluate if the Commission requires the divestiture of St. Luke's.

The remedy the FTC imposed in *Evanston Northwestern Healthcare* is appropriate in this case, as there would be substantial costs associated with a divestiture, both in terms of dollars and its effect on patient care. St. Luke's has already allocated part of ProMedica's initial capital contribution toward {i } that will meet the "meaningful use" requirements imposed by healthcare reform legislation. (RPF 2125, 2155, *in camera*, 2156; *see also* Johnston, Tr. 5380-5381 (stating St. Luke's has completed the implementation of several components necessary to achieve meaningful use requirements and

that, as of July 27, 2011 was beginning work on the next stage of the implementation plan).[27] It would take St. Luke's significant time and effort to unwind the work that has been completed to date and then install an EMR system on its own, potentially jeopardizing its ability to meet the government mandated meaningful use requirements. Moreover, St. Luke's ability to both finance the acquisition and implementation of an EMR system, which will cost millions of dollars, and cover the additional, ongoing IT personnel costs necessary to manage that system, is questionable. (RPF 1724-1726, 1727, *in camera*, 1728, 1729, *in camera*, 1733-1737).

Imposing a conduct remedy is appropriate in this case, where divestiture would eliminate significant benefits to patients and the alleged victims of the joinder's potential anticompetitive effects are large, sophisticated MCOs that can successfully navigate an order requiring separate negotiation of MCO contracts (as they did prior to the joinder). For these reasons, the ALJ should reject Complaint Counsel's proposed remedy and, if the ALJ concludes that the joinder violated Clayton Act Section 7, enter Respondent's alternative proposed order, which is attached as Exhibit A.

C. Complaint Counsel's Proposed Remedy Conflicts with the Remedial Purpose of the Clayton Act

Even if the Court were to reject Respondent's alternative proposed order, the ALJ should still reject Complaint Counsel's proposed order. Complaint Counsel acknowledge that an appropriate remedy for a Clayton Act violation should restore competition to its pre-joinder state. CCBR at 104. Yet, Complaint Counsel's proposed order confers a competitive advantage on St. Luke's that it did not have before its joinder with ProMedica. Moreover, the order as drafted is

[27] Complaint Counsel's assertion that St. Luke's would have already begun implementation of an EMR system on its own in 2010 but for the joinder, wholly ignores the reality that {S .} (Johnston, Tr. 5482-5483, *in camera*; RPF 1724-1726, 1727, *in camera*, 1728, 1729, *in camera*, 1733-1737).

overbroad and punitive, because it imposes restrictions on ProMedica that are unnecessary to eliminate any effects of the joinder. *See In re The Raymond Lee Org.*, 1978 FTC LEXIS 124, at *227-28, *337-52 (eliminating provisions of a proposed order that were overbroad and unnecessary to remedy the abuse found and stating that the order "must not be punitive, but must assure correction of those practices found to be unlawful and prevent their reoccurrence in the future."); *N. Tex. Speciality Physicians*, 528 F.3d at 371 (remanding the proceeding to the FTC after holding portions of the FTC's remedy were overly broad and internally inconsistent). The order that Complaint Counsel propose is improper for several reasons.

First, the proposed order forecloses ProMedica and St. Luke's from simply unwinding the joinder and returning St. Luke's to its pre-joinder status as an independent hospital. CCBR, Attachment C at II.A.1. That is surprising given Complaint Counsel's position that St. Luke's was neither failing nor flailing but was capable of competing successfully as a free-standing hospital into the foreseeable future because, at the time of the joinder, it was in the midst of a financial turnaround with all economic indicators "trending up." CCBR 89-104. Assuming Complaint Counsel believe what they and their economic and financial experts have represented to the ALJ throughout this proceeding, their proposed order should not require that ProMedica only divest St. Luke's to a willing buyer.[28] Complaint Counsel's position is also puzzling since, just like its joinder with ProMedica, a merger of St. Luke's and either Mercy or UTMC, the only two affiliation alternatives that Complaint Counsel suggest St. Luke's had, would be presumptively unlawful under the *Horizontal Merger Guidelines*. (*Compare Horizontal Merger Guidelines*, § 5.3 *with* PX01030 at 017). And the very same St. Luke's documents that Complaint Counsel tout as evidence that St. Luke's joinder with ProMedica will result in an

[28] Indeed, the parties considered including an "unwind" provision in the Joinder Agreement, but St. Luke's rejected that proposal because of its commitment to the joinder with ProMedica. (RPF 999).

increase in St. Luke's reimbursement rates show that St. Luke's also expected to realize increased reimbursement rates with MCOs through an affiliation with either Mercy or UTMC. (*See* PX0106 at 023-024, *in camera*). Thus, Complaint Counsel's proposed order would create the same competitive harms that they assert exist in this case.

Second, the proposed order prohibits ProMedica from terminating any agreement between Paramount and St. Luke's that makes St. Luke's or its affiliates participating providers in Paramount's commercial insurance products and provider networks. CCBR at Attachment C at II.N. It is undisputed, however, that St. Luke's was not a member of Paramount's network prior to the joinder (RPF 317), and Complaint Counsel and their expert financial analyst did not believe that St. Luke's needed to be an in-network Paramount provider to return to profitability. (Dagen, Tr. 3402 (testifying that he believed St. Luke's was a viable hospital competitor in Lucas County prior to the joinder ), 3244 (testifying that the majority of St. Luke's {f

:}), *in camera*). Any order that requires ProMedica to retain St. Luke's as a participating provider in Paramount after the joinder is dissolved gives St. Luke's a competitive advantage that it did not have (and, apparently, did not need) pre-joinder and results in a financial penalty to ProMedica. Accordingly, Complaint Counsel's proposed order is contrary to the purpose of a Clayton Act Section 7 remedy, which is to return the competitive environment to what it would have been absent the violation. *See In re Evanston*, 2007 FTC LEXIS 210, at *244. It also conflicts with established Supreme Court precedent which holds that a firm – in this case, ProMedica – has no duty to deal with a competitor, which, once divested, St. Luke's would be. *Verizon Commc'ns.*, 540 U.S. at 408.

Finally, Complaint Counsel's requirement that ProMedica notify the Commission prior to any proposed dissolution, acquisition, merger, or consolidation of ProMedica *outside* of the relevant geographic market of Lucas County is overbroad and finds no support in any evidence presented in this case. CCBR, Attachment C at IX. Here, in addition to its Lucas County hospitals, ProMedica owns three hospitals in Michigan and three hospitals in other Ohio counties. (RPF 69-70). Complaint Counsel has never suggested during this proceeding – nor, could it – that the joinder is reasonably likely to have significant anticompetitive effects in any market outside of Lucas County. Accordingly, the order is overbroad in requiring ProMedica to report back to the Commission on its activities with regard to these hospitals, all of which are outside of the relevant geographic market.[29]

## VII. CONCLUSION

For the foregoing reasons, Complaint Counsel have not carried their burden of proving by a preponderance of the evidence that St. Luke's joinder with ProMedica will substantially lessen competition by permitting ProMedica to raise rates for general acute-care inpatient services to MCOs for a prolonged period. *Oracle Corp.*, 331 F. Supp.2d at 1109; *Long Island Jewish Med. Ctr.*, 983 F. Supp. at 135. The Court should therefore dismiss the Complaint and deny Complaint Counsel's prayer for relief in its entirety. Alternatively, should the Court believe that the joinder violates Section 7 of the Clayton Act – which the evidence shows it does not – it should enter Respondent's proposed remedial order because it cures any harm to competition while preserving the benefits of the joinder for St. Luke's and the community.

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[29] The proposed order makes no allowance for {
.} (RPF 2230, *in camera*). This is particularly galling because Complaint Counsel specifically approved the consolidation. (RPF 2230, *in camera*). Had ProMedica known that it was relying on Complaint Counsel's "approval" to its detriment, it would not have implemented the consolidation, and St. Luke's would have fewer beds in which to provide general acute care inpatient services and still be turning ER patients away because it lacked adequate capacity to treat them. (RPF 2232).

Dated: September 29, 2011

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*Attorneys for Respondent, ProMedica Health System, Inc.*

I, Christine Devlin, hereby certify that I served a true and correct copy of the foregoing Respondent's Post-Trial Reply Brief, Public Version, upon the following individuals by hand on September 29, 2011.

Hon. D. Michael Chappell
Chief Administrative Law Judge
Federal Trade Commission
600 Pennsylvania Avenue, NW, Room H110
Washington, DC 20580

Donald S. Clark
Secretary
Federal Trade Commission
600 Pennsylvania Avenue, NW, Room 172
Washington, DC 20580

I, Christine Devlin, hereby certify that I served a true and correct copy of the foregoing Respondent's Post-Trial Reply Brief, Public Version, upon the following individuals by electronic mail:

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C. Devlin

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# EXHIBIT A

**UNITED STATES OF AMERICA**
**BEFORE THE FEDERAL TRADE COMMISSION**

| | | |
|---|---|---|
| In the Matter of | ) | |
| | ) | |
| PROMEDICA HEALTH SYSTEM, INC. | ) | Docket No. 9346 |
| a corporation. | ) | |
| | ) | |

**FINAL ORDER**

It is ordered that the following order to cease and desist be, and hereby is, entered:

**I.**

**IT IS ORDERED** that, as used in this Order, the following definitions apply:

A. "Commission" means Federal Trade Commission.

B. "Contract Administration" means the act or acts associated with compliance with and implementation of final contract terms, such as payment monitoring, communication of Payor medical and administrative policies, utilization management, liaison to the business office, annual updates, and organizing managed care-related budget information.

C. "Contract Management System" means a software application or other system that houses contract rates and is utilized for patient billing and modeling Pre-existing Contract rates and/or proposed rates.

D. "Corporate Managed Care Department" means the department that will be responsible for Contract Administration for ProMedica Hospitals and St. Luke's.

E. "Final Offer Arbitration" means a manner of arbitration whereby each party in a disputed matter submits its best and final offer to an arbitrator who is then required to choose what he or she believes is the best offer (sometimes referred to as "baseball style arbitration").

F. "Hospital" means any human medical care facility licensed as a hospital in the state in which the facility is located.

G. "Hospital Services" means all inpatient hospital services, which include a broad cluster of medical, surgical, diagnostic, treatment, and all other services that are included as part of an admission of a patient to an inpatient bed within the ProMedica Hospitals or St. Luke's, and all outpatient services that are related to the use of that Hospital.

H. "Joinder" means the 2010 joinder of ProMedica with St. Luke's.

I. "Managed Care Contract" means a contract or agreement for Hospital Services between ProMedica and a Payor, including but not limited to rates, definitions, terms, conditions, policies, and pricing methodology (*e.g.*, per diem, discount rate, and case rate).

J. "Managed Care Contracting Information" means information concerning Managed Care Contracts and negotiations with a specific Payor for Hospital Services; provided, however, that "Managed Care Contracting Information" shall not include: (i) information that is in the public domain or that falls in the public domain through no violation of this Order or breach of any confidentiality or nondisclosure agreement with respect to such information by Respondent; (ii) information that becomes known to ProMedica from a third party that has disclosed that information legitimately; (iii) information that is required by law to be publicly disclosed; or (iv) aggregate information concerning the financial condition of ProMedica.

K. "Operate" means to own, lease, manage or otherwise control or direct the operations of a Hospital, directly or indirectly.

L. "Ownership Interest" means any and all rights, present or contingent, of Respondent to hold any voting or nonvoting stock, share capital, equity or other interests or beneficial ownership in an entity.

M. "Payor" means any Person that pays, or arranges for payment, for all or any part of any Hospital Services for itself or for any other Person. Payor includes any Person that develops, leases, or sells access to networks of Hospitals. The term does not include government payors for public health insurance programs, such as Medicare and Medicaid.

N. "Person" means any individual, partnership, joint venture, firm, corporation, association, trust, unincorporated organization, joint venture, or other business or government entity, and any subsidiaries, divisions, groups or affiliates thereof.

O. "Pre-existing Contract" means a Managed Care Contract between a Payor and ProMedica that is in effect on the date this Order becomes final.

P. "ProMedica" or "Respondent" means ProMedica Health System, its directors, officers, employees, agents, representatives, successors, and assigns; its joint ventures, subsidiaries, divisions, groups and affiliates controlled by ProMedica Health System, and the respective directors, officers, employees, agents, representatives, successors, and assigns of each.

Q. "ProMedica Hospitals" means The Toledo Hospital, Toledo Children's Hospital, Flower Hospital, and Bay Park Community Hospital, the hospitals owned by ProMedica and located in Lucas County in Toledo, Ohio.

R. "ProMedica Negotiating Team" means the team responsible for negotiating a Managed Care Contract for Hospital Services for ProMedica Hospitals.

S. "St. Luke's" means St. Luke's Hospital, owned by ProMedica, located at 5901 Monclova Road, Maumee, Ohio.

T. "St. Luke's Negotiating Team" means the team responsible for negotiating a Managed Care Contract for Hospital Services for St. Luke's.

**II.**

**IT IS FURTHER ORDERED** that Respondent shall

A. Negotiate Managed Care Contracts for Hospital Services for St. Luke's separately and independently from Managed Care Contracts for Hospital Services for ProMedica Hospitals, and vice versa;

B. Not make any Managed Care Contract for Hospital Services for ProMedica Hospitals contingent on entering into a Managed Care Contract for Hospital Services for St. Luke's, or vice versa;

C. Not make the availability of any price or term included in a Managed Care Contract for Hospital Services for ProMedica Hospitals contingent on entering into or agreeing to any particular price or term included in a Managed Care Contract for Hospital Services at St. Luke's, or vice-versa; and

D. At the request of the Payor, submit any disputes as to prices and/or terms arising out of the separate and independent negotiations required by Paragraphs II.A.- C. of this Order:

1. first to mediation under the Commercial Mediation Rules of the American Arbitration Association ("AAA"), and, if the dispute cannot be settled by mediation, at the request of the Payor to a single arbitrator, mutually agreed upon by ProMedica and the Payor, who shall conduct binding arbitration in accordance with the Commercial Arbitration Rules of the AAA at a location mutually agreed upon by ProMedica and the Payor, in order to determine fair and reasonable prices and/or terms assuming competition between the hospitals as would exist but for the Joinder;

2. the arbitration shall be conducted as Final Offer Arbitration, unless ProMedica and the Payor agree to an alternative manner of arbitration;

3. costs of the arbitration (other than attorneys fees, which shall be borne by the party that incurs them) shall be borne by the loser if Final Offer Arbitration; if a manner other than Final Offer Arbitration or if the parties settle the matter prior to issuance of the final decision by the arbitrator, the arbitrator shall assess costs, unless the parties agree as to the allocation of costs;

4. *provided, however*, that neither the mediator nor the arbitrator shall have any responsibility or authority to resolve issues concerning any violation

or possible violation of this Order; the Commission retains jurisdiction over these issues.

*Provided further, however*, that nothing in this Paragraph shall prohibit Respondent from negotiating a Managed Care Contract with a particular Payor for Hospital Services for both St. Luke's and ProMedica Hospitals jointly, if that Payor elects to negotiate jointly for all Hospitals rather than to negotiate separate Managed Care Contracts.

**III.**

**IT IS FURTHER ORDERED** that

A. No later than thirty (30) days after this Order becomes final, Respondent shall establish and thereafter maintain the ProMedica Negotiating Team and the St. Luke's Negotiating Team, which teams shall operate independent of each other and negotiate Managed Care Contracts separately and in competition with each other and other Hospitals.

B. The St. Luke's Negotiating Team shall be exclusively responsible for negotiating Managed Care Contracts for Hospital Services for St. Luke's when separate contracts are negotiated pursuant to Paragraph II. of this Order.

C. The ProMedica Negotiating Team shall be exclusively responsible for negotiating Managed Care Contracts for Hospital Services for ProMedica Hospitals when separate contracts are negotiated pursuant to Paragraph II. of this Order.

D. At the request of a specific Payor, ProMedica shall be permitted to negotiate a Managed Care Contract for Hospital Services jointly for ProMedica Hospitals and St. Luke's for that specific Payor for that specific Managed Care Contract; *provided, however*, that neither the St. Luke's Negotiating Team nor the ProMedica Negotiating Team shall be involved in the joint negotiations.

**IV.**

**IT IS FURTHER ORDERED** that

A. Respondent shall maintain Managed Care Contracting Information with respect to ProMedica Hospitals separate and confidential from Managed Care Contracting Information with respect to St. Luke's.

B. Managed Care Contracting Information with respect to ProMedica Hospitals shall not, directly or indirectly, be transmitted to or received by the St. Luke's Negotiating Team, and Managed Care Contracting Information with respect to St. Luke's shall not, directly or indirectly, be transmitted to or received by the ProMedica Negotiating Team, except as otherwise provided in this Order.

C. No later than thirty (30) days after this Order becomes final, Respondent shall implement procedures and protections to ensure that Managed Care Contracting

Information for ProMedica Hospitals, on the one hand, and St. Luke's, on the other, is maintained separate and confidential, including but not limited to:

1. establishing a firewall-type mechanism that prevents the ProMedica Negotiating Team from requesting, receiving, sharing, or otherwise obtaining any Managed Care Contracting Information with respect to St. Luke's, and prevents the St. Luke's Negotiating Team from requesting, receiving, sharing, or otherwise obtaining any Managed Care Contracting Information with respect to ProMedica Hospitals;

2. establishing a Contract Management System for the St. Luke's Negotiating Team that is separate or clearly-partitioned from the Contract Management System for the ProMedica Negotiating Team to ensure the confidentiality of Managed Care Contracting Information; and

3. causing each of Respondent's employees with access to Managed Care Contracting Information to maintain the confidentiality required by the terms and conditions of this Order, including but not limited to:

    a. requiring each employee to sign a statement that the individual will comply with these terms;

    b. maintaining complete records of all such statements at Respondent's headquarters; and

    c. providing an officer's certification to the Commission stating that such statements have been signed and are being complied with by all relevant employees.

D. Nothing in this Order shall prevent the St. Luke's Negotiating Team from requesting, receiving, sharing, using or otherwise obtaining Managed Care Contracting Information with respect to Hospital Services for St. Luke's.

E. Nothing in this Order shall prevent the St. Luke's Negotiating Team from requesting, receiving, sharing, using or otherwise obtaining non-Managed Care Contracting Information relating to any ProMedica Hospital or the entire ProMedica system, including, but not limited to, information related to costs, quality, patient mix, service utilization, experience data, budgets, capital needs, expenses, and overhead.

F. Nothing in this Order shall prevent the ProMedica Negotiating Team from requesting, receiving, sharing, using, or otherwise obtaining Managed Care Contracting Information with respect to Hospital Services for ProMedica Hospitals.

G. Nothing in this Order shall prevent the ProMedica Negotiating Team from requesting, receiving, sharing or otherwise obtaining non-Managed Care Contracting Information relating to any Hospital in the ProMedica system or the

entire ProMedica system, including, but not limited to, information related to costs, quality, patient mix, service utilization, experience data, budgets, capital needs, expenses, and overhead.

H. If a Payor elects to negotiate and contract jointly for Hospital Services for St. Luke's and ProMedica Hospitals, nothing in this Order shall prohibit ProMedica from requesting or obtaining Managed Care Contracting Information with respect to Hospital Services for ProMedica Hospitals and St. Luke's for that particular Payor or from using that Managed Care Contracting Information for that particular Payor with respect to the joint negotiations and contracting for that particular Managed Care Contract.

I. Nothing in this Order shall prevent the Corporate Managed Care Department from requesting Managed Care Contracting Information from the ProMedica Negotiating Team or the St. Luke's Negotiating Team, *provided, however*, that

1. the Managed Care Contracting Information that is requested and obtained is used solely for the purpose of Contract Administration, and

2. the Corporate Managed Care Department is prohibited from providing, sharing, or otherwise making available Managed Care Contracting Information:

a. from the St. Luke's Negotiating Team to or with the ProMedica Negotiating Team; or

b. from the ProMedica Negotiating Team to or with the St. Luke's Negotiating Team.

**V.**

**IT IS FURTHER ORDERED** that, no later than ten (10) days after being contacted by a Payor to negotiate a Managed Care Contract, Respondent shall notify said Payor of its rights under this Order by sending a copy of this Order to the Chief Executive Officer, the General Counsel, and the network manager of the Payor by first class mail or e-mail, with return receipt requested. Respondent shall maintain complete records of all such notifications and return receipts at Respondent's headquarters and shall include in reports filed to the Commission an officer's certification to the Commission stating that such notification requirement has been implemented and is being complied with.

**VI.**

**IT IS FURTHER ORDERED** that Respondent shall,

A. Within ten (10) days after this Order becomes final, and every sixty (60) days thereafter until submission of the first annual report required by Paragraph VI.B. of this Order, submit a verified written report to the Commission setting forth in detail

1. the manner and form in which it will comply with Paragraphs II. and III. of this Order, including but not limited to the composition, structure, and intended operation of the ProMedica Negotiating Team and the St. Luke's Negotiating Team, including but not limited to who will comprise the teams, where they will be located, who will supervise the teams, who will approve the Managed Care Contracts, what instructions the team members will receive, how the team members will be compensated, what other responsibilities the team members will have, and other details necessary for the Commission to evaluate Respondent's compliance with this Order; and

2. the manner and form in which Respondent will comply with Paragraph IV. of this Order.

B. One (1) year from the date this Order becomes final, annually for the next nineteen (19) years on the anniversary date this Order becomes final, and at such other times as the Commission may require, submit a verified written report to the Commission setting forth in detail the manner and form in which it has complied and is complying with the Order. In each such verified written report, include, among other things that are required from time to time, the following:

1. a full description of the efforts being made to comply with each Paragraph of the Order, including all internal memoranda and all reports and recommendations concerning compliance with the requirements of this Order;

2. notification of all requests for mediation and/or arbitration and a full description of the mediation and/or arbitration, including but not limited to identification of the arbitrator and the location of the arbitration, a full description of the status and results of mediation, a full description of the status of the arbitration and, if resolved, of the resolution of each arbitration; and

3. the identity of each member of the ProMedica Negotiating Team, the St. Luke's Negotiating Team, and the Corporate Managed Care Department.

C. Within sixty (60) days after the date this Order becomes final, and every sixty (60) days thereafter until Respondent has fully complied with Paragraph VIII.A., and has obtained the signed statements of all of Respondent's employees described in Paragraph IV.C.3. and who are employed by the Respondent as of the date this Order becomes final, submit a verified written report to the Commission setting forth in detail the manner and form in which it has complied and is complying with the Order.

## VII.

**IT IS FURTHER ORDERED** that, for the purpose of determining or securing compliance with this Order, and subject to any legally recognized privilege, and upon written

request and five (5) days notice to the Respondent made to its headquarters address, Respondent shall, without restraint or interference, permit any duly authorized representative of the Commission:

A. Access, during business office hours of the Respondent and in the presence of counsel, to all facilities and access to inspect and copy all books, ledgers, accounts, correspondence, memoranda, calendars, and all other records and documents in its possession, or under its control, relating to any matter contained in this Order, which copying services shall be provided by Respondent at the request of the authorized representative(s) of the Commission and at the expense of the Respondent; and

B. To interview officers, directors, or employees of the Respondent, who may have counsel present, regarding such matters.

**VIII.**

**IT IS FURTHER ORDERED** that Respondent shall

A. Within thirty (30) days after the date this Order becomes final, send by first class mail, return receipt requested, a copy of this Order to each officer and director of ProMedica; and

B. Within ten (10) days of appointment of any new officer or director of ProMedica, send by first class mail, return receipt requested, a copy of this Order to such officer or director.

**IX.**

**IT IS FURTHER ORDERED** that, Respondent shall notify the Commission at least thirty (30) days prior to (1) any proposed dissolution of Respondent in Lucas County, Ohio; (2) any proposed acquisition, merger, or consolidation of Respondent in Lucas County, Ohio; or (3) any other change in Respondent in Lucas County, Ohio including, but not limited to, assignment or creation or dissolution of subsidiaries, if such change might affect compliance obligations arising out of this Order.

**X.**

**IT IS FURTHER ORDERED** that this Order shall terminate twenty (20) years from the date on which this Order becomes final.

By the Commission.

Donald S. Clark
Secretary

SEAL

ISSUED:

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