

**IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION**

FEDERAL TRADE COMMISSION,

Plaintiff,

v.

U.S. ANESTHESIA PARTNERS, INC.,

Defendant.

Case No. 4:23-cv-03560-KH

**DEFENDANT U.S. ANESTHESIA PARTNERS, INC.'S
UNOPPOSED MOTION TO SEAL**

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USAP respectfully requests to seal a limited set of material submitted in connection with the FTC’s Motion To Exclude Expert Opinions and Analyses Not Contained in Expert Reports (Dkt. No. 295) (the “Motion To Exclude”).

In briefing the Motion To Exclude, the FTC and USAP submitted numerous excerpts of expert reports and expert depositions. With just one exception (addressed *infra*, pp. 6-8), USAP seeks to seal material that is irrelevant to the issues before the Court, not at issue in the Motion To Exclude, and not cited in either party’s briefing, but happens to be part of the record simply because it appears on the same page as other material that is relevant. The balance of the equities favors sealing that irrelevant material: revealing it would do nothing to enhance the public’s understanding of the issues relevant to the Motion To Exclude, and would only risk harming USAP’s ability to compete. The Court should grant USAP’s Motion To Seal.

NATURE AND STAGE OF THE PROCEEDINGS

On January 30, 2026, the FTC moved to strike from the discovery record certain deposition testimony from USAP’s expert witnesses—Dr. Lona Fowdur, Dr. Zeev Kain, and Mr. David Fix. Dkt. No. 295. In briefing both sides of this dispute, the FTC and USAP submitted under temporary seal unredacted excerpts of expert reports and expert deposition transcripts that were designated as Confidential and Highly Confidential Material. Dkt. Nos. 297, 304, 308; *see* Dkt. No. 149-1 ¶ 2(a)-(b) (defining “Confidential Material” and “Highly Confidential Material”). This Court granted those temporary sealing motions on March 13, and further ordered that any party seeking to maintain under permanent seal any portion of those expert reports and deposition transcripts must file the appropriate motion on March 27. Dkt. Nos. 313, 314.

BACKGROUND

The FTC's Motion To Exclude focused on three narrow topics of testimony for each of USAP's experts.

First, the FTC sought to strike Dr. Fowdur's allegedly "new" opinions offered in response to new analyses performed by the FTC's economic expert, Dr. Cory Capps, in his reply report. *See* Dkt. No. 295 at 8-9; Dkt. No. 305 at 11-15. The parties' disputes center on the results of, and methodologies underlying, Drs. Fowdur's and Capps's data analyses that support each expert's market definition and monopoly power opinions. In nearly all respects, those analyses do not reveal any USAP Confidential or Highly Confidential Material.

Second, the FTC alleged that Dr. Kain, during his deposition, changed "the analytical framework" he used to render his opinions about USAP's quality of care. Dkt. No. 295 at 10. Here again, the parties' dispute does not concern any USAP Confidential or Highly Confidential Material.

Third, the FTC asserted that Mr. Fix offered a single "new" opinion during the re-direct examination of his deposition by clarifying the scope of services that will be offered by Elevated Practice Solutions, a USAP affiliate that will offer third-party anesthesia providers with back-office administrative services. *See* Dkt. No. 295 at 11-12; Dkt. No. 295-6 (Fix Dep. Tr. at 234:25-235:14).

Though the parties' disputes are narrow, the scope of USAP Confidential and Highly Confidential Material that appears in the briefing record is broad. That is, in large part, because the FTC attached to its motion an excerpt of Mr. Fix's expert report that includes every page in which Mr. Fix referenced his interview with Mr. Burns. *See* Dkt. No. 295-4. The material discussed on those pages, and in other exhibits, reveals Confidential and Highly Confidential

Material relating to USAP's cybersecurity infrastructure; USAP's proprietary revenue cycle management tools; confidential contractual provisions; and other commercially-sensitive information that USAP does not disclose to its competitors in the ordinary course of business. USAP's instant Motion To Seal targets this information that appears in the exhibits to the parties' briefing on the FTC's Motion To Exclude and is not relevant to the issues raised in those briefs. Indeed, USAP does not object to the unsealing of the presently-sealed versions of the FTC's Motion (Dkt. No. 295), USAP's Opposition (Dkt. No. 305), or the FTC's Reply (Dkt. No. 309).

STATEMENT OF THE ISSUE

Whether the Confidential and Highly Confidential Material associated with the FTC's Motion To Exclude should be permanently sealed in light of USAP's interest in safeguarding the confidentiality of the specific, competitively-sensitive business information, and the absence of any meaningful public interest in disclosure of court records given that the information at issue is unnecessary to adjudicate the FTC's Motion To Exclude?

STANDARD OF REVIEW

Federal Rule of Civil Procedure 5.2(e) "permits district courts, upon a finding of good cause, to issue a protective order requiring redaction of information filed in the public record." *EEOC v. A'Gaci, LLC*, 2015 WL 510254, at *5 (W.D. Tex. Feb. 5, 2015); *see also* Fed. R. Civ. P. 5.2(d) ("The court may order that a filing be made under seal without redaction. The court may later . . . order the person who made the filing to file a redacted version for the public record.").

The common law imposes a "working presumption" that the public will have access to all judicial records. *See, e.g., Binh Hoa Le v. Exeter Fin. Corp.*, 990 F.3d 410, 419 (5th Cir. 2021). But that "common law right is not absolute." *SEC v. Van Waeyenberghe*, 990 F.2d 845, 848 (5th Cir. 1993) (citing *Nixon v. Warner Commc'ns, Inc.*, 435 U.S. 589, 598 (1978)). This Court's

“supervisory power over its own records and files,” gives it the discretion to restrict public access to judicial records. *Nixon*, 435 U.S. at 598; *see also Vantage Health Plan, Inc. v. Willis-Knighton Med. Ctr.*, 913 F.3d 443, 450 (5th Cir. 2019) (“The decision whether to allow public access to court records ‘is one best left to the sound discretion of the trial court.’” (quoting *Nixon*, 435 U.S. at 599)). “In exercising this discretion, ‘the court must balance the public’s common law right of access against the interests favoring nondisclosure.’” *Vantage Health*, 913 F.3d at 450 (quoting *Van Waeyenberghe*, 990 F.2d at 848). If the moving party shows “that the interest in secrecy outweighs the presumption [of access,]” *N. Cypress Med. Ctr. Operating Co. v. Cigna Healthcare*, 2012 WL 12893404, at *4 (S.D. Tex. Sept. 27, 2012), then redactions that are “congruent to the need” for secrecy are appropriate, *Le*, 990 F.3d at 420.

ARGUMENT

Historically, “courts have refused to permit their files to serve . . . as sources of business information that might harm a litigant’s competitive standing.” *Nixon*, 435 U.S. at 598. In line with that historical practice, courts in this Circuit and across the country routinely find that a party’s interest in protecting its confidential, proprietary, or commercially-sensitive information outweighs the public’s right to access it in a judicial record when disclosure would harm the party’s competitive standing in the market. *See, e.g., Udowea v. Plus4 Credit Union*, 754 F. Supp. 2d 850, 883-84 (S.D. Tex. 2010) (sealing an exhibit that “contain[ed] significant amounts of sensitive financial and personnel information,” and another that “contain[ed] extensive financial information of a sort that is often kept confidential”); *In re Qualcomm Litig.*, 2019 WL 845659, at *2 (S.D. Cal. Feb. 21, 2019) (allowing the parties to redact motions and exhibits thereto because they “detail[ed] sensitive financial terms, royalty agreements, proprietary business strategies, and

confidential licensing negotiations” that “would harm their competitive standing” if disclosed “to market competitors”), *aff'd*, 457 F. App'x 391 (5th Cir. 2012).

Courts have also recognized that when the information subject to a redaction request “bears only a marginal relationship to the performance of Article III functions,” the public’s interest in disclosure is “weak.” *United States v. Amodeo*, 71 F.3d 1044, 1051-52 (2d Cir. 1995); *see also Arkansas Tchr. Ret. Sys. v. State St. Bank & Tr. Co.*, 523 F. Supp. 3d 181, 196 (D. Mass. 2018) (“[T]he public’s interest in the disclosure of information that ‘does not appear necessary or helpful in resolving’ an issue is less weighty than its interest in information on which a court relies in resolving disputes.”) (quoting *Refco Grp. Ltd., LLC v. Cantor Fitzgerald, L.P.*, 2015 WL 4298572, at *5 (S.D.N.Y. July 15, 2015)). In these circumstances, none of the purposes the common law right of access furthers—promoting trustworthiness and faith in the judicial system, and allowing the public to understand the nature of the claims being litigated, *United States v. Sealed Search Warrants*, 868 F.3d 385, 395 (5th Cir. 2017)—are materially enhanced. *See United States v. Valencia*, 2006 WL 3707867, at *10 (S.D. Tex. Aug. 25, 2006) (redacting from trial exhibits certain confidential information because it was not required to assist “[t]he public’s right to understand the evidence against Defendants”); *League of United Latin Am. Citizens v. Abbott*, 2022 WL 2806850, at *5 (W.D. Tex. July 18, 2022) (redacting the plaintiffs’ names in part because “the public can intelligently follow the proceedings without [their] names”); *Jones v. RealPage, Inc.*, 2021 WL 268824, at *1-2 (N.D. Tex. Jan. 27, 2021) (granting the defendant’s request for “minimal redactions” of a court order that “implicate[d] [the defendant’s] most private and confidential information” because doing so would not “contravene the purpose behind public access to judicial records”).

All of these factors coalesce to justify granting USAP its requested protective order. Some of the exhibits supporting the FTC's Motion To Exclude and USAP's Opposition, most notably the excerpt of Mr. Fix's expert report, contain narrow categories of information that, if left unredacted and disclosed, would undercut USAP's ability to compete for the provision of anesthesia services. None of that information meaningfully assists the public's comprehension of the merits of the FTC's or USAP's positions on the Motion To Exclude. And some of it, as explained below, implicates the privacy interests of innocent third parties. The Court should therefore grant USAP's sealing motion.

Confidential Contractual Terms, Including Pricing Terms. Within two of the parties' exhibits are references to terms in USAP's contracts with commercial payors.

First, the excerpt of Dr. Capps's Reply Report contains three figures that reveal USAP's reimbursement rates with the four largest commercial payors in Texas. *See* Dkt. No. 305-7, Figs. 15, 16, and 17. USAP's reimbursement rates are some of its most confidential material. USAP does not share the contractual reimbursement rates it negotiates with individual insurance providers with third parties (such as competing anesthesiology practices or with other insurance providers), and it takes steps to preserve the confidentiality of this competitively-sensitive information. Indeed, USAP's network agreements with the payors *prohibit* USAP from revealing its rates. Disclosure of USAP's reimbursement rates (whether directly or indirectly) would give other insurance companies and USAP's competitors an unfair advantage in contract negotiations and in the marketplace and would directly harm USAP's competitive position. Courts across the country have recognized the competitive harms that would flow from the revelation of such information justify sealing. *See, e.g., Vantage Health*, 913 F.3d at 451 (affirming order sealing from the public record any "information that reveal[s] reimbursement rates and percentages . . .

[and] overall percentage increases from year to year”); *United States v. Anthem, Inc.*, 2016 WL 11164037, at *2 (D.D.C. Dec. 23, 2016) (granting motion to seal trial exhibits reflecting “highly confidential pricing information, negotiation strategies, reimbursement rate information, and product pricing information”); *Shane Grp., Inc. v. Blue Cross Blue Shield of Michigan*, 2018 WL 1811471, at *4-5 (E.D. Mich. Apr. 17, 2018) (granting Blue Cross’s request to redact its reimbursement rates because of the competitive harms it would suffer); *W. Penn Allegheny Health Sys., Inc. v. UPMC*, 2013 WL 12141532, at *23-24 (W.D. Pa. Sept. 16, 2013) (sealing a hospital’s reimbursement rates with competitors).

Sealing these figures from the public record is consistent with the public’s right of access to judicial proceedings. The narrow dispute before the Court is whether Dr. Fowdur’s description during her deposition of two analyses she ran in response to Dr. Capps’s inclusion of Figures 15-17 in his Reply Report is a violation of Federal Rule of Civil Procedure 26. *See* Dkt. 305 at 14-15. The public retains the same ability to comprehend the nature of the FTC’s and USAP’s arguments concerning that issue without access to USAP’s “most private and confidential information,” *Jones*, 2021 WL 268824, at *1; *see also, e.g., Valencia*, 2006 WL 3707867, at *10 (redacting from trial exhibits certain confidential information because it was not required to assist “[t]he public’s right to understand the evidence against Defendants”). The Court should therefore seal each of those figures in their entirety, as reflected in **Exhibit 1**.¹

¹ Counsel for Aetna Inc. (“Aetna”) has informed the undersigned counsel that Aetna views the scatterplots in Figures 15-17 of the Capps Reply Report, respectively, as conveying Aetna’s confidential, competitively-sensitive pricing information. In Aetna’s view, public disclosure of such information would result in harm to Aetna’s competitive standing and business interests, as well as to anesthesia provider and health insurance competition in Texas that will ultimately harm consumers. In addition to these figures, a footnote on a separate figure reveals confidential information about another payor’s claims data processing, which is proprietary and should likewise remain under seal. Sealing this detail does not interfere with the public’s understanding of the figure or the arguments. *See* Ex. 1 at 27 (fig. 5).

Second, the excerpt of Dr. Fowdur’s deposition transcript contains a reference to terms in a contract between USAP and UnitedHealth Group. *See* Dkt. No. 305-3 at 290:22-291:4. USAP similarly does not publicly disclose the terms of its confidential contracts. Doing so would undercut USAP’s ability to negotiate future contracts with other commercial payors on an arm’s length basis. For similar reasons, this Court should seal that discussion from the record, as reflected in **Exhibit 2**, because of the business harm that would flow from the disclosure of USAP’s proprietary contract terms and confidential negotiation strategies. *See DISH Network, LLC v. WLAJ-TV, LLC*, 2017 WL 1333057, at *2 (W.D. La. Apr. 3, 2017) (sealing an entire contract because it contained “extremely sensitive, proprietary provisions” that were subject to “a strict confidentiality provision”); *FTC v. Microsoft Corp.*, 2023 WL 5186252, at *4 (N.D. Cal. Aug. 11, 2023) (approving redactions of “[n]on-public information about Sony’s approach to contract negotiations with third party partners and discussions of particular contract terms with particular partners that could competitively harm Sony if publicly disclosed”). USAP’s proposed redactions strike the appropriate balance, as they do not undermine the public’s ability to understand the nature of the FTC’s claims; indeed, USAP’s contract with United is irrelevant to the issues raised in the FTC’s Motion To Exclude.² *See Sealed Search Warrants*, 868 F.3d at 395.

USAP’s Confidential Revenue Cycle Management Business Strategies. Included in the excerpt of Mr. Fix’s expert report and deposition are several references to USAP’s confidential strategies and internal data related to its revenue cycle management (“RCM”) process. *See* Dkt. No. 295-4 ¶¶ 111-117; Dkt. No. 295-6 at 234; Dkt. No. 305-5 at 81-85, 89-90, 205, 207. As part of the RCM process, anesthesia practices like USAP translate medical records and procedures into

² Counsel for United has informed the undersigned counsel that it does not oppose USAP’s effort to maintain this information under seal.

formal claims for reimbursement from commercial payors. Practices like USAP that do not outsource this process compete in their ability to complete the RCM process more accurately and efficiently. To that end, USAP has developed its own proprietary RCM methods that it keeps confidential in the ordinary course of business, as well as proprietary methods of monitoring and auditing its employees' implementation of the RCM process. Those proprietary RCM methods are trade secrets that USAP developed and does not publicly disclose; forced disclosure would diminish USAP's ability to compete on the merits.

The excerpt of Mr. Fix's report that the FTC filed contains highly sensitive information relating to USAP's confidential RCM business strategies, including its internal auditing standard; internal analysis of USAP's confidential RCM data from the last two years; and a reference to how much USAP invests in its RCM process each year. The Court should seal those references from Mr. Fix's report as reflected in **Exhibit 3**, and from his deposition transcript as reflected in **Exhibit 4**.³ *See Decapolis Grp., LLC v. Mangesh Energy, Ltd.*, 2014 WL 702000, at *2 (N.D. Tex. Feb. 24, 2014) (sealing a two-year old arbitration award that "contain[ed] sensitive information such as business strategies"); *Horizon v. Pharma Ireland Ltd. v. Lupin Ltd.*, 2017 WL 11634621, at *2 (D.N.J. Oct. 11, 2017) (approving redactions of references to "commercially sensitive" information detailing "business insight into strategies and negotiations" that was never "publicly available" or "disseminated to anyone other than on a confidential basis"). Those redactions are particularly appropriate, as they do not bear on the ultimate question the Court must answer—whether he offered a "new" opinion about services that Elevated Practice Solutions will offer to

³ Both the FTC and USAP filed excerpts of Mr. Fix's deposition transcript. *See* Dkt. No. 295-6; Dkt. No. 305-5. The redacted excerpt of Mr. Fix's deposition filed as **Exhibit 4** to this Motion To Seal combines the two excerpts and contains all of USAP's proposed redactions.

third-party anesthesia providers—therefore preserving the public’s access to judicial proceedings. *See Valencia*, 2006 WL 3707867, at *10.

USAP’s IT Incident Response Plan. The excerpt of Mr. Fix’s report, filed by the FTC, also includes highly sensitive material relating to USAP’s proactive planning for cyberattacks, and its specific strategies in reacting to data breaches at two specific facilities in the last two years. *See* Dkt. No. 295-4 ¶¶ 140-143. These strategies are particularly sensitive to USAP, and are not revealed publicly, given the ever-growing cybersecurity threats that companies like USAP—which handle highly confidential information relating to patients’ medical care—face on a daily basis. If USAP’s cybersecurity plans and strategies were publicly disclosed, that would make it easier for threat actors to circumvent USAP’s defenses and obtain sensitive patient data. The public has no interest in that outcome; indeed, many members of the public would be adversely affected by it. The Court should therefore seal references to these confidential cybersecurity strategies appearing in paragraphs 140 to 143 of Mr. Fix’s expert report, as reflected in **Exhibit 3**, especially considering that they are irrelevant to the issues in the FTC’s Motion To Exclude. *See Decapolis*, 2014 WL 702000, at *2; *Horizon*, 2017 WL 11634621, at *2.

USAP’s Confidential Financial Information. Portions of Mr. Fix’s report, Dr. Kain’s report, and Dr. Kain’s deposition transcript reveal the specific dollar amounts that USAP has invested in its RCM processes (Dkt. No. 295-4 ¶ 116), information technology infrastructure (*id.* ¶ 209); and improvements to quality of care (Dkt. No. 295-5 at 171:8-15, 172:15-17; Dkt. No. 305-8 ¶ 72). “Courts commonly find that documents that contain . . . revenue information, pricing information, and the like satisfy the sealing standard[.]” *Kewazinga Corp. v. Microsoft Corp.*, 2021 WL 1222122, at *3 (S.D.N.Y. Mar. 31, 2021) (citation omitted); *see also, e.g., Apple Inc. v. Samsung Elecs. Co.*, 727 F.3d 1214, 1225 (Fed. Cir. 2013) (“[I]t seems clear that if [the parties’]

suppliers have access to their profit, cost, and margin data, it could give the suppliers an advantage in contract negotiations, which they could use to extract price increases for components.”). USAP proposes only targeted redactions to the specific dollar amounts referred to, which strike the appropriate balance: the public can still “intelligently follow the proceedings,” *United Latin Am. Citizens*, 2022 WL 2806850, at *5, while protecting USAP’s “most private and confidential information,” *Jones*, 2021 WL 268824, at *1. The Court should therefore maintain under seal the references to these dollar amounts as reflected in **Exhibits 3, 5, and 6**.

USAP’s Confidential Recruitment Strategies and Facility Staffing. Finally, the excerpt of Mr. Fix’s report reveals certain of USAP’s recruitment strategies, including the number of clinicians USAP hired in 2024; the locations that USAP targets for its hires; and the exact number of clinicians it staffs at certain facilities, all of which USAP treats in the ordinary course as competitively sensitive information. *See* Dkt. No. 295-4 ¶¶ 47-48, 165-67. Anesthesia practices in Texas compete vigorously to hire a limited and highly sought-after pool of qualified anesthesia clinicians; giving USAP’s competitors insight into its specific recruitment strategies would degrade USAP’s ability to compete to hire those clinicians. And USAP’s staffing levels at specific facilities, which are not shared with competitors, would disadvantage USAP in future competition for anesthesia services agreements at those facilities. The Court should therefore maintain references to this information in Mr. Fix’s report under seal, as reflected in **Exhibit 3**.

CONCLUSION

For the foregoing reasons, USAP respectfully requests that the Court permanently seal the information redacted from Exhibits 1-6, and maintain under permanent seal the following documents previously filed under temporary seal: Dkt Nos. 295-4, 295-5, 295-6, 305-3, 305-4, 305-5, 305-7, and 305-8.

Dated: March 27, 2026

Respectfully submitted,

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CERTIFICATE OF CONFERENCE

I hereby certify that on March 26, 2026, counsel for USAP met and conferred via Zoom teleconference with counsel for the FTC concerning the relief requested in this motion to seal. Counsel for USAP and the FTC further conferred via email and telephone on March 27, 2026. I am authorized to state that the FTC does not oppose the relief sought in this Motion To Seal.

Respectfully submitted,

/s/ Kyle M. Wood

Kyle M. Wood

CERTIFICATE OF SERVICE

I hereby certify that on March 27, 2026, I filed the foregoing document with the Court and served it on opposing counsel through the Court's CM/ECF system. All counsel of record are registered ECF users.

Respectfully submitted,

/s/ Geoffrey M. Klineberg

Geoffrey M. Klineberg

Exhibit 1

**IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION**

Federal Trade Commission,

Plaintiff,

v.

U.S. Anesthesia Partners, Inc.,

Defendant.

Case No.: 4:23-CV-03560-KH

REPLY EXPERT REPORT OF CORY S. CAPPS, PHD

December 12, 2025

Reply Expert Report of Cory S. Capps, PhD

or not hospital-only and non-hospital-only anesthesia services have the same price.⁷⁵ And it is true whether or not those prices are set forth in the same contracts between payers and anesthesia groups.⁷⁶

- (66) Understanding that payers are relevant customers in the market definition exercise makes clear that Dr. Fowdur’s arguments to expand the service market to include services provided at ASCs rest on what economists refer to as “supply-side substitution” and what the 2023 Merger Guidelines refer to as “rapid entry.”⁷⁷ These terms refer to market circumstances in which the responsive actions of suppliers not currently active in a relevant market are sufficiently effective and rapid that it may be appropriate to expand the relevant market to include those sellers in the relevant market. The rationale is that such sellers’ products or services, though not at present reasonably substitutable or interchangeable, could quickly become so in response to a price increase. However, as I explain in the remainder of this section, Dr. Fowdur has provided no evidence establishing that anesthesiologists providing anesthesia services at ASCs would and could rapidly enter in response to a price increase by a hypothetical monopolist of hospital-only anesthesia services.
- (67) To start, Dr. Fowdur’s argument that anesthesia providers at ASCs could and would rapidly enter is at odds with her own “relevant background” section, in which she identifies significant differences in how anesthesia services are rendered across the two care settings:⁷⁸

Elements of differentiation among anesthesia groups can also include each group’s suitability and preferences to provide services to patients in hospitals as opposed to other surgical facilities such as ambulatory surgical centers (“ASCs”), that can have more manageable schedules (e.g., no need to be “on call” overnight, on weekends or holidays) and a more desirable payor mix; elective, emergency and trauma care-settings; and an ability to provide complex and specialized care.

- (68) Dr. Fowdur provides no analysis to show that anesthesia providers would leave the ASC care setting for the different work and lifestyle of the hospital setting in response to a SSNIP for hospital-only

⁷⁵ While it is generally true that products in the same market will have the same price if that market is perfectly competitive, it is a logical fallacy to assume the converse—that is, two products having the same price does *not* generally imply that they are necessarily in the same market. And, strictly speaking, average prices for a given anesthesia services will generally be lower in the ASC setting because a higher proportion of services in an ASC is rendered by CRNAs, whose services are commonly billed at a decrement from services provided by anesthesiologists. (USAP is an exception to this practice.). Capps Report, n. 174; *see also, supra* note 69.

⁷⁶ As a point of comparison, prices for inpatient and outpatient hospital services are typically set forth in a single contract between a payer and a hospital system. But, as many hospital merger cases have established, inpatient services are in a distinct relevant product market from hospital outpatient services. Capps Report, n. 180.

⁷⁷ Fowdur Report, ¶ 128 (“In particular, Dr. Capps’ method ignores the potential supply response from anesthesiologists who perform non-hospital services in the same hospital facilities or elsewhere.”). 2023 Merger Guidelines, § 4.4.A (“Firms that are not currently active in a relevant market, but that very likely would rapidly enter with direct competitive impact in the event of a small but significant change in competitive conditions, without incurring significant sunk costs, are also considered market participants. These firms are termed ‘rapid entrants.’”).

⁷⁸ Fowdur Report, ¶ 28.

Reply Expert Report of Cory S. Capps, PhD

anesthesia services. On the contrary, she quotes Dr. Thomas Kenjarski's (Noble Anesthesia) elaboration of the differences between providing anesthesia services in the two settings:⁷⁹

Q. [D]o you currently have plans to expand into hospitals? A. Every minute of every day. But no, we're always looking for opportunities. But Noble over the past decade has focused on ambulatory anesthesia services. So we would look for similar hospitals where it was only an acute care surgical hospital. So same day surgery or maybe a brief overnight stay. . . .

Q. And does Noble provide 24/7 care at any of the ASCs? A. See, that's the beautiful part about ambulatory anesthesia. The ambulatory surgery centers and the offices are only open Monday through Friday. There's no nights, no weekends, no call coverage. And matter of fact, they're closed at least seven federal holidays a year. So there is no call coverage required in any of them. There is no ER. . . .

Q. And does [a] focus on outpatient anesthesia allow clinicians to have a higher quality of life? [...] A. It depends on how you define quality. If you define quality of life as an anesthesiologist by how many dollars that you can make per week or per month, it's not as high quality. If your quality is, you know, being done, you know, sometime before dinner and being able to sleep every night in your own bed and to have your weekends and -- and Christmas and Thanksgiving off, then by all means, yes. The -- the type of job Noble provides would be a better quality of life given that definition.

- (69) Consistent with Dr. Kenjarski's testimony, I show in Figure 5 that a significant majority of anesthesia providers in the Houston, Dallas, and Austin MSAs worked primarily in either the hospital setting or in the ASC setting.⁸⁰ For example, the left-most blue bar labeled "0%-10%" shows that 12% of anesthesia providers in the three MSAs have 90% or more of their claims at ASCs; likewise, anesthesia providers who have 60% or more of their claims at ASCs account for only 19% of anesthesia providers serving facilities in the three MSAs. Conversely, more than 50% of anesthesia providers have 90% or more of their claims occur in a hospital rather than an ASC; likewise, 73% of anesthesia providers have 60% or more of their cases in hospitals.⁸¹ In addition, the green line shows the composition of medical doctors relative to CRNAs among the providers depicted in each of the blue bars. Compared with anesthesia providers who have the majority of their cases in hospitals, the

⁷⁹ Fowdur Report, note 39.

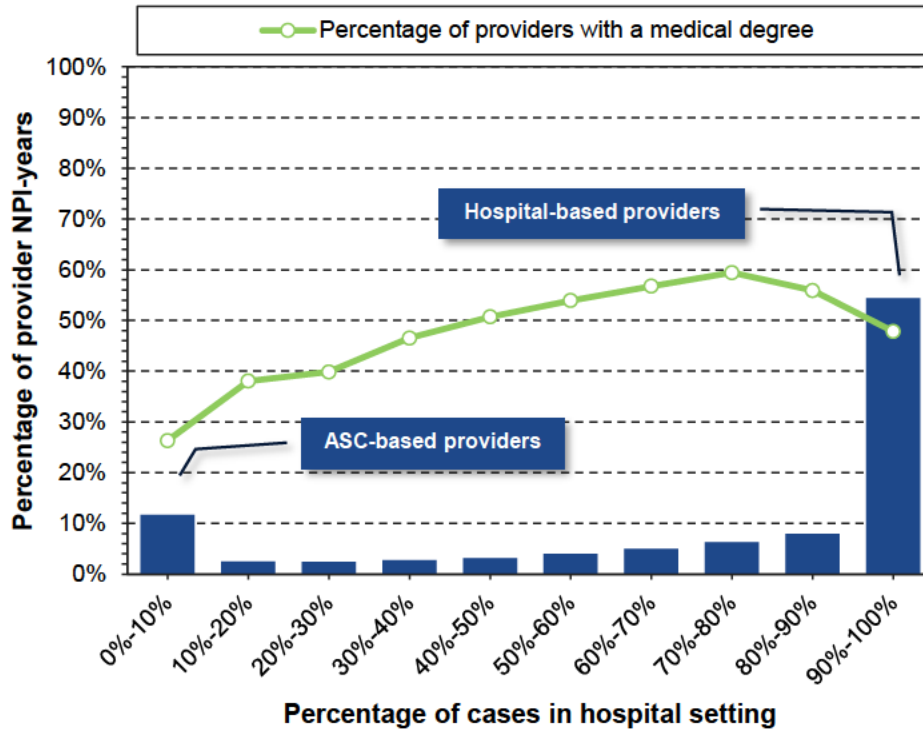
⁸⁰ The figure includes cases from 2014–2023. The results and takeaways remain the same when looking at a more recent range, like 2022–2023.

⁸¹ Dr. Fowdur's Exhibit 33 shows that, compared with other anesthesia groups, USAP has a higher proportion of its claims volume in hospitals.

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percentage of medical doctors among anesthesia providers who have more of their cases at in ASCs is lower.⁸²

Figure 5. Distribution of cases performed in the hospital and ASC settings, 2014–2023



Source: Professional claims data (Aetna, Cigna, United).

Notes: Limited to commercial cases for anesthesia services from 2015–2023 in the Austin, Dallas, and Houston MSAs. A case is a unique combination of patient, date, and service provider NPI. Provider-years are limited to those with at least 12 cases in the given calendar year. The hospital setting is defined as place of service codes 21, 22, or 23; ASCs are identified as place of service code 24. [REDACTED]

(70) In addition, there are more anesthesia cases in hospitals than in ASCs.⁸³ This implies that, even if one assumes—despite evidence and testimony to the contrary—that anesthesia providers working in ASCs could and would be rapid entrants, it is not clear that there are enough of them to mitigate a

⁸² In Exhibit 31, Dr. Fowdur reports percentages of hospital-based anesthesia providers who also provided services at ASCs in the prior 1, 3, and 5 years, and shows that about 38% did so in the prior year and about 55% did so in the prior 5 years. She identifies a provider as having served in an ASC if they had at least 12+ yearly claims in an ASC, but she does not otherwise account for variation in the extent to which providers served in an ASC versus a hospital, nor for variation in the extent of medical doctors relative to CRNAs. Figure 5 accounts for both factors.

In addition, Dr. Fowdur’s exhibit addresses the wrong question: because she is attempting to establish that anesthesia providers currently working *in ASCs* could and would rapidly switch to providing services to *hospitals*, she should have looked at the share of ASC-based providers that previously worked at hospitals.

⁸³ Capps Report, ¶ 139, n. 186 (“ASCs account for a minority of cases of anesthesia services provision and an even smaller minority of payments for anesthesia services”) and Capps Report, Figure 4.

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70–80 provider bin through the 220–230 bin. The red line represents the *same* two groups (USAP and NAPA) across all of those bins. In contrast, there are nine hospitals represented by the blue bars across those bins (i.e., the bins located where the red line equals two). Those are nine *different* hospitals. Each of those nine hospitals was served by USAP or NAPA in 2023.¹³⁵ There are not two *replacement* groups ready to serve each of the hospitals captured by the blue bars: the groups represented by the red line are *already* serving the hospitals represented in the blue bars.

- (120) While hospitals do have the ability to switch anesthesia providers (and incur switching costs), Dr. Fowdur’s analysis provides no basis to conclude that there is a ready supply of anesthesia groups in the three MSAs available to replace anesthesia groups such as USAP that provide hospital-only anesthesia services. Instead, the appearance of excess supply in her exhibits is an artifact of data processing errors and misleading analytical choices.

II.A.3.b.ii. Hospitals switching anesthesia groups

- (121) Dr. Fowdur next conducts an analysis that, she claims, shows that a significant percentage of hospitals or facilities (she uses both terms) in the Austin, Dallas, Houston, and San Antonio MSAs switched their anesthesia group from 2019–2023.¹³⁶ One of Dr. Fowdur’s definitions of a switch is if a facility was served by a single anesthesia group exclusively and then “sliced” its anesthesia coverage across multiple groups.¹³⁷ However, her errors in matching facility and professional claims that I discussed above may create spurious switches if Dr. Fowdur assigns the wrong anesthesia groups to a given facility and then incorrectly concludes that the facility is served by multiple groups.
- (122) Setting this issue aside, inspection of the anesthesia groups that Dr. Fowdur claims hospitals switched to reveals that many of her identified switches are spurious. For example, in Austin, the large majority of the “switches” she counts were actually a new anesthesia group (NAPA) acquiring an existing group.¹³⁸ Removing these spurious switches reduces her percentage of Austin MSA hospitals that switch anesthesia groups from 40% to 4%.

¹³⁵ See Dr. Fowdur’s payer claims data.

¹³⁶ Fowdur Report, Exhibit 11.

In typical usage, the term “facility” is a general term that can mean hospital or an ASC. Dr. Fowdur sometimes switches terminology in ways that make her intended meaning ambiguous. For example, the title of Section IV.A.2 uses the term “facilities” (“Facilities Do Switch Among Exclusive Anesthesia Provider Groups”), but the first sentence in that section uses the term “hospital facilities” and the only exhibit in the section has the subtitle, “Hospitals With Exclusive Anesthesia Providers 2019-2023” (and then the column headings and notes within that very exhibit use the term “Facilities”). Further confusing matters, Dr. Fowdur includes non-hospital facilities in her analyses despite claiming to focus on hospitals, which she also sometimes refers to as facilities.

¹³⁷ Dr. Fowdur counts as a switch any instance in which a previously exclusive anesthesia group dropped below 75% claim share at a facility over a 12-month period. Fowdur Report, Exhibit 11.

¹³⁸ This is similar to Dr. Fowdur’s error of conflating entry/expansion events that create a new/larger competitor with acquisition events that change the name of an existing competitor (and sometimes eliminate a competitor).

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- (123) Similarly, Dr. Fowdur’s analyses for Houston and Dallas, particularly Houston, also overstate the frequency of switches. For these MSAs, I algorithmically flagged instances that were potentially (but not necessarily) switches from one exclusive anesthesia group to a different exclusive anesthesia group.¹³⁹ Using Dr. Fowdur’s data, I first identify the set of “core” anesthesia providers that make up at least 75% of a hospital’s anesthesia claims in the six months before the potential switch. If fewer than 90% of these “core” providers are still present at the hospital in the six-month time period after the purported switch, I count that as a potential switch rather than an event that was more likely to have been an acquisition.¹⁴⁰
- (124) Figure 12 reproduces Dr. Fowdur’s Exhibit 11 data under the columns titled “Facilities with exclusive providers” and “Facilities that Switch Providers.” Dr. Fowdur concludes that, across the four MSAs, between 22% and 46% of “Facilities” with exclusive providers switch to either another exclusive provider or to slicing over the 2019–2023 period. This overstates the frequency of switching.
- (125) Under the “Modification to remove likely acquisitions” heading, I eliminate purported switches that were more likely to have been acquisitions. For Austin and San Antonio, I establish this based on manual research, so I am removing actual acquisitions. For Houston and Dallas, I rely on the algorithm described above, so I am removing likely acquisitions but may not have removed all instances of acquisitions. After removing these acquisitions and likely acquisitions, the number of switches in Austin, Dallas, and Houston is lower than Dr. Fowdur reports.
- In Austin, 8 of Dr. Fowdur’s 10 switches were acquisitions, 1 was an affiliation of an anesthesia group with a management company, and 1 was a switch from one exclusive group to another. This is a maximum switching rate of 4% over the five-year period, not 40%.
 - In Dallas, at least 1 of Dr. Fowdur’s 17 switches was more likely to have been an acquisition and the remaining 16 were a mix of potential switches between exclusive groups and potential switches to slicing.
 - In Houston, at least 7 of Dr. Fowdur’s 27 switches were more likely to have been acquisitions, leaving 20 potential switches. This is a maximum switching rate of 34% over the five-year period, not 46%.
- (126) In Houston and Dallas, these “potential switches” are upper bounds on the extent of actual switches because errors in Dr. Fowdur’s matching of professional claims to facility claims could result in overstating the extent of switches to slicing.

¹³⁹ For Austin and San Antonio, I manually review the switches identified by Dr. Fowdur.

¹⁴⁰ The logic is that if most of the core providers from before the switch are still present afterwards, it is more likely that the group changed owners or retained a management service organization. If a significant fraction of the core providers are absent after the event, it is more likely that a new anesthesia group began serving at the hospital—i.e., a “potential switch.”

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Figure 12. Evaluating Dr. Fowdur's purported switches

MSA	Dr. Fowdur's calculations			Modification to remove likely acquisitions			
	"Facilities with exclusive providers"	"Facilities that Switch Providers"		Potential switches to slicing		Potential switches to exclusive	
		Count	% of total	Count	% of total	Count	% of total
Austin	25	10	40.0%	0	0.0%	1	4.0%
Dallas	78	17	21.8%	7	9.0%	9	11.5%
Houston	59	27	45.8%	6	10.2%	14	23.7%
San Antonio	21	6	28.6%	3	14.3%	3	14.3%

Source: Dr. Fowdur's payer claims data; Fowdur Report, Ex. 11

- (127) Despite referring to “hospitals” in the title of her Exhibit 11, Dr. Fowdur includes in her “facilities that switch providers” several facilities that are not hospitals.¹⁴¹ These include North Austin Pediatric Dental PLLC, Round Rock Eyecare, and St. David's Austin Surgery Center in the Austin MSA; Houston Behavioral Healthcare Hospital and Bayshore Dermatology Clinic in the Houston MSA; and Christus Santa Rosa Surgery Center in the San Antonio MSA. (I have not removed switches for these non-hospital facilities from Dr. Fowdur's analysis on this basis, but I excluded from the “potential switches” category if either manual research or the algorithmic method indicate that a switch likely did not occur.)
- (128) In addition, the facilities that make up the “potential switch” category are disproportionately smaller than average. In Figure 13, I weight switches by the 2023 anesthesia claims volume at each hospital. In each row, the percentage of potential switches declines relative to the corresponding unweighted percentages, which shows that the facilities that may have switched anesthesia groups were smaller than average.

Figure 13. Evaluating Dr. Fowdur's purported switches, weighted by claims volume

MSA	Claims at "Facilities with exclusive providers"	"Facilities that Switch Providers"	Potential switches to slicing	Potential switches to exclusive	Total potential switches
Austin	68,419	28.6%	0.0%	0.9%	0.9%
Dallas	251,765	8.6%	2.5%	5.8%	8.3%
Houston	265,956	20.8%	4.8%	8.4%	13.2%
San Antonio	55,906	9.3%	2.8%	6.6%	9.3%

Source: Dr. Fowdur's payer claims data.

¹⁴¹ Fowdur Report, Exhibit 11.

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II.A.3.b.iii. Hospitals contracting with multiple anesthesia groups (“slicing”)

(129) Finally, Dr. Fowdur asserts that “facilities can contract with multiple anesthesia provider groups at once,” which she refers to as “slicing.”¹⁴² I agree that hospitals can do this and that some in fact do so.¹⁴³ However, the flaws in Dr. Fowdur’s matching of professional anesthesia claims to facility claims will cause her to overstate the extent of slicing.¹⁴⁴

(130) Putting aside Dr. Fowdur’s likely overstatement of the extent of slicing, her main argument is as follows:¹⁴⁵

An ability for hospital facilities to slice their anesthesia-service coverage introduces greater competition among groups because groups of smaller size can bid on slices of a facility’s business. Further, slicing reduces the cost of switching because any switch would only affect a portion of the facility’s procedures. Even the threat of slicing can force exclusive groups to deliver competitive and high quality services to their facility customers because it is easy to replace them if their service offerings are sub-par or if better options become available.

(131) Dr. Fowdur provides no support for these statements. Even accepting them as true, they would not support a conclusion that USAP is unable to exercise market power. First, “groups of smaller size” that “bid on slices of a facility’s business” by definition do not threaten the remaining business that is served by the incumbent anesthesia group. Second, even if “slicing reduces the cost of switching,” it would also necessarily reduce the benefit of switching. A hospital that is dissatisfied with its existing anesthesia group but only partially replaces that group only partially alleviates its dissatisfaction.¹⁴⁶

(132) Finally, Dr. Fowdur purports to show examples of facilities served by USAP that switched and sliced anesthesia groups.¹⁴⁷ I do not dispute that some facilities use anesthesia groups that are not USAP;

¹⁴² Fowdur Report, ¶ 52.

¹⁴³ Dr. Fowdur states that “Some hospitals, especially in Dallas, and to a lesser extent in other MSAs, do not exclusively contract with only one provider group and instead ‘slice’ their anesthesiology services across multiple provider groups.” Fowdur Report, ¶ 52. I made a similar statement in my initial report: “The prevalence of exclusivity varies across geographies and over time. For example, in 2015 Welsh Carson estimated that about 95% of hospitals in Houston used exclusive contracts, whereas in Dallas, 40% of hospitals did so. Testimony indicates that, since 2015, exclusive contracting has become more common in Dallas.” Capps Report, ¶ 51 (internal citations omitted).

¹⁴⁴ Consider a hospital that has “true” exclusive anesthesia group and assume that at least some of the professional anesthesia claims that Dr. Fowdur matches to that hospital are, correctly, from the “true” exclusive group. If Dr. Fowdur also incorrectly assigns claims to the hospital from other anesthesia groups then the hospital will appear to be “slicing” when it is in fact using an exclusive anesthesia group.

¹⁴⁵ Fowdur Report, ¶ 53.

¹⁴⁶ Dr. Fowdur may argue that a hospital could contract with multiple smaller anesthesia groups to replace a larger incumbent group, but that would undermine her statement that “slicing reduces the cost of switching.” That is, there is no reason to expect that the switching costs of replacing one group with two or three replacement groups are lower than the switching costs of replacing one group with a single replacement group.

¹⁴⁷ Fowdur Report, ¶¶ 55–58.

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- Instances of meaningful differences are attributable to deficiencies in the payers' claims data that Dr. Fowdur failed to take into account. Dr. Fowdur's approach generates many instances in which her computed prices per unit are not plausible measures of the underlying conversion factors, as well as instances of apparent price changes for which there is no evidence in the record. The latter appears to be a spurious artifact of Dr. Fowdur computing price per unit using claims data in which units are not only frequently missing but also missing in a non-random fashion.

(146) I explain these points in the next two subsections and then turn to Dr. Fowdur's other points related to direct evidence of USAP's market power.

II.B.1.a. Price per case and price per unit are closely correlated

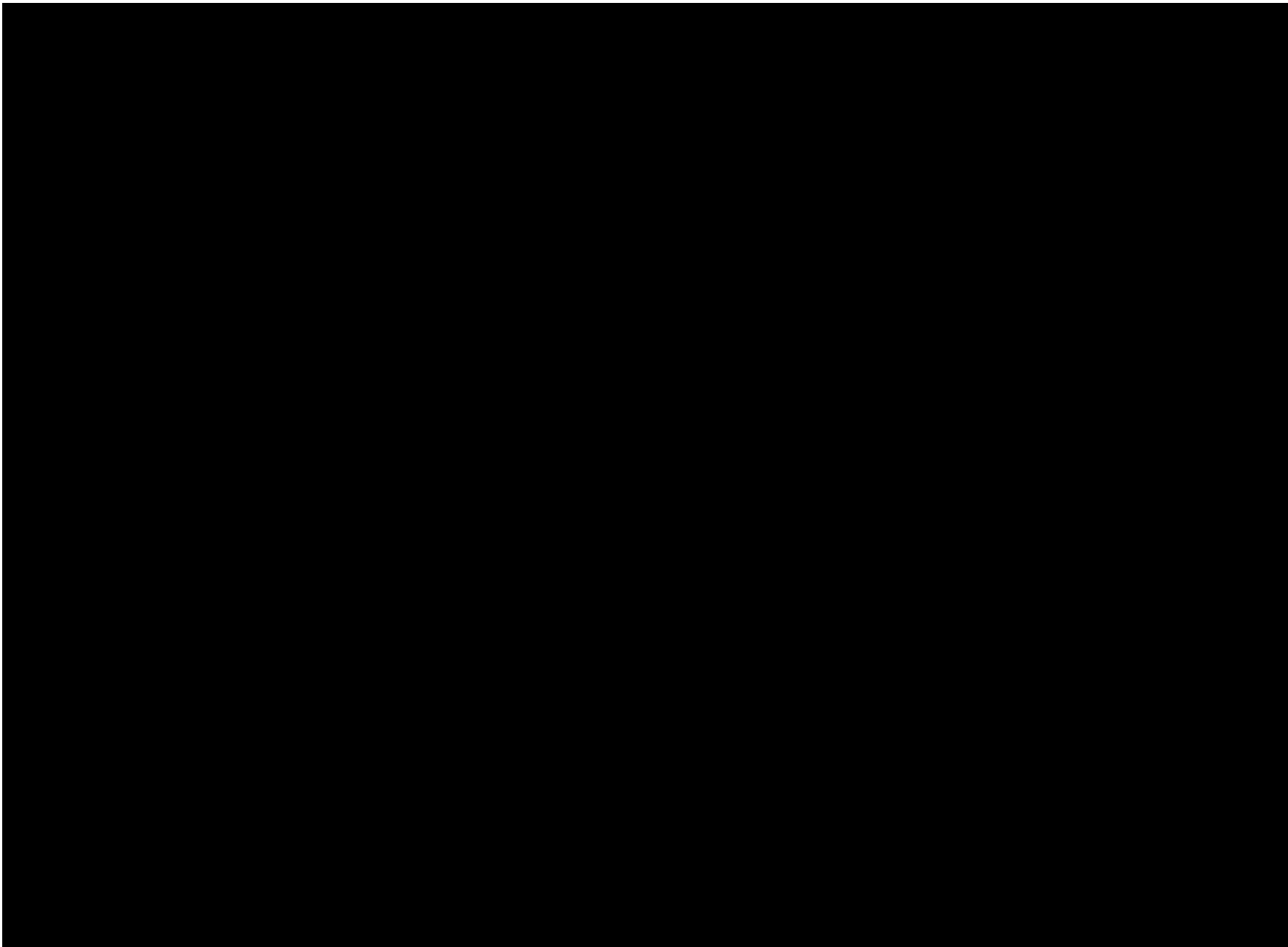
- (147) While Dr. Fowdur asserts that my price measure is "incorrect," my price measure is highly correlated with hers. Below, I present a series of scatterplots, broken out by payer and MSA, that relate Dr. Fowdur's price per unit measure with my price per case. Each dot on the scatterplot represents a quarter-payer-MSA combination for one of two sets of providers: "eventual USAP" providers and "never USAP" providers.¹⁶⁶ The x-axis represents Dr. Fowdur's price per unit and the y-axis represents my price per case. Thus, the position of each dot on the scatterplot represents a pair of Dr. Fowdur's price per unit and my price per case for that quarter-payer-MSA-anesthesia group combination.¹⁶⁷
- (148) The comparisons for Houston, Dallas, and Austin are in Figure 15 through Figure 17. For nearly all payer-MSA pairs, there is a tight, linear relationship between the two price metrics. Moreover, many of the relationships have a correlation coefficient of 0.95 or above and 10 out of 12 have a correlation coefficient above 0.90.¹⁶⁸

¹⁶⁶ Recall from my initial report that "eventual USAP" providers include any provider that uses the billing NPI of USAP or any of the billing NPIs eventually acquired by USAP. In Houston, for example, any provider billing under USAP, Guardian, MetroWest, and North Houston would be included in the "eventual USAP" set of providers. By contrast, the "never USAP" set of providers would be limited to any provider billing under an NPI that is never acquired by USAP.

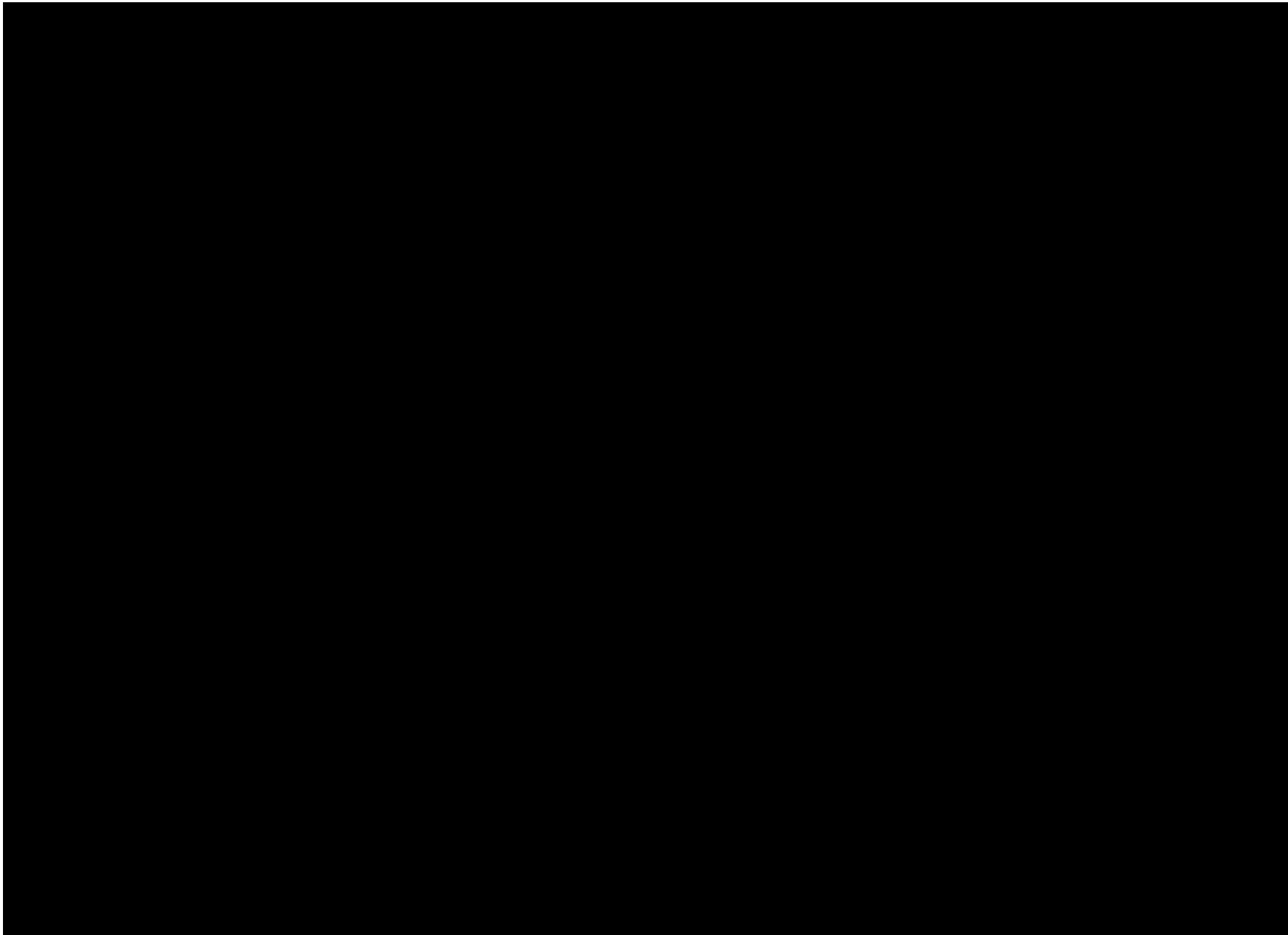
¹⁶⁷ In many of her analyses, Dr. Fowdur computes the price per unit at the claim line level and takes a simple average to calculate prices at a more aggregated level. By contrast, I calculated weighted average prices in my initial report. To be consistent, I calculate weighted average prices per unit using Dr. Fowdur's data. I sum allowed amounts and units to the payer-MSA-anesthesia group-quarter level and then divide the summed allowed amount by the summed units.

¹⁶⁸ The correlation coefficient, commonly denoted ρ , between two variables is a continuous measure of the direction and strength of a linear relationship between two variables. It ranges between -1 and +1. Values less than zero indicate a negative relationship (an increase in the value of one variable is associated with a decrease in the other) and correlations greater than zero indicate a positive relationship. A value of ρ that is close to -1 or +1 indicates a strong relationship and a value near 0 indicates a weak or no relationship.

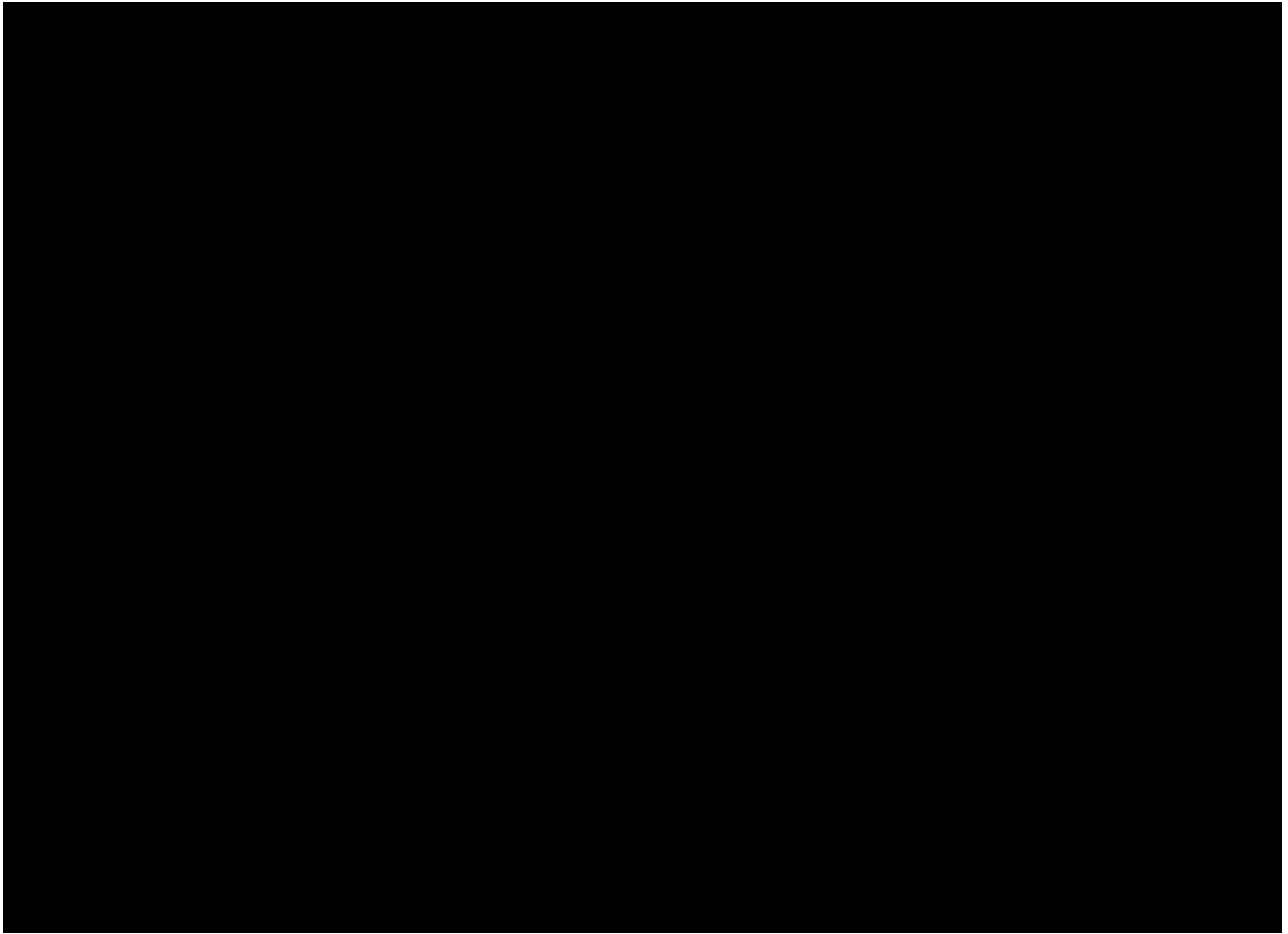
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- (288) Fifth, Dr. Fowdur asserts that “The goal of divestitures is not to spin off competitors that are more resource-constrained, especially if the head-to-head competition that divestitures are meant to produce remains absent.”³⁶⁰ In other words, Dr. Fowdur’s opinion is that anesthesia groups do not compete. Hence, Dr. Fowdur effectively assumes away the question at the heart of this case. Under her theory, an anesthesia group could become a 100% monopolist in a market and there would be no harm to competition. At points throughout both of my reports, I have identified ways in which anesthesia groups compete within an MSA. That aside, Dr. Fowdur’s assertion contradicts the dimension of competition between anesthesia groups she emphasizes—competition for placement at hospitals. Having more anesthesia groups available would increase competition for placement in hospitals.

IV.B. Mr. Fix

- (289) Mr. Fix opines on what he purports would be “the likely harms that would result from a divestiture order . . .”³⁶¹ He claims that (1) “divestiture could decrease access to other providers, including specialists, which could directly harm all the facilities USAP currently serves and their patients,” (2) “Dr. Capps also assumes that individual physicians who chose to join USAP will agree to work at some divested entity (contrary to their preference), ignoring the possibility that physicians will retire or move elsewhere, leaving facilities and patients in the lurch,” and (3) “USAP’s top-of-the-line back-office services provide significant benefits to facilities, patients, and individual providers. A divestiture would eliminate these benefits.”³⁶² Mr. Fix’s first two claims are couched as conditional statements (“could decrease access” and “ignoring the possibility”) and not as conclusions or even predictions of likely harms from divestiture.
- (290) More generally, the harms he describes are largely the removal of the benefits he asserts. But, as I explained in section III.D. Mr. Fix does not advance substantive or reliable evidence to show that the benefits he asserts actually exist, that they were an otherwise not reasonably attainable consequence of USAP’s series of acquisitions and price increases, or that any benefits to USAP and the groups it acquired were passed on to consumers.
- (291) Absent a basis to conclude that benefits of USAPs acquisitions were substantial and merger-specific, Mr. Fix has no basis to conclude that divestiture would have adverse effects on consumers.
- (292) As one example, Mr. Fix asserts that “A divestiture that reduces the number of clinicians providing services at certain hospitals could negatively impact those hospitals and patients by reducing the

³⁶⁰ Fowdur Report, ¶ 247.

³⁶¹ Fix Report, ¶ 13.

³⁶² Fix Report, ¶ 183.

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hospitals' access to anesthesiology providers, including specialists.”³⁶³ Again, Mr. Fix only claims that a divestiture “*could* negatively impact hospitals and patients” (emphasis added). I explained in section III.D that Mr. Fix provides no evidence of greater access to anesthesia providers or that any purported access was a merger-specific result of USAP’s acquisitions; hence, Mr. Fix has no basis to claim that this access would be reduced through divestiture. Mr. Fix additionally refers to “significant transition costs for the divested provider, the facilities, and the payors” but provides no evidence for such transition costs or any sense of their magnitude and how they compare to the supracompetitive prices USAP charges payers.³⁶⁴

- (293) Mr. Fix further purports to show several “examples” of facilities that would lose access to anesthesia providers under a divestiture. He uses the following framework:³⁶⁵

I have evaluated what would happen if a divestiture were implemented such that current USAP clinicians who spend 80% of their time at certain hospitals were no longer part of USAP, and USAP no longer provided services at those hospitals. In that scenario, the divested clinicians would no longer be allowed to provide anesthesiology services at other facilities. And other USAP providers could no longer provide services at the divested facilities.

- (294) Mr. Fix’s intended point here is that many USAP providers who primarily render services at a given “home” hospital sometimes also render services at other hospitals at which USAP provides services. If the USAP group at the “home” hospital were divested then those anesthesia providers would no longer be able to provide services to the other USAP hospitals at which they sometimes spent time (because they are no longer part of USAP). Mr. Fix then claims that the reduction in providers rendering services at facilities other than their home hospitals “could materially impact the facility’s ability to staff procedures, which would impact patient access.”³⁶⁶ With respect to a post-divestiture USAP, Mr. Fix ignores that USAP would remain a large provider group. With respect to divested groups, Mr. Fix implicitly assumes that physicians at the divested groups would uniformly only serve at a single hospital rather than spend a minority of time at various non-home hospitals.
- (295) And, in any event, the effect size that he proffers, even if it were valid, is small. He examines the non-home hospitals served by 76 USAP providers who were part of one of five USAP acquisitions and had a home facility (i.e., a facility that accounted for at least 80% of the provider’s time). He concludes that “the facilities listed in Figure 4 would collectively lose 112 providers and 932 provider days annually.”³⁶⁷ Using a 250-day work year, this amounts to 3.7 full-time equivalent providers

³⁶³ Fix Report, ¶ 184.

³⁶⁴ Fix Report, ¶ 184.

³⁶⁵ Fix Report, ¶ 186.

³⁶⁶ Fix Report, ¶ 190.

³⁶⁷ Fix Report, ¶ 188.

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across 12 facilities, or 0.3 providers per facility. (He does not distinguish between anesthesiologists and CRNAs but, based on the USAP-wide mix of provider type, this would likely amount to about 1.6 FTE anesthesiologists and about 2.0 CRNAs.)

- (296) As another example of using the removal of benefits that have not been established or shown to be merger-specific as a basis for claiming that divestiture would result in harms, Mr. Fix claims that “divested clinicians and the associated hospitals would no longer be able to use USAP’s back-office infrastructure” which “would create significant dis-synergies that would undermine any divested practice and hurt its ability to deliver efficient and cost-effective care to facilities and patients.”³⁶⁸ But, as explained above, Mr. Fix provides no evidence that USAP’s back-office infrastructure in fact reduced costs for the acquired groups in a way that translated into lower prices for consumers. On the contrary, the pricing evidence shows the opposite.
- (297) Mr. Fix also claims that I “ignore[d] the fact that the practices that chose to be acquired by and the physicians that chose to be hired by USAP may not want to return to working in a group that has all of the disadvantages described above. Individual physicians and CRNAs cannot be forced to work for a particular employer, and many may choose to retire or move rather than be told where to go.”³⁶⁹ However, Mr. Fix provides no evidence that divested anesthesia providers will retire or move, much less that they would do so because of a divestiture. Nor does he provide an analysis of the ordinary rate of departures for USAP to which hypothesized rates of departure from divested groups could be compared.

³⁶⁸ Fix Report, ¶ 195. As I acknowledge in my initial report, “[i]nefficiency due to lower scale could, theoretically, be another form of social cost from divestiture. However, given that many anesthesia groups smaller than USAP exist and serve hospitals and patients in Texas at prices substantially lower than USAP’s, this cost is also unlikely to be high.” Capps Report, n. 318.

³⁶⁹ Fix Report, ¶ 191.

Exhibit 2

1 UNITED STATES DISTRICT COURT
2 FOR THE SOUTHERN DISTRICT OF TEXAS

3 _____
4 FEDERAL TRADE COMMISSION :
5 Plaintiff, :
6 v. : Case No.
7 U.S. ANESTHESIA PARTNERS, : 4:23-cv-03560-KH
8 INC., :
9 Defendants. :
10 _____

11 HIGHLY CONFIDENTIAL UNDER PROTECTIVE ORDER

12 Tuesday, January 13, 2026

13
14 Video Deposition of LONA FOWDUR, PH.D.,
15 taken at the Law Offices of Kellogg Hansen
16 Todd Figel & Frederick PLLC, located at 1615 M
17 Street, NW, Suite 400, Washington, DC, beginning
18 at 9:26 a.m., EST, before Ryan K. Black,
19 Registered Professional Reporter, Certified
20 Livenote Reporter and Notary Public in and for
21 the District of Columbia.

22
23
24
25 Job No. CS7782803

1 to give you an exact breakdown, though.

2 Q. How big is your team?

3 A. Somewhere between 8 and 12 people.

4 Q. Who wrote your report?

5 A. I did.

6 Q. Did you write every word?

7 A. I certainly reviewed every word.

8 Q. When did USAP hire you?

9 A. I was hired on behalf of USAP by
10 Kellogg Hansen I would say at some point in
11 2023. Actually, maybe early 2024.

12 I'm sorry. I'm getting my dates mixed
13 up.

14 I'd say mid-2024.

15 Q. Other than working on the expert
16 report, have you performed any other work for
17 USAP -- let me rephrase that question.

18 Have you performed any work for USAP
19 directly other than working on this expert
20 report?

21 A. Can you explain what you mean by
22 "directly"?

23 Q. Sure.

24 I'll -- I'll rephrase it again, and
25 I'll withdraw that last question.

1 Other -- other than drafting the expert
2 report, have you worked in any way for USAP?

3 A. You mean on a different project?

4 Q. Yes.

5 A. No.

6 Q. Have you ever worked for a -- another
7 portfolio company of Welsh Carson?

8 A. No.

9 Q. Does your report, PX5516, the corrected
10 report, contain a complete statement of all
11 opinions you'll express at trial?

12 A. No.

13 Q. What opinions are you planning to
14 express at trial that are not in your report?

15 A. Well, since filing my report, I have
16 received and reviewed the rebuttal report of
17 Dr. Cory Capps, and I have certain opinions
18 about Dr. Capps's opinions that I hope to be
19 able to speak to at trial as well.

20 Q. Other than Dr. Capps's reply report,
21 are you relying on any other information for the
22 basis of your new opinions?

23 A. I would say I continue to be informed
24 by market dynamics as they pertain to this case
25 and as they evolve over time. So to the extent

1 that evolution bears on any of my opinions, I
2 reserve the right to speak to those publicly
3 available facts as well.

4 Q. So when you refer to new information
5 concerning market dynamics, you're referring to
6 information you learned from the public record,
7 not information you received from USAP.

8 A. Not necessarily.

9 Q. What do you mean by "not necessarily"?

10 A. Well, as an example, at the time I was
11 filing my report, I did not know that USAP
12 presently would be out of network with
13 UnitedHealth Plan. So that's a new fact that I
14 have learned since filing my report that bears
15 on my opinions.

16 Q. Did you learn that from USAP or from
17 public research?

18 A. From USAP.

19 Q. Are there other facts that have changed
20 in your opinions?

21 A. I wouldn't say that there are facts
22 that have changed my opinions. I would say that
23 there are facts that bear on my opinions.

24 Q. Okay. Are there other new facts that
25 bear on your opinions that you've learned since

1 submitting your report?

2 A. Not so far.

3 Q. Are you aware whether USAP and Blue
4 Cross have entered into a contract?

5 A. I am not.

6 Q. Okay. So after reviewing Dr. Capps's
7 reply report, you submitted a corrected version
8 of your report that addressed some of the errors
9 that he identified; is that right?

10 A. He identified a couple of errors, and
11 we fixed them in this new set of -- in these
12 -- in the corrected expert report.

13 Q. When did you first identify the errors
14 that Dr. Capps mentioned in his reply report?

15 A. When I read his report after its
16 submission.

17 Q. So I think he submitted his report on
18 December 12th. So sometime around then is when
19 you identified the errors?

20 A. Sometime in that following week when I
21 read the report.

22 Q. And how long did it take you to fix the
23 errors?

24 A. A while.

25 Q. Why did you wait until yesterday to

1 submit the corrections to the FTC?

2 A. The corrections were only completed
3 over this past weekend. And as soon as they
4 were completed, I submitted the corrected
5 report.

6 Q. Okay. I want to make sure I understand
7 something about your corrected report. When a
8 document is listed in the Materials Relied Upon
9 but isn't cited in the report, what does that
10 mean?

11 A. You would need to show me an example.

12 Q. Sure. Let's turn to Page B7 of your
13 report, and let me know when you're there.

14 A. I'm there.

15 Q. So you'll see that you rely on five
16 papers by Dr. Capps in your report; is that
17 right?

18 A. Yes.

19 Q. And one of the papers by Dr. Capps is
20 called "The Continuing Saga of Hospital Merger
21 Enforcement" -- it's the third one down of the
22 list of five -- his five publications. Do you
23 see it?

24 A. I do.

25 Q. I'll represent to you that that's not

1 cited in your paper. So what -- what were you
2 relying on "The Continuing Saga of Hospital
3 Merger Enforcement" by Dr. Capps for?

4 A. So you're telling me this paper is not
5 in any one of the citations within my report?

6 Q. Correct.

7 A. It just means that I read this paper in
8 conjunction with the others that are cited in
9 this list here. I didn't cite to it, but relied
10 on it as part of opinions or as part of academic
11 findings that Dr. Capps has published in the
12 past.

13 Q. Did you rely on "The Continuing Saga of
14 Hospital and Merger Enforcement" by Dr. Capps
15 for background information, basically?

16 A. Yes.

17 Q. Now, you agree that patients are
18 consumers of medical services, correct?

19 MR. WHITE: Objection to form.

20 THE WITNESS: Patients are recipients
21 of medical services.

22 THE VIDEOGRAPHER: Pardon the
23 interruption.

24 Please make sure your hair is not
25 touching the mic.

1 Q. And that's group size?

2 A. Correct.

3 Q. Okay. Other than in -- strike that.

4 In Exhibits 6 through 9, other than by
5 distinguishing through group size, do you make
6 any other -- strike that question too.

7 In Exhibits 6 through 9, you didn't
8 distinguish whether the anesthesia groups listed
9 practice at a hospital or an ASC, correct?

10 A. The way that this information is
11 presented in these exhibits, I did not. But
12 it's relatively straightforward to look at my
13 backup and pass out these facilities into counts
14 of hospitals as opposed to ASCs.

15 Q. You didn't perform that exercise
16 anywhere in your report, however, correct?

17 A. For purposes of this exhibit, I did
18 not. But the information is contained in my
19 backup.

20 Q. You didn't evaluate whether the
21 anesthesia groups available to hospitals listed
22 in Exhibits 6 through 9 would provide
23 specialized care?

24 MR. WHITE: Object to form.

25 THE WITNESS: I did not.

1 BY MR. PERLMAN:

2 Q. You did not evaluate whether the
3 anesthesia groups available to hospitals in
4 Exhibits 6 through 9 employ complex care?

5 MR. WHITE: Object to form.

6 THE WITNESS: I did not.

7 BY MR. PERLMAN:

8 Q. You didn't evaluate whether the
9 anesthesia groups available to hospitals in
10 Exhibits 6 through 9 have ever submitted RFPs to
11 work in a hospital?

12 MR. WHITE: Object to form.

13 THE WITNESS: That I would say I
14 would disagree with, because I know from the
15 information underlying the bottom parts of these
16 exhibits that the majority of these groups do
17 have hospital contracts for at least some
18 portion of the time that they are listed in
19 these grids.

20 BY MR. PERLMAN:

21 Q. Where does it say that in your report?

22 A. I did not make that distinction for
23 purposes of these exhibits. But the underlying
24 information that supports these exhibits
25 corroborates what I just said.

1 Q. Your claim is that in the underlying
2 information, there's details about whether the
3 groups listed in Exhibits 6 through 9 submitted
4 bids in response to RFPs?

5 A. My testimony is that the underlying
6 information behind these grids shows that these
7 groups -- the majority of these groups have held
8 hospital facility contracts over the time period
9 analyzed. So if they have held facility
10 contracts -- hospital contracts -- and we're
11 talking about an RFP bidding market -- then they
12 would have participated in the bidding for the
13 RFPs that were issued for purposes of winning
14 the RFP in the first place.

15 Q. In your actual report, you don't state
16 that these groups listed in Exhibits 6 through 9
17 have par -- have worked at a hospital or not,
18 correct?

19 MR. WHITE: Object to form.

20 THE WITNESS: In my report, for
21 purposes of replying to Professor Capps's
22 original report, in these exhibits, I don't make
23 the distinction. But the underlying information
24 supporting these exhibits readily shows that the
25 majority of these groups have held hospital

1 contracts in the duration of the time period
2 analyzed, thereby confirming that they have
3 participated in RFPs for hospital facility
4 contracts over the same span of time as well.

5 BY MR. PERLMAN:

6 Q. And you're, again, assuming that
7 hospitals use an RFP process to obtain
8 anesthesia services, correct?

9 MR. WHITE: Objection to form.

10 THE WITNESS: At a minimum, they're
11 contracting. And in order to finalize those
12 contracts, typically, they go through an RFP
13 process.

14 BY MR. PERLMAN:

15 Q. And, again, you haven't done any kind
16 of survey of hospitals in Texas to learn how
17 they undergo anesthesia contracting?

18 MR. WHITE: Objection, form.

19 THE WITNESS: I have not done a survey
20 of hospitals in Texas, but I have read the
21 deposition testimony of various hospital
22 witnesses who describe the way that they go
23 about hiring hospital groups to provide
24 anesthesia services coverage to their
25 facilities.

1 BY MR. PERLMAN:

2 Q. Are you familiar with the term
3 "capacity" as it's used in healthcare?

4 A. Sure.

5 Q. What does "capacity" mean in that
6 context?

7 A. "Capacity" means the quantum of
8 resources that you have to be able to supply
9 a particular product. So if you are fully
10 utilized, then your supplies are maxed out
11 because you're using all of your capacity. But
12 if you have some capacity in reserve that is not
13 utilized, then you may be able to increase the
14 total quantity that you're supplying, relying on
15 that capacity.

16 Q. Turning specifically to anesthesia
17 services, what would "capacity" refer to as it
18 pertains to a specific anesthesia service
19 provider?

20 A. Well, it kind of depends what time
21 period that we're talking about. What we
22 observe about these groups is that, at a
23 particular point in time, they have a certain
24 number of anesthesiologists that they have
25 employed. But many of the examples that I

1 percentage of the price increase is a result of
2 improved bargaining skill?

3 A. I don't think either I or Dr. Capps
4 does that in any of our analyses.

5 Q. Now, USAP has sought to include
6 -- well, let me -- let me take a step back.

7 Are you familiar with the term "tuck-in
8 clause"?

9 A. Yes. But my interpretation may be
10 different from yours. So maybe if you wouldn't
11 mind clarifying what you mean, that will be
12 helpful.

13 Q. Why don't you give me your
14 interpretation.

15 A. A "tuck-in clause" is basically a
16 contractual provision that would say that after
17 a physician is hired or a group is acquired USAP
18 will have the ability to bill for the services
19 provided by physicians that have newly become
20 employed or acquired under the USAP tax ID at
21 rates that have been negotiated by USAP for
22 physicians billing under USAP's tax ID.

23 Q. USAP is the party in the negotiations
24 between USAP and payers that sought the tuck-in
25 clauses?

1 MR. WHITE: Object to form.

2 THE WITNESS: I don't know that I can
3 say definitively which way it went.

4 My understanding is that sometimes
5 there have been either acquisition clauses or
6 tuck-in clauses sought by payers. I don't know
7 that is always something sought by USAP.

8 BY MR. PERLMAN:

9 Q. Do you ever cite in your report an
10 example of a payer seeking a tuck-in clause?

11 A. I would need to review the information
12 in my appendix -- my appendix reviewing the
13 -- the language and the documentation that we
14 found around those. I can't tell you
15 definitively as I sit here right now.

16 Q. In your review of the record, you only
17 found three other examples of a tuck-in clause
18 between a anesthesia provider group and a payer,
19 correct?

20 MR. WHITE: Object to form.

21 THE WITNESS: There are three examples
22 cited in the report. I would need to check with
23 the team whether there were others or not.

24 BY MR. PERLMAN:

25 Q. Sitting here today, you're not aware of

1 any other examples of a tuck-in clause in a
2 contract between an anesthesia group and a payer
3 in Texas?

4 A. As I sit here right now, what I can
5 point to are the three examples in my report of
6 groups of much lesser size than USAP being able
7 to obtain tuck-in clauses within their contracts
8 with payers.

9 Q. Do you have any idea what the
10 reimbursement rate was for any of those three
11 groups?

12 MR. WHITE: Object to form.

13 THE WITNESS: I would have that in the
14 data. I wouldn't be able to tell you as I sit
15 here right now.

16 BY MR. PERLMAN:

17 Q. And you don't have that in your report?

18 A. I have it in my backup data.

19 Q. You've referred to your backup data a
20 number of times today and said things are in
21 there.

22 Does your backup data refer to the raw
23 data files that were provided to you by counsel
24 from payer discovery?

25 MR. WHITE: Object to form.

1 A. Yes, I think I can.

2 So if we look at the Houston grid, for
3 instance, I think one example would be Sound
4 Physicians. Metro Management was the one we
5 looked at.

6 Actually, anything that is -- anything
7 that has a blank under 2014 would be an entrant
8 or expander. But then we would need to net
9 those out over time.

10 So basically the delta from 2023 and
11 2014 is what I am counting in Exhibit 10.

12 Q. I guess I'm a little confused. Could
13 -- are you able to identify who the additional
14 seven entrants you claim to have entered the
15 market are or not?

16 A. Let me see if I can do it for at least
17 one MSA.

18 Okay. So if we look at Exhibit 10 and
19 Exhibit 8, counting the physicians with at
20 least 30 NPI in 2014 we have Capitol, Austin
21 Anesthesiology, Integrated and Westlake.

22 By the time we get to 2023, Westlake is
23 still there. Scott & White Clinic is another.
24 NAPA has acquired Austin Anesthesiology.
25 Anesthesia Dynamics is another, and Metro

1 Management is another.

2 I'm sorry. I think it's a little hard
3 doing it that way. I would need to look a
4 little closer at the underlying data.

5 Q. You know, I don't want to make you have
6 to do analysis here on the spot. Is -- is it
7 fair to say -- or sitting here today, you can't
8 identify who the additional entrants are beyond
9 Exhibit 37?

10 MR. WHITE: Object to form.

11 THE WITNESS: I'll say it this way.
12 They are a subset of the facilities listed
13 within Exhibits 6 to 9.

14 BY MR. PERLMAN:

15 Q. And you don't -- you can't identify
16 sitting here today which groups listed in
17 Exhibits 6 through 9 are the entrants?

18 A. I probably could do it with a little
19 bit more time.

20 Q. Let's turn back to Exhibit 10, which,
21 again, is on Page 42.

22 Exhibit 10 doesn't account for changes
23 in ownership of an anesthesia practice?

24 MR. WHITE: Object to form.

25 THE WITNESS: They --

1 BY MR. PERLMAN:

2 Q. Let me rephrase that. I'll strike that
3 question. Let me rephrase it.

4 Do you -- in Exhibit 10, do you include
5 anesthesia practices who just changed -- who
6 changed ownership but otherwise remained the
7 same?

8 A. Yes. I include them.

9 Q. You don't identify any year of
10 purported entry, expansion or repositioning in
11 Exhibit 10?

12 A. Not in Exhibit 10. But you
13 would be able to see the number of facilities
14 corresponding to entry or expansion in the prior
15 four exhibits.

16 Q. And Exhibit 10 -- let me rephrase that.

17 So your contention is that from 2014 to
18 2023 in Houston, for example, it went from 11
19 to -- to 12 anesthesia providers within the
20 metrics you chose, correct?

21 A. Correct.

22 Q. And that additional an -- anesthesia
23 provider is Compass Anesthesia, correct?

24 A. Yes.

25 Q. And for Dallas, you identified six

1 A. I don't know that it would be relevant
2 from the standpoint of identifying a market for
3 anesthesia services coverage.

4 Q. Well, let's turn to Exhibit 31 which
5 you just mentioned. That's on Page 93 of your
6 report. Let me know when you're there.

7 A. I am.

8 Q. So Exhibit 31 is the share of hospital
9 providers that also perform anesthesia services
10 in ASCs; is that correct?

11 A. Correct.

12 Q. And by "hospital providers," you mean
13 providers that perform anesthesia services at
14 hospitals, correct?

15 A. I mean anesthesiologists that perform a
16 subset of their services -- at least a subset of
17 their services at hospitals.

18 Q. So Exhibit 31 shows how many providers
19 -- let me -- let me rephrase that.

20 Exhibit 31 shows of the providers who
21 have some hospital-based services, how many of
22 them also performed services at ASCs. Is that
23 fair?

24 A. Correct. Either in the previous year
25 or in the previous three years or in the

1 previous five years.

2 Q. This exhibit doesn't show the reverse,
3 the share of providers who provide -- performed
4 anesthesia services at an ASC who also performed
5 services at a hospital, right?

6 A. It does not. But if you did it the
7 other way, you would find more physicians
8 performing services in ASCs who also provide
9 services in hospitals.

10 Q. That information is not in your report,
11 is it?

12 A. It's not. But it's a fact.

13 Q. Why do you say, "it's a fact"?

14 A. Because I looked at the critique that
15 Dr. Capps had of this exhibit in his report
16 claiming that I should have done it the reverse.
17 And I did it the reverse, and I find that the
18 conclusion would be even stronger if I had done
19 it the way that he proposes.

20 Q. And that analysis is not in your
21 report?

22 A. It's not in my report.

23 Q. Other than Exhibit 31, you didn't do
24 any other empirical analysis to support your
25 opinion that ASC providers can provide services

1 at a hospital?

2 MR. WHITE: Object to form.

3 THE WITNESS: No. I think there's
4 significantly more analysis or evaluation of the
5 qualitative record in the case.

6 BY MR. PERLMAN:

7 Q. I asked about empirical analysis. This
8 is the only empirical analysis you performed?

9 MR. WHITE: Object to the form.

10 THE WITNESS: I would have to say this
11 is the only empirical analysis in the report.
12 But since receiving Dr. Capps's report and
13 looking at the charts within his own report,
14 I've done more analysis that further entrenches
15 my conclusion that there's much more split
16 amongst anesthesia providers who provide
17 services in hospitals as well as the ASCs.

18 MR. PERLMAN: Let's go off the record.

19 Could we take a quick five-minute
20 break?

21 THE VIDEOGRAPHER: Going off the
22 record. This is the end of Media Unit 3. The
23 time is 2:05 p.m.

24 (Recess taken.)

25 THE VIDEOGRAPHER: We're back on the

1 A. Not necessarily, no. I think as
2 economists and statisticians, what we try
3 to do is look for measures that are free of
4 measurement error. So two variables being
5 correlated does not rule out the possibility
6 that one of the measures actually embeds
7 measurement error. And in this case it would
8 embed measurement error because it didn't
9 account for the differences in length and
10 complexity of the procedures that were being
11 performed.

12 Q. Do you dispute Dr. Capps's finding that
13 your price per unit and his price per case were
14 correlated?

15 A. I don't dispute the correlation. I
16 dispute which measure is the more accurate at
17 being able to capture the price changes.

18 Q. Now, earlier you said that there may be
19 papers on providers facing derived demand; is
20 that right?

21 A. I think there are some papers out
22 there that look generally at the provision of
23 emergency services, radiology services and,
24 perhaps, anesthesia services, as well.

25 Q. Are any of those papers cited in your

1 report?

2 A. I don't know. I would need to go back
3 and look.

4 Q. Go for it.

5 A. I don't know that I'll be able to tell
6 just by looking at the titles.

7 Q. Okay. That's fair. We can move on.

8 So I think we're pretty close to the
9 last question. Can you list all of the ways
10 that your analyses were supplemented or
11 changed -- strike that. Let me ask a different
12 question.

13 My understanding is that you intend to
14 offer additional analyses beyond those included
15 in your report after reviewing Dr. Capps's reply
16 report; is that correct?

17 A. I don't intend to offer additional
18 analyses, at least as I sit here right now,
19 unless my assignment changes.

20 My opinion was that after reviewing
21 Dr. Capps's rebuttal report, I have overlaid
22 those critiques over my own work to determine
23 whether any of the critiques that Dr. Capps
24 puts forth warrants any change to my initial
25 opinions. And the answer to that question is

1 no.

2 Q. Okay. So I think at the very beginning
3 of the day I asked you, "Does your report
4 contain a complete statement of all opinions
5 that you'll express at trial," and I think you
6 said, "No."

7 A. Correct.

8 Q. So what are the additional opinions you
9 plan to express?

10 A. The additional opinions can be
11 summarized in the way that I just expressed
12 it, that there's nothing that I have seen in
13 Dr. Capps's rebuttal report that cause me to
14 have to change any of the initial opinions that
15 I presented in my opening report.

16 Q. Did you conduct additional analyses as
17 a result of reviewing Dr. Capps's reply report?

18 A. Yes.

19 Q. What were those additional analyses?

20 A. Well, some of them we talked about
21 today. I looked at the correlation, for
22 instance, whether that changes anything that I
23 have done. I would need to go through one by
24 one to refresh my recollection. It's kind of
25 late in the day.

1 Q. That's all right.

2 A. Let me see what I can recall.

3 Q. Why don't I go ahead and introduce
4 Dr. Capps's Reply Expert Report which we've
5 labeled PX5511.

6 (Exhibit No. PX5511, a document titled
7 Reply Expert Report of Cory S. Capps, Ph.D, was
8 introduced electronically.)

9 (Whereupon reporter handed Exhibit
10 PX551 to the witness.)

11 MR. PERLMAN: Thank you.

12 BY MR. PERLMAN:

13 Q. So in addition to the correlation issue
14 that we just discussed, what other analyses did
15 you perform that you intend to opine on at trial
16 after reviewing Dr. Capps's reply report?

17 A. So the entry and switching analyses,
18 I think I have provided in the corrected report.
19 As to Dr. Capps's opinion about his pricing
20 measure being more reliable than mine, we just
21 talked about the correlational analysis that I
22 did.

23 Q. What was the correlational analysis
24 that you did?

25 A. So I checked whether the correlations

1 were correct.

2 Q. And you confirmed that they were
3 correct, right?

4 A. I confirmed that they were correct,
5 but that Dr. Capps's pricing measure was still
6 inaccurate, more inaccurate than mine. Because
7 it did not account for complexity and length of
8 procedures.

9 Q. Anything else?

10 A. I looked at Dr. Capps's opinions
11 about USAP's pricing being high relative to
12 competitive benchmarks, reaching the conclusion
13 that EBITDA is not a measure of economic profit
14 in comparison with average prices, does not
15 indicate whether pricing was competitive to
16 begin -- I'm sorry, a comparison with average
17 prices does not mean that that's the relevant
18 competitive benchmark for USAP.

19 Q. Why not?

20 A. Because we are operating in a
21 differentiated product market where the level of
22 differentiation and the costs of different
23 groups varies significantly from group to group.

24 Q. Anything else?

25 A. With respect to "USAP's price increases

1 are large and persist over time," I don't agree
2 with Dr. Capps's opinion that they are based on
3 spurious analyses. And I didn't see anything in
4 Dr. Capps's report that merited any changes to
5 my own event studies.

6 Q. So you didn't conduct any additional
7 analyses in response to Dr. Capps's opinion
8 about your event studies?

9 MR. WHITE: Object to form.

10 THE WITNESS: I did not see a need to.

11 BY MR. PERLMAN:

12 Q. Is there any dispute that the prices
13 for the acquired groups went up after the
14 acquisitions --

15 MR. WHITE: Object to form.

16 BY MR. PERLMAN:

17 Q. -- between you and Dr. Capps?

18 A. I think we talked about this before,
19 whereby my testimony was that, subject to
20 negotiation with different payers at different
21 points in time, the pricing of the acquired
22 groups changed. But that doesn't inform the
23 relevant question in the case, which is whether
24 that pricing changed as a result of market
25 power or differentiation or bargaining skill or

1 contractual split of the joint gains from trade
2 that payers and providers determine is
3 appropriate.

4 Q. Let's go back to the previous question,
5 which is, other than the examples you've
6 identified so far, did you conduct any
7 additional analyses in response to Dr. Capps's
8 reply report that you intend to present at
9 trial?

10 A. I think we talked about Dr. Capps's
11 Figure 36 having an error in it. So that was
12 subject to additional analyses that we did.

13 Q. What was the error, again, in Figure
14 36? It's on Page 108.

15 A. The identified out-of-network period is
16 wrong. These four blue columns of the grid
17 should have been shifted by two quarters.

18 Q. Other than that, you didn't identify
19 any other errors?

20 A. Other than that, my pricing measures
21 being more accurate, we did not identify any
22 errors, but would dispute the conclusions that
23 Dr. Capps reaches based on his analyses.

24 Q. Okay. So other than the examples
25 you've given so far, any other new analyses that

1 you plan to testify about that you developed in
2 response to Dr. Capps's reply report?

3 A. It's probably minor, but there were
4 -- there was a set of analyses that Dr. Capps
5 did where he treated as acquisitions groups
6 that came in and that took over 90 percent or
7 more of the physicians already practicing at a
8 particular facility. I think there are a couple
9 of those examples, at least, that were not
10 acquisitions, but that were actual different
11 groups coming in and taking over the physicians.

12 So that was a check on his analysis
13 that we did.

14 Q. I'm sorry. I don't follow that one.
15 Can you be a little bit more specific where
16 that's located?

17 A. Yes.

18 Q. Are you saying that there are times
19 that USAP -- that he listed USAP acquisitions
20 that you don't think are acquisitions?

21 A. No.

22 Q. Okay.

23 A. There are times when he treats certain
24 instances of switching as not a true switch but
25 an acquisition-related switch. So some of those

1 examples that are predicated on his finding of
2 the new group coming in and taking over more
3 than 90 percent of the physicians practicing
4 there, those -- if you do some manual research
5 about those instances, you would find that,
6 for example, there are some that were true
7 acquisitions -- I'm sorry, there were some that
8 were true switches and not acquisitions.

9 Q. I see. Okay.

10 Yeah. If you wouldn't mind taking a
11 moment and trying to identify which ones you
12 think are wrong, that would be helpful.

13 A. I don't know that I can identify them
14 as I sit here right now.

15 Q. Okay. Can you identify the part of the
16 report that you're talking about?

17 A. The part of Dr. Capps's report?

18 Q. Correct.

19 Are you talking about Paragraph 99?

20 A. There's somewhere here that references
21 a 90 percent threshold.

22 I'm close.

23 In Paragraph 125, I believe there were
24 a couple of the examples for Dallas and Houston
25 that were true switches and not acquisitions.

1 Q. So let's make sure -- we've been
2 talking kind of informally here. Let me just
3 ask you a couple of questions to make sure I
4 understand.

5 A. Sure.

6 Q. So in Paragraph 125 of Dr. Capps's
7 report, he identifies in Houston that seven of
8 your switches were more than likely to have been
9 acquisitions than switches, correct?

10 A. Correct.

11 Q. And you think that a couple of them
12 were actually switches and not acquisitions
13 based on your manual research?

14 A. Correct.

15 Q. And in Dallas, Dr. Capps identified one
16 of your 70 switches that was more likely to have
17 been an acquisition; is that right?

18 A. Correct.

19 Q. And is that one you think, based on
20 your manual research, a true switch?

21 A. I'm going off of memory here. So
22 amongst these eight that pertains to Dallas and
23 Houston, I think there are at least a couple
24 that were true switches and not acquisitions.

25 Q. Okay. Other than the analyses you've

1 identified already, do you intend to offer any
2 other analyses at trial as a response to
3 Dr. Capps's reply report?

4 A. Let me just make sure -- one second --
5 if anything else comes to mind.

6 (Reviews document.)

7 Oh, and we talked earlier about my
8 exhibit looking at the share of ASC providers
9 that also worked at hospitals. So that's one
10 set of analyses that we did, looking at the
11 share of hospital providers that also worked at
12 ASCs.

13 One more piece of analysis that
14 pertains to Dr. Capps's Figure 5, I had the team
15 redo this analysis focusing on physicians that
16 were truly specialized, meaning I broke up the
17 zero to 10 bar into those that are zero only
18 and then 1 to 10. And I broke up the 90 to a
19 hundred bar into physicians that have between
20 90 and 99, as opposed to strictly a hundred.

21 So once we do that breaking up of this
22 analysis, we find that the distribution is much
23 more balanced in that the 90 to a hundred bar
24 would come down to about 33, and the zero to 10
25 bar would come down to single-digit percentages,

1 because a good proportion of these physicians in
2 these two extreme bars would actually be
3 splitting their practice as well.

4 Q. It's late in the day. Could you just
5 repeat again what the modification you made was?

6 A. Sure.

7 So if you take the zero to 10 bar and
8 you split it into strictly zero and one to a
9 hundred, that zero to 10 bar would go down to
10 mid single digits; go down to about half of what
11 it is now. And if you take the 90 to a hundred
12 bar and split that into those that do 90 to 99,
13 as opposed to those that are strictly at a
14 hundred, again you would find this bar would
15 come down significantly to, if I recall
16 correctly, the -- the mid- to low 30s.

17 Q. So to make sure I understand, let's
18 take the 90 to a hundred bar. In your analysis,
19 if you split it into two different percentages,
20 90 to 99 and then a hundred, there's one bar
21 that's around 30 and the other bar is the
22 remaining 20?

23 A. Thereabouts.

24 Q. Okay. Anything else?

25 A. I think that's it in terms of analyses.

1 We talked about IDR.

2 The rest of my rebuttal would be
3 qualitative in nature, not quantitative.

4 Q. Go ahead and tell me how -- let
5 me rephrase that. What do you mean by
6 "qualitative"?

7 A. Meaning I would have things to say
8 about the opinions in Dr. Capps's rebuttal
9 report.

10 Q. Did you rely on additional qualitative
11 evidence that's not disclosed in your initial
12 report?

13 A. Other than the fact that USAP is
14 currently out of network with United, that I
15 didn't know at the time I filed the report,
16 I don't believe so, no.

17 Q. Okay. And you learned about that from
18 counsel?

19 A. From USAP and counsel, yes.

20 Q. Did you get any documents?

21 A. I don't believe so, no.

22 Q. They just told you that USAP was out of
23 network with United?

24 A. My understanding is [REDACTED]
25 [REDACTED]. So I was informed that

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[REDACTED],
[REDACTED],
but currently USAP is out of network with
United.

Q. What else do you know about United and
USAP's current out-of-network status, other than
what you've described?

A. I think that's pretty much it. They're
currently out of network.

Q. Is that based on something that counsel
from Kellogg Hansen told you?

A. This is something based on what I have
learned from USAP executives.

Q. Which USAP executives?

A. It would be Mr. David Anderson.

Q. Who?

A. David Anderson.

Q. Have you interviewed -- did you
interview Dr. Anderson?

A. Yes. I didn't interview him. I had a
conversation with him.

Q. Other than your conversation with
Dr. Anderson, have you had conversations with
other USAP executives?

A. Informally.

1 Q. Which ones?

2 A. I'm terrible with names. I'm not going
3 to remember.

4 Q. Were they substantive conversations
5 about your report?

6 A. No.

7 Q. What was the context of the
8 conversations?

9 THE WITNESS: I'll take guidance from
10 counsel here as to whether I can answer?

11 MR. WHITE: Well, if you have a
12 question about some particular conversation,
13 we can have it off the record. But if you're
14 asking -- if you're asking about things that
15 she's relying on for purposes of her report,
16 that's one thing. If you're asking about
17 conversations about, you know, other things,
18 then we have a different problem. So I don't
19 know what you're asking exactly, but ...

20 MR. PERLMAN: What would the "different
21 problem" be?

22 MR. WHITE: If you're asking questions
23 about things that a witness considered
24 but didn't rely on -- that might have been
25 conversations with counsel -- then those are

1 possibly subject to protections. So that's the
2 only thing.

3 MR. PERLMAN: Sure.

4 BY MR. PERLMAN:

5 Q. Yeah. So to be clear, I'm not talking
6 about your conversations with counsel. I'm
7 asking -- it sounds like you had some informal
8 conversations with USAP executives; is that
9 right?

10 A. With USAP's counsel and counsel from
11 Kellogg Hansen being present.

12 Q. What was the purpose of those
13 conversations?

14 A. I don't know that there was any general
15 purpose, really.

16 Q. I guess I'm not trying to -- because
17 this is such a, you know, sensitive area, I'm
18 not trying to tread on anything here. Were --
19 were you just getting introduced to them as the
20 expert in this case?

21 A. Yes.

22 Q. Okay. Was there anything else going
23 on?

24 A. No.

25 Q. Okay. That's -- that's really all I

1 was getting at.

2 Okay. Let's turn to Page 64 of
3 Dr. Capps's Reply Report, Figure 18.

4 We're looking at Figure 18, which is on
5 Page 64 of Dr. Capps's Reply Report, PX5511.

6 I'll note that the title of Figure 18 is
7 "Missing units bias Dr. Fowdur's price per
8 unit measure for USAP." Do you see that?

9 A. Well, actually, I have to say this
10 reminds me of two more sets of analyses that
11 we did. So one is to look at this figure --
12 instead of just Austin and [REDACTED], to
13 look at this figure for other combinations of
14 MSAs and payers, and the figures for those other
15 MSAs and payers look significantly different
16 than what this picture shows.

17 And, actually, another set of analyses
18 that we did that I didn't remember, Professor
19 Capps's analysis correlating market shares and
20 pricing is based on this, I would say tortured
21 specification, that uses a kink in the shares of
22 different providers 1.5 percent. So changing
23 the threshold at which that kink is established
24 to half a percent, for instance, would
25 significantly alter the correlations that

1 Dr. Capps finds. Adding back the fixed effects
2 to that analysis, which would be the appropriate
3 way of doing the analysis, would significantly
4 change the correlations that Professor Capps
5 finds, making them insignificant. And dropping
6 USAP from the analysis would also significantly
7 alter the correlations that Dr. Capps finds,
8 frequently making them insignificant.

9 So, basically, the findings
10 that Dr. Capps reports with respect to the
11 correlation and -- between shares and price
12 are highly sensitive to the specification
13 that Dr. Capps uses. And even within those
14 specifications the correlations that he finds
15 for Houston and Dallas are to the order of 3 or
16 4 percent -- 3 or 4 percent of the variability
17 in pricing for Houston and Dallas are explained
18 by market shares, meaning that the significant
19 proportion of the variation in pricing is not
20 explained by shares and are explained by other
21 factors, likely differentiation, bargaining
22 skill and contractual provisions that were not
23 controlled for in those simplistic correlation
24 analyses.

25 Q. So turning back to Figure 18 which was

1 on Page 64 of Dr. Capps's Reply Report, you
2 agree that Dr. Capps found that for at least in
3 the Austin MSA with [REDACTED], that
4 there was a missing units bias for your measure?

5 A. There was a missing units bias for
6 a small proportion of the claims. For the
7 majority of the claims, there was still
8 sufficient claims and units that allowed a
9 robust calculation of the average conversion
10 factor price, which is per unit.

11 Q. Okay. So you don't dispute the
12 accuracy in Figure 18?

13 A. I don't dispute the accuracy of Figure
14 18. I think Figure 18 is cherry-picked as the
15 example that shows the most instance of missing
16 claims. But even put -- putting aside the issue
17 of missing claims and the extent of missing
18 claims in this analysis, I don't think the
19 missing claims biases my calculation of an
20 average, because there's still a significant
21 volume of claims based on which the average can
22 be calculated.

23 MR. PERLMAN: Let's go off the record.

24 THE VIDEOGRAPHER: We're going off the
25 record. The time is 5:55 p.m.

1 (Recess taken.)

2 THE VIDEOGRAPHER: We're back on the
3 record. The time is 5:56 p.m.

4 MR. PERLMAN: No further questions.
5 Thank you for your time.

6 THE WITNESS: Thank you.

7 MR. PERLMAN: Let's go off the record.

8 MR. WHITE: No questions from us.

9 MR. PERLMAN: Sorry.

10 THE VIDEOGRAPHER: Please stand by.

11 We're going off the record at 5:56 p.m.

12 This concludes today's testimony given by Lona
13 Fowdur. The total media units used was six and
14 will be retained by Veritext Legal Solutions.

15 (Deposition concluded -- 5:56 p.m.)

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C E R T I F I C A T E

I do hereby certify that I am a Notary Public in good standing, that the aforesaid testimony was taken before me, pursuant to notice, at the time and place indicated; that said deponent was by me duly sworn to tell the truth, the whole truth, and nothing but the truth; that the testimony of said deponent was correctly recorded in machine shorthand by me and thereafter transcribed under my supervision with computer-aided transcription; that the deposition is a true and correct record of the testimony given by the witness; and that I am neither of counsel nor kin to any party in said action, nor interested in the outcome thereof.

WITNESS my hand and official seal this 14th day of January, 2026.



Notary Public

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ERRATA SHEET FOR THE DEPOSITION OF DR. LONA FOWDUR**Case Name:** *FTC v. U.S. Anesthesia Partners, Inc.*, No. 4:23-cv-03560 (S.D. Tex.)**Date:** January 13, 2026**Deponent:** Dr. Lona Fowdur

Page(s)	Line(s)	From	To	Reason
13	13, 15, 22	-3	300	Clarity
23	23	Kane	Kain	Transcription error
24	3, 5	Kane	Kain	Transcription error
61	13	pass out	parcel out	Transcription error
61	13	and pass	and parse	Transcription error
74	14	passing out	parsing out	Transcription error
83	1	attain	obtain	Transcription error
91	11	ASPI	ASPE	Transcription error
92	6	recourse	resort	Transcription error
112	18	significant	significantl y	Transcription error
122	4	process	processed	Transcription error
123	22	Kane	Kain	Transcription error
157	12	facilities	providers	To conform to the facts
171	10	Kinwood	Kingwood	Transcription error
181	8	group	group	Transcription error
186	18	which	with	Transcription error
198	3	ASPI	ASPE	Transcription error
199	18	absolute favor	absolute leverage	Transcription error
217	7	And Austin	And in Austin,	Transcription error
240	2	context putting	context of putting	Transcription error
258	14	is where why	is why	Transcription error
264	8	patient	patients	Transcription error

Page(s)	Line(s)	From	To	Reason
273	3	to what's	towards	Transcription error
273	6	follower	far lower	Transcription error
274	12	Kane's	Kain's	Transcription error
274	25	Katz	Capps	Transcription error
275	12	Katz's	Capps's	Transcription error
294	22	different providers 1.5 percent	different providers at 1.5 percent.	Transcription error

I have read the transcript of my deposition and have listed all changes and corrections above, along with my reasons therefore.

Date: 2/13/2026

Signature of Witness: /s/ Dr. Lona Fowdur
Dr. Lona Fowdur

Exhibit 3

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**IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION**

FEDERAL TRADE COMMISSION,

Plaintiff,

v.

U.S. ANESTHESIA PARTNERS, INC. et al.

Defendants.

Case No.: 4:23-CV-03560-KH

REVISED EXPERT REPORT OF DAVID A. FIX

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transitioned to the operations team, which monitors recent changes to how clinicians operate with a patient or any process re-design.

44. After a transaction is complete, practices obtain access to USAP's MSO, which enhances certain functions such as RCM and offers access to the suite of services described in paragraph 40.²⁸ The practices that have joined USAP in a Challenged Transaction either performed these functions themselves (often requiring significant clinician time) or outsourced them to a third party. USAP provides dedicated teams and resources that the previous practice did not have, such as payor contracting and compliance.

IV. FACILITIES AND PATIENTS BENEFIT FROM USAP'S EXPANSIVE PROVIDER NETWORK AND SPECIALISTS

45. Two key benefits that result from a practice joining USAP are increased provider coverage and access to specialty anesthesiology care. Contrary to Dr. Capps' opinion (at § VI.B), both benefits directly help facilities and patients. Similarly, Dr. Pimentel fails to acknowledge these important enhancements to the quality of the services delivered as a result of the Challenged Transactions.

A. Increased Coverage and Access to Specialists

46. After a practice joins USAP, the practice – and in turn the facilities and patients it serves – gain access to a larger number and more specialized physicians, CRNAs, and CAAs who are available to serve the facility.
47. The increase in coverage is demonstrated by comparing the number of physicians who cover a facility before and after joining USAP. For example, before NHA joined USAP

²⁸ See Burns Dep. Tr. 111:4-113:12 (describing how USAP integrates a new practice into USAP's RCM).

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in 2014, NHA had 30 total providers (21 physicians and 9 CRNAs),²⁹ and provided anesthesia at three facilities (Memorial Hermann Northeast, HCA Houston Healthcare Kingwood, and Memorial Hermann Surgical Hospital Kingwood).³⁰ After the transaction, USAP was able to provide those three facilities with substantially more clinicians. Specifically, in 2023, [REDACTED] USAP clinicians provided care at Memorial Hermann Northeast, HCA Houston Healthcare Kingwood, and Memorial Hermann Surgical Hospital Kingwood – a [REDACTED] increase in coverage.³¹

48. Similarly, prior to joining USAP in 2017, MetroWest had 130 total clinicians (51 physicians and 79 CRNAs)³² and provided anesthesia coverage at six facilities (Memorial Hermann Memorial City Medical Center, Memorial Hermann Katy Hospital, Memorial Hermann Memorial Village Surgery Center, Memorial Hermann Orthopedic & Spine Hospital, Memorial Hermann Katy Surgery Center, CCRM Fertility of Houston).³³ As of 2023, USAP staffed [REDACTED] clinicians across these six facilities – a more than [REDACTED] increase.
49. Indeed, access to additional providers is a reason that some practices joined USAP. For example, Dr. Mark Goldstein, who was serving as president of MetroWest before it joined the USAP platform in 2017, stated that a driving factor behind the practice’s decision to join USAP was that its facilities were encountering significant growth,

²⁹ Compl. ¶ 103.

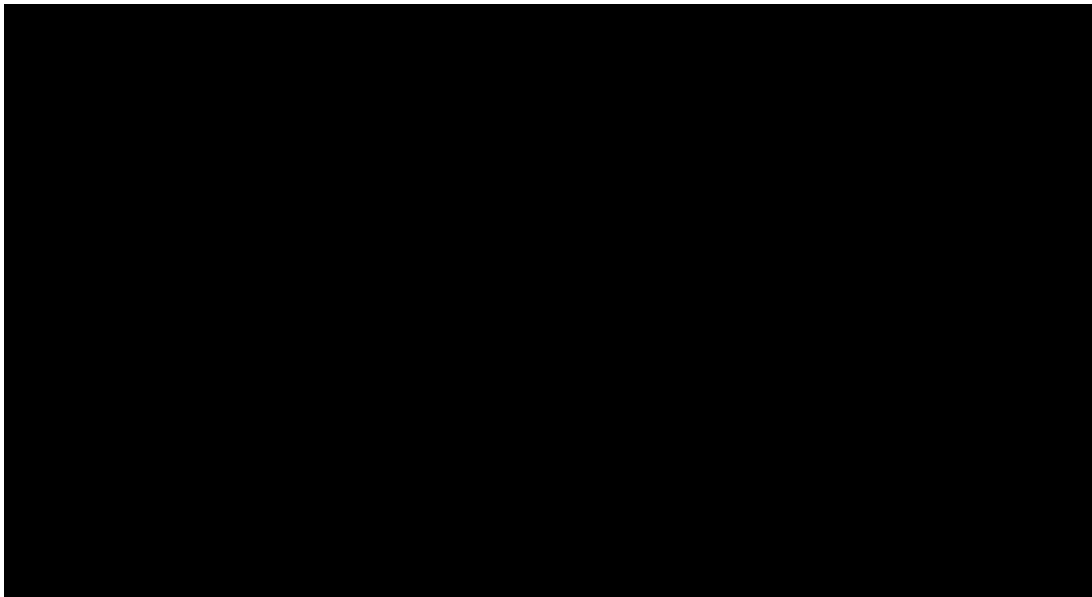
³⁰ D. Fix Interview with F. Burns (9/19/2025).

³¹ 2024 11 18 USAP Responses to First Set of Interrogations – Exhibit A. The pre-USAP coverage assumption that all providers supported all the facilities is conservative in the sense that it likely overstates coverage for the pre-USAP period.

³² Compl. ¶ 108.

³³ D. Fix Interview with F. Burns (9/19/2025).

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111. In short, the strength of USAP’s RCM platform is evident by comparing USAP’s RCM KPIs to its peer group. These metrics indicate that USAP has a strong revenue collections capability, which benefits hospitals, patients, and practices that join USAP for the reasons explained at the end of this section.
112. Based on my discussions with Dr. Dai Lu (formerly of NHA) and Dr. Patrick Koons (formerly of Guardian), their prior practice’s RCM capabilities increased significantly upon joining the USAP platform.¹¹⁴ This was largely driven by NHA and Guardian not having electronic billing capabilities until joining USAP.¹¹⁵

3. Auditing

113. As part of USAP’s robust RCM platform, USAP has an extensive auditing process and continually monitors performance related to coding and documentation. Audits are completed by both internal dedicated resources, and external consultants who conduct a

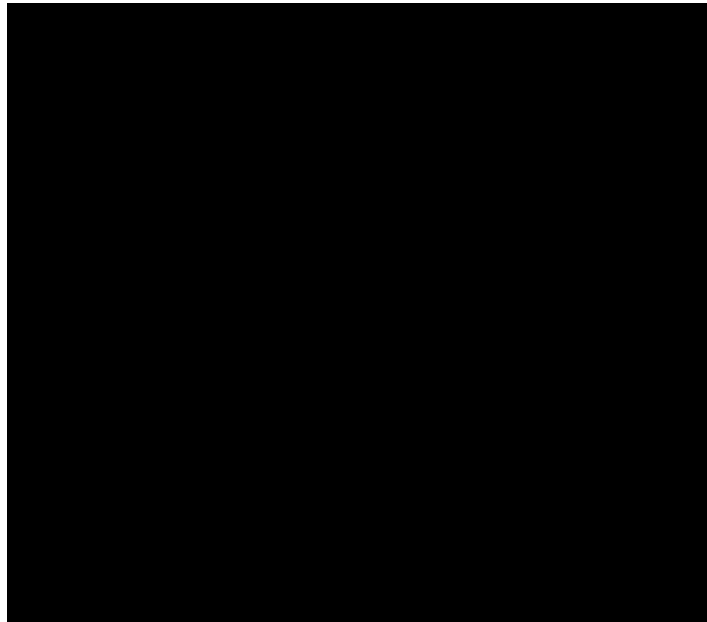
¹¹⁴ D. Fix Interview with Dr. P. Koons (9/8/2025); D. Fix Interview with Dr. D. Lu (9/8/2025).

¹¹⁵ D. Fix Interview with Dr. P. Koons (9/8/2025); D. Fix Interview with Dr. D. Lu (9/8/2025).

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review of the internal auditors’ findings, colloquially referred to as “Audit the Auditor.”¹¹⁶ There are █ auditors at USAP in fiscal year 2025 with a total annual labor cost of █.¹¹⁷

114. The internal auditing process involves USAP’s auditors assessing all RCM coders before they are permitted to join USAP RCM group to ensure they hit at least █% accuracy.¹¹⁸ Coders translate patient information from medical records, procedures, and treatment into Current Procedural Terminology (CPT) codes. Even after joining, coders continue to be audited on an ongoing basis. Internal audits reflect that the coding team is consistently performing above the goal of █% accuracy, which is higher than the industry standard.¹¹⁹



¹¹⁶ D. Fix Interview with F. Burns (8/28/2025).

¹¹⁷ USAPTX-00742091.

¹¹⁸ D. Fix Interview with F. Burns (8/28/2025).

¹¹⁹ USAPTX-00742103, Revenue Cycle Management – Coding and RCM Operations Quality Scores (January 2024 – January 2025).

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115. An external review of the auditing program has substantiated the internal audit findings that the Coding Department has above █% accuracy.¹²⁰



116. In addition to dedicated auditors, USAP has educators who are part of the coding team.¹²¹ They train coders on clinical documentation, maintaining medical records in the system, and coding.¹²² There are █ educator FTEs with a labor spend of \$█.¹²³

117. USAP's extensive auditing process contributes to its strong billing accuracy rate.

4. Automation

118. USAP has worked for years to implement automation technology that ensures its claims are as accurate as possible for both commercial and government payors, as well as

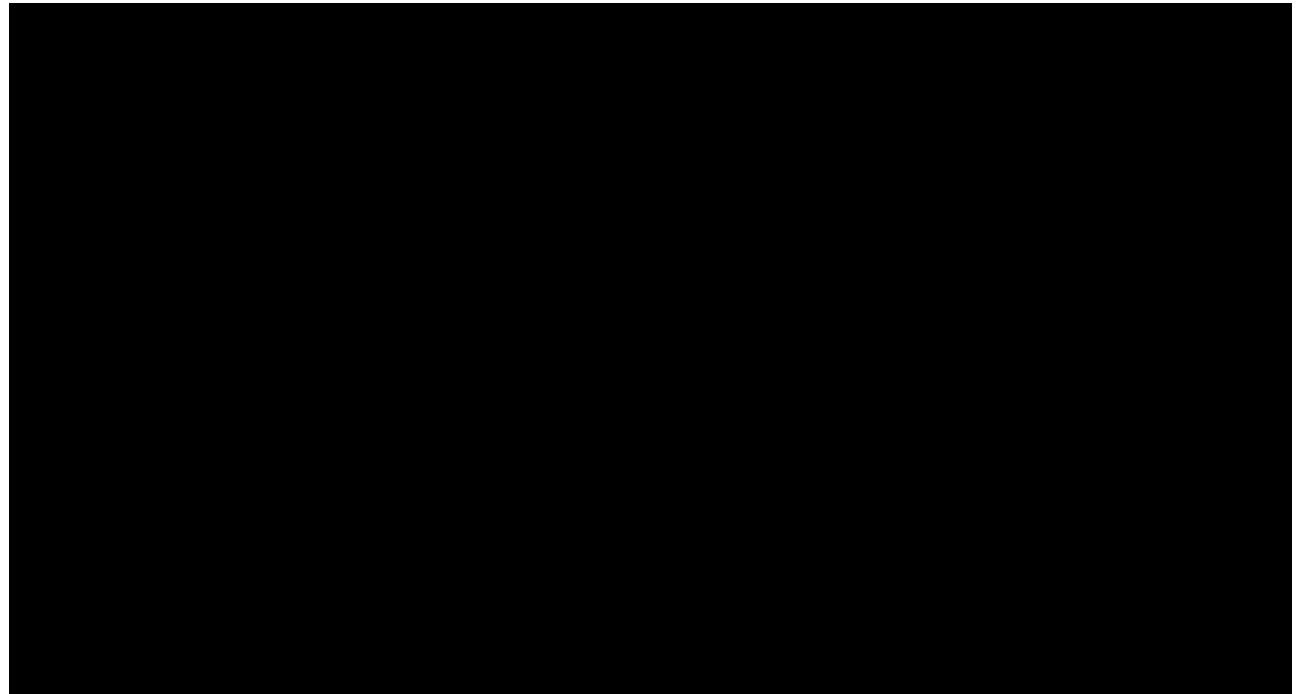
¹²⁰ *Id.*

¹²¹ D. Fix Interview with F. Burns (8/28/2025).

¹²² *Id.*

¹²³ USAPTX-00742091.

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140. USAP’s robust disaster recovery capabilities were exhibited when Ascension Health was hit with a major ransomware attack in May 2024. Ascension is a Catholic health system with 140 hospitals in at least 10 states. The ransomware attack shut down Ascension’s electronic medical records (“EMR”) system, locking providers out of systems that track and coordinate nearly every aspect of patient care.¹⁵³
141. Despite Ascension’s EMR being shut down in May of 2024,¹⁵⁴ USAP’s electronic quality and charge capabilities allowed USAP to continue collecting quality metrics and continue operating its revenue cycle management.¹⁵⁵ Ascension Health [REDACTED]
[REDACTED]. Specifically,

¹⁵³ Rachana Pradhan & Kate Wells, Ransomware attack led to harrowing lapses at Ascension hospitals, staffers say, NPR (June 19, 2024), <https://www.npr.org/2024/06/19/nx-s1-5010219/ascension-hospital-ransomware-attack-care-lapses>.

¹⁵⁴ Steve Adler, Ascension Ransomware Attack Affects 5.6 Million Patients, The HIPPA J. (Dec. 30, 2024), <https://www.hipaajournal.com/ascension-cyberattack-2024/>.

¹⁵⁵ D. Fix Interview with F. Burns (9/18/2025).

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[REDACTED]

[REDACTED]

[REDACTED].¹⁵⁶ This had significant value for the hospital and the patients during that time that most other anesthesia practices could not provide. USAP IT expertise and technology allowed it to assist Ascension during this incident.

142. Additionally, during the outages caused by the cyberattack on Change Healthcare (a company that provides billing and related services) in February 2024, USAP [REDACTED]

[REDACTED]. Change Healthcare [REDACTED]

[REDACTED].

Fortunately, in preparation for such an occurrence, USAP [REDACTED]

[REDACTED]

[REDACTED].¹⁵⁷ Given these preparations and USAP's infrastructure, it was able to get its system back up in running in only about a month.

143. In contrast, most practices that had leveraged Change Healthcare for billing services were unable to bill for between three and nine months,¹⁵⁸ which would have shuttered smaller providers.¹⁵⁹ The impact of the Change Healthcare cyberattack to USAP was not nearly as disruptive given the IT infrastructure at USAP, [REDACTED]

[REDACTED]. Other smaller anesthesiology practices (like

¹⁵⁶ *Id.*

¹⁵⁷ *Id.*

¹⁵⁸ *Id.*

¹⁵⁹ Indeed, this incident forced Corvallis Clinic in Oregon to merger with Optum Oregon, due to significant cash flow issues it was facing as a result of the Change Healthcare cyberattack. See Amelia Templeton, Update: Oregon approves controversial Corvallis Clinic, Optum merger, Oregon Public Broadcasting (Mar. 14, 2024), <https://www.opb.org/article/2024/03/13/corvallis-clinic-optum-merger-oregon-health-care/>.

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USAP Anesthesia Clinical Training Affiliations Texas		
SRNA Programs	Total # of Students	Program Director
Baylor College of Medicine	5	Rachel Davis, DNP, CRNA, CHSE, FAANA
Fairfield University	8	Carrie Cromwell, DNP, MS, CRNA, APRN
Texas Christian University (TCU)	30	Robyn Ward, PhD, CRNA, FAANA
Texas Wesleyan University (TWU)	2-4	Terri Kane, DNAP, CRNA
UT San Antonio	20-30	Dr. Steven Kertes, DNP, CRNA
UT Houston	14-17	Haley DeLa Garza, DNP, CRNA
SAA Program		Program Director
UT Houston	10	Charlie Phung, MD
Residency Program		Program Director
Houston Methodist Anesthesiology Residency	23	Nancy Cheng, MD,

165. In addition to training the next generation of providers, USAP’s involvement in training programs is important for its recruiting initiatives as █% of USAP’s clinical hires nationally in 2024 were new grads.¹⁷⁸
166. For recruiting initiatives, USAP deploys an individualized approach at each practice and for each position, rather than using a one-size-fits-all approach. USAP █. On █. On average, USAP annually recruits and hires █ physicians and █ CRNA’s █. █, increasing access to care for Texas patients.¹⁷⁹
167. In 2024, USAP hired █ individuals across the nation, which translated into █ FTEs.¹⁸⁰ Broken down by type of provider, USAP hired:¹⁸¹
- a. Physician: █ FTEs

¹⁷⁸ USAPTX-00742096, Board KPI’S (2024 - 2025).

¹⁷⁹ D. Fix Interview with F. Burns (9/19/2025).

¹⁸⁰ USAPTX-00742096, Board KPI’S at Slide 2.

¹⁸¹ *Id.*

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207. Additionally, USAP’s charge capture enables USAP to share quality information with the hospitals.²⁰² Thus, the interface hospitals use to exchange charge capture with divested clinicians would likely have to be changed to be interoperable with the new outsourced vendor’s platform. This level of disruption negatively impacts hospitals by creating significant administrative work that does not improve patient care and can take away from time otherwise spent on patient care. In short, in my opinion, a transition to a new billing platform would likely be costly, time-intensive, and disruptive to operations at the hospitals serviced by divested providers.

4. Information Technology (“IT”) and Cybersecurity

208. Divestiture would also eliminate all the benefits of USAP’s IT and cybersecurity programs that I identified earlier. *See supra* § V.E.6.

209. USAP has dedicated significant resources to creating a robust IT infrastructure, supported by more than █ employees at a cost of \$█ annually.²⁰³ It would be difficult for divested clinicians to recreate these services given the smaller size. Many of the anesthesia groups that joined USAP did not have dedicated IT teams prior to joining USAP, raising the likelihood that they would not be able to recreate USAP’s IT support if there were a divestiture. Similarly, many smaller medical practices do not have the capital to invest in dedicated cybersecurity resources, making them more susceptible to a successful cyberattack.²⁰⁴

²⁰² D. Fix Interview with F. Burns (9/18/2025).

²⁰³ USAPTX-00742091.

²⁰⁴ Lee Barrett & Michael Parisi, *Smaller medical practices increasingly targeted for cyber attacks*, Urology Times (Jan. 24, 2023), <https://www.urologytimes.com/view/smaller-medical-practices-increasingly-targeted-for-cybersecurity-attacks>.

Exhibit 4

1 UNITED STATES DISTRICT COURT
2 FOR THE SOUTHERN DISTRICT OF TEXAS

3 _____
4 FEDERAL TRADE COMMISSION :

5 Plaintiff, :

6 v. : Case No.
: 4:23-cv-03560-KH

7 U.S. ANESTHESIA PARTNERS, :
8 INC., :

9 Defendants. :
10 _____

11 HIGHLY CONFIDENTIAL UNDER PROTECTIVE ORDER

12 Friday, January 09, 2026

13
14 Video Deposition of DAVID A. FIX,
15 taken at the Law Offices of Kellogg Hansen
16 Todd Figel & Frederick PLLC, located at 1615 M
17 Street, NW, Suite 400 Washington, DC, beginning
18 at 8:55 a.m., EST, before Ryan K. Black,
19 Registered Professional Reporter, Certified
20 Livenote Reporter and Notary Public in and for
21 the District of Columbia.

22
23
24
25 Job No. CS7782794

1 Q. And if I refer to PX5507 as "your
2 report," will you understand?

3 A. Yes.

4 Q. And if you turn to PX5507-090, you
5 should see a signature page. Let me know when
6 you're there.

7 A. Yes.

8 Q. And is that your signature next to the
9 date of December 2nd, 2025?

10 A. Yes, it is.

11 Q. Why did you revise your report on
12 December 2nd, 2025?

13 A. We revised the -- I revised the report
14 to withdraw certain sections of the report.

15 Q. And does this report, PX5507, contain a
16 complete statement of all the opinions you expect
17 to testify about in this case?

18 A. I believe I reserve my right to
19 adjust or modify those opinions based upon new
20 information. But as we sit here today, yes.

21 Q. And does your report contain all the
22 bases and reasons for your opinions?

23 A. As we sit here to -- today for
24 the re -- for the report, yes, it does.

25 Q. Have you done any work on this case

1 since submitting your revised report, other than
2 preparation for this deposition?

3 A. No, no further work.

4 Q. Did you review any of the reply reports?

5 A. I did.

6 Q. Did they change any of your opinions?

7 A. They did not.

8 Q. And did you do any additional analysis
9 since submitting your revised report?

10 A. No additional analysis.

11 Q. Does your expert report contain all
12 the facts considered by you in forming your
13 opinions?

14 A. Yes. It contains -- yes.

15 Q. Does your expert report contain all data
16 considered by you in forming your opinions?

17 MS. KNOFCZYNSKI: Objection, form.

18 THE WITNESS: Yes. Subject -- subject
19 to some of the changes that we have on this
20 -- this page, which we'll share.

21 Cassie, can we maybe do the lights,
22 please? Just a little more on lights.

23 Thank you.

24 BY MR. WEPRIN:

25 Q. Are you aware of any errors in your

1 expert report?

2 A. There are a -- there are a few errors
3 that we have here in the -- the correction page
4 that we'll talk through.

5 (Whereupon Ms. Redlingshafer brightened
6 the conference room lights.)

7 THE WITNESS: Thank you.

8 BY MR. WEPRIN:

9 Q. And are you aware of any other errors?

10 A. I'm not.

11 MS. KNOFCZYNSKI: I'm -- I'm sorry to
12 interrupt. We have a -- Mr. Fix has in front of
13 him a page with corrections on it that I think is
14 what he's referencing.

15 MR. WEPRIN: Ah, okay.

16 MS. KNOFCZYNSKI: We're happy to provide
17 a copy --

18 MR. WEPRIN: Yes, please.

19 MS. KNOFCZYNSKI: -- to you as well.

20 Just wanted to make sure the record was
21 clear.

22 MR. WEPRIN: Thank you.

23 BY MR. WEPRIN:

24 Q. And if you could turn now to
25 Paragraph 5 of your report, which is at

1 Q. And during the interviews, did you ask
2 questions?

3 A. I did.

4 Q. Did anyone else ask questions?

5 A. Ms. Kim asked questions as well.

6 Q. And did anyone else ask questions?

7 A. I think there was only -- we were the
8 only ones who asked questions.

9 Q. Roughly how long did each interview last
10 on your materials relied upon?

11 MS. KNOFCZYNSKI: Objection, form.

12 THE WITNESS: Sorry. For all of these
13 interviews?

14 BY MR. WEPRIN:

15 Q. For each individual interview, roughly
16 how long each one lasted.

17 A. I would say they were generally 45
18 minutes to an hour.

19 Q. And do you recall anything discussed in
20 your interview of these three doctors that did
21 not make it into your report?

22 A. No. We kept it pretty on -- on point of
23 what we are -- what we were asking them. So it
24 -- I mean, it was a very focused interview.

25 Q. And who is Frank Burns?

1 A. Frank Burns is the current chief
2 administrative officer at USAP.

3 Q. And why did you interview Frank Burns
4 three times?

5 A. Frank Burns would have been interviewed
6 three times because his -- his conversation -- we
7 had a little more of an iteration because it was
8 a little more data-driven. And so, you know, he
9 had a previous role as the SVP of revenue cycle
10 management, for instance. So we would have gone
11 back to him to make sure that data that we
12 requested was accurately, you know, displayed in
13 the report.

14 Q. And do you recall anything you discussed
15 in your interviews with Frank Burns that did not
16 make it into your report?

17 A. The only thing that didn't make it into
18 our report -- there's a subsequent discussion
19 with Mr. Burns around services provided by a
20 company called EPS.

21 Q. And when did you have that conversation
22 with Mr. Burns?

23 A. Yesterday.

24 Q. And how long was that conversation?

25 A. Well, hold on.

1 Q. Sorry.

2 A. Was it yesterday, or was it two days
3 ago? I'm trying to remember.

4 It was either -- either the 8th -- the
5 7th or the 8th. I'm a little fuzzy on exactly
6 when we had that conversation, so ...

7 Q. And about how long was that
8 conversation?

9 A. 30 minutes.

10 Q. And what did you discuss in that
11 conversation?

12 A. The services that would be provided by a
13 -- a company called EPS.

14 Q. And what is EPS?

15 A. Elevated Practice Solutions.

16 Q. And can you describe what Elevated
17 Practice Solutions is?

18 A. So my understanding of the -- the -- the
19 company is a -- a service-based company for
20 anesthesia providers to provide certain
21 back-office functions.

22 Q. And is EPS a subsidiary of USAP?

23 A. I don't know the legal structure of it.
24 I believe it's a separate company. But I don't
25 know the -- if it's a -- a subsidiary, I don't

1 know the legal structure.

2 Q. And why did you have this conversation
3 with Frank Burns about EPS?

4 A. Because subsequent -- EPS is not
5 mentioned in my report. And in reading
6 transcripts preparing for this I came across that
7 in his -- his deposition. So I wanted to make
8 sure I understood exactly what that was.

9 Q. And so you were not familiar with EPS
10 when you wrote your initial report?

11 A. No, I was not.

12 Q. And did you interview anyone at USAP
13 other than these four people?

14 A. I don't believe so, no.

15 Q. Did you consider interviewing anyone
16 other than these four people?

17 A. That -- we didn't con -- I didn't
18 consider interviewing anyone else. You know,
19 again, we had to stay pretty on point with --

20 Q. Let's turn now to PX5507-005, to
21 Paragraph 1 of -- or to Paragraph 3 of your
22 report.

23 Let me know when you've had a chance to
24 get there.

25 A. Yes, I'm there.

1 THE WITNESS: No, I did not.

2 BY MR. WEPRIN:

3 Q. Did Dr. Lu mention whether NHA used an
4 MSO preacquisition?

5 MS. KNOFCZYNSKI: Objection to form.

6 THE WITNESS: Again, an M -- I don't
7 believe he talked about an MSO, no.

8 BY MR. WEPRIN:

9 Q. Did Dr. Lu mention any third-party
10 administrative services that NHA used
11 preacquisition?

12 MS. KNOFCZYNSKI: Objection, form.

13 THE WITNESS: I believe he -- he said
14 that they used a third-party revenue cycle
15 management company.

16 BY MR. WEPRIN:

17 Q. Did he say how much that service cost on
18 an annual basis, or at all?

19 A. No.

20 Q. Did Dr. Koons mention whether Guardian
21 used an MSO preacquisition?

22 MS. KNOFCZYNSKI: Objection, form.

23 THE WITNESS: He may -- he may have.
24 I -- I don't recall specifically.

25 BY MR. WEPRIN:

1 Q. And he didn't dis -- did Dr. Koons
2 discuss how much Guardian paid for MSO services
3 preacquisition?

4 MS. KNOFCZYNSKI: Objection, form.
5 Foundation.

6 THE WITNESS: No. I don't -- I
7 don't recall that he mentioned an MSO in our
8 conversation.

9 BY MR. WEPRIN:

10 Q. Did Dr. Goldstein mention whether
11 MetroWest used an MSO preacquisition?

12 MS. KNOFCZYNSKI: Objection, form.

13 THE WITNESS: I don't believe he -- he
14 did say that. I don't -- I don't recall
15 specifically.

16 Certainly not an MSO.

17 BY MR. WEPRIN:

18 Q. I want to go back to talking
19 about Elevated Practice Solutions. Would you
20 understand if I say "EPS" to refer to Elevated
21 Practice Solutions?

22 A. Yes.

23 MR. WEPRIN: I'd like to introduce an
24 exhibit that's been premarked as PX6002.

25 ///

1 (Exhibit No. PX6002, a printout of a
2 press release from USAP web page dated December
3 10th, 2024, was introduced electronically.)

4 MR. WEPRIN: 6002.

5 Sorry. One second.

6 THE WITNESS: Thank you.

7 MS. KNOFCZYNSKI: Thank you.

8 MS. REDLINGSHAFER: Thank you.

9 BY MR. WEPRIN:

10 Q. And while you take a minute to review
11 that document, I'll say for the record that it is
12 a printout of a press release from USAP web page
13 dated December 10th, 2024. It was accessed on
14 April 22nd, 2025, before being PX stamped, and I
15 last accessed it on January 6th, 2026.

16 Let me know when you've had a minute to
17 review the document.

18 A. (Reviews document.)

19 Yes.

20 Q. Do you recognize this document?

21 A. I don't know that I've seen this
22 document, no.

23 Q. What does it appear to be?

24 A. It appears to be a press release from
25 USAP's website around Elevated Practice

1 Solutions.

2 Q. And the first sentence of this press
3 release says, "Elevated Practice Solutions Inc.
4 (EPS) is a new subsidiary of USAP." Do you see
5 that?

6 A. Yes.

7 Q. And so EPS is a subsidiary of USAP?

8 MS. KNOFCZYNSKI: Objection, form.
9 Foundation.

10 THE WITNESS: I wouldn't know the legal
11 structure. It says here on the page it's a
12 subsidiary. But I don't know the legal structure
13 of EPS.

14 BY MR. WEPRIN:

15 Q. And if you turn to the next page,
16 PX6002-002, do you see where it said "About
17 Elevated Practice Solutions" in bold?

18 A. Yes, I do.

19 Q. And it says, "Elevated Practice
20 Solutions Inc. (EPS) provides administrative
21 and business support to anesthesia practice and
22 health systems, making a positive impact on
23 anesthesia service lines and overall clinical
24 operations, leveraging the proven infrastructure,
25 as well as best in class technological and

1 administrative capabilities of U.S. Anesthesia
2 Partners Inc.," and I'll stop there. Do you see
3 that?

4 A. I do.

5 Q. So through EPS, USAP is selling its MSO
6 services to other anesthesia practices?

7 MS. KNOFCZYNSKI: Objection, form.
8 Foundation.

9 THE WITNESS: I'm not sure what they're
10 selling, per se. This is a press release.

11 BY MR. WEPRIN:

12 Q. But they -- they say that they are
13 providing administrative and business support to
14 anesthesia practices, correct?

15 MS. KNOFCZYNSKI: Objection, form.

16 THE WITNESS: I think that's essentially
17 what they're saying in the --

18 BY MR. WEPRIN:

19 Q. And if you look at the first page,
20 PX6002-001, do you see the bullet point in the
21 middle of the page listing EPS's services?

22 A. I do.

23 Q. So EPS offers anesthesia practice
24 clients RCM services; is that right?

25 MS. KNOFCZYNSKI: Objection, form.

1 Foundation.

2 THE WITNESS: Yeah. That's what it says
3 here on the page. I'm not sure what they're --

4 BY MR. WEPRIN:

5 Q. Did --

6 A. -- offering.

7 Q. In your conversation with Mr. Burns, did
8 he confirm that EPS offers anesthesia practice
9 clients RCM services?

10 A. Yes.

11 Q. And are these the same RCM services you
12 discuss in your report?

13 A. I believe they're similar, but they're
14 not a hundred percent like for like.

15 Q. What are the differences?

16 A. So, for instance, USAP's billing

17 platform [REDACTED]

18 [REDACTED]. [REDACTED]

19 [REDACTED]

20 [REDACTED]

21 [REDACTED]. [REDACTED]

22 [REDACTED]

23 [REDACTED]

24 Now, a new -- an outside provider

25 wouldn't [REDACTED]

1 [REDACTED]. And so they
2 wouldn't have the access [REDACTED]
3 [REDACTED]. So they would provide revenue
4 cycle services. But it wouldn't be the same,
5 [REDACTED]
6 [REDACTED]

7 Q. And what would be some of the
8 similarities between the services EPS providers
9 and USAP providers internally?

10 MS. KNOFCZYNSKI: Objection, form.

11 THE WITNESS: For?

12 BY MR. WEPRIN:

13 Q. For RCM services.

14 MS. KNOFCZYNSKI: Sorry.

15 Objection, form.

16 THE WITNESS: So passing claims. So
17 billing a -- a -- a, you know, third-party payer
18 through the claims system. That would be a
19 similarity.

20 BY MR. WEPRIN:

21 Q. And would the net collection rate be
22 comparable between USAP and EPS services?

23 MS. KNOFCZYNSKI: Objection, form and
24 foundation.

25 THE WITNESS: Yeah. I wouldn't know

1 what the --

2 BY MR. WEPRIN:

3 Q. And back to the bullet points, EPS
4 offers anesthesia clients hospital credentialing
5 services; is that right?

6 MS. KNOFCZYNSKI: Objection, form and
7 foundation.

8 THE WITNESS: Yeah. That's what it says
9 on the page.

10 BY MR. WEPRIN:

11 Q. Did Mr. Burns mention whether EPS
12 offered hospital credentialing services?

13 A. I -- I think he said that, yes.

14 Q. And are these the same credentialing
15 services used by USAP discussed in your report?

16 A. They could potentially be the same.

17 Q. And EPS offers anesthesia practice
18 clients MIPS quality reporting and digital charge
19 and quality capture services. Do you see that?

20 A. I do.

21 Q. And are these the -- some of the same
22 services discussed in your report on quality data
23 used by USAP?

24 MS. KNOFCZYNSKI: Objection, form.

25 THE WITNESS: These would be the same.

1 BY MR. WEPRIN:

2 Q. And EPS offers anesthesia practice
3 clients provider scheduling services. Do you see
4 that?

5 A. I do.

6 Q. Would these be the same electronic
7 scheduling services that USAP uses?

8 MS. KNOFCZYNSKI: Objection, form and
9 foundation.

10 THE WITNESS: So I -- I wouldn't -- I
11 wouldn't know exactly if they are the same. [REDACTED]

12 [REDACTED]

13 [REDACTED]

14 [REDACTED]

15 [REDACTED]. [REDACTED]

16 [REDACTED]

17 [REDACTED]

18 [REDACTED]

19 [REDACTED]

20 [REDACTED].

21 BY MR. WEPRIN:

22 Q. And -- and would EPS offer the ability
23 to customize those services for clients?

24 MS. KNOFCZYNSKI: Objection, form.
25 Foundation.

1 THE WITNESS: Yeah. I'm not sure I
2 would know what they -- if they could -- could do
3 that per se. But what -- what I would say is
4 it's not just USAP. There's operations at the
5 practice -- at the outside practice that needs to
6 be resident in the practice to make that work
7 properly.

8 So it -- it's -- it's one thing to
9 provide a -- they can only provide the services
10 that they can provide, right, and whether that be
11 a -- a piece of software. But the practice
12 ultimately has a lot of responsibility into how
13 that service actually works, right.

14 BY MR. WEPRIN:

15 Q. And do EPS customers [REDACTED]
16 [REDACTED]
17 [REDACTED] ?

18 MS. KNOFCZYNSKI: Objection, form.
19 Foundation.

20 THE WITNESS: I wouldn't be sure if they
21 have access or not. But in my conversation with
22 -- with Mr. Burns, I believe [REDACTED]
23 [REDACTED].

24 BY MR. WEPRIN:

25 Q. And EPS offers anesthesia practice

1 clients operating room efficiency dashboards,
2 right?

3 MS. KNOFCZYNSKI: Objection, form.
4 Foundation.

5 THE WITNESS: That's what the -- the
6 page says.

7 BY MR. WEPRIN:

8 Q. And would these be like the dashboards
9 discussed in your report?

10 MS. KNOFCZYNSKI: Objection, form.
11 Foundation.

12 THE WITNESS: Yeah. Again, it's what it
13 says here. I'm not sure what those dashboards
14 would be.

15 BY MR. WEPRIN:

16 Q. And so can anesthesia practices in Texas
17 that are not affiliated with USAP now access many
18 back-office services discussed in your report
19 through EPS?

20 MS. KNOFCZYNSKI: Objection, form.
21 Foundation.

22 THE WITNESS: I wouldn't know if -- if
23 they can access what's here on this page. I'm
24 not sure that the -- that this company is
25 providing services right now. I believe it's

1 not.

2 BY MR. WEPRIN:

3 Q. What is your basis to say that EPS is
4 not providing services right now?

5 A. A conversation with Mr. Burns.

6 Q. What did Mr. Burns say about EPS's
7 current ability to provide services?

8 A. We didn't talk about the ability. I
9 said currently providing services, so currently
10 providing services to another customer. He said
11 they're not currently providing services to an
12 active customer.

13 Q. Let's now introduce another exhibit
14 -- you could set that one to the side -- PX
15 -- I'm going to introduce an exhibit that's been
16 premarked as PX6003.

17 (Exhibit No. PX6003, a printout of the
18 "About Us" page from the URL www.elevatedpracticesolutions.com/about-us, was introduced
19 electronically.)

21 THE WITNESS: Thank you.

22 MS. KNOFCZYNSKI: Thank you.

23 MS. REDLINGSHAFFER: Thanks.

24 BY MR. WEPRIN:

25 Q. And then if you take a moment to look at

1 this document, while you review it, I'll say for
2 the record that it is a printout of the "About
3 Us" page from El -- www.elevated
4 practicesolutions.com/about-us.

5 It was accessed on April 24th, 2025,
6 before being stamped, and I last accessed it on
7 January 6th, 2026.

8 Let me know when you've had a chance to
9 look at it.

10 A. Yes.

11 Q. What does this document appear to be?

12 A. This appears to be an -- an About Us
13 section off of the website for EPS.

14 Q. And if you turn to PX6003-002, do you
15 see that has a table with some RCM metrics?

16 MS. KNOFCZYNSKI: Objection, foundation.

17 THE WITNESS: I -- I see a -- I see
18 metrics listed here. And I can see it on the
19 page, yes.

20 BY MR. WEPRIN:

21 Q. And so are these RCM metrics being
22 advertised to EPS customers?

23 MS. KNOFCZYNSKI: Objection, foundation.

24 THE WITNESS: Yeah. I wouldn't know
25 what's being advertised. It's what's on their

1 website.

2 BY MR. WEPRIN:

3 Q. And the net collection rate that EPS
4 listed on its website is it 95.6 percent.
5 Do you see that?

6 MS. KNOFCZYNSKI: Objection, foundation.

7 THE WITNESS: I see the numbers on the
8 page. I'm not --

9 BY MR. WEPRIN:

10 Q. And I believe that's actually [REDACTED]
11 [REDACTED] than the net collection rate from USAP
12 that you reference in your report at PX5507-048;
13 is that correct?

14 A. Sorry. 048?

15 Q. Yes.

16 PX5507-048 has a series of net
17 collection rates for USAP. And all of them
18 [REDACTED] listed
19 on the EPS website; is that right?

20 MS. KNOFCZYNSKI: Objection, foundation.

21 THE WITNESS: Yeah. I -- I don't
22 know how these were calculated, if they were
23 calculated on a like-for-like basis or time
24 periods.

25 BY MR. WEPRIN:

1 Q. And if you look at PX5507-407 of your
2 report, you could see that USAP currently has a
3 clean claim rate of [REDACTED] percent.

4 A. Sorry. 4?

5 MS. KNOFCZYNSKI: I'm sorry. Could you
6 repeat that?

7 MR. WEPRIN: I apologize.

8 BY MR. WEPRIN:

9 Q. If you turn the page back to PX5507-047
10 of your report, do you see the table titled
11 "Executive KPI Summary"?

12 A. I do.

13 Q. And do you see next to "Clean Claim
14 Rate" it says, "current value, [REDACTED] percent"?

15 A. I do.

16 Q. And if you turn back to PX6003-002, do
17 you see that in this table it has a clean claim
18 rate of 99.5 percent?

19 MS. KNOFCZYNSKI: Objection, foundation.

20 THE WITNESS: I see the number.
21 I'm not -- again, I'm not sure how that's
22 calculated.

23 BY MR. WEPRIN:

24 Q. If a practice is divested from USAP,
25 could it become an EPS customer?

1 MS. KNOFCZYNSKI: Objection, foundation.

2 THE WITNESS: I wouldn't know if it
3 could or could not.

4 BY MR. WEPRIN:

5 Q. In your interview with Mr. Burns from
6 January of this year, did Mr. Burns say anything
7 that we have not already discussed about EPS's
8 capabilities?

9 A. When you say "January of this year," do
10 you mean --

11 Q. I mean your most recent interview with
12 Mr. Burns.

13 A. My most recent.

14 Yes, we talked about the things that EPS
15 won't provide or can't provide.

16 Q. And did you talk about the things that
17 USAP -- I'm sorry. Strike that.

18 Did Mr. Burns tell you about the things
19 that EPS can provide?

20 A. We discussed some of the things that can
21 be provided.

22 Q. Did Mr. Burns discuss the rollout
23 schedule for EPS?

24 A. No, he did not.

25 Q. Did Mr. Burns discuss marketing for EPS?

1 A. No, he did not.

2 Q. Did Mr. Burns discuss competitors for
3 EPS?

4 MS. KNOFCZYNSKI: Objection, form.

5 THE WITNESS: No, he did not.

6 BY MR. WEPRIN:

7 Q. Did Mr. Burns discuss why EPS doesn't
8 currently have a customer?

9 A. No.

10 Q. Let's turn back to your report now. You
11 can set that document aside.

12 And turn to PX5507-028 to Paragraph 60
13 of your report.

14 And I would like to discuss Figure 1 of
15 your report. Let me know when you're ready.

16 A. Yes.

17 MS. KNOFCZYNSKI: Apologies. If you can
18 give me just a second?

19 MR. WEPRIN: Sure.

20 MS. KNOFCZYNSKI: Ready.

21 BY MR. WEPRIN:

22 Q. Who created Figure 1?

23 A. So this chart would have been created by
24 Emily Buhl, who's a member of Dr. Fowdur's staff.

25 Q. And so Dr. Fowdur's staff created Figure

1 1?

2 A. Yes.

3 Q. And the source cited for Figure 1 is
4 Payer Claims Data. Do you see that?

5 A. Yes.

6 Q. Where did this data come from?

7 A. So this is a database that Dr. Fowdur's
8 group possesses to -- of claims data that they
9 possess to do the analysis. So I believe -- I
10 -- I don't know the exact source of -- of the
11 data, but it -- it's a commercial -- I believe
12 it's a commercially available database that they
13 utilize to -- to look at.

14 Q. And did you personally look at the data
15 yourself?

16 A. I did not personally look at the data.

17 Q. So did Dr. Fowdur's team work with the
18 actual data?

19 A. Yes.

20 Q. And the figure's titled "Change in
21 average monthly anesthesia units before and after
22 acquisition for selected physicians."
23 Do you see that?

24 A. Yes.

25 Q. What is included in an average monthly

1 A. I don't know exactly when it -- the
2 investment started. But what I'm citing here is
3 the -- through that date, that's how much had
4 been invested.

5 Q. And you don't know if the \$ [REDACTED]
6 was all from 2023 or if it was spread out over a
7 longer period of time?

8 A. I do not know that.

9 Q. And you don't know when USAP first
10 started investing in its data warehouse?

11 A. Yeah. I'm not -- I'm not sure when they
12 started the investment into that -- that data
13 warehouse.

14 Q. And you mentioned that the data
15 warehouse could be used for quality and
16 scheduling data. Do you know if the data
17 warehouse is used exclusively for quality and
18 scheduling, or if it's also used for other
19 purposes?

20 MS. KNOFCZYNSKI: Objection, form.

21 THE WITNESS: So there's -- there are
22 other things that we talk about here in this
23 paragraph that it would be used for, such as

24 [REDACTED]
25 [REDACTED]. So the

1 -- that's what we say here. But my experience
2 would be that a data warehouse would in -- would
3 have a lot of different data that goes into it
4 from different aspects of the company.

5 BY MR. WEPRIN:

6 Q. So do you think a data warehouse is also
7 used for things beyond the ones you mentioned in
8 this paragraph?

9 A. It could be.

10 Q. And do you know if this data warehouse
11 referenced in Paragraph 85 is used nationally for
12 USAP?

13 A. I don't know for certain that it's used
14 nationally, but I would expect that it is. It's
15 -- typically you have -- when you have a platform
16 like that, you would use it across all your
17 operations.

18 Q. And would USAP use this data warehouse
19 to provide services to EPS customers?

20 MS. KNOFCZYNSKI: Objection, form.
21 Foundation.

22 THE WITNESS: So I'm not sure what EPS
23 would -- is going to provide or not provide,
24 you know, in complete detail. They probably
25 could utilize a warehouse. But I think I -- as

1 we discussed earlier, [REDACTED]
2 [REDACTED]
3 [REDACTED].

4 So it's -- you know, it -- I'm -- I
5 would imagine it could be used in some way, but
6 [REDACTED]
7 -- [REDACTED].

8 BY MR. WEPRIN:

9 Q. And did you investigate whether any
10 other -- any other anesthesia providers in Texas
11 have data warehouses?

12 A. I did not investigate that. No, I did
13 not.

14 Q. Can you turn now to Paragraph 82 of your
15 report on PX5507-036, the prior page?

16 A. Sorry. 82?

17 Q. 82.

18 A. Yeah.

19 Okay.

20 Q. And you note here that -- I'm sorry. In
21 this paragraph you discuss USAP's Clinical
22 Quality Committee, correct?

23 A. Yes.

24 Q. And you abbreviate that as CQC?

25 A. Yes.

1 Q. And so you note that USAP's CQC monitors
2 USAP quality and developments in the anesthesia
3 field and provides recommendations for best
4 practices. Do you see that?

5 A. Yes.

6 Q. Did you look into any specific best
7 practices that the CQC recommended?

8 A. Well, I'm not a clinician, so, you know,
9 I didn't look at specific quality recommendations
10 they would have. So I --

11 Q. And do specific USAP practices have
12 clinical autonomy on if and how to implement
13 these prac -- best practices?

14 MS. KNOFCZYNSKI: Objection, form.
15 Foundation.

16 THE WITNESS: Again, I'm not a -- I'm
17 not a clinician or a quality expert, so I'm not
18 sure how that's administered.

19 BY MR. WEPRIN:

20 Q. Do you know if the CQC can force a
21 specific USAP practice to adopt a best practice
22 that they recommend?

23 MS. KNOFCZYNSKI: Objection, form.
24 Foundation.

25 THE WITNESS: Yeah. I -- again, I'm not

1 So let's make sure we get it all right.

2 So some of those services are

3 [REDACTED]. Recruitment
4 is one that is highlighted in my report that's
5 not going to be provided by EPS. That's
6 clinician recruitment.

7 I don't believe that [REDACTED]

8 [REDACTED]
9 [REDACTED].

10 There are limitations around what
11 IT services would be provided. So, for instance,
12 things such as a -- a general ledger for
13 financial reporting purposes or a human resource
14 management system wouldn't be included.

15 Q. Would payer contracting or hospital
16 contracting be included in EPS's services?

17 MR. WEPRIN: Objection to form.

18 THE WITNESS: Those also would not be
19 included.

20 BY MS. KNOFCZYNSKI:

21 Q. Are there any services that you didn't
22 discuss in your report that USAP offers to its
23 practices that EPS wouldn't offer?

24 A. Sorry. Can you state that again?

25 Q. Are there any services that you didn't

1 discuss in your report that USAP offers to
2 practices that are part of USAP that Mr. Burns
3 told you EPS won't offer to potential customers?

4 MR. WEPRIN: Objection. Outside the
5 scope of the report.

6 THE WITNESS: Can I answer the question?

7 MS. KNOFCZYNSKI: Yes.

8 THE WITNESS: Yes. So human resources
9 management would be one that's not included in
10 the report that would also not be included by
11 EPS. Financial management, finance and
12 accounting. Risk management and malpractice,
13 would be two areas that -- that would also not be
14 included in EPS.

15 MS. KNOFCZYNSKI: Okay. Thank you,
16 Mr. Fix. No further questions.

17 MR. WEPRIN: I have no further questions
18 either.

19 MS. KNOFCZYNSKI: We're ready to go off
20 the record.

21 MR. WEPRIN: Go off the record.

22 THE VIDEOGRAPHER: The time is 2:48 p.m.
23 We're going off the record.

24 (Deposition concluded -- 2:48 p.m.)
25

C E R T I F I C A T E

1
2
3 I do hereby certify that I am a Notary
4 Public in good standing, that the aforesaid
5 testimony was taken before me, pursuant to
6 notice, at the time and place indicated; that
7 said deponent was by me duly sworn to tell the
8 truth, the whole truth, and nothing but the
9 truth; that the testimony of said deponent was
10 correctly recorded in machine shorthand by me and
11 thereafter transcribed under my supervision with
12 computer-aided transcription; that the deposition
13 is a true and correct record of the testimony
14 given by the witness; and that I am neither of
15 counsel nor kin to any party in said action, nor
16 interested in the outcome thereof.

17 WITNESS my hand and official seal this
18 12th day of January, 2026.

19
20
21 

22 Notary Public
23
24
25

ERRATA SHEET FOR THE DEPOSITION OF MR. DAVID A. FIX**Case Name:** *FTC v. U.S. Anesthesia Partners, Inc.*, No. 4:23-cv-03560 (S.D. Tex.)**Date:** January 9, 2026**Deponent:** Mr. David A. Fix

Cite	Original	Corrected	Reason
28:18-19	would you have done	would have done	Transcription error
70:3	Yeah	-	Transcription error
79:24	operations, leveraging	operations. Leveraging	Transcription error
92:24	Buhl	Buell	Transcription error
99:17	increase in reduction	increase and reduction	Transcription error
101:5	BCBS, Texas	BCBSTX	Transcription error
111:19	show	showed	Transcription error
111:21	69	16	Transcription error
111:21	employment	deployment	Transcription error
115:1	employment	deployment	Transcription error
124:16	postnoon	post-noon	Transcription error
133:17	kind of	-	Transcription error
152:17	competitive	competitor	Transcription error
178:11	NHA	NHA's	Transcription error
188:22	HCAP	HCAHPS	Transcription error
189:1	HCAP	HCAHPS	Transcription error
202:14	used	-	Transcription error

I have read the transcript of my deposition and have listed all changes and corrections above, along with my reasons therefore.

Date: 2/10/2026Signature of Witness: /s/ David A. Fix
Mr. David A. Fix

Exhibit 5

**IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION**

FEDERAL TRADE COMMISSION,

Plaintiff,

v.

U.S. ANESTHESIA PARTNERS, INC. et al.

Defendants.

Case No.: 4:23-CV-03560-KH

EXPERT REPORT OF DR. ZEEV N. KAIN

10. Taken together, my three decades of leadership in anesthesiology—spanning Yale, UC Irvine, consulting, national organizations, and international collaborations—have centered on the evaluation, measurement, and improvement of clinical quality. I have applied this experience to evaluate the quality of care delivered by USAP and to benchmark it against both academic and private practice anesthesia models. My full curriculum vitae is provided in Appendix A.

III. Compensation

11. I have billed at an hourly rate of \$1,000 for my services. I have received no additional compensation for my work related to this matter. My compensation is not contingent on the outcome of this litigation.

IV. Information Considered

12. In addition to drawing on my educational background and training detailed above, my three decades of experience in the fields of anesthesiology and healthcare, outcome research, hospital management, negotiations with payors, quality and patient safety, my clinical practice, and my familiarity with the medical literature to prepare this report, I have also relied upon the documents listed in Appendix B.
13. I reserve the right to amend or supplement my opinions should additional documents or information become available. I further reserve the right to modify or expand my analysis in response to any critique of my report or to any alternative opinions offered by or on behalf of the FTC.

V. Summary of Opinions

14. Based on the Donabedian Model, assessing the quality of an anesthesia practice requires a comprehensive evaluation of its resources (structure), the systems it deploys (process), and the results it achieves for patients (outcomes). Each of these domains reinforces the others: strong governance, infrastructure, and clinical expertise enable systematic data collection, evidence-based protocols, and continuous improvement, which in turn increase the likelihood of better patient experiences and clinical results.
15. In my opinion, the evidence across all three domains shows that USAP has made extraordinary investments in quality, including multimillion-dollar infrastructure and governance commitments, that it operationalizes those investments through disciplined and large-scale processes, and that these efforts yield outcomes that compare favorably to benchmarks on measures such as mortality, cardiac arrests, reintubations, readmissions, and patient satisfaction. Together, these findings support the conclusion that USAP delivers high-quality anesthesia care and that practices that join USAP benefit from its investments in quality.
16. Though Dr. Pimentel acknowledges the importance of structure and process in assessing anesthesia quality, he ignores those components of quality when assessing USAP. He instead focuses narrowly on USAP's patient outcomes. I disagree both with how Dr. Pimentel conducts his analysis and with the conclusions he reaches.

VI. Overview of Anesthesia Quality Measurement

A. Framework Used

17. In writing this report, I have employed the Donabedian Model¹ to assess USAP's delivery of clinical care.
18. The Donabedian Model, introduced in the 1960s, is still the dominant paradigm for healthcare quality evaluation. Donabedian's insight was that healthcare quality depends on three things: the resources you have (structure), how care is provided (process), and what happens to patients (outcomes).² Donabedian recognized that healthcare quality cannot be captured by a single metric or domain (such as outcomes); instead it reflects a complex interplay of three distinct but interconnected domains. The model's conceptual framework rests on the hypothesis that good structure increases the likelihood of good process, and good process increases the likelihood of good outcomes.
19. Dr. Pimentel correctly identifies (at ¶¶ 28-29) the Donabedian Model as the proper lens for evaluating anesthesia quality, but then applies only one component of that framework by focusing almost exclusively on outcomes, which he acknowledges are difficult to measure and attribute.
20. I disagree with that approach. One cannot meaningfully assess quality while ignoring the structural and process elements that create the conditions for better outcomes. In this report, I therefore highlight the substantial ways in which USAP has invested in structure (Part VII.A) and process (Part VII.B), which together provide a reliable foundation for improved patient care. Only after laying that foundation, do I turn to outcomes (Part VII.C), where I show that Dr. Pimentel misinterprets the available data and that his criticisms do not withstand scrutiny (Part VIII).
21. While outcome measures might intuitively seem like the "gold standard" for measuring quality, outcomes generally and anesthesia outcomes in particular are influenced by many factors "beyond providers' control."³ That is why the AHRQ recommends the Donabedian Model's balanced approach.⁴
22. This report applies the Donabedian Model by highlighting USAP's:
 - a. **Structure**, including its leadership, governance, infrastructure, and IT systems that provide the foundation for quality of care;

¹ See Avedis Donabedian, *The Quality of Care: How Can it be Assessed?*, 260 JAMA 1743, 1745 (1988).

² See *id.*

³ *Types of Health Care Quality Measures*, AHRQ, <https://www.ahrq.gov/talkingquality/measures/types.html>.

⁴ *Id.*

- b. **Process**, including its data collection, education, guidelines, monitoring, quality improvement activities, and dissemination; and
 - c. **Outcomes**, including its rates of reintubation and readmission, length of stay, complications, and patient experience.
23. Under the Donabedian Model, mature programs have a well-defined governance structure and dedicated infrastructure, integrate automated data collection systems, conduct regular morbidity and mortality (M&M) review processes with actionable follow-up, provide educational activities, and monitor results continuously against both internal targets and external benchmarks.

B. Challenges to Anesthesia Quality in 2025

1. Structure, process, and outcomes barriers

a. Structural barriers

24. Efforts to improve anesthesia quality face structural barriers. Some examples of those barriers, including my assessment of their importance, are listed below.
- a. **Compensation models (critical):** Anesthesia operates under a fee-for-service model that often fails to provide incentives to deliver higher quality clinical care.⁵ The traditional fee-for-service model emphasizes volume over quality, discouraging investment in infrastructure or time for non-billable quality activities such as M&M conferences. This is a particularly difficult challenge to overcome for anesthesiologists who are compensated based on a unit system that is limited to direct patient interactions. This unit-based model discourages anesthesiologists from developing any infrastructure or processing to improve their quality, since they derive no compensation from these activities. Indeed, under the current system, any minute an anesthesiologist devotes to quality activities is a minute that does not generate income. This problem is discussed in multiple articles I have published on this topic.⁶

⁵ See *Moving the Health Care System Away from Fee-for-Service*, Commonwealth Fund, <https://www.commonwealthfund.org/publications/newsletter-article/moving-health-care-system-away-fee-service>.

⁶ See, e.g., Zeev Kain and Thomas Vetter, *The Involvement of Anesthesiologists in Alternative Payment Models, Value-Based Care, and Care-Redesign: Myth or Reality*, 140 *Anesthesia & Analgesia* 24 (2025); Zeev Kain, *Systems Anesthesiology: A New Conceptual Framework*, 135 *Anesthesia & Analgesia* 671 (2022); Edward R. Mariano et al., *The Perioperative Surgical Home Is Not Just a Name*, 125 *Anesthesia & Analgesia* 1443 (2017); Navid Alem and Zeev Kain, *Evolving healthcare delivery paradigms and the optimization of 'value' in anesthesiology*, 30 *Current Op. Anesthesiology* 223 (2017); Olivier Desebbe et al., *The perioperative surgical home: An innovative, patient-centred and cost-effective perioperative care model*, 35 *Anesthesia Critical Care & Pain Med.* 59 (2016).

A provider is then given a composite score based on these metrics. This data is used in USAP's scorecards to facilities.¹⁰³

72. In 2018, USAP worked to improve patient satisfaction scores through “educational publications and presentations, group and individual coaching, systematic improvements to hospital facilities and policies and outreach to dis-satisfied patients.”¹⁰⁴ Based on data I have reviewed, 96.19% of patients rate their Overall Anesthesia Experience with USAP as a 4 “good” (4/5) or “great” (5/5), and 97.26% of patients give the same 4/5 or 5/5 ratings for their USAP Clinicians.¹⁰⁵
73. From the 2021 data, 86% of patients in USAP practices gave the highest possible rating (5/5) for their overall anesthesia experience, compared to 83.9% nationally. Similarly, 87% rated their anesthesiologist at the top level, compared to 86% nationally.¹⁰⁶ At first glance, a one-point gap may not seem meaningful, but in patient satisfaction surveys, the scores cluster tightly at the high end of the scale, so even small differences reflect real performance advantages. In my experience, I have seen repeatedly that moving the needle even a single percentage point in this range requires significant effort and signals measurable improvement. As Dr. Dutton has observed, USAP's results place it around the 60th percentile of SurveyVitals practices—a cohort already skewed toward higher quality because only a small fraction of anesthesia groups invest in patient satisfaction measurement at all.¹⁰⁷ Indeed, USAP patients constitute a majority of the patients who respond to SurveyVitals.¹⁰⁸ As a simple matter of math, when one group supplies most of the responses, its own performance heavily influences the distribution, making it unsurprising that USAP's results would cluster near the median.

VIII. Specific Rebuttals to Dr. Pimentel

74. There are broad problems with Dr. Pimentel's report: he references the correct framework for judging quality, but then ignores much of it, focusing almost entirely on outcomes, while overlooking the systems and investments that facilitate better outcomes. I disagree with his specific critiques as well. On MIPS (federal quality reporting), he dismisses USAP's high scores, without recognizing that achieving those scores requires major investment in infrastructure and that every practice that joined USAP improved its MIPS scores after integration. With respect to the Chartis analysis (conducted by an

¹⁰³ See, e.g., USAP-FTC-CID-00102419, Patient Satisfaction Scorecard for TCH Pavilion for Women, Q1-Q3 2018, at -2443.

¹⁰⁴ See USAP-FTC-CID-01462157 (PX1199), USAP Increases the Value of Anesthesia Care: Patient Satisfaction, at -2161.

¹⁰⁵ See USAPTX-00198737, at slide 6.

¹⁰⁶ See Dutton Dep. Tr., at 79:7-83:23, 85:18-88:1; *Scaling up quality in an anesthesia practice* (PX4006), *supra*, at 3.

¹⁰⁷ See Dutton Dep. Tr., at 83:24-84:4, 86:4-14.

¹⁰⁸ Interview with Dr. Richard P. Dutton (Sept. 17, 2025).

outside consultant to USAP), Dr. Pimentel discounts meaningful findings, including the finding that USAP's patients have shorter hospital stays and fewer USAP patients needing rehabilitation after surgery. Instead, he relies on studies that do not apply to anesthesia and ignores the role of USAP's large-scale adoption of evidence-based quality improvement projects. On the *Scaling Up Quality* study (Dr. Dutton's peer reviewed and published case study), he ignores its clear documentation of the improvements in quality processes after practices joined USAP. And on patient surveys, he treats USAP's above-benchmark results as insignificant, while failing to note that very few anesthesia groups measure satisfaction at all—making USAP's consistent measurement and strong scores especially meaningful.

A. Overarching issues

75. I agree with Dr. Pimentel (at ¶¶ 29, 36) that anesthesia quality must be assessed using a mix of structure, process, and outcome measures. But he does not apply this framework in his own analysis. For example, Dr. Pimentel acknowledges that structure measures include staff qualifications such as board certification, yet he ignores the Chartis data from 2020 showing that 93% of USAP anesthesiologists are board-certified or eligible, compared to only 81% statewide in Texas.¹⁰⁹ He also ignores the more recent data showing 97% of USAP anesthesiologists are board-certified or board eligible.¹¹⁰ This is a clear structural indicator of quality, and it cannot simply be set aside when evaluating the care USAP delivers.
76. Dr. Pimentel observes (at ¶¶ 31-33) that it is difficult to gather data on process measures. While I agree that the effort can be resource-intensive, that is not a reason to dismiss process measures altogether. On the contrary, it shows why a robust quality-data-collection infrastructure is so important. Process measures are essential to evaluating quality, and USAP has invested about [REDACTED] annually¹¹¹ to build that capability—an investment that Dr. Pimentel does not acknowledge. His report begins by recognizing the need to consider structure, process, and outcomes, yet he relies almost entirely on outcomes, while ignoring the significant structure and process data available.
77. Dr. Pimentel claims (at ¶ 34) that process measures are too far removed from outcomes to matter. That view is inconsistent with AHRQ's views and with the Donabedian Model, both of which emphasize that process measures are the most actionable and immediately useful quality indicators.¹¹² Outcomes are shaped by many factors outside an anesthesiologist's control—patient comorbidities, social determinants of health, or

¹⁰⁹ See USAP-FTC-CID-01462157 (PX1199), Chartis, US Anesthesia Partners Payor & Health System Value Proposition Development, Initial Findings (May 12, 2020).

¹¹⁰ See USAPTX-00198737, at slide 3.

¹¹¹ Interview with Dr. Richard P. Dutton (Sept. 17, 2025).

¹¹² See Donabedian, *supra*, at 1745; *Types of Health Care Quality Measures*, *supra*.

multiple providers—while process measures directly capture whether clinicians are delivering evidence-based care.¹¹³

78. Dr. Pimentel also highlights (at ¶ 48) case registries like Multicenter Perioperative Outcomes Group (“MPOG”) as the “latest advances” in anesthesia quality measurement. While MPOG is valuable, it is a relatively small registry, limited to 87 hospitals, most of which are elite academic centers, and its “minimal required” data includes very limited outcome data.¹¹⁴ NACOR, by contrast, includes more than 100 million cases and represents both university and private practices, capturing structure and process elements as well as outcomes.¹¹⁵ As NACOR was designed for the entire anesthesia community, USAP should be evaluated against this broader standard. By focusing on MPOG, Dr. Pimentel takes an academic-centric view that does not reflect the realities of private practice anesthesia.

B. MIPS anesthesia quality measures

79. Dr. Pimentel argues (¶¶ 58-63, 79) that USAP’s improvements on MIPS measures are not meaningful because many of the measures are “topped out” and because groups can selectively report measures on which they perform best. I disagree that those critiques of MIPS apply here.
80. Dr. Pimentel critiques (at ¶ 58-62) the use of MIPS data to show quality improvements because many of the MIPS measures are “topped out”—meaning that too many practices receive perfect scores for the measures to be valuable differentiators. Two points are important here. First, USAP generally out-performs national benchmarks. Second, MIPS participation is voluntary; even as late as 2018, only about half of providers reported. Non-reporting groups are likely lower-quality, which means USAP’s strong scores reflect strong performance against a self-selected, quality-focused cohort.
81. Dr. Pimentel further suggests (at ¶¶ 63, 79) that improvements on MIPS measures may simply reflect selection bias, because physician groups select which six quality measures to report. But that point does not apply here: as Dr. Dutton has already explained, the measures that USAP has selected are substantially the same as the ones the acquired practices used “before and after” integration.¹¹⁶ Moreover, the *Scaling Up Quality* study shows that all groups joining USAP had clear improvements in MIPS scores post-integration.

¹¹³ See *Measurement*, AHRQ: TeamSTEPPS Program, <https://www.ahrq.gov/teamstepps-program/curriculum/implement/pre/measure.html>.

¹¹⁴ See *Member Hospitals*, MPOG, <https://mpog.org/memberhospitals/>; MPOG, *Member Hospitals* (Sept. 9, 2025), <https://mpog.org/files/membership/memberhospitals.pdf>.

¹¹⁵ See *NACOR and the benefits of Participation, supra; Measures & Metrics*, Anesthesia Quality Institute: Quality, <https://www.asahq.org/aqi/quality/measures>.

¹¹⁶ See Dutton Dep. Tr., at 57:2-58:16.

Exhibit 3

Filed Under Seal

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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

)	
FEDERAL TRADE COMMISSION,)	
)	
Plaintiff,)	
)	
vs.)	Case Number
)	4:23-CV-03560-KH
U.S. ANESTHESIA PARTNERS,)	
INC. ET AL.,)	
)	
Defendants.)	
_____)	

** HIGHLY CONFIDENTIAL UNDER THE PROTECTIVE ORDER **
IN-PERSON PROCEEDINGS OF
VIDEOTAPED DEPOSITION OF ZEEV N. KAIN, M.D.
Costa Mesa, California
Friday, January 9, 2026

Reported Stenographically by:
REAGAN EVANS
CA CSR NUMBER 8176
TX CSR NUMBER 3308
RPR, RMR, RDR, CRR, CCRR, CLR, CRC
Job Number CS 7782716

1 Q But to back up a little bit, you just
2 mentioned the structured process and outcomes. And
3 I just want to take a step and say, in your report
4 you described the Donabedian Model; is that correct?

5 A Yes.

6 Q And what is the Donabedian Model?

7 A The Donabedian Model was established or
8 described by Dr. Donabedian in 1966, so 60 years
9 ago, and 1988.

10 And the original model was a linear model
11 that essentially had three components, which is
12 structure, process, and outcomes.

13 The relationship between those was a linear
14 flow.

15 Q And could you describe what you mean by "a
16 linear flow"?

17 A We are now getting into the modern
18 operational descriptions of this model. And there
19 are -- fundamental difference in 60 years is a long
20 time.

21 But within the context of linear, the model
22 today talks about a bidirectional relations between
23 the these three variables.

24 So structure leads to process, and process
25 leads to structure. And then structure leads to

1 outcomes, and outcomes lead to structure. And then
2 the missing part, process, is connected to outcomes
3 and so on.

4 And I can probably later on get into
5 details of how does it exactly work.

6 But this is no -- not a linear flow of
7 A leads to B leads to C, but rather a continuous
8 improvement process where they're all connected to
9 each other.

10 Q In your own practice, what structural
11 measures do you review your own performance on?

12 A And, again, structural measures that exist
13 in the department include the classical structural
14 measures that have been described originally, and
15 then the modern definition of those, which includes
16 now data warehouses, which include dashboards, which
17 includes ongoing feedback loop and adaptive learning
18 systems, and probably a number of others.

19 Q What process measures do you track your own
20 performance on?

21 A And, again, the process measures today
22 include a variety of measures, anywhere from
23 implementation of perioperative surgical home in
24 health recovery, more to model pain management,
25 perioperative temperature control, and so on.

1 MR. REINBOLD: We have been going about an
2 hour. Are you coming up on a time where we might
3 take a break?

4 MR. ARIN: If I could just tackle one more
5 subject, if that's all right.

6 THE WITNESS: I would rather have a break.
7 I'm sorry.

8 MR. REINBOLD: Is that okay?

9 MR. ARIN: We can go off the record.

10 THE VIDEOGRAPHER: Time is 10:05 a.m.
11 We are off the record.

12 (Recess was taken at 10:04 a.m.
13 until 10:14 a.m.)

14 THE VIDEOGRAPHER: The time is 10:14 a.m.
15 We're back on the record.

16 BY MR. ARIN:

17 Q Does your report contain a complete
18 statement of all opinions you will express?

19 A Sorry?

20 Q Does your report contain a complete
21 statement of all opinions you will express?

22 A It does not.

23 Q What is incomplete about your report?

24 A I have had the opportunity to review the
25 rebuttal by Dr. Pimentel. And as a result of that,

1 BY MR. ARIN:

2 Q Why do you want to validate that your
3 thinking is correct?

4 A Because I want to validate why it's
5 correct.

6 Q What do you mean by "validate"?

7 A Validate is to see if CMS, AHRQ agree with,
8 and more agree with the opinions that I have given
9 in this report.

10 Q Do you currently plan to supplement your
11 expert report?

12 A I can't answer that.

13 If there will be new information brought to
14 me, then it is possible. If new information -- if
15 no new information will be brought to me, then no.

16 Q Based on the knowledge that you currently
17 have, you do not intend to supplement your report;
18 correct?

19 MR. REINBOLD: Object to the form.

20 THE WITNESS: Correct.

21 BY MR. ARIN:

22 Q Does your report contain all bases and
23 reasons for your opinions?

24 A Not all of them.

25 Q What bases and reasons for your opinions

1 are not included in your report?

2 A For example, the June 2025 rule by CMS on
3 the Patient Safety Structural Measure, and any
4 information that was on the CMS and AHRQ and IOM
5 websites for the past couple of weeks, because I
6 reviewed them all.

7 Q Your report does not currently contain all
8 facts you relied upon in forming your opinions?

9 MR. REINBOLD: Object to the form.

10 THE WITNESS: When you say "facts," do you
11 mean the exhibits that were submitted to me?

12 BY MR. ARIN:

13 Q I mean facts.

14 A You'll have to define that, please.

15 Q How do you define facts?

16 Does your report currently contain all the
17 exhibits you relied upon in forming your opinions?

18 A Yes, beside the report by Dr. Pimentel that
19 was received later on.

20 Q Does your report contain all data you
21 relied upon in forming your opinions?

22 A Data that has been received vis-à-vis the
23 specific case of USAP, the answer is yes.

24 Q Is there data that you relied upon that is
25 not in your report?

1 report?

2 MR. REINBOLD: Same instruction.

3 THE WITNESS: I wrote this report.

4 BY MR. ARIN:

5 Q Did you have any student researchers that
6 helped with your report?

7 A No.

8 Q Did you have any staff working underneath
9 you that helped with this report?

10 A No.

11 Q Did you use any artificial intelligence to
12 write your report?

13 A No.

14 Q I want to ask you about Section 6(a) of
15 your report, titled, "Framework Used," that begins
16 on page 4 of your expert report.

17 Are you with me?

18 MR. REINBOLD: Can you -- I think that was
19 not the Bates number.

20 MR. ARIN: Oh, excuse me. You're right.

21 Q Please turn to page PX5504-007.

22 A Yes.

23 Q You applied the Donabedian Model to
24 evaluate USAP's clinical quality; correct?

25 A I've applied the modernized version of the

1 Donabedian Model as adopted by CMS, AHRQ, and IOM,
2 yes.

3 Q And could you elaborate what you mean by
4 "the modernized version"?

5 A The Donabedian Model was introduced in
6 1966. That is 60 years ago. There were some
7 revisions made maybe 40 years ago.

8 At that time, there were no data
9 warehouses. There was no electronic health records.

10 The original record, or the Donabedian
11 Model, indicated things under structural things like
12 fire extinguishers, which today it has been
13 modernized, and the structural elements today
14 include, among others, data warehouses, electronic
15 health records, monetary support, organizational
16 structures, dashboards, adaptive learning,
17 continuous feedback loops between the structural
18 measure, the process, and the outcomes.

19 And those elements have simply not existed
20 when Donabedian had came up with his model.

21 And so obviously my opinion is, after doing
22 this after 35 years in multiple capacity, is that
23 you can't take writings from 1966 and apply them
24 literally as they are today. And that's why CMS and
25 AHRQ have obviously modernized his framework, which

1 is fantastic, by the way. It's ingenious.

2 And that is why CMS came up with the
3 Patient Safety Structural Measure.

4 In 2025, that has, in fact, five domains.
5 And I don't recall all the five domains, but I can
6 tell you that it does include leadership structure.
7 It does include culture of safety, transparency,
8 patient satisfaction, and so on.

9 Q Are there any academic articles that
10 explain the difference between the traditional
11 Donabedian Model and the modernized Donabedian Model
12 that you just described?

13 A I will have to do a search for it. I did
14 not do a search, but I would refer you to, the way I
15 would say, to the government or governmental
16 agencies.

17 And by that I mean CMS and AHRQ, as well as
18 the Institute of Medicine, which is obviously not a
19 governmental agency but is a leading authority in
20 medicine.

21 Q And to be clear, the Institute of Medicine
22 is known today as the National Academy of Medicine;
23 correct?

24 A It is kind of. It's the -- the Institute
25 of Medicine is the branch of the National Academy of

1 BY MR. ARIN:

2 Q Dr. Kain, have any articles been accepted
3 for publication in a journal that you have written
4 on the Donabedian Model?

5 A No.

6 And as I've indicated, I've practiced for
7 35 years based on the modernized model in multiple
8 roles, including the associate dean of Clinical
9 Operations and Safety, on a system that has
10 1200 beds, for example.

11 Or the acting chief medical officer of that
12 same system, or leading national initiatives.

13 MR. REINBOLD: I'm sorry. I need to
14 insert.

15 I object to the form of that question.

16 THE WITNESS: Sorry.

17 BY MR. ARIN:

18 Q The Donabedian Model requires consideration
19 of structure, process, and outcomes; correct?

20 A Correct.

21 Q And under the Donabedian Model, the
22 relationship between structure, process, and
23 outcomes is a causal one; correct?

24 MR. REINBOLD: Object to the form.

25 THE WITNESS: It is probabilistic.

1 BY MR. ARIN:

2 Q What do you mean by "probabilistic"?

3 A It means that there is an increased
4 probability that if you implement a clinical
5 warehouse model, for example, then it increases the
6 probability that your outcomes will improve because
7 many of the anesthesia outcomes are rare, and you
8 just don't know when they even occur.

9 And I will give you an example to perhaps
10 answer a few questions you'll ask me in a few
11 minutes.

12 In a typical private practice, you may have
13 10 or 15, 20 anesthesiologists practicing alone in
14 the rooms.

15 You may have an adverse event, such as
16 reintubation, which is the process where the tube
17 came out and you have to put the tube back in.

18 Because these individuals practice alone in
19 the rooms, and because those practices don't have
20 ways to measure this, they wouldn't even know that
21 as a practice they have a problem.

22 The role of the data warehouse now is to
23 aggregate that data. And now you see in that
24 structure that, oh, my God, in this practice for the
25 past year, we had 22 cases of reintubation.

1 The practitioners wouldn't know because
2 there are 50 of them.

3 And then that warehouse compares that to
4 the overall rate of NACOR, as an example.

5 And now that will lead to a process which
6 will fade if it exists, and unfortunately it doesn't
7 exist, but if it would exist, that will say we need
8 now to change the way we deliver care.

9 Specifically we'll apply a twitch monitor,
10 which is a monitor that measures, Does the patient's
11 NF [phonetic] have enough muscle strength in order
12 to not needing the tube after I took it out the
13 first time?

14 That process now will change the rate of
15 reintubations. And I think this is an example of
16 how the structure process outcome work together in a
17 circular way, which, again, in the original
18 Donabedian writings simply did not exist, because
19 he -- at that time there were no data warehouses.
20 And that's why his writing is more about distinct
21 domain rather than really A, B, C combined in a
22 circle.

23 Q So I want to turn to paragraph 18 of your
24 report.

25 Are you with me?

1 Dr. Donabedian.

2 And I would like to show you a document
3 that has been marked for identification as PX 4023,
4 and ask you to review it.

5 (Whereupon PX Exhibit 4023 was
6 marked for identification by the
7 Court Reporter.)

8 BY MR. ARIN:

9 Q I have handed a copy of PX 4023 to the
10 court reporter as well.

11 While you are reviewing the document, I
12 will read for the record what PX 4023 appears to be.

13 It appears to be an article written by
14 Dr. Avedis Donabedian in 1988, titled, "The quality
15 of care: How can it be assessed?"

16 Dr. Kain, do you recognize PX 4023?

17 A I may have seen it in the past.

18 Q What is PX 4023?

19 A Based on the writing, I see that it's an
20 article that was published on September 23rd, 1988,
21 about 40 years ago.

22 Q And you said that you may have seen it in
23 the past?

24 A Yeah.

25 Q Are you unsure whether you have seen it in

1 the past?

2 A I'm sure I have seen it in the past
3 35 years of my study in this area.

4 I don't typically go back to articles that
5 are 40 years old when I practice today. The world
6 has changed in the past 40 years.

7 Q So it is not your practice to rely on
8 articles that are 40 years old; is that correct?

9 MR. REINBOLD: Object to the form.

10 THE WITNESS: Generally speaking, I would
11 like to have some more contemporary evidence for
12 things that have worked since the world has moved in
13 the past 40 years.

14 BY MR. ARIN:

15 Q Could I direct your attention to page 7 of
16 your report -- excuse me, that's page 7 of PX 5504,
17 which is page 4 of your report.

18 A Yes.

19 Q And I would like you to look at the
20 footnote, Footnote Number 1.

21 A Sorry. One second.

22 Page?

23 MR. REINBOLD: The next page.

24 THE WITNESS: 4?

25 MR. REINBOLD: Uh-huh.

1 Q Did you rely on this article by
2 Dr. Donabedian in forming the opinions expressed in
3 your expert report?

4 A By this article directly? No.

5 Q You cited the article on page 4 of your
6 report; correct?

7 A Absolutely.

8 And it is -- it is a paradigm, and I cite
9 the paradigm here.

10 And obviously, as we've said before, this
11 is a 60-year-old paradigm.

12 So it is absolutely very useful as a
13 paradigm.

14 But 60 years ago, you did not have
15 dashboards, electronic health records, even
16 computers.

17 And so to say that I relied on this article
18 when I wrote this 40-page report on dashboard,
19 electronic health record systems, is a stretch.

20 Q Let's look at the second page of PX 4023.
21 That's back to the article that Dr. Donabedian
22 wrote.

23 Ah, excuse me.

24 Could you actually turn to -- I believe
25 it's actually the third page.

1 BY MR. ARIN:

2 Q Could you direct me to the page that you
3 were just reading from.

4 A Sure.

5 It's, in fact, the first page of the -- of
6 the press release.

7 Q And where in the AMA press release does it
8 attribute the shift towards larger entities with the
9 burden of quality reporting?

10 MR. REINBOLD: Object to the form.

11 THE WITNESS: Honestly, I don't know. I
12 have to look at it again. And I may or may not have
13 taken that part from -- directly from here. And
14 perhaps the reference should have been right after
15 the wording, "the shift."

16 I can't tell you.

17 And, again, I would -- I would advocate
18 that if you wanted citation for everything, I could
19 supply that to you. Just -- that's all I'm going to
20 say.

21 This report does not include everything I
22 know and does not include everything I've looked at.
23 And that's how I think it should be treated. I have
24 35 years of experience.

25 ///

1 BY MR. ARIN:

2 Q Your report is incomplete; correct?

3 MR. REINBOLD: Object to the form.

4 THE WITNESS: This report does not have all
5 the knowledge and expertise that I've acquired in
6 35 years.

7 This report is a response to another
8 report, plus an assessment. There's a lot more
9 knowledge and understanding from 35 years of leading
10 quality programs than is reflected in this report.

11 So, please, do not try and box me into just
12 that I know or I think only what's in this report.

13 BY MR. ARIN:

14 Q Dr. Kain, it's a fairly simple question, I
15 think.

16 Does the AMA press release attribute the
17 shift towards larger entities to the burden of
18 quality reporting anywhere?

19 A I -- I don't know.

20 MR. REINBOLD: Object to form.

21 THE WITNESS: I will have to look at it
22 specifically to tell you.

23 BY MR. ARIN:

24 Q You reviewed the press release and the
25 report just now --

1 system is, it's a logic that's built into the
2 medical record. And it looks at the databases that
3 it has, interprets the data that you get at that
4 moment, and immediately recommends an action which
5 is a process to improve outcome, which is, again --
6 and all that happens within 3 seconds.

7 And that is an example of a system today
8 that it really integrates all three of them
9 together.

10 And so, again, to say that today it's a
11 blank process, that is really just not accurate.

12 Q Dr. Kain, can you direct me where in your
13 report you talk about AI?

14 MR. REINBOLD: Object to the form.

15 THE WITNESS: I don't think I talked about
16 AI.

17 BY MR. ARIN:

18 Q Is that a new opinion that you are
19 offering?

20 MR. REINBOLD: Object to the form.

21 THE WITNESS: That is not an opinion. That
22 is a statement of my knowledge at the current time
23 about structure, process, and measure -- in fact,
24 structure, process, and outcomes. And I do think we
25 have discussed that the report is 40 pages long.

1 And I really hope there is no expectation that
2 anything I will tell you today was mentioned in the
3 report.

4 BY MR. ARIN:

5 Q In your structure assessment of USAP, do
6 you evaluate USAP's use of AI?

7 A No.

8 Q In paragraph -- I would like you now to
9 return to paragraph 33 of your report.

10 Paragraph 33 begins with, (as read and/or
11 reflected:)

12 Since 2020, USAP has invested
13 (conservatively) [REDACTED] in
14 quality-related initiatives
15 annually.

16 Do you see that?

17 A I do.

18 Q You only cite an interview with Dr. Dutton
19 for that figure; correct?

20 A That is correct as far as the citation. I
21 don't recall if we had another validation of the
22 number, but I may have had, yes. So ...

23 Q That interview occurred on September 17th,
24 2025; correct?

25 A If that's what you're saying, yes. I don't

1 remember.

2 Q If you look at Footnote 15 --

3 A Yes.

4 Q -- it states September 17th, 2025.

5 A Ah, perfect, yes.

6 Q Does that refresh your recollection of when
7 the interview occurred?

8 A Absolutely.

9 Q And the interview occurred on
10 September 17th, 2025; correct?

11 A That's what it says.

12 Q And September 17th, 2025, was two days
13 before you finalized your report; correct?

14 A Yes.

15 Q Did Dr. Dutton provide the [REDACTED]
16 estimate to you during that interview?

17 A I think so.

18 And while it's not cited, I think I had
19 another source of information for that through
20 another communication that I can't recall right now,
21 but he absolutely talked about that number, yes.

22 Q And the only source of information that you
23 cite is the interview with Dr. Dutton; correct?

24 A I do, yeah.

25 Q Was the interview on September 17th, 2025,

1 includes the academic material as well.

2 Q Will you offer any opinions based on the
3 CMS patient safety structural measures rule?

4 A The CMS practice -- the measure for
5 structural patient safety that has been introduced
6 in June 2025 by CMS asks is any material, guidelines
7 that CMS has issued or will issue on this topic, is
8 in the -- in my scope of offering opinion.

9 I will not limit my knowledge based on the
10 report, what I included or not in the report. As we
11 have indicated before, this is a 40-page report
12 only.

13 And if you ask my opinions and knowledge
14 about this topic, I could probably fill up
15 500 pages.

16 And so the report is really limited to my
17 assessment of USAP and is not limited to what --

18 THE REPORTER: Wait. I'm sorry. Is not
19 limited to what?

20 THE WITNESS: For example, modern
21 conceptual framework of the Donabedian Model is as
22 an example.

23 Are we done?

24 BY MR. ARIN:

25 Q No. I have a few more minutes remaining.