

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

CASE NO. 9:25-CV-80526-DMM

GOOD SAMARITAN MEDICAL
CENTER, INC., et al.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

**THE COMMUNITY HOSPITALS' OPPOSITION TO
LEAPFROG'S MOTION TO EXCLUDE
THE COMMUNITY HOSPITALS' EXPERT WITNESSES**

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INTRODUCTION

Plaintiffs, five community hospitals—Delray Medical Center, Good Samaritan Medical Center, Palm Beach Gardens Medical Center, St. Mary’s Medical Center, and West Boca Medical Center (the “Community Hospitals”)—challenge Defendant The Leapfrog Group’s (“Leapfrog”) “Hospital Safety Grades,” including Leapfrog’s undisputed practice of arbitrarily penalizing hospitals that do not participate in its 350+ page Hospital Survey and Leapfrog’s public representations about its Safety Grade methodology. The Community Hospitals have moved for summary judgment, *see* ECF 86, but should this case proceed to trial, they intend to offer three experts—Dr. Sean Nicholson, Dr. Jonah Berger, and Thomas Chakurda—to assist the Court in evaluating Leapfrog’s Safety Grade methodology, whether consumers understand that methodology, and the reputational and economic injuries the Community Hospitals have suffered due to Leapfrog’s conduct. Each of these experts is exceptionally well-qualified, and their opinions uniformly satisfy the admissibility requirements of Federal Rule of Evidence 702 and *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993). Leapfrog does not challenge these experts’ qualifications in their fields; instead, it focuses on isolated methodological quibbles that at most go to weight, not admissibility. The Court should deny in full Leapfrog’s motion to exclude the Community Hospitals’ experts (ECF 97 (“Mot.”)).

(1) Dr. Sean Nicholson (health economics expert). Dr. Nicholson is a Cornell Professor of Economics with an extensive background in researching and evaluating hospital quality grading methodologies. He offers four opinions about Leapfrog’s Safety Grade methodology: the methodology (1) significantly deviates from peer-reviewed principles for reliably measuring hospital quality (Nicholson Opinion One); (2) systematically deflates Safety Grades for hospitals that do not participate in Leapfrog’s Survey (Opinion Two); (3) does not generate Safety Grades that reliably predict hospital quality and safety (Opinion Three); and (4) inflicts reputational and economic injuries on hospitals that do not participate in Leapfrog’s Survey (Opinion Four).¹

Dr. Nicholson’s expertise in health economics and hospital grading methodologies—encompassing a Ph.D. in economics, authorship of more than 50 peer-reviewed articles, 16 years as a researcher at the National Bureau of Economic Research, 23 combined years as a hospital board member, and prior expert testimony in nearly 20 cases—makes him indisputably **qualified** under

¹ Leapfrog’s motion references only Dr. Nicholson’s Opinions One and Two. *See* Mot. 3, 17.

Rule 702 to offer opinions on Leapfrog’s Safety Grade methodology. His opinions are also **helpful** under Rule 702(a) because his specialized expertise will assist this Court in assessing that methodology, which lies at the heart of this case. And his opinions are **reliable** under Rule 702(b)–(d) because they are built on facts about the Safety Grade methodology, peer-reviewed literature and principles, and peer-reviewed methods. Those methods include a counterfactual analysis in which he sought to measure the extent to which non-participation in Leapfrog’s Survey impacts hospitals’ Safety Grades. Using a *conservative* approach, he found that the Community Hospitals’ Safety Grades would have been at least one or two letter grades higher had they participated in the Survey.

Notably, Leapfrog does not contest Dr. Nicholson’s qualifications, the relevance or helpfulness of his opinions, or the reliability of his Opinions One, Three, or Four. Leapfrog takes issue only with Dr. Nicholson’s counterfactual analysis, which is just one of three independent bases for his Opinion Two. Leapfrog’s sole argument is that the counterfactual analysis is “not tethered to the actual facts of this case,” Mot. 17, but that criticism ignores both the record and the purpose of the analysis. Dr. Nicholson’s approach is tied to undisputed evidence showing that most participating hospitals receive perfect—or near-perfect—scores on the Survey-related measures. Assigning the Community Hospitals the *average* scores received by participating hospitals on those measures was therefore a conservative way to isolate the impact of Leapfrog’s penalty scheme. That method also draws from peer-reviewed studies applying the same approach, and it is akin to *the Safety Grade methodology that Leapfrog itself employed before Fall 2024*—providing the Court with a reliable point of comparison to assess the effect of the Fall 2024 methodology change on the Community Hospitals’ Safety Grades.

Because Dr. Nicholson’s opinions reflect a helpful and reliable application of his formidable expertise to the facts of this case, they are admissible under Rule 702 and *Daubert*.

(2) Dr. Jonah Berger (consumer-behavior, consumer-psychology, and digital-marketing expert). Dr. Berger is a Professor of Marketing at the University of Pennsylvania’s Wharton School and one of the nation’s leading experts in the fields of consumer behavior, consumer psychology, and digital marketing. He offers four opinions: (1) Leapfrog’s Safety Grades likely negatively impact consumers’ perceptions of the Community Hospitals (Berger Opinion One); (2) the Safety Grades likely deter consumers from seeking care at the Community Hospitals (Opinion Two); (3) repeated publication of the Community Hospitals’ “D” and “F” Safety Grades will likely amplify these effects on consumers (Opinion Three); and (4) consumers are unlikely to understand

central aspects of Leapfrog’s Safety Grade methodology—namely, that hospitals opting out of Leapfrog’s Survey are automatically assigned the lowest possible scores on certain measures and that this part of the methodology lowers those hospitals’ Safety Grades (Opinion Four).²

Dr. Berger’s extensive background in consumer behavior, consumer psychology, and digital marketing, developed over more than 20 years—including a Ph.D. in marketing, a professorship at the Wharton School of Business, and authorship of more than 80 peer-reviewed articles in leading academic journals—makes him more than **qualified** under Rule 702 to offer opinions about how consumers are likely to respond to the Community Hospitals’ Safety Grades (and repeated dissemination of those Grades) and whether they are likely to understand Leapfrog’s complex online disclosures about those Grades. These are precisely the domains in which his scholarship and applied work have long focused, and they align directly with the issues the Court must evaluate. These opinions are **helpful** under Rule 702(a) because they illuminate two core issues: whether Leapfrog’s disclosures about its Safety Grade methodology mislead consumers and whether that deception aggrieves the Community Hospitals by harming how consumers perceive them. These opinions are **reliable** under Rule 702(b)–(d) because they are rooted in Dr. Berger’s impressive expertise, his application of specialized consumer-behavior principles from peer-reviewed literature, a detailed mapping of the disclosures on Leapfrog’s website, and his analysis of Leapfrog’s own Google Analytics data about how consumers interact with Leapfrog’s website.

Leapfrog’s main critiques are that Dr. Berger’s opinions are *too* sensible and that he did not muster enough support for these sound opinions across 73 pages of expert reports and 206 footnotes. But consumer reactions to hospital-safety information—particularly when presented through a layered, digital interface—are not intuitive. The factors that shape those reactions, including credence-good dynamics (*i.e.*, that hospital quality can be difficult for consumers to reliably assess), betrayal aversion (*i.e.*, that consumers are more likely to experience strong emotions

² Leapfrog frames Dr. Berger’s testimony as offering three opinions—combining his Opinions One and Two, *see* Mot. 3—but Dr. Berger’s report contains four main opinion headings, *see* Ex. 1 (Berger Rep.) at i–ii, and he testified that he is offering “four main opinions,” Ex. 3 (Berger) at 149:14–17. Separately, Exhibit B to Leapfrog’s motion, *see* ECF 97-2, contains the version of Dr. Berger’s August 7 report served on August 7. But the Community Hospitals served an updated version of that report on August 11, which added Bates numbers to certain citations for the parties’ convenience. Dr. Berger also submitted an August 21 supplemental report, which begins on the 88th page of Exhibit B to Leapfrog’s motion. To ensure maximum clarity in the record, the Community Hospitals have filed the updated version of Dr. Berger’s August 7 report (served on August 11) as Exhibit 1 to this opposition, and have filed his August 21 supplemental report as Exhibit 2 to this opposition.

when presented with negative information about a service they expect to be safe), the illusory truth effect (*i.e.*, that consumers are more likely to perceive information as accurate the more it is repeated), and online-engagement patterns (*e.g.*, that consumers are substantially less likely to view information on a website if they must scroll down to see it) are well-established behavioral mechanisms that warrant expert explanation. If Dr. Berger’s ultimate conclusions track common sense, that just confirms their reliability and helpfulness. The rigor comes not from the bottom-line intuition, but from the analytical path—applying dozens of peer-reviewed studies and synthesizing Leapfrog’s Google Analytics (website-traffic) data that a layperson could not parse without expertise. Those methods are also more than sufficient to lay a reliable foundation for Dr. Berger’s opinions, and he explained why those methods—which allowed him to assess consumer behavior and understanding on a large scale—were superior to the additional methods Leapfrog claims he should have used, such as surveys of individual consumers and analysis of patient-admission and revenue data. Because the Community Hospitals seek only injunctive and declaratory relief, Dr. Berger’s task is not to quantify damages but to explain the mechanisms through which failing Safety Grades predictably influence consumer perception and decision-making. His opinions fit that role exactly.

Dr. Berger’s expertise in consumer behavior, consumer psychology, and digital marketing ably supports his opinions, each of which will provide this Court with reliable and helpful insight into how consumers perceive the Community Hospitals’ failing Safety Grades and Leapfrog’s disclosures about its Safety Grade methodology. His testimony should be admitted.

(3) Thomas Chakurda (marketing and branding expert). Mr. Chakurda is an award-winning former hospital Chief Marketing Officer with 40 years of experience in the hospital-branding industry, including in the South Florida region. He offers two opinions: (1) a hospital’s brand is critical to its reputational and economic success (Chakurda Opinion One); and (2) hospitals that are assigned “D” and “F” Safety Grades experience harm to their brand (Opinion Two).

Mr. Chakurda’s long experience in the hospital-branding industry—including experience with the reputational impacts of Leapfrog’s Safety Grades—renders him **qualified** under Rule 702. His opinions are **helpful** under Rule 702(a) because they will assist the Court in evaluating the abundant factual evidence showing that the Community Hospitals have suffered reputational and economic harm because of their failing Safety Grades—indeed, that the scarlet letter of a “D” or “F” Safety Grade *itself* causes harm. And his opinions are **reliable** under Rule 702(b)–(d) because

they are the product of Mr. Chakurda reliably applying his extensive experience in the industry, and principles drawn from peer-reviewed literature, to the record evidence in the case.

Leapfrog does not (and cannot) dispute Mr. Chakurda's qualifications. Instead, it repackages the same two arguments levied against Dr. Berger: that Mr. Chakurda's opinions are "readily understood" (Mot. 7) and that Mr. Chakurda did not conduct supplemental analyses, such as consumer surveys, which would have only further bolstered his findings. These arguments fail for the same basic reasons they fail with respect to Dr. Berger. Mr. Chakurda's opinions are grounded in his 40 years of experience in hospital branding—expertise that far exceeds a layperson's understanding of the dynamics of a hospital's brand and the effects of hospital rating systems on that brand. That some conclusions may seem intuitive does not diminish their admissibility; the relevant question under Rule 702 is whether specialized knowledge will assist the Court, and the ways that brand-level messaging interacts with patient choice, physician referral patterns, and payer reimbursement practices are not within common lay experience. Additionally, case law makes clear that consumer surveys are not the only method, much less always the best method, that a marketing expert can deploy. Mr. Chakurda's methods—applying experience and peer-reviewed literature to the facts of this case—were more than sufficient to form reliable opinions.

Mr. Chakurda's vast and undisputed experience in hospital branding and marketing allowed him to form reliable opinions that will help shed light on the severe reputational and economic injuries the Community Hospitals have suffered as a result of Leapfrog's challenged conduct. His opinions satisfy the requirements for admissibility.

* * *

The Community Hospitals' experts should be permitted to testify at any trial in this case. They are highly qualified, offer opinions that match their fields of deep expertise, understand the facts of this case, opine on relevant issues, and apply reliable principles and methods. Their expertise will provide valuable insight into the factual testimony and evidence. Leapfrog's motion to exclude these experts should be denied in full.

LEGAL STANDARDS

"[T]he admissibility of expert testimony" is "govern[ed]" by "[t]he framework set forth in Federal Rule of Evidence 702 and *Daubert v. Merrell Dow Pharms., Inc.*, 509 U.S. 579 (1993)." *Wopshall v. Travelers Home & Marine Ins. Co.*, 2022 WL 16949015, at *2 (S.D. Fla. Sept. 6, 2022) (Middlebrooks, J.). Under this framework, expert testimony is admissible if "(1) the expert

is qualified to testify competently regarding the matters he intends to address; (2) the methodology by which the expert reaches his conclusions is sufficiently reliable; and (3) the testimony assists the trier of fact, through the application of scientific, technical, or specialized expertise, to understand the evidence or to determine a fact in issue.” *City of Tuscaloosa v. Harcros Chem., Inc.*, 158 F.3d 548, 562 (11th Cir. 1998). The Court thus assesses an expert’s “qualification[s], reliability, and helpfulness.” *United States v. Frazier*, 387 F.3d 1244, 1260 (11th Cir. 2004) (en banc).

Qualifications. A witness may be qualified as an expert by virtue of his “knowledge, skill, experience, training, or education.” *Quiet Tech. DC-8, Inc. v. Hurel-Dubois UK Ltd.*, 326 F.3d 1333, 1342 (11th Cir. 2003) (quoting Fed. R. Evid. 702).

Reliability. In assessing reliability, courts consider: “(1) whether the expert’s theory can be and has been tested; (2) whether the theory has been subjected to peer review and publication; (3) the known or potential rate of error of the particular scientific technique; and (4) whether the technique is generally accepted in the scientific community.” *Quiet Tech.*, 326 F.3d at 1341. The question is whether the expert’s opinion is “supported by appropriate validation” or “properly grounded, well-reasoned, and not speculative.” *Frazier*, 387 F.3d at 1261–62 (citations omitted).

To proffer a reliable opinion, an expert need not conduct “original research,” *Maiz v. Virani*, 253 F.3d 641, 665 (11th Cir. 2001), and may rely on the work of others “so long as the facts or data on which [the expert] rel[ies] [are] of the type reasonably relied on by experts in the relevant field,” *City of St. Petersburg v. Total Containment, Inc.*, 2009 WL 3335013, at *4 (S.D. Fla. Mar. 19, 2009). In evaluating reliability, “it is not the role of the district court to make ultimate conclusions as to the persuasiveness of the proffered evidence.” *Quiet Tech.*, 326 F.3d at 1341.

Helpfulness. An expert opinion is helpful if the expert’s “scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue.” Fed. R. Evid. 702(a). Because expert testimony “need only *assist* the trier of fact” to be helpful, it need not “prove the plaintiffs’ case.” *City of Tuscaloosa*, 158 F.3d at 564–65. Instead, helpfulness “goes primarily to relevance,” *Daubert*, 509 U.S. at 591, and it also concerns whether the testimony addresses “matters that are beyond the understanding of the average lay person,” *Frazier*, 387 F.3d at 1262.

ARGUMENT

- I. **Dr. Nicholson Is Undisputably Qualified To Opine On Leapfrog’s Safety Grade Methodology, And His Opinions About That Methodology Are Reliable And Helpful**
Leapfrog attempts to reduce Dr. Nicholson’s 43-page expert report and 196 pages of

deposition testimony to just two opinions, *see* Mot. 3, 17, but he intends to offer four opinions: (1) Leapfrog’s Safety Grade methodology is flawed because it deviates from foundational principles for measuring hospital quality (Opinion One), ECF 97-3 (Nicholson Rep.) ¶¶ 22–30, 39–57; (2) systematic biases in Leapfrog’s Safety Grade methodology inflate participating hospitals’ Safety Grades and deflate non-participating hospitals’ Safety Grades (Opinion Two), *id.* ¶¶ 58–68; (3) Leapfrog’s Safety Grades are not reliable predictors of actual patient health and safety outcomes (Opinion Three), *id.* ¶¶ 69–71; and (4) Leapfrog’s Safety Grades can harm patients and hospitals (Opinion Four), *id.* ¶¶ 31–38. Leapfrog’s motion makes no meaningful attempt to grapple with most of this work. It trains its *Daubert* challenge on a single basis for Opinion Two, leaving Dr. Nicholson’s remaining opinions—and the other independent bases for Opinion Two—effectively unchallenged.

A. Dr. Nicholson’s Qualifications Are Undisputed

There is no dispute that Dr. Nicholson is qualified to offer his opinions. He is an expert on assessing the merits and impact of hospital grading methodologies, and all his opinions here relate to Leapfrog’s Safety Grade methodology. *See, e.g., Maiz*, 253 F.3d at 665 (finding expert qualified where “[t]he subject matter of his testimony ... was sufficiently within his expertise”). Dr. Nicholson’s credentials speak for themselves. He holds a Ph.D. in economics, specializing in health economics; serves as a Professor in Cornell University’s Department of Economics; has been a research associate at the National Bureau of Economic Research for 16 years; has served for more than two decades combined on the boards of both individual hospitals and multi-hospital systems; served as the director of a Cornell graduate program in health administration for 9 years; worked as a management consultant before obtaining his Ph.D.; and has testified in nearly 20 federal and state cases. ECF 97-3 (Nicholson Rep.) ¶¶ 1, 4–15; *id.* app. A & B. He is also a prolific author, having published more than 50 peer-reviewed articles, “[m]any” of which have “examine[d] how to develop novel measures of the quality of medical care delivered by, or influenced by, different health care entities.” *Id.* ¶ 7. “[T]hrough” his roles and research, Dr. Nicholson has “developed extensive experience in health care quality measurement and improvement.” *Id.* ¶ 5.

These are the ideal qualifications for an expert who seeks to opine on a hospital grading methodology like Leapfrog’s. And Leapfrog nowhere disputes that Dr. Nicholson is qualified to opine on its Safety Grade methodology. *See* Mot. 17–19. In a case where the core dispute is how a private entity designs and applies a hospital “safety” rating system, there is no more fitting expert

than a health economist who has spent decades studying, building, and evaluating precisely these kinds of measures.

B. Leapfrog Also Does Not Challenge The Relevance And Helpfulness Of Dr. Nicholson's Opinions

Leapfrog similarly does not dispute that Dr. Nicholson's "specialized knowledge" regarding hospital grading methodologies "will help" this Court "to understand the evidence or to determine a fact in issue." Fed. R. Evid. 702(a). Dr. Nicholson's Opinions One, Two, and Three—which concern the pervasive flaws in Leapfrog's Safety Grade methodology—are all directly relevant to a key issue in this case: whether Leapfrog's Safety Grade methodology arbitrarily penalizes hospitals that do not participate in Leapfrog's Survey. ECF 86 at 8–15. Dr. Nicholson's expert opinions will help the Court assess the abundant evidence on this subject—including the testimony from Leapfrog's own witnesses *admitting* that the methodology imposes an arbitrary penalty on non-participating hospitals.³ Leapfrog does not argue otherwise. *See* Mot. 17–19.

Dr. Nicholson's Opinion Four—that Leapfrog's Safety Grades can harm patients and damage hospitals' admission rates and reputations—will also assist this Court. To obtain injunctive and declaratory relief under FDUTPA, the Community Hospitals must show that they were "aggrieved" by Leapfrog's conduct, *Ahearn v. Mayo Clinic*, 180 So. 3d 165, 171 (Fla. 1st DCA 2015)—for example, that Leapfrog's Safety Grades have caused "consumer confusion" that harms the Community Hospitals' reputations, *Wyndham Vacation Resorts, Inc. v. Timeshares Direct, Inc.*, 123 So. 3d 1149, 1152 (Fla. 5th DCA 2012); *see* ECF 41 at 8 (order denying Leapfrog's motion to dismiss) (recognizing that reputational harm satisfies FDUTPA's "aggrieved" requirement). Dr. Nicholson's opinion about the harms caused by Leapfrog's Safety Grades thus bears directly on the "aggrievement" element and will help the Court assess the record evidence on this issue, including testimony from the Community Hospitals' CEOs regarding the reputational and business harms their hospitals have suffered due to Leapfrog's conduct, *see* ECF 87 ¶¶ 56–60. Again, Leapfrog does not argue to the contrary. *See* Mot. 17–19.

In short, Dr. Nicholson is the Community Hospitals' indisputably qualified expert on hospital grading methodologies, and his opinions go straight to the heart of this case about Leapfrog's

³ *See, e.g.*, ECF 88-97 (Romano) at 142:12–22 ("purpose" of "assign[ing] a penalty to the nonresponding hospitals" "is not accuracy"); ECF 88-84 (Austin) at 298:9–20 ("there is a structural bias against ... nonreporting hospitals"); ECF 88-23 at 863–64 ("we're arbitrarily assigning them points").

Safety Grade methodology. His expert opinions are relevant and helpful.

C. Dr. Nicholson’s Opinions Are Grounded In The Facts Of This Case And Are Based On Reliable Principles And Methods

No doubt due to his on-point expertise and many hours devoted to studying this case and the pertinent academic literature, Dr. Nicholson’s opinions are well-supported and analytically rigorous. They are uniformly reliable under Rule 702(b)–(d). Leapfrog’s *Daubert* challenge therefore reduces to a narrow complaint about one component of one opinion—not a serious attack on the reliability of his work as a whole.

1. Opinion One: Dr. Nicholson’s Opinion That Leapfrog’s Methodology Is Fundamentally Flawed Is Based On Reliable Principles Drawn From Peer-Reviewed Literature

Dr. Nicholson’s Opinion One is that Leapfrog’s Safety Grade methodology “departs from” “guiding principles for measuring hospital quality.” ECF 97-3 (Nicholson Rep.) ¶ 51. This opinion is reliable because it is based on Dr. Nicholson’s application of those principles—drawn from peer-reviewed literature—to the facts of Leapfrog’s Safety Grade methodology. *See, e.g., Cardenas v. Toyota Motor Corp.*, 2022 WL 3370886, at *3 (S.D. Fla. Aug. 16, 2022) (expert testimony was reliable where it was based on “academic research” and the expert’s “own expertise and experience in the field”). And Dr. Nicholson’s report and testimony confirm he understood that methodology. *Contra* ECF 96 at 30–34 (explaining that Leapfrog’s putative methodology expert, Dr. Anthony Harris, relied on false assumptions about how the methodology works and how it was devised).

Dr. Nicholson grounded Opinion One in statistical principles derived from over 30 peer-reviewed articles that define standards for evaluating hospital safety and quality. *See* ECF 97-3 (Nicholson Rep.) ¶¶ 2, 22–30, 52, 54–61, app. C; Ex. 5 (Nicholson) at 29:17–30:10, 51:6–14, 62:21–63:6, 66:24–67:3, 73:18–74:9, 82:25–83:15, 86:1–6, 169:3–19. For example, hospital evaluators should: (i) collect and report data in a standardized format, ECF 97-3 (Nicholson Rep.) ¶¶ 25–26, 50; (ii) avoid making inferences when missing data, *id.* ¶ 53; and (iii) implement audits to ensure accuracy, *id.* ¶ 30. Applying these principles, Dr. Nicholson concluded that Leapfrog’s Safety Grade methodology falls short on each metric.

First, Dr. Nicholson concluded that Leapfrog’s Safety Grade methodology lacks standardization because it treats hospitals that *do not* participate in Leapfrog’s Survey differently than hospitals that *do* participate. ECF 97-3 (Nicholson Rep.) ¶¶ 43, 54, 61; Ex. 5 (Nicholson) at 39:3–16. In particular, for the 12 process measures that factor into the Safety Grade, hospitals that participate

in Leapfrog’s Survey receive scores based on the self-reported data they provide in response to the Survey. ECF 97-3 (Nicholson Rep.) ¶¶ 41, 43, 58–60. By contrast, for hospitals that do not participate in the Survey, Leapfrog follows a “two-step imputation” methodology for four of the process measures: Computerized Physician Order Entry (CPOE), Bar Code Medication Administration (BCMA), ICU Physician Staffing (IPS), and Hand Hygiene (collectively, the “Four Measures”). *Id.* ¶ 44. The “[f]irst” step is that Leapfrog will assign, for each of the Four Measures, “the same score as the [hospital’s] most recent available score on” the given measure, but only if the hospital has “historical [Survey] data from the last two rounds of [Safety Grades].” *Id.* But if a hospital does not have this historical data, Leapfrog proceeds to the second step, where it “assigns ‘a point value that is equivalent to receiving ‘Limited Achievement’ for th[e] [given] measure,’ which is the lowest possible score a hospital can receive” for a measure—corresponding to a value of 15 (out of 100) for CPOE; 25 for BCMA; 5 for IPS; and 15 for Hand Hygiene. *Id.* There are other differences as well for non-participating hospitals—for example, three of the other process measures are removed from the calculation entirely for those hospitals. *Id.* ¶ 43 & n.80.

Second, Dr. Nicholson determined that Leapfrog’s Safety Grade methodology fails to adhere to statistical principles governing missing data. “The statistics literature,” he explained, “has found” that “any ‘statistical analysis is likely to be biased when more than 10% of the data are missing.’” ECF 97-3 (Nicholson Rep.) ¶ 53 & n.108 (citation omitted). Yet, as just discussed, Leapfrog still assigns a Safety Grade even when it *has no data* from a hospital for the Four Measures, *id.* ¶ 44—measures that “account for 24% of the overall Hospital Safety Grade,” *id.* ¶ 50. In addition, as Dr. Nicholson explained, Leapfrog still assigns and publishes Safety Grades even though “approximately 23%” of graded hospitals do not participate in the Survey and thus do not report data to Leapfrog. *Id.* ¶ 53.

Third, Dr. Nicholson concluded that Leapfrog’s Safety Grade methodology flouts auditing best practices because Leapfrog “audits very few hospitals.” ECF 97-3 (Nicholson Rep.) ¶ 47. Dr. Nicholson relied on a 2019 study finding that Leapfrog formally audited only 5 of 2,600 graded hospitals and that only 72 of those hospitals underwent an “electronic audit.” *Id.* ¶ 47 & n.98 (citation omitted); *see* Ex. 5 (Nicholson) at 100:7–101:10. He also reviewed documents showing that Leapfrog still conducts (via a contractor) only “five or six audits per year.” Ex. 5 (Nicholson) at 100:15–18.

Leapfrog offers no challenge to Dr. Nicholson’s Opinion One, and for good reason: it is

based on accepted statistical principles and, in turn, his reliable application of those principles to undisputed features of Leapfrog's Safety Grade methodology and other record evidence.

2. Opinion Two: Dr. Nicholson's Opinion That Leapfrog's Safety Grade Methodology Is Systematically Biased Toward Participating Hospitals Is Rooted In Facts And Reliable Methods

Dr. Nicholson's Opinion Two is that Leapfrog's Safety Grade methodology is unreliable and systematically biased because it artificially inflates Safety Grades for hospitals that participate in Leapfrog's Survey and deflates Safety Grades for non-participants. ECF 97-3 (Nicholson Rep.) ¶¶ 58–68. This opinion is reliable because it rests on three independent foundations, each of which by itself satisfies Rule 702: (i) Dr. Nicholson's analysis of Leapfrog's own data; (ii) his analysis of published studies reaching the same conclusion that he did; and (iii) his counterfactual analysis that Leapfrog singularly targets. *See, e.g., Navelski v. Int'l Paper Co.*, 244 F. Supp. 3d 1275, 1290 (N.D. Fla. 2017) (expert's reliance on "empirical data" and "known science" rendered his opinion reliable).

Dr. Nicholson first reviewed Leapfrog's data. Most hospitals that participate in Leapfrog's Survey self-report the "best possible answer[s]" to the Survey and therefore receive *perfect scores* on the Four Measures and the three measures that are excluded for non-participating hospitals. Ex. 5 (Nicholson) at 132:1–22; *see id.* at 63:7–15, 150:3–151:3; ECF 97-3 (Nicholson Rep.) ¶ 59 & Ex. 2. Based on this "very unusual statistical distribution," Ex. 5 (Nicholson) at 194:16–195:11, Dr. Nicholson concluded that scores are inflated for hospitals that participate in Leapfrog's Survey, *id.* at 130:18–131:19. He also determined, from a review of other Leapfrog documents, that participating hospitals earn an average of 302 out of 400 total possible points on the Four Measures. ECF 97-3 (Nicholson Rep.) ¶ 44 & n.85. Conversely, hospitals that do not have Survey data from within the past year can "receive only 60 out of 400 possible points" on the Four Measures (15 for CPOE; 25 for BCMA; 5 for IPS; and 15 for Hand Hygiene). *Id.* ¶ 44. This 242-point discrepancy, Dr. Nicholson found, "can correspond to an average [Safety] [G]rade that is one letter worse for non-participating hospitals, relative to the average letter grade received by participating hospitals, even if both types of hospitals received identical scores across all other measures." *Id.*

Dr. Nicholson corroborated this independent analysis with past studies that have similarly documented Safety Grade deflation for hospitals that do not participate in Leapfrog's Survey. *See* ECF 97-3 (Nicholson Rep.) ¶¶ 59 & Ex. 1; *id.* ¶¶ 60, 64–65, 68. One of those past studies conducted a counterfactual analysis to determine the effect of Survey non-participation and found that

many hospitals would have received a “one- or two- letter grade improvement” had they participated. *Id.* ¶¶ 64–65. Building on that study, Dr. Nicholson conducted his own counterfactual analysis. *Id.* ¶ 66. Specifically, he re-calculated the Spring 2025 Safety Grades for all non-participating hospitals—including the Community Hospitals—by assigning them “the average score that participating hospitals gave themselves” “for each of the seven self-reported measures in the [S]urvey” (*i.e.*, the Four Measures, plus the three measures that are excluded for non-participating hospitals). *Id.* This was a deliberately conservative approach—assigning average values rather than the near-uniform perfect values that most participating hospitals actually report—making it more likely to understate, not overstate, the extent of the bias against non-participating hospitals. This analysis resulted in all five of the Community Hospitals receiving a Safety Grade of “C” instead of “D” or “F.” *Id.* ¶ 66 & Ex. 6. This analysis thus confirmed what was already evident from Leapfrog’s data and the prior studies: Leapfrog’s Safety Grade methodology systematically results in lower Safety Grades for non-participating hospitals *because* they do not participate in the Survey. Dr. Nicholson’s Opinion Two is therefore based on several mutually reinforcing analyses and entirely sound.

3. Opinion Three: Dr. Nicholson’s Opinion That Leapfrog’s Safety Grades Are Not Predictive Of Health Outcomes Is Based On Peer-Reviewed Studies And Empirical Analysis

Dr. Nicholson’s Opinion Three is that Leapfrog’s Safety Grade methodology does not reliably predict actual patient safety outcomes. ECF 97-3 (Nicholson Rep.) ¶¶ 69–71; *see* Ex. 5 (Nicholson) at 80:3–81:1. This opinion is based on Dr. Nicholson’s findings regarding the deficiencies in the methodology, *see* Ex. 5 (Nicholson) at 80:3–81:1; ECF 97-3 (Nicholson Rep.) ¶ 71, peer-reviewed literature analyzing “empirical evidence” bearing on this question, ECF 97-3 (Nicholson Rep.) ¶¶ 70–71, and his “own analysis” of data produced in this case, *id.* ¶ 70 n.154; *see, e.g., Melendez v. Dixon*, 2023 WL 4364457, at *9 (M.D. Fla. July 6, 2023) (allowing expert to offer opinions that were “informed by his own research” and the “extant literature in the field”). Prior studies have found, for example, “no statistically significant relationship” between Leapfrog’s Safety Grades and “the actual incidence of certain common infections in hospitals.” ECF 97-3 (Nicholson Rep.) ¶ 70; *see also id.* ¶ 70 Exs. 8 & 9. And Dr. Nicholson’s own analysis found that for “many of th[e] outcome measures” scored by Leapfrog—*i.e.*, the measures that assess actual safety outcomes rather than processes—“there are no statistically significant differences between hospitals assigned different [S]afety [G]rades.” *Id.* ¶ 70 n.154 (emphasis added). Opinion

Three thus rests on multiple reliable grounds, and Leapfrog does not contend otherwise. *See* Mot. 17–19.

4. Opinion Four: Dr. Nicholson’s Opinion That Leapfrog’s Safety Grades Can Harm Patients And Hospitals Is Based On Experience And Rigorous Analysis

Dr. Nicholson’s Opinion Four is that Leapfrog’s Safety Grades can harm both patients and hospitals alike by damaging the reputations and admission rates of hospitals with failing Safety Grades and incentivizing patients to seek care from hospitals that are not actually safer for patients. ECF 97-3 (Nicholson Rep.) ¶¶ 31–38. This opinion is reliable because it is rooted in Dr. Nicholson’s experience as a hospital board member, health economics studies, facts about how Leapfrog aggressively promotes its Safety Grades, and documents produced in this case. *See, e.g., In re Trasyol Prods. Liab. Litig.*, 2010 WL 1489738, at *3 (S.D. Fla. Mar. 3, 2010) (Middlebrooks, J.) (admitting expert testimony where the expert relied on his “substantial experience” and scientifically valid literature). For example, Dr. Nicholson analyzed studies finding that “patients pay attention to hospital ratings and these ratings affect where patients seek medical care.” ECF 97-3 (Nicholson Rep.) ¶ 32. Dr. Nicholson also evaluated the “evidence that [Leapfrog] promotes its [H]ospital [S]afety [G]rades as a reliable tool for patients to use in choosing their hospitals,” such as its (false and unfounded) claims that hospitals with failing Safety Grades “carry nearly twice the risk of mortality as A hospitals.” *Id.* ¶ 33 & n.50 (citation omitted). He also analyzed discovery showing that the Community Hospitals “have received reports from patients who have made hospital choices based on” Leapfrog’s Safety Grades. *Id.* ¶ 34 n.52. This and other evidence, he concluded, demonstrates that Leapfrog’s Safety Grades can have a “significant impact on which hospitals patients choose” and the “reputation[s]” of hospitals. *Id.* ¶¶ 34, 38. Opinion Four is well-supported and reliable, and again Leapfrog does not argue to the contrary. *See* Mot. 17–19.

D. Leapfrog’s Sole Argument For Excluding Dr. Nicholson—Contesting Just One Of Multiple Independent Bases For Only One Of His Four Opinions—Falls Well Short

Leapfrog disputes almost none of the above—it does not dispute Dr. Nicholson’s qualifications, does not contest the relevance of his opinions, does not suggest that his opinions are within a layperson’s understanding, and does not meaningfully challenge the reliability of his Opinions One, Three, or Four. *See* Mot 17–19. Instead, Leapfrog argues only that Dr. Nicholson’s Opinion Two—that Leapfrog’s Safety Grade methodology is systematically biased against non-participating hospitals—is unreliable because it is “not tethered to the actual facts of this case.” *Id.* at 17.

That narrow challenge cannot justify exclusion under Rule 702.⁴

As an initial matter, Leapfrog focuses exclusively on Dr. Nicholson’s counterfactual analysis, *see* Mot. 18–19, but that is just *one of three* independent bases for Opinion Two, *supra* at 11–12; *see, e.g., Seamon v. Remington Arms Co., LLC*, 813 F.3d 983, 989 (11th Cir. 2016) (district court “abused its discretion” in “excluding” expert testimony based on “mischaracteriz[ations]” of the expert’s “opinion and the evidence supporting it”). Dr. Nicholson also (i) analyzed Leapfrog’s own underlying data, which shows that participating hospitals overwhelmingly receive perfect scores on Survey-related measures, and (ii) relied on published studies reaching the same conclusion about systematic bias against non-participating hospitals. *See* ECF 97-3 (Nicholson Rep.) ¶¶ 44 & n.85, 59 & Exs. 1–2; *id.* ¶¶ 60, 64–65, 68. Leapfrog does not challenge either of these independent bases, each of which demonstrates systematic bias in Leapfrog’s Safety Grade methodology and refutes Leapfrog’s claim that Opinion Two lacks grounding in the record.

In any event, Dr. Nicholson’s counterfactual analysis is amply supported and grounded in the facts of the case. *Cf. Morris v. ADT Sec. Servs., Inc.*, 2009 WL 3334915, at *1 (S.D. Fla. July 27, 2009) (Middlebrooks, J.) (admitting expert opinion based on a “counterfactual” analysis). In particular, the counterfactual is a *conservative* approximation of the Safety Grades the Community Hospitals would have received in Spring 2025 under Leapfrog’s Safety Grade methodology had the Community Hospitals participated in Leapfrog’s Survey. The counterfactual thus uses Leapfrog’s current Safety Grade methodology as the baseline: under that methodology, participating hospitals receive scores on the Four Measures (and the three measures removed from the mix for non-participating hospitals) based on their responses to Leapfrog’s Survey. And data produced by Leapfrog *in this case* shows that most participating hospitals provide Survey responses that translate into perfect scores for those seven measures. ECF 97-3 (Nicholson Rep.) ¶ 59 & Ex. 2. Based on those facts, Dr. Nicholson adopted a deliberately “conservative” approach, in which he assigned the Community Hospitals only the “*average score[s]*” received by participating hospitals on the seven measures, not the near-uniform perfect scores that most of the participating hospitals actually receive. *Id.* ¶ 66 n.140 (emphasis added); *see* Ex. 5 (Nicholson) at 22:24–23:7, 156:9–21, 158:5–9, 170:13–21. This resulted in each of the Community Hospitals improving by one or two

⁴ Leapfrog asserts in passing that “the rest of Dr. Nicholson’s report and testimony” “is not tethered to the actual facts of this case,” Mot. 17, but addresses no aspect of Dr. Nicholson’s opinions other than his counterfactual analysis, *see id.* at 17–19.

letter grades, a finding that strongly supports the conclusion that those hospitals receive “D” and “F” Safety Grades simply because they choose not to participate in the Survey. Dr. Nicholson’s conservative analysis is thus tethered to the facts of this case—in particular, the facts showing that most participating hospitals receive perfect scores on the Survey-related measures, which *a fortiori* justifies his more conservative method of assigning the average scores.

That method is also peer-reviewed. A prior study that sought to answer the same question—whether non-participation in Leapfrog’s Survey materially affects Safety Grades—took the same approach, ECF 97-3 (Nicholson Rep.) ¶ 64, and using average values “is a common method of handling missing data” in the “academic statistics literature” more generally, *id.* ¶ 66 n.140. Notably, moreover, this method is similar to Leapfrog’s *own previous methodology for grading non-participating hospitals*: prior to Fall 2024, Leapfrog used mean scores when data was missing and specifically did so to reduce systematic bias against non-participating hospitals. Ex. 5 (Nicholson) at 56:13–57:7, 58:5–59:20, 82:25–83:15, 85:2–12. In short, multiple rationales support Dr. Nicholson’s counterfactual analysis.

Dr. Nicholson had good reason not to do a counterfactual analysis based on “how [the Community Hospitals] would have actually responded to” Leapfrog’s Survey. *Contra* Mot. 19.⁵ That was not the question his analysis was designed to answer. The purpose of Dr. Nicholson’s analysis was *not* to determine exactly what the Community Hospitals’ Safety Grades would have been had they participated in the Survey—indeed, he conducted his analysis for “all non-participating hospitals,” not just the Community Hospitals. ECF 97-3 (Nicholson Rep.) ¶ 66. Instead, the purpose was to measure whether Leapfrog’s Safety Grade methodology is systematically biased against non-participating hospitals, *see, e.g.*, Ex. 5 (Nicholson) at 27:1–10, because that is relevant to whether the methodology arbitrarily penalizes those hospitals, *see* ECF 86 at 8–15. His *conservative* approach—assigning average scores that were likely *lower* than what the Community Hospitals would have received based on actual Survey responses—amply demonstrated that the mere fact of non-participation lowers Safety Grades by at least one or two letter grades. Dr. Nicholson’s method was therefore precisely tailored to the question he sought to address.

⁵ It is ironic—and telling—for Leapfrog now to argue that *it is unreliable to calculate the Safety Grades without using actual data from hospitals*, given that the very basis for this suit is Leapfrog’s deceptive and unfair decision to assign failing Safety Grades to the Community Hospitals without having any data from those hospitals. Leapfrog’s insistence on actual data all but proves the merits of the Community Hospitals’ case. *See* ECF 86 at 8–15.

Regardless, “Rule 702 and *Daubert* do not require an expert to use the best method available” (though Dr. Nicholson did so), only that the method used “be relevant and reliable.” *Lary v. Bos. Sci. Corp.*, 2014 WL 7152769, at *15 (S.D. Fla. Dec. 15, 2014) (emphasis and citation omitted), *aff’d*, 633 F. App’x 781 (11th Cir. 2016). Accordingly, “the issue for a *Daubert* methodology challenge is not what it was *possible* for an expert to do, but rather what it was *reasonably necessary* for an expert to do in order for his opinions to be reliable.” *Rothschild v. Great N. Ins. Co.*, 2022 WL 11204272, at *8 (S.D. Fla. Oct. 18, 2022) (emphases added; citation omitted). Dr. Nicholson’s analysis was grounded in the record, rooted in peer-reviewed and generally accepted principles, similar to Leapfrog’s own prior methodology, and directly responsive to the question he was addressing. Under settled law, that is more than sufficient.⁶

Leapfrog also summarily asserts that Dr. Nicholson “ignore[d]” the Community Hospitals’ “one-star and two-star CMS ratings,” Mot. 19, but never explains why or how Dr. Nicholson should have accounted for those ratings in an analysis that sought to assess *Leapfrog’s* Safety Grade methodology—not CMS’s. CMS’s star-rating program is separate and distinct from Leapfrog’s Safety Grades, as Leapfrog’s own witnesses have conceded, and any testimony about those star ratings is irrelevant. *See* ECF 96 at 35–36. Leapfrog’s reference to the star ratings also confirms that it misunderstands the purpose of Dr. Nicholson’s counterfactual analysis—the goal was not to measure the Community Hospitals’ safety performance but instead whether Leapfrog’s Safety Grade methodology arbitrarily penalizes them for not participating in the Survey.

Notably, two of Leapfrog’s putative experts attempted to conduct counterfactual analyses of their own—yet neither analysis is rooted in Leapfrog’s actual scoring practices or generally accepted or peer-reviewed missing-data techniques. In particular, neither of their methods bears any resemblance to how Leapfrog has ever graded a hospital that participates in the Survey. Mark Rule excluded the Four Measures from the calculation and did not assign scores for the already-excluded three measures either (even though participating hospitals would receive scores for all

⁶ In Leapfrog’s cited cases, by contrast, the questions the experts addressed *did* require them to use “actual known factual data.” *Sheffield v. Int’l Paper Co.*, 2020 WL 1882906, at *2 (W.D. Tenn. Feb. 26, 2020); *see Laumann v. Nat’l Hockey League*, 117 F. Supp. 3d 299, 316–17 (S.D.N.Y. 2015) (reliance on “actual, readily-obtainable information” was “standard operating procedure” for experts in antitrust context). Leapfrog also cites *Kumho Tire Company v. Carmichael* for the generic proposition that an expert’s opinion must “assist” the trier of fact “in deciding the particular issues in the case.” 526 U.S. 137, 156 (1999) (citation omitted). As explained, Dr. Nicholson’s counterfactual analysis is closely tethered to the record and issues in this case.

seven of those measures). ECF 96-4 (Rule Rep.) at Exs. 6–10. Dr. Anthony Harris arbitrarily assigned the Community Hospitals scores corresponding to “Some Achievement” on the Four Measures (despite the data showing that most participating hospitals receive perfect scores on those measures) and did not assign any scores for the three measures (even though participating hospitals would receive scores for those measures). ECF 96-8 (Harris) at 255:8–256:12, 258:4–262:1, 324:7–325:9. That Leapfrog’s experts could not even *agree amongst themselves* on what counterfactual method was appropriate—and the fact that neither followed Leapfrog’s actual Safety Grade methodology—underscores the reliability of Dr. Nicholson’s approach and the infirmity of their methods. *See* ECF 96 at 27–30, 38–39.

II. Dr. Berger’s Opinions Are Tailored To His Considerable Expertise In Consumer Behavior And Consumer Psychology

The four opinions that Dr. Berger intends to offer at trial are grounded in his decades of expertise in consumer behavior, consumer psychology, and marketing; based on reliable principles and methods; and will assist the Court in evaluating the impact of the Safety Grades on consumer behavior and whether consumers accurately understand the Fall 2024 Safety Grade methodology. Leapfrog does not dispute Dr. Berger’s qualifications in his fields of expertise, and instead focuses its critique on the good sense of his bottom-line conclusions (which just *reinforces* why they are admissible) and other types of analyses he might have done (none of which Rule 702 requires, and none of which undercuts the reliability of the methods he *did* use). Dr. Berger is a qualified, reliable, and helpful expert. His testimony should be admitted.⁷

A. Opinions One, Two, And Three: Dr. Berger’s Opinions Regarding The Effects Of Leapfrog’s Safety Grades On Consumer Behavior Are Well-Supported And Will Help This Court Understand The Harms That Those Safety Grades Inflict

Dr. Berger’s first three opinions address how the Community Hospitals’ “D” and “F” Safety Grades influence consumers—here, patients and their caregivers. He opines that: these failing Safety Grades likely damage the Community Hospitals’ reputations among consumers (Opinion One), Ex. 1 (Berger Rep.) ¶¶ 20–27; Ex. 3 (Berger) at 40:8–22, 41:22–42:10; the failing Safety Grades likely deter consumers from choosing to receive care at the Community Hospitals (Opinion

⁷ As noted, *see supra* at 3 n.2, Leapfrog counts Dr. Berger’s four opinions as “three,” Mot. 3, by combining his Opinions One and Two, *see id.* Leapfrog’s discussion of Dr. Berger’s “first and second opinions,” *id.* at 10–16, thus corresponds to his Opinions One, Two, and Three, and Leapfrog’s discussion of Dr. Berger’s “third opinion,” *id.* at 16–17, corresponds to Dr. Berger’s Opinion Four.

Two), Ex. 1 (Berger Rep.) ¶¶ 28–54; Ex. 3 (Berger) at 40:15–22, 42:7–10; and the repeated publication and promotion of the failing Safety Grades would likely amplify the reputational harm over time (Opinion Three), Ex. 1 (Berger Rep.) ¶¶ 55–59; Ex. 3 (Berger) at 26:21–27:25, 155:5–11, 157:21–25, 167:10–19. These opinions are admissible, and Leapfrog’s contrary arguments fail to show valid grounds for exclusion under Rule 702.

1. Dr. Berger Is Well Qualified To Offer His Opinions One, Two, and Three, And Those Opinions Are Reliable And Helpful

Dr. Berger’s Opinions One, Two, and Three satisfy the requirements of Rule 702.

a. *Qualified (Rule 702).* Leapfrog does not and cannot dispute that Dr. Berger—a consumer-behavior and digital-marketing expert—is qualified to offer opinions that relate to how the Community Hospitals’ widely publicized “D” and “F” Grades are likely to affect consumer behavior. He is a tenured Professor of Marketing at the Wharton School of the University of Pennsylvania and holds a Ph.D. in marketing from Stanford University. Ex. 1 (Berger Rep.) ¶ 1; Ex. 3 (Berger) at 7:8–13. His research—which spans more than 20 years—focuses on how information design, repetition, and social influence shape consumer behavior, and he has published more than 80 academic articles on those topics. Ex. 1 (Berger Rep.) ¶¶ 2–4; Ex. 3 (Berger) at 7:13–16, 13:22–25, 40:15–22, 64:14–19. He has frequently applied this research in commercial contexts, including within the healthcare industry. Ex. 1 (Berger Rep.) ¶¶ 2–4; Ex. 3 (Berger) at 11:1–4. Given this deep well of expertise, it is unsurprising that Leapfrog does not challenge Dr. Berger’s qualifications with respect to Opinions One, Two, or Three. *See* Mot. 10–16. He is precisely the type of expert that courts admit to explain how consumers perceive, process, and act on complex or potentially misleading information.

b. *Reliable (Rule 702(b)–(d)).* These opinions are also reliable. Courts consistently recognize that expert opinions grounded in *either* peer-reviewed scholarship *or* empirical evaluation are reliable. *See, e.g., United States v. Hinestroza-Newbbooll*, 2022 WL 2678773, at *3 (11th Cir. July 12, 2022) (expert’s opinion was reliable where it was “supported by peer-reviewed studies”); *Navelski*, 244 F. Supp. 3d at 1290 (expert’s opinion was reliable where it relied on “empirical data”).

Here, Dr. Berger used both methods. *First*, “a good deal” of peer-reviewed “literature”—and numerous principles drawn from the literature—“support” his opinions that the Community Hospitals’ failing Safety Grades “are likely to” “both negatively impact consumer perceptions and deter consumers from choosing [those] hospitals.” Ex. 3 (Berger) at 130:17–22. He explained, for example, that healthcare is a “prototypical example of a ‘credence good,’” *i.e.*, a “good or service

whose quality can be difficult for consumers to reliably assess,” thus heightening the impact that easily digestible “heuristics”—like “D” or “F” Safety Grades—can have on consumer perceptions and choices. Ex. 1 (Berger Rep.) ¶¶ 20–40; *see* Ex. 3 (Berger) at 102:2–10, 117:4–118:17. He also invoked research regarding “betrayal aversion”—*i.e.*, the principle that consumers are likely to experience “strong negative emotions” when presented with information (*e.g.*, failing Safety Grades) suggesting that “a product or service [they] expect to be safe” presents a “*risk of harm*,” which leads consumers to “disregard” “positive” information about the service. Ex. 1 (Berger Rep.) ¶¶ 41–49; *see* Ex. 3 (Berger) at 200:7–201:19. Further, principles like the “illusory truth effect”—*i.e.*, “the tendency of repeated information to be perceived as more true”—make it likely that consumers’ negative perceptions of the Community Hospitals will solidify if their “D” and “F” Safety Grades continue to be publicized. Ex. 1 (Berger Rep.) ¶¶ 55–59; *see* Ex. 3 (Berger) at 167:10–168:25. *Second*, Dr. Berger corroborated all these conclusions with an empirical analysis of Leapfrog’s own Google Analytics data. The analysis showed dramatic spikes in visitor traffic to the Community Hospitals’ Safety Grade webpages following Leapfrog’s public release of the Fall 2024 and Spring 2025 Safety Grades, thus reinforcing that those Safety Grades and their continued publication are likely to have an outsized influence on consumers’ choices regarding hospital care. *See* Ex. 2 (Berger Supp. Rep.) ¶¶ 13–17.

In employing these two methods—applying peer-reviewed literature and analyzing data from this case—Dr. Berger exhibited “the same level of intellectual rigor that characterizes” his work as an undisputed expert in the consumer-behavior field. *Kumho Tire Co. v. Carmichael*, 526 U.S. 137, 152 (1999). The analysis he conducted was “similar to what [he] would do in [his] academic work,” which is “look[ing] to the literature” and then “analyz[ing] ... data.” Ex. 3 (Berger) at 43:18–22. Accordingly, these opinions are rooted in reliable principles and methods, and Leapfrog’s disagreement with his conclusions does not make those methods unreliable.

3. Helpful (Rule 702(a)). Dr. Berger’s Opinions One, Two, and Three are also helpful. The helpfulness requirement “goes primarily to relevance,” *Daubert*, 509 U.S. at 591, and these opinions are directly relevant to a core issue in the case: the “aggrieve[ment]” that the Community Hospitals have suffered due to Leapfrog’s conduct, ECF 86 at 15–17. Under FDUTPA, litigants seeking injunctive and declaratory relief must show they are aggrieved. Aggrievement in this context is an identifiable, non-speculative injury, *Ahearn*, 180 So. 3d at 173, and reputational and economic harm both qualify, *see, e.g., Wyndham*, 123 So. 3d at 1152; ECF 41 at 8. Dr. Berger’s

expert opinions about the likely effects of the Community Hospitals’ “D” and “F” Safety Grades—*i.e.*, causing consumers to hold the Community Hospitals in low regard and to avoid seeking care from those hospitals—are powerful evidence of reputational and economic harm. At bare minimum, those opinions “will help [this Court] to understand” the Community Hospitals’ abundant factual evidence regarding those harms. Fed. R. Evid. 702(a); *see* ECF 86 at 16–17.

Dr. Berger’s opinions also address “matters that are beyond the understanding of the average lay person.” *Frazier*, 387 F.3d at 1262. As detailed above, he applied specialized consumer-behavior principles to explain *why* and *how* Leapfrog’s Safety Grades and media campaigns influence consumer perception and choice. His testimony does not merely assert that “bad grades are bad for business”—he applies his considerable expertise to analyze the underlying behavioral mechanisms that make that true. Courts “regularly” find such expert analysis helpful. *Tershakovec v. Ford Motor Co.*, 2021 WL 2592390, at *10 (S.D. Fla. May 12, 2021) (“When an issue before the court pertains to the effect of a marketing or advertising campaign on a potential consumer, courts regularly permit expert testimony to aid the jury on the precise topic of marketing strategies.”), *report and recommendation adopted*, 2021 WL 3578011 (S.D. Fla. Aug. 13, 2021); *see also, e.g., Cardenas*, 2022 WL 3370886, at *3–4 (admitting expert opinions, in FDUTPA case, regarding “consumer behavior” and “consumer purchasing decisions”). In short, Dr. Berger’s Opinions One, Two, and Three reflect quintessential expert analysis that will help the Court understand the considerable harms posed by Leapfrog’s conduct.

2. Leapfrog’s Critiques Of Dr. Berger’s Opinions One, Two, And Three—That They Make Sense And That Additional Methods Might Have Further Corroborated His Conclusions—Only Confirm Their Admissibility

As noted, Leapfrog does not challenge Dr. Berger’s (extensive) qualifications to opine on how consumers are likely to respond to the Community Hospitals failing Safety Grades. Instead, Leapfrog argues that his Opinions One, Two, and Three are unhelpful because they reflect “common knowledge” and that those opinions are “not based on sufficient facts or data” because Dr. Berger did not deploy every conceivable analysis that might have bolstered his conclusions. Mot. 10–16. These are not valid grounds for excluding Dr. Berger’s specialized and well-supported testimony.

a. Opinions One, Two, and Three Are the Product of Specialized Expertise. Leapfrog contends that Dr. Berger’s first three opinions are unhelpful because the notion that “D” and “F”

Safety Grades “might negatively impact consumer perception” is “undoubtedly a matter of common knowledge.” Mot. 11. The Community Hospitals welcome Leapfrog’s tacit admission that the failing Safety Grades by their nature inflict reputational harm on the Community Hospitals, as this only confirms there is no genuine dispute of material fact that the Community Hospitals were aggrieved. *See* ECF 86 at 15–17. But if this case proceeds to trial, the Community Hospitals should be permitted to elicit testimony from expert witnesses who can speak to those harms.

If Dr. Berger’s bottom-line conclusions align with common sense, that is no reason to exclude them—it just underscores that his analysis is grounded in reality, not speculation. As courts have recognized, “scientific conclusions (and testimony)” “[o]bviously” “rely upon common sense and logic”—indeed, “a conclusion that is *not* based on common sense is likely inadmissible.” *Meyerson v. Walgreen Co.*, 2006 WL 5249740, at *6 n.2 (S.D. Fla. May 19, 2006) (emphasis added). Accordingly, “the mere fact that an expert uses common sense to reach a conclusion is not grounds to exclude the testimony.” *Id.* Instead, what distinguishes expert opinion from lay testimony is whether “[t]he logic” and “factual underpinnings” of the opinion lie beyond the understanding of a layperson. *Id.* For example, “it may be obvious that ‘bad things will happen if one runs an engine without oil,’” but “the time it takes to inflict damage and the precise nature of the damage is not common knowledge to the average citizen.” *Hyundai Motor Am. Corp. v. N. Am. Automotive Servs., Inc.*, 2021 WL 7082997, at *4 (S.D. Fla. Oct. 26, 2021) (Middlebrooks, J.). The same is true here: although a layperson might intuit that Leapfrog’s dissemination of the Community Hospitals’ failing Safety Grades likely harms those hospitals’ reputations and patient admissions, only an expert like Dr. Berger can explain how strongly and through what cognitive mechanisms those effects manifest. His opinions do just that.

The extensive peer-reviewed literature on which Dr. Berger relied—and the consumer-behavior concepts he derived from that literature, such as “credence goods” and “betrayal aversion”—confirm that his opinions are not built on lay concepts. *See supra* at 18–19. And Leapfrog does not suggest that a layperson could have conducted Dr. Berger’s Google Analytics analysis. His opinions on consumer behavior are the product of specialized expertise, not common knowledge.

That inescapable fact distinguishes the cases on which Leapfrog relies, which each involved opinions that did not rest on any specialized foundation. *See United States v. Castaneda*, 997 F.3d 1318, 1331 (11th Cir. 2021) (“not all communications on the internet are truthful”); *Cook*

ex rel. Est. of Tessier v. Sheriff of Monroe Cnty., Fla., 402 F.3d 1092, 1111–12 (11th Cir. 2005) (a county jail’s failure to prevent a suicide in custody resulted from inadequate suicide-prevention procedures; and “a correctional officer should read and respond to an inmate’s medical request”); *United States v. Rouco*, 765 F.2d 983, 995 (11th Cir. 1985) (criminal defendant “might have been confused or mistaken” as to the identity of an undercover officer; and “the average citizen might have expected” the undercover officer “to have acted differently in attempting” an arrest); *Dem-boske v. Autry Greer & Sons, Inc.*, 740 F. Supp. 3d 1172, 1180 (N.D. Fla. 2024) (“a tile floor with finish is slippery when wet” and “standing water makes a floor slippery”). The cited portion of Leapfrog’s other case is even further afield; there, the putative expert sought to offer “improper legal conclusions.” *Hyde Park Storage Suites Daytona, LLC v. Crown Park Storage Suites, LLC*, 631 F. Supp. 3d 1203, 1221 (M.D. Fla. 2022) (emphasis added).

Leapfrog’s attempt to label Dr. Berger’s consumer-behavior opinions as “obvious” and therefore inadmissible (Mot. 12) also has no discernible limiting principle. *All* adults are consumers, and thus naturally have strong intuitions about how they would respond to consumer-facing information. So, in virtually *every* case, a reliable consumer-behavior expert opinion is likely to align with the trier of fact’s common sense and intuition. Yet cases admitting these types of expert opinions abound. *See, e.g., Tershakovec*, 2021 WL 2592390, at *10. Dr. Berger’s opinions should likewise be admitted.

b. Opinions One, Two, and Three Are Based on Abundant Facts and Data. Taking a different (and contradictory) tack, Leapfrog next argues that Dr. Berger did not muster *enough* support for his supposedly obvious conclusions. Mot. 12–16. Leapfrog correctly observes that Dr. Berger’s first three opinions are directly relevant to FDUTPA’s “aggrievement” prong but claims he did not analyze “the best and most probative evidence” of aggrievement, which Leapfrog identifies as “empirical evidence of actual patient admissions and actual revenue.” *Id.* at 12 (emphases omitted). Leapfrog also broadly suggests that Dr. Berger should have engaged in several other analyses, including patient “survey[s],” interviews with “employees or officers of the [Community] Hospitals,” and analysis of “the impact of” of *other* hospital rating systems. *Id.* at 12–14. These critiques fail for several reasons.

To start, none of these arguments directly attacks the reliability of the methods that Dr. Berger *did* use to form Opinions One, Two, and Three. Dr. Berger applied consumer-behavior principles from peer-reviewed literature to facts about both Leapfrog’s Safety Grades and how Leapfrog

presents and publicizes those Safety Grades to consumers, and he backed up that qualitative analysis with an analysis of Leapfrog’s Google Analytics data. *Supra* at 19. Leapfrog does not dispute the reliability of the principles that Dr. Berger applied, does not suggest that Dr. Berger misunderstood any of the facts or data on which he relied, and does not contend that additional facts or data would have been necessary to the analyses he conducted. Notably, a study that Leapfrog itself promoted on its website—which analyzed letter grades “modeled directly after” Leapfrog’s Safety Grades, Ex. 3 (Berger) at 130:10–131:6—found that consumers choose higher-safety-rated hospitals “97%” of the time, Ex. 1 (Berger Rep.) ¶ 32 & nn.47–50 (emphasis added) (citing C. C. Duke, et al., *The Effects of Hospital Safety Scores, Total Price, Out-of-Pocket Cost, and Household Income on Consumers’ Self-Reported Choice of Hospitals*, 13 J. Patient Safety 192 (2017)); see Ex. 3 (Berger) at 41:22–42:10, 108:3–24, 129:17–130:9. All this alone is dispositive of the reliability of Opinions One, Two, and Three. See, e.g., *Frazier*, 387 F.3d at 1262 (expert testimony is reliable if “it is properly grounded, well-reasoned, and not speculative” (citation omitted)).⁸

Dr. Berger also repeatedly and credibly explained why his methods *were*, in fact, the “most appropriate” here. Ex. 3 (Berger) at 44:4–16; see *id.* at 41:22–42:10, 43:7–44:3, 58:7–22, 62:7–18, 93:23–94:10, 115:13–25. Drawing on his “decades’ worth of expertise in this space,” he found that the “decades’ worth of academic literature” addressing consumer behavior in similar contexts—including the study analyzing grades “directly modeled or designed after [Leapfrog’s] [H]ospital [Safety] [G]rades”—provided a fulsome answer to the questions posed. *Id.* at 41:22–42:10, 44:4–16, 58:7–22. He also explained that analyzing Leapfrog’s Google Analytics data—which showed him “what a large number of consumers actually did”—was preferable to surveying “individual consumer[s].” *Id.* at 43:7–44:3. Dr. Berger’s methods were comprehensive and led to sound conclusions.

Ignoring this testimony, Leapfrog suggests that Dr. Berger should have undertaken additional analyses (e.g., consumer surveys) because he and other consumer-behavior experts have previously done so in other contexts. Mot. 14. Relatedly, Leapfrog suggests that Dr. Berger should have analyzed data about the Community Hospitals (e.g., admission and revenue data) because he analyzed Leapfrog’s Google Analytics data. *Id.* at 15–16. But the variation in methods just

⁸ Leapfrog’s failure to challenge the reliability of Dr. Berger’s *actual* methodology renders *Banuchi v. City of Homestead*, 606 F. Supp. 3d 1262 (S.D. Fla. 2022), inapposite. *Contra* Mot. 13. *Banuchi* recognizes that trial courts must examine “the proffered expert’s methodology.” 606 F. Supp. 3d at 1269 (citation omitted).

reinforces Dr. Berger’s reliability—it confirms he has a deep understanding of what methods are available and which are most appropriate for the specific questions at hand, tailoring his approach instead of using a cookie-cutter approach. *See* Ex. 3 (Berger) at 62:7–18 (“I treat every case differently, analyzing the issues of the case and thinking about the available data.”); *id.* at 115:13–25 (similar). And Leapfrog’s complaint about the specific data Dr. Berger analyzed is a non-sequitur. Leapfrog’s Google Analytics data is especially pertinent to an opinion about consumer response to Leapfrog’s Safety Grades because that data shows visitor traffic *on the website that displays those Safety Grades to consumers*. There is no reason why Dr. Berger’s analysis of that data should have led him to analyze a completely different data set about the Community Hospitals’ admission rates and revenue—data that would at best tell only an indirect story about consumer perceptions and choices (much less the effects of *continued* publication of the Safety Grades in the future).

Leapfrog also resorts to mischaracterizing Dr. Berger’s testimony, which is another good reason to reject Leapfrog’s arguments. *See, e.g., Seamon*, 813 F.3d at 989 (“abus[e] [of] discretion” to exclude expert testimony based on “mischaracteriz[ations]” of “the evidence supporting it”). Leapfrog claims Dr. Berger “acknowledged” that “consumer surveys are likely the best method for assessing consumer conduct.” Mot. 16; *see also id.* at 14 (claiming Dr. Berger “acknowledged” that “consumer survey information is often the best data to answer relevant questions about consumer behavior” (citing Ex. 3 (Berger) at 77–78)). But Dr. Berger simply noted that consumer surveys can be the appropriate method “[i]n *some* cases.” Ex. 3 (Berger) at 77:9–78:13 (emphasis added). And he repeatedly explained why surveys were *not* “the best method to answer the questions asked here,” *id.* at 115:13–25—in particular, they would not have offered valuable insight into the perceptions and choices of a large number of consumers, *id.* at 43:7–44:3. Indeed, Leapfrog has created a hospital grading system designed to influence consumers at scale—that mission defeats its litigation position that the Community Hospitals and their experts must identify particular consumers that were influenced by the Safety Grades.

Dr. Berger also was not required to analyze any additional facts or data. “[A]ggrieve[ment]” under FDUTPA is an “expansive” concept, *Ahearn*, 180 So. 3d at 172, and it simply requires the plaintiff to show a non-speculative injury—for example, “consumer confusion about [the] [p]laintiff’s business, rates, and quality of service,” *Colonial Van Lines, Inc. v. Colonial Moving & Storage, LLC*, 2020 WL 6700449, at *4 (S.D. Fla. Oct. 20, 2020). This aggrievement need not be quantified. *See, e.g., Ahearn*, 180 So. 3d at 172–73. In addition, a plaintiff is not

required to show that the defendant’s conduct was the “*sole cause*” of its injuries. *Cox v. Adm’r U.S. Steel & Carnegie*, 17 F.3d 1386, 1399 (11th Cir. 1994) (emphasis added). The Community Hospitals—and their experts—are thus under no obligation to demonstrate that the Community Hospitals suffered any particular quantum of reputational damage or economic harm, nor are they required “to account and control for other factors that might influence the number of patients receiving treatment from the [Community] Hospitals.” Mot. 13; *contra id.* at 11–12.⁹ Dr. Berger’s opinions are perfectly tailored to the aggrievement element: he identified multiple non-speculative grounds to conclude that the Community Hospitals’ failing Safety Grades likely harm their reputations and patient admissions (and thus revenues), which is consistent with—and will help the Court evaluate—the copious factual evidence demonstrating that the Community Hospitals in fact suffered these harms. *See, e.g.*, ECF 87 ¶¶ 56–60 (collecting testimony from CEOs of all the Community Hospitals). No more was required for his opinion to be reliable or helpful. Accordingly, there is no “impermissible sword and shield conduct” going on here, *contra* Mot. 15; the Community Hospitals are simply offering the fact and expert evidence necessary to meet their burden and to address their central goal of stopping the ever-escalating reputational damage they are suffering from Leapfrog’s widespread dissemination of their failing Safety Grades.¹⁰

In all events, Rule 702 contains no “best ... evidence” requirement, *contra* Mot. 12, or “best method” requirement, *Lary*, 2014 WL 7152769, at *15 (emphasis and citation omitted); *see supra* at 16. For that reason, courts in this Circuit routinely reject the suggestion that consumer-behavior and marketing experts need to collect “direct evidence from consumers” for their opinions to be reliable. *Pandora Jewelers 1995, Inc. v. Pandora Jewelry, LLC*, 2011 WL 2295269, at *2 (S.D. Fla. June 8, 2011); *accord, e.g., Cardenas*, 2022 WL 3370886, at *2 (admitting, over a party’s objection, consumer-behavior expert in FDUTPA case that “did not do any of his own

⁹ To be sure, Dr. Berger made clear that, even if third-party rating systems “also impact[ed] consumer perceptions,” “that doesn’t change [his] opinion that [Leapfrog’s] [Safety] [G]rades” “likely impacted perceptions and hospital choice,” Ex. 3 (Berger) at 98:3–99:5, given “all th[e] data and academic literature” demonstrating that impact, *id.* at 112:2–113:3.

¹⁰ The facts of Leapfrog’s cited case—*BPI Sports, LLC v. ThermoLife Int’l LLC*, 2020 WL 10180911 (S.D. Fla. June 4, 2020)—were completely different. There, the defendants objected to discovery because the information was under the control of a nonparty and then again objected after the nonparty was subpoenaed, thereby using the nonparty “as a sword and a shield” to frustrate the litigation. *Id.* at *1–2. The Community Hospitals have done nothing of the sort here—they *waived* their damages claim with prejudice. ECF 54 at 2; ECF 66 at 4. And far from “stym[ying] discovery,” *BPI Sports, LLC*, 2020 WL 10180911, at *2, that waiver streamlined the discovery process and narrowed the issues in this case.

surveys, nor ... otherwise communicate with consumers”); *JHO Intellectual Prop. Holdings, LLC v. Ignite Int’l, Ltd.*, 2022 WL 1605339, at *5 (S.D. Fla. May 20, 2022) (admitting marketing expert that “did not interview customers, did not study consumer focus groups, [and] did not analyze the demographics of customers”); *cf. Maiz*, 253 F.3d at 665 (expert need not conduct “original research” for his testimony to satisfy Rule 702). At most, Leapfrog’s “disagreement[s] over the particular methodolog[ies] employed by” Dr. Berger “go to the weight, not the admissibility, of [his] expert testimony.” *SEC v. Complete Bus. Sols. Grp., Inc.*, 2021 WL 9098213, at *1 (S.D. Fla. Nov. 16, 2021). Dr. Berger’s Opinions One, Two, and Three should be admitted.

B. Opinion Four: Dr. Berger’s Opinion That Consumers Are Unlikely To Understand Core Features Of Leapfrog’s Safety Grade Methodology Is Rooted In Expertise And Appropriate Facts

Dr. Berger’s Opinion Four is that consumers are unlikely to understand central aspects of Leapfrog’s Safety Grade methodology—namely, that Leapfrog “assigns the minimum score” on the Four Measures and that this practice “lowers” the Safety Grades of hospitals that do not participate in Leapfrog’s Survey. Ex. 3 (Berger) at 50:22–52:5, 149:18–150:17; *see* Ex. 1 (Berger Rep.) ¶¶ 60–86; Ex. 2 (Berger Supp. Rep.) ¶¶ 7–12. Like his other opinions, this opinion fits squarely within Dr. Berger’s area of expertise; rests on reliable methods; and will help this Court understand key issues and evidence in the case. Indeed, because consumer misunderstanding is central to FDUTPA deception, Opinion Four goes directly to an issue the Court must resolve. Leapfrog’s counterarguments are insubstantial.

1. Dr. Berger Is Well Qualified To Offer Opinion Four And His Rigorous Analysis Of Leapfrog’s Website Is Reliable And Helpful

Dr. Berger’s Opinion Four meets the admissibility requirements of Rule 702.

a. *Qualified (Rule 702).* Dr. Berger’s undisputed qualifications in “consumer behavior,” “consumer psychology,” and “digital marketing” (Ex. 1 (Berger Rep.) ¶ 2) are perfectly aligned with his Opinion Four regarding how consumers perceive and understand disclosures about Leapfrog’s Safety Grade methodology on Leapfrog’s website. Indeed, his prior research in these areas has included “analyzing individuals’ interactions with websites.” Ex. 3 (Berger) at 64:2–19; *see, e.g.*, Ex. 1 (Berger Rep.) ¶ 82 n.157 (citing, *e.g.*, J. Berger & K. L. Milkman, *What Makes Online*

Content Viral?, 49 J. of Mktg. Rsch. 192 (2012)).¹¹ The suggestion that Dr. Berger must also be a “website design” expert, Mot. 16, misunderstands the nature of Opinion Four, which is about consumer perception—not coding or user-interface design.

b. Reliable (Rule 702(b)–(d)). Dr. Berger’s Opinion Four is also reliable. As with his first three opinions, he relied on *both* empirical analysis and peer-reviewed literature. He conducted a replicable process that combined qualitative mapping of Leapfrog’s consumer-facing website with quantitative review of Leapfrog’s own Google Analytics data. *See, e.g., Navelski*, 244 F. Supp. 3d at 1290 (expert’s reliance on “empirical data” and “known science” rendered his opinion reliable).

First, Dr. Berger mapped Leapfrog’s website, which revealed that the only location where Leapfrog fully discloses its Safety Grade methodology—including the decision to assign non-participating hospitals the lowest possible scores on the Four Measures—is page 16 of a 28-page document accessible only after multiple navigation steps. *See* Ex. 1 (Berger Rep.) ¶¶ 64–80 & Ex. 8; Ex. 3 (Berger) at 47:5–48:16, 50:22–52:5, 66:9–67:23, 121:18–122:24. The mapping also documented other parts of the website that contain inconsistent or incomplete disclosures about the methodology, such as an opaque footnote at the bottom of the webpage that displays a given hospital’s Safety Grade. Ex. 1 (Berger Rep.) ¶¶ 71, 80; Ex. 3 (Berger) at 66:9–68:11, 84:4–23. This exercise allowed Dr. Berger to define what steps a consumer would need to take to access the relevant information and what information consumers were likely to encounter. And he applied well-established principles from consumer-behavior literature in conducting his analysis—for example, he concluded that website users are “unlikely to read the footnote disclosure” because research shows that information placed “below-the-fold”—in this case, at the bottom of a webpage—is “less likely to be viewed” by users. Ex. 1 (Berger Rep.) ¶¶ 81–82; *see* Ex. 3 (Berger) at 50:22–52:5, 88:13–90:8.

Second, Dr. Berger analyzed Leapfrog’s Google Analytics data, which tracks what users actually do on Leapfrog’s website: which pages they visit, how much time they spend on each, and whether they download certain files. Using that data, Dr. Berger found that only about 3% of visitors to the Community Hospitals’ Safety Grade webpages downloaded Leapfrog’s 28-page

¹¹ Leapfrog suggests (without elaboration) that it was inappropriate for Dr. Berger to rely in part on peer-reviewed articles for which “he was an author or co-author.” Mot. 3. But his prior publications on the topics that relate to his opinions just confirm that he is qualified to offer those opinions. *See, e.g., Melendez*, 2023 WL 4364457, at *9 (allowing expert to offer opinions that were “informed by his own research”).

methodology document—which, as he noted, is likely to be an overestimate of how many people read the relevant disclosure on page 16 because “not everybody who downloaded the document necessarily got to page 16.” Ex. 3 (Berger) at 50:22–52:5, 47:5–48:16; Ex. 2 (Berger Supp. Rep.) ¶¶ 10–12. Dr. Berger also explained that these findings from the Google Analytics data align with literature showing that consumers are unlikely to read dense materials that can be accessed only through multiple navigation steps. *See* Ex. 1 (Berger Rep.) ¶¶ 83–84; Ex. 3 (Berger) at 70:19–71:12.

This analysis—mapping what consumers see and analyzing what they actually do—mirrors standard approaches in behavioral marketing research and thus meets Rule 702’s reliability threshold. As Dr. Berger testified, “[t]here is a good bit of academic research on data like Google Analytics,” including his own “research on analyzing individuals’ interactions with websites,” and such data “is quite appropriate to examine” in forming an opinion about consumer understanding. Ex. 3 (Berger) at 64:2–19. His methods thus reflect “the same level of intellectual rigor that characterizes the practice of an expert in [his] field.” *Kumho Tire*, 526 U.S. at 152.

c. Helpful (Rule 702(a)). Dr. Berger’s analysis of whether consumers are likely to understand Leapfrog’s disclosures about its Safety Grade methodology is directly relevant to the central issue here: whether Leapfrog’s presentation of that methodology is deceptive. *See* ECF 86 at 8–13. Dr. Berger’s analysis also will assist the Court because the complexity of Leapfrog’s website and disclosures, and the technical nature of its website-traffic data, lie far “beyond the understanding of the average lay person.” *Frazier*, 387 F.3d at 1262. Indeed, similar Google Analytics data confounded Leapfrog’s own putative expert, who misinterpreted it and thus withdrew his opinion concerning that data. ECF 96 at 14 (quoting ECF 96-10 (Vredenburg) at 302:18–303:7). Dr. Berger’s analysis, by contrast, translates that data into concrete, comprehensible findings about how ordinary consumers interact with Leapfrog’s website and why they are unlikely to uncover critical information about the Safety Grade methodology. Ex. 2 (Berger Supp. Rep.) ¶¶ 7–12. His testimony will therefore aid the Court in evaluating key issues.

2. Leapfrog’s Scattershot Attacks On Dr. Berger’s Opinion Four Lack Merit

In little more than one page of text, Leapfrog advances four critiques of Dr. Berger’s Opinion Four: (1) he lacks relevant expertise; (2) he did not offer any suggestions about how Leapfrog could design its website in a less deceptive fashion; (3) he did not further bolster his conclusions with consumer surveys; and (4) the Court does not need expert testimony about Leapfrog’s

website. Mot. 16–17. Each of these arguments fails.

a. Dr. Berger Does Not Need Expertise in Irrelevant Fields. Leapfrog summarily asserts that Dr. Berger “is not qualified to opine on the means by which consumers encounter, interact with, and understand websites” because he does not claim to be an expert in “website design” or “digital low literacy.” Mot. 16. This is misdirection. Dr. Berger’s *undisputed* expertise in fields such as consumer behavior, consumer psychology, and digital marketing is more than sufficient to qualify him to opine on whether consumers are likely to understand disclosures on a website. Dr. Berger’s prior research has specifically addressed consumer interactions with websites, *see supra* at 26–27, and he has “helped companies think about aspects of their websites and how those aspects interact with consumers and consumer behavior,” Ex. 3 (Berger) at 11:19–12:4; *see id.* at 13:17–14:1 (similar). Leapfrog’s argument makes little sense: a nationally renowned consumer-psychology expert—particularly in an era when consumers receive the vast majority of their information online—is exactly the type of expert who evaluates how consumers perceive and process website disclosures.

Dr. Berger’s Opinion Four does not depend on any expertise in “website design” or “digital low literacy” (the latter of which Leapfrog’s counsel defined as a subspecies of website design—“how websites should be designed in order to properly provide information to low literacy consumers”). Ex. 3 (Berger) at 14:2–15. His opinion is not about the design of Leapfrog’s website, but instead about Leapfrog’s *readers*—*i.e.*, whether those consumers would understand the website’s current disclosures. His expertise about how consumers think, behave, and respond to information is perfectly tailored to that opinion.

b. Dr. Berger Had No Obligation to Advise Leapfrog on Website Design. Relatedly, Leapfrog argues that Dr. Berger’s Opinion Four is “unhelpful” because he did not “offer an alternative” website design that could “disclose information in a way that consumers would understand.” Mot. 17. But the Community Hospitals’ burden under FDUTPA is to show that Leapfrog’s *current* website disclosures are deceptive. Dr. Berger’s Opinion Four—which demonstrates that consumers are unlikely to understand those disclosures—is directly relevant and helpful on that question. Dr. Berger was under no obligation to advise Leapfrog on how it could design its website to make it less deceptive, and it is highly puzzling that Leapfrog would expect its adversary’s expert to do that work for it—especially when none of Leapfrog’s own putative experts offered any such opinion.

c. Dr. Berger Did Not Need to Conduct Consumer Surveys. Leapfrog suggests that Dr. Berger’s Opinion Four is unreliable because he “never asked consumers” whether “they understand the website’s disclosures.” Mot. 16. But his Opinion Four is based on facts about the website itself and direct analytics of actual user behavior on the website. Dr. Berger carefully explained why this analysis was a “better” approach than reliance on consumer “focus group[s]” in this context. Ex. 3 (Berger) at 53:21–54:16. For one, asking consumers “whether they understand” the disclosures would be unreliable because “consumers may think they understand the information, but they may not actually.” *Id.* at 52:6–18. In addition, Dr. Berger determined that the 28-page document on the website was “the only place” where consumers could potentially gain a full “understanding” of Leapfrog’s Safety Grade methodology, *id.* at 52:6–21—a factual premise that Leapfrog does not dispute. Accordingly, by analyzing the “number of people that downloaded that document,” he necessarily obtained a “conservative estimate” of the number of consumers that could understand the methodology. *Id.* at 52:6–53:2; *see id.* at 53:3–65:24. Given the reliability of that method—which Leapfrog does not directly challenge—Dr. Berger had no obligation to undertake other “possible” methods that would have further corroborated Opinion Four. *Rothschild*, 2022 WL 11204272, at *8; *see supra* at 16.

d. Opinion Four Will Aid This Court in Assessing Consumer Understanding. Finally, Leapfrog suggests that, in the absence of consumer surveys, Dr. Berger’s analysis of “consumer understanding” is unhelpful because he “simply navigated the website himself and read the webpages.” Mot. 16–17. That mischaracterizes Dr. Berger’s analysis. *See, e.g., Seamon*, 813 F.3d at 989 (“abus[e] [of] discretion” to exclude expert testimony based on “mischaracteriz[ations]” of the expert’s “opinion and the evidence supporting it”). He did far more than navigate the website—he applied consumer-behavior principles to assess what users would likely encounter on that website and how they would process it, and he analyzed hard data about how users interact with the website. *See, e.g., Georgian v. Zodiac Grp., Inc.*, 2011 WL 13214041, at *3 (S.D. Fla. June 24, 2011) (marketing expert’s ability to “analyze ... data,” present it in a “coherent fashion,” and “extrapolate additional information from that data” would assist the trier of fact even though the expert used “publicly available tools,” such as “Google’s Keyword Tool and Traffic Estimator”). Certainly, this Court is capable of clicking through the website, but Dr. Berger’s analysis provides specialized insight into the average *consumer* perspective on that website. Leapfrog’s own admissions crystallize why this analysis is necessary and helpful—Leapfrog’s staff acknowledged in

internal communications that “the public may misinterpret the assigned measure scores” for the Four Measures. ECF 87 ¶ 33. Dr. Berger’s Opinion Four will provide expert insight into how and why this misinterpretation occurs.

Tellingly, one of Leapfrog’s *own* putative experts (Michael Vredenburgh) acknowledged that Dr. Berger’s methods were consistent with “best practices,” ECF 96-10 (Vredenburgh) at 243:11–245:17, and attempted to conduct a similar analysis of Leapfrog’s website. But Mr. Vredenburgh made a significant and conceded mathematical error in analyzing Google Analytics data, formed opinions that account for only a sliver of the website, and lacks expertise in consumer behavior. *See* ECF 96 at 11–15. Dr. Berger’s Opinion Four, by contrast, will provide the Court with empirical, data-driven insight into whether Leapfrog’s disclosures are effective in communicating essential information to consumers. This is exactly the type of specialized testimony that Rule 702(a) contemplates.

III. Mr. Chakurda’s 40 Years’-Worth Of Qualifications As A Marketing And Branding Expert Are Undisputed, And That Expertise Has Translated Into Reliable Opinions That Will Assist This Court In Evaluating The Severe Harms Caused By Leapfrog’s Safety Grades

Mr. Chakurda offers two opinions: that a “hospital’s brand—which is fostered and publicized by hospital marketing—is critical to a hospital’s reputational and economic success” (Opinion One), ECF 97-1 (Chakurda Rep.) ¶ 12; *see id.* ¶¶ 16–30; Ex. 4 (Chakurda) at 63:8–17; and that hospitals receiving “D” and “F” Leapfrog Safety Grades “experience reputational harm to their brand” (Opinion Two), ECF 97-1 (Chakurda Rep.) ¶ 13; *see id.* ¶¶ 31–55; Ex. 4 (Chakurda) at 24:7–25:1. These opinions are reliably “based on” Mr. Chakurda’s “almost 40 years of marketing experience and [his] impression of the impact that D or F [Safety Grades] would have on” the “brand” of the Community Hospitals, numerous “articles and studies,” and several documents and declarations produced in this litigation. Ex. 4 (Chakurda) at 26:13–25. These well-supported opinions will help this Court understand the aggrievement that the Community Hospitals have suffered as a result of Leapfrog’s Safety Grades.

Leapfrog does not challenge Mr. Chakurda’s qualifications to offer these opinions. Instead, Leapfrog’s arguments largely track the arguments it levies against Dr. Berger—in particular, that Mr. Chakurda’s opinions are *too* sensible, yet simultaneously are not based on *enough* sources and data. These arguments fail for largely the same reasons they fail with respect to Dr. Berger. Mr. Chakurda should be admitted as an expert witness.

A. Mr. Chakurda’s Qualifications Are Undisputed And His Opinions Are Reliable And Helpful

Mr. Chakurda’s opinions satisfy the requirements of Rule 702.

a. *Qualified (Rule 702).* Mr. Chakurda’s qualifications to opine on hospital branding—and the negative effects of Leapfrog’s Safety Grades on those brands—are formidable and undisputed. He has over four decades of experience in hospital marketing, branding, and communications. ECF 97-1 (Chakurda Rep.) ¶¶ 3–4; *id.* Ex. A (Chakurda CV); Ex. 4 (Chakurda) at 9:9–12:15. From 2019 to 2024, Mr. Chakurda served as the Chief Marketing and Communications Officer for a Pennsylvania health system, overseeing all communications and leading its branding initiatives. ECF 97-1 (Chakurda Rep.) ¶ 6; *id.* Ex. A at A-1; Ex. 4 (Chakurda) at 11:8–12:15. Previously, he spent a decade as Vice President for Marketing and Communications at Boca Raton Regional Hospital, where he managed all marketing functions and directed a rebranding effort that strengthened the hospital’s market position in South Florida. ECF 97-1 (Chakurda Rep.) ¶ 4; *id.* Ex. A at A-1; Ex. 4 (Chakurda) at 10:18–22. And before that, he spent more than two decades as Vice President for Communications for other hospitals and health systems. ECF 97-1 (Chakurda Rep.) Ex. A at A-1; Ex. 4 (Chakurda) at 15:9–24. All told, Mr. Chakurda spent nearly 40 years in the hospital marketing and branding business. In these roles, he constantly evaluated how hospital rating systems and press coverage about ratings affect patient volumes, referral patterns, and staff recruitment. ECF 97-1 (Chakurda Rep.) ¶¶ 4–7, 18–20, 25–30; *id.* Ex. A at A-1–A-2; Ex. 4 (Chakurda) at 38:15–23. In short, Mr. Chakurda is an expert’s expert on hospital brands, and Leapfrog does not argue otherwise. *See* Mot. 6–10.

b. *Reliable (Rule 702(b)–(d)).* Mr. Chakurda’s opinions are reliable because they are founded on his deep experience and other reliable sources and data. Experience is a valid basis for expert opinions where the expert describes “how his experience leads to the conclusion[s] he reached, why that experience provides a sufficient basis for the opinion[s], and how that experience is reliably applied to the facts.” *Clena Invs., Inc. v. XL Specialty Ins. Co.*, 280 F.R.D. 653 (S.D. Fla. 2012); *see also, e.g., SEC v. BankAtlantic Bancorp, Inc.*, 2013 WL 12009694, at *3 (S.D. Fla. Nov. 14, 2013) (an expert’s unchallenged “qualifications” “are a factor to take into consideration when assessing the reliability of [his] opinions”). Mr. Chakurda did all of that. His Opinion One—that a hospital’s brand is critical to a hospital’s economic success—is built on principles that flow directly from his 40 years of experience in the field: for example, that “[t]he healthcare industry is highly competitive” due to “market pressures” from “alternative providers” and “public and

private payers,” ECF 97-1 (Chakurda Rep.) ¶ 16; that “patients and caregivers” have become “more informed” “in recent years,” *id.* ¶ 23; that hospitals depend not just on direct patient admissions but also “refer[als]” from physicians, *id.* ¶¶ 25–27; that referral relationships and patient choice are influenced by reputation and perceived quality, *id.* ¶¶ 25–30; and that attracting doctors is an ongoing competitive process because they can “choose to obtain admitting privileges at more than one hospital,” *id.* ¶¶ 28–30. His Opinion Two—that failing Leapfrog Safety Grades harm a hospital’s brand—is likewise grounded in his experiences with hospital brands and Leapfrog’s Safety Grades specifically. *See, e.g., id.* ¶ 51 (“experience” shows that Leapfrog’s Safety Grades “reach referring physicians and impact the conversation between those physicians and their patients”); *id.* ¶ 45; Ex. 4 (Chakurda) at 13:16–21.

Mr. Chakurda also applied his decades of experience to the facts of this case. *See, e.g., BankAtlantic Bancorp, Inc.*, 2013 WL 12009694, at *3 (expert opinion was reliable where expert “applied” her “extensive experience” in the relevant field “to the factual record”). Mr. Chakurda reviewed, and his report cited, dozens of documents produced in discovery; he also repeatedly explained how the combination of that evidence and his experience led to his conclusions. For example, he reviewed the abundant evidence demonstrating that Leapfrog “vigorously” publicizes the Community Hospitals’ “D” and “F” Safety Grades on “public platforms,” Ex. 4 (Chakurda) at 68:24–69:20; *see id.* at 81:20–82:21 (“extremely ambitious campaign ... across all media outlets”), and documents produced by the Community Hospitals—including declarations from their CEOs—showing that the Community Hospitals were forced to “engag[e] in crisis management efforts to counteract statements about [their failing Safety Grades] in the media,” ECF 97-1 (Chakurda Rep.) ¶¶ 50–51 & nn.52–53. Mr. Chakurda also reviewed evidence of “reports that patients avoided [the Community] [H]ospitals following release of” their “D” and “F” Fall 2024 Safety Grades. *Id.* ¶ 51 & n.56. All this evidence “confirm[ed]” for Mr. Chakurda “that the reputation[s] of [the Community] [H]ospitals w[ere] impacted by [Leapfrog’s] ‘D’ and ‘F’ [Safety] [G]rades, consistent with [his] experience and general expectations in the healthcare industry.” *Id.* ¶ 50; *see id.* ¶ 51 (similar).

Finally, as Leapfrog’s own counsel recognized, Mr. Chakurda relied on a *third* source for his opinions: branding and marketing principles drawn from numerous peer-reviewed articles. *See* Ex. 4 (Chakurda) at 26:21–22 (“You cite to a lot of articles and studies in your opinion.”); *see also, e.g., Hinestroza-Newbbooll*, 2022 WL 2678773, at *3 (expert’s opinion was reliable where it was

“supported by peer-reviewed studies”). For example, he relied on articles demonstrating that hospital ratings influence patient choice, referrals, and staffing. ECF 97-1 (Chakurda Rep.) ¶¶ 34–36 & nn.17–18. He also relied on articles assessing principles like “negativity bias,” *i.e.*, the concept that “[t]he impact of” an “F” Safety Grade on a hospital’s brand “is going to last a lot longer than the positive impact of” an “A” Safety Grade. Ex. 4 (Chakurda) at 128:9–129:5. In short, through rigorous application of his 40 years of experience and this peer-reviewed literature to the record in this case, Mr. Chakurda formed opinions that are well-supported and reliable. *See, e.g., Cardenas*, 2022 WL 3370886, at *3 (admitting expert in FDUTPA case who “cite[d] and relie[d] upon academic research on consumer behavior in reaching his conclusions[,] [a]nd ... deploy[ed] his own expertise and experience in the field to apply the research”).

c. Helpful (Rule 702(a)). Mr. Chakurda’s opinions are directly relevant to the “aggrieve-ment” prong of FDUTPA, which—as explained—requires the Community Hospitals to show that Leapfrog’s conduct has caused them non-speculative harm, such as reputational and economic harms. *See supra* at 8, 19, 24; ECF 41 at 8. Mr. Chakurda’s opinions show both: his Opinion Two is evidence that Leapfrog’s Safety Grades have inflicted severe reputational harm on the Community Hospitals, and his Opinion One is evidence that this reputational harm translates to tangible economic harm. At minimum, these opinions—rooted in decades of experience and marketing principles—will help this Court understand and evaluate the same evidence that Mr. Chakurda reviewed regarding the far-reaching reputational impact of Leapfrog’s aggressive dissemination of hospitals’ failing Safety Grades. *See, e.g., ECF 97-1 (Chakurda Rep.)* ¶ 50 & nn.52–53. And because this is a bench trial, any questions about the weight of his testimony are for the Court alone to resolve—not a basis for exclusion under Rule 702.

B. Leapfrog’s Arguments For Exclusion Are Similar To Their Meritless Attacks On Dr. Berger’s Opinions And Fail For Similar Reasons

Leapfrog seeks exclusion of Mr. Chakurda’s testimony on three principal bases: (1) his opinions are not “material” to any issues in the case; (2) his opinions address “readily understood” concepts; and (3) he did not provide *enough* support for his supposedly easy-to-understand opinions. Mot. 6–10. These arguments fail. Each mischaracterizes what Mr. Chakurda did and ignores the governing Rule 702 standards.

1. Mr. Chakurda’s Opinions Are Relevant. Although Leapfrog recognizes that one “relevant issu[e]” in this case is “whether [the Community] Hospitals are ‘aggrieved’ by” their “D” and “F” Safety Grades, it asserts in conclusory fashion that Mr. Chakurda’s opinions “d[o] not

address” that issue or any of the other issues in the case. Mot. 7. But Mr. Chakurda’s opinions *are* directly relevant to aggrievement, and Leapfrog does not explain how they are not. This Court has already held that reputational harm satisfies FDUTPA’s “aggrieved” requirement, ECF 41 at 8; *see also, e.g., Wyndham*, 123 So. 3d at 1152, and economic harm qualifies as well, *see, e.g., Blue-green Vacations Unlimited, Inc. v. Timeshare Termination Team, LLC*, 2023 WL 4105529, at *8 (S.D. Fla. June 21, 2023) (“loss of contractual payments”). Mr. Chakurda’s opinions are about those very injuries: the reputational harm the Community Hospitals have suffered due to Leapfrog’s Safety Grades, and the economic harm they have incurred because of the damage to their brands. Those are precisely the types of non-speculative harms that FDUTPA requires the Court to evaluate. Mr. Chakurda’s opinions are highly relevant.

Leapfrog also accuses Mr. Chakurda of causing “confusion” by “conflat[ing] the issues.” Mot. 8. But Leapfrog’s only proffered example reveals that *Leapfrog* is eliding different issues. It points to the section of Mr. Chakurda’s report explaining that hospitals with “*positive* [Safety] [G]rades must expend money to fully *capitalize* on those [G]rades.” *Id.* Leapfrog asserts that this point “is wholly irrelevant to how [Leapfrog] calculates the [Safety] [G]rades or how [Leapfrog] discloses the [Safety Grade] methodology.” *Id.* But Mr. Chakurda is not opining about Leapfrog’s Safety Grade methodology or Leapfrog’s disclosures—the Community Hospitals’ other experts address those issues. Instead, as his report explained, the significant expenditures that hospitals make to promote positive Safety Grades underscore the importance of those Grades to a “hospital’s brand and patient utilization”—and conversely, the detrimental reputational impact of *failing* Safety Grades. ECF 97-1 (Chakurda Rep.) ¶¶ 44–45; *see* Ex. 4 (Chakurda) at 99:12–101:6. That goes to aggrievement. Moreover, Leapfrog says it “does not dispute” that hospitals with “positive” Safety Grades—including those in Florida—“have a variety of options for promoting” the Grade, including “options that require payment to [Leapfrog].” Mot. 8. The Community Hospitals welcome this admission, which confirms beyond dispute that Leapfrog operates in “trade or commerce” in Florida as required for a FDUTPA claim, ECF 86 at 15; *see generally* ECF 102 (not disputing this element), and further reinforces the importance of Safety Grades in the marketplace—underscoring why failing Safety Grades cause concrete harm.¹²

¹² Leapfrog also suggests (at 8) that Mr. Chakurda “creates the misleading impression that there is a significant cost to participate in [Leapfrog’s] [S]urvey” because he stated that “there is a general lack of harmony and standardization among the various third-party rating organizations, leading to additional expenditure

2. Mr. Chakurda Offers Specialized Expertise That Will Assist This Court. Recycling a similar argument levied against Dr. Berger, Leapfrog claims that Mr. Chakurda’s opinions are unhelpful because they reduce to “general, readily understood marketing concepts.” Mot. 7. The Community Hospitals are pleased to learn that Leapfrog accepts as “undisputed” that: (1) “negative” Leapfrog Safety Grades “are bad”; and (2) “some consumers might care about patient safety ratings when choosing a health care provider.” *Id.* at 7–8 (emphases omitted). This is yet additional confirmation that the Community Hospitals were indisputably aggrieved by their failing Safety Grades. *See* ECF 86 at 15–17; *supra* at 8, 19–21, 24–25.

But if this case proceeds to trial, the Community Hospitals should be permitted to put on experts who can testify to the reputational and economic harm that the Community Hospitals have suffered. Mr. Chakurda’s opinions cannot be excluded merely because they may be “readily understood,” Mot. 7—if anything, any alignment with “common sense” buttresses their admissibility. *Meyerson*, 2006 WL 5249740, at *6 n.2; *see supra* at 21. And an expert is certainly permitted to rely on concepts that are “well-known” within the expert’s industry (Mot. 7 (emphasis omitted))—indeed, that is normally the type of testimony that an expert with “experience in [an] industry” offers. *Reese v. CSX Transp., Inc.*, 2020 WL 5740253, at *9 (S.D. Ga. Sept. 24, 2020).

In any event, “*the facts underlying*” Mr. Chakurda’s opinions—and his “appl[ication]” of those facts to this case—undoubtedly exceed a “layman[’s]” “understand[ing].” *Meyerson*, 2006 WL 5249740, at *6 n.2. Mr. Chakurda’s opinions are grounded in 40 years of experience and his application of marketing principles drawn from peer-reviewed literature—far more than what a “school child” (or adult layperson) could understand (*contra* Mot. 7). Indeed, even if it were “obvious” that “bad things will happen” to hospitals that receive failing Safety Grades, only an experienced industry leader like Mr. Chakurda could reliably speak to “the precise nature” of those negative consequences and the mechanisms that bring them about. *Hyundai Motor Am. Corp.*, 2021 WL 7082997, at *4. For example, he describes in detail the tools through which Leapfrog amplifies publicity of the Safety Grades: press embargoes, coordinated media “pitches,” radio and

and effort.” ECF 97-1 (Chakurda Rep.) ¶ 37. But the un rebutted evidence in the record is that Leapfrog’s 350+ page Survey is burdensome. ECF 87 ¶ 6. Moreover, although Mr. Chakurda’s testimony does not “confus[e]” any issues, that argument is inapt insofar as Leapfrog is invoking Rule 403 at this motion *in limine* stage in advance of a bench trial (*cf.* Mot. 1). *See Mycko v. Sun*, 2015 WL 11197788, at *1 (S.D. Fla. May 26, 2015) (the “confuse the issues” “provisio[n]” of Rule 403 is “not applicable to bench trials” (citing *Gulf States Utils. Co. v. Ecodyne Corp.*, 635 F.2d 517, 519 (5th Cir. 1981))).

television packages, and social-media campaigns that generate hundreds of stories. ECF 97-1 (Chakurda Rep.) ¶¶ 47–49; Ex. 4 (Chakurda) at 34:17–25, 37:11–18. His opinions are highly probative evidence of the Community Hospitals’ reputational and economic injuries, and they will at minimum assist the Court in understanding the copious factual evidence that demonstrates those injuries.

To be sure, as Mr. Chakurda acknowledged, “[t]here is a significant aspect of marketing that is intuitive.” Ex. 4 (Chakurda) at 105:24–25. But courts routinely admit the testimony of marketing experts and benefit from their expertise. *See, e.g., JHO Intellectual Prop. Holdings, LLC*, 2022 WL 1605339, at *7–8 (deeming qualitative deductions by a marketing expert helpful). And not *all* aspects of marketing are intuitive—“[a]dvertising methodologies” are often “esoteric,” and experts in that field can “hel[p]” explain “how they work,” *Tershakovec*, 2021 WL 2592390, at *10, just as Mr. Chakurda explains how Leapfrog’s marketing campaigns work.¹³

3. Mr. Chakurda Did Not Need to Conduct Additional Analyses. Leapfrog also argues that Mr. Chakurda’s 40 years of experience in hospital branding “is insufficient to support a proper expert opinion,” Mot. 10, and that he should have conducted multiple additional studies to support his “easily understandable” conclusions—including “consumer surveys,” analysis of “data from the [Community] Hospitals in the form of patient testimony, patient data, and financial data,” and interviews with employees at the Community Hospitals, *id.* at 9.

Like Dr. Berger, Mr. Chakurda had no obligation to deploy all conceivable methods that might have further bolstered his opinions. It would have been more than sufficient for him to rely “solely” on his many decades of hospital-branding experience, which he “reliably applied to the facts” here. *Frazier*, 387 F.3d at 1261 (emphasis added; citation omitted); *see supra* at 32–33. In any event, he did not rely solely on that experience. He also applied well-established marketing principles from peer-reviewed literature and applied those principles to facts in the record, including evidence that patients have elected not to admit themselves to the Community Hospitals following the release of their “D” and “F” Safety Grades. *See* ECF 97-1 (Chakurda Rep.) ¶ 51 & n.56.

¹³ Leapfrog cites three cases (at 6–7) for general propositions regarding Rule 702(a)’s helpfulness requirement. The facts of those cases are distinguishable and their substantive analyses largely concerned *reliability*. One concerned an expert who strayed outside his area of expertise. *See Blue Chip All., LLC v. Chetu, Inc.*, 2025 WL 50391, at *11–12 (S.D. Fla. Jan. 8, 2025). Another was about an expert who “offered precious little in the way of a reliable foundation or basis for his opinion.” *Frazier*, 387 F.3d at 1265. And the third involved medical experts who offered scant basis for their opinions regarding the cause and severity of the plaintiff’s injury. *McDowell v. Brown*, 392 F.3d 1283, 1299–1302 (11th Cir. 2004).

This multi-faceted method—and Mr. Chakurda’s detailed report explaining that method—easily distinguishes Leapfrog’s cited case, in which the expert “d[id] *not* elaborate as to how [his] analysis was conducted, how his experience informed that analysis, [or] what steps he took to verify the results of his analysis.” *Umana-Fowler v. NCL (Bahamas) Ltd.*, 49 F. Supp. 3d 1120, 1123 (S.D. Fla. 2014) (emphasis added). Mr. Chakurda’s opinion is the opposite of “*ipse dixit*,” *id.*—it reflects a rigorous application of insights gleaned over a nearly 40-year career from one of the most well-regarded hospital Chief Marketing Officers in the country. *See* ECF 97-1 (Chakurda Rep.) ¶ 9 (“I ... have earned over 100 awards for excellence in marketing and communications, including two American Hospital Association Touchstones.”). Indeed, it is difficult to conceive of a more reliable basis for the opinions that Mr. Chakurda offers than his four decades of hands-on experience combined with his application of literature-based principles to undisputed facts.

In any event, as discussed, *see supra* at 16, 25, there is no “best method” requirement in Rule 702. *Lary*, 2014 WL 7152769, at *15 (emphasis and citation omitted). What matters is whether the expert did what “was reasonably necessary ... to do in order for his opinions to be reliable.” *Rothschild*, 2022 WL 11204272, at *8 (citation omitted). Mr. Chakurda’s experience- and principles-based approach clears this minimal hurdle. Because “aggravement” under FDUTPA requires no quantification of harm, *see supra* at 24, Mr. Chakurda did not need to analyze “financial data such as revenue and marketing budget.” Mot. 9–10.

Nor did Mr. Chakurda need to conduct “consumer surveys.” Mot. 9. As noted, *see supra* at 25–26, courts regularly hold that marketing experts need not collect “direct evidence from consumers,” *Pandora Jewelers 1995, Inc.*, 2011 WL 2295269, at *2, “interview customers,” *JHO Intellectual Prop. Holdings, LLC*, 2022 WL 1605339, at *5, or “perform [their] own testing,” *Cardenas*, 2022 WL 3370886, at *3. And Mr. Chakurda did not state that “conducting consumer surveys” is “the *only* methodology he is aware of for assessing a company’s brand.” *Contra* Mot. 9 (emphasis added) (citing Ex. 4 (Chakurda) at 18:21–19:4). He simply agreed that consumer surveys are *one* possible means of evaluating a hospital’s brand, *see* Ex. 4 (Chakurda) at 18:21–19:4, and identified several other methods, including the ones he deployed: his “almost 40 years of marketing experience” and his application of marketing principles derived from peer-reviewed literature, *id.* at 26:13–27:9. Mr. Chakurda’s methods were more than sufficient.

CONCLUSION

The Court should deny in full Leapfrog's motion to exclude the Community Hospitals' expert witnesses.

Dated: November 26, 2025

Respectfully submitted,

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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

CASE NO. 9:25-CV-80526-DMM

GOOD SAMARITAN MEDICAL
CENTER, INC., et al.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

**DECLARATION OF LEE R. CRAIN IN SUPPORT OF
THE COMMUNITY HOSPITALS' OPPOSITION TO
LEAPFROG'S MOTION TO EXCLUDE
THE COMMUNITY HOSPITALS' EXPERT WITNESSES**

I, Lee R. Crain, declare and state as follows:

1. I am a partner at the law firm of Gibson, Dunn & Crutcher LLP. I am an attorney and admitted to practice law in the State of New York. I have been granted permission by the Court to participate *pro hac vice* in this case. ECF 14. I represent the Community Hospitals in this matter and submit this declaration in support of the Community Hospitals' Opposition to Leapfrog's Motion to Exclude the Community Hospitals' Expert Witnesses (the "Opposition") filed contemporaneously herewith.

2. I am over the age of eighteen and make this declaration from personal knowledge based on the information and documents referenced in this declaration.

3. Attached as **Exhibit 1** is a true and correct copy of the report of Dr. Jonah Berger, one of the Community Hospitals' expert witnesses, dated August 7, 2025.¹

¹ Exhibit B to Leapfrog's Motion to Exclude the Community Hospitals' Expert Witnesses contains the version of Dr. Berger's report served on August 7. *See* ECF 97-2. But the Community Hospitals served an updated version of that report on August 11, which added Bates numbers to certain citations for the parties' convenience. To ensure maximum clarity in the record, the Community Hospitals attach the updated version of Dr. Berger's report served on August 11.

4. Attached as **Exhibit 2** is a true and correct copy of the supplemental report of Dr. Jonah Berger, dated August 21, 2025.²

5. Attached as **Exhibit 3** is a true and correct copy of the transcript of the deposition of Dr. Jonah Berger, taken in the above-captioned action on August 28, 2025.³

6. Attached as **Exhibit 4** is a true and correct copy of the transcript of the deposition of Thomas Chakurda, one of the Community Hospitals' expert witnesses, taken in the above-captioned action on September 2, 2025.

7. Attached as **Exhibit 5** is a true and correct copy of the transcript of the deposition of Dr. Sean Nicholson, one of the Community Hospitals' expert witnesses, taken in the above-captioned action on September 8, 2025.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on November 26, 2025, in New York, New York.



Lee R. Crain

² Dr. Berger also submitted an August 21 supplemental report, which begins on the 88th page of Exhibit B to Leapfrog's Motion. *See* ECF 97-2 at 88. To ensure maximum clarity in the record, the Community Hospitals attach Dr. Berger's August 21 supplemental report.

³ Exhibits 3, 4, and 5 contain red boxes around the cited transcript portions that have been added for the convenience of the Court.

Exhibit 1

**UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION**

GOOD SAMARITAN MEDICAL CENTER
INC., DELRAY MEDICAL CENTER, INC.,
PALM BEACH GARDENS COMMUNITY
HOSPITAL, INC. D/B/A PALM BEACH
GARDENS MEDICAL CENTER, ST.
MARY'S MEDICAL CENTER, INC., AND
WEST BOCA MEDICAL CENTER, INC.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

Case No. 9:25-CV-80526

Expert Report of Jonah Berger, Ph.D.

August 7, 2025

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I. Qualifications

1. My name is Jonah Berger. I am a Marketing professor at the Wharton School at the University of Pennsylvania. I received my Ph.D. in Marketing from the Graduate School of Business at Stanford University and my B.A. in Human Judgment and Decision Making, also from Stanford University.

2. My research focuses on consumer behavior, digital marketing, social influence, and technology. I have spent over 20 years studying how consumers make purchase decisions and how firms communicate with and influence consumers. I have published over 75 peer-reviewed articles in top-tier academic journals in marketing, consumer psychology, and other disciplines, including in the *Journal of Marketing Research*, *Journal of Consumer Research*, *Journal of Marketing*, *Marketing Science*, *Journal of Advertising*, and *Journal of Consumer Psychology*. I have also written four best-selling books that have been printed in dozens of different languages. In addition, I have served as an Associate Editor at the *Journal of Marketing* and *Journal of Marketing Research*.

3. I have received numerous awards for my research and writing. In 2014, I received the American Marketing Association's Leonard L. Berry Marketing Book Award, which is given for a book that has had a significant impact in marketing and related sub-fields. In 2015, I was a finalist for the best article published in 2012 in the *Journal of Consumer Research*. In 2017, I received the *Journal of Marketing*'s William F. O'Dell Award for the article that made the most significant, long-term contribution to marketing theory, methodology, and/or practice. I was recognized by the American Marketing Association as a top ten most productive researcher in marketing every year from 2013 to 2024 (the most recent year of the award). In 2023, I received the Sage 10-Year Impact Award, which recognizes articles published in Sage journals with lasting influence in the decade since their publication. In 2024, I was a finalist for the Shelby D. Hunt/Harold H. Maynard Award, which recognizes scholars for significant contributions to marketing theory and thought. In 2025, I received the Sheth Foundation Award for the article published in the *Journal of Marketing* that has made long-term contributions to the field of

marketing. The American Management Association named me one of the top 30 leaders in business and *Fast Company* magazine named me one of the most creative people in business.

4. In addition to my research, I have extensive experience teaching and consulting on these topics. I have won numerous teaching awards from the Wharton School, where I have taught the core graduate marketing curriculum, and have consulted with hundreds of firms (including hospitals) on topics such as consumer behavior, digital marketing, go-to-market strategy, branding, word of mouth, and helping products and ideas catch on. As part of my consulting work, I have helped design and develop grading systems.

5. A complete list of my publications and other academic and professional experience is in my curriculum vitae, which is attached to this report as **Appendix A**. A list of my testimony in the last four years is attached as **Appendix B**.

II. Case Background and Allegations

6. Defendant, The Leapfrog Group (“TLG”), is a not-for-profit organization that evaluates hospital performance by collecting self-reported data in a voluntary survey that TLG administers to hospitals.¹ TLG combines its survey data and other data sources to assign its “Hospital Safety Grades” to hospitals biannually, which purport to represent in a single letter grade how well a hospital keeps patients safe from preventable harm and medical errors.² I understand that TLG communicates the Hospital Safety Grades it assigns to hospitals to the general public through press releases, media communications, and its consumer-facing website, www.hospitalsafetygrade.org, and also markets and references the grades on its other website, www.leapfroggroup.org, among other avenues.³

¹ See, e.g., “About Leapfrog Group”, *The Leapfrog Group*, <https://www.leapfroggroup.org/about>, PBHN000003152–4.

² See, e.g., Motion to Dismiss, Exhibit 4, p. 2 (citing “About the Grade”, *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/about-the-grade>), PBHN000002619–25.

³ Complaint and Demand for Jury Trial, *Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group*, United States District Court for the Southern District of Florida, West Palm Beach Division, Case No.: 9:25-cv-80526, April 30, 2025 (“Complaint”), ¶ 1. See also “Leapfrog’s Spring 2025 Safety Grades Are In — New Trend Data Shows One in Eight Hospitals Sustained an ‘A’ for More Than Two Years,” *The Leapfrog Group*, May 1, 2025, <https://www.leapfroggroup.org/news-events/leapfrog%E2%80%99s-spring-2025-safety-grades-are-%E2%80%94-new-trend-data-shows-one-eight-hospitals>, PBHN000002523–4; “Press Resources: Spring 2025 Leapfrog Hospital Safety Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/for-press>, PBHN000004113–5.

7. For each hospital it rates, TLG reports both an overall letter grade and numeric scores on individual “measures” (e.g., “Patient falls and injuries”) underlying the letter grade.⁴ Scores for some measures rely solely on hospitals’ self-reported data from TLG’s survey. When a hospital chooses not to participate in TLG’s survey, TLG uses an “imputation model” to assign scores to the hospital for four such measures (i.e., “Handwashing,” “Doctors order medications through a computer,” “Safe medication administration,” and “Specifically trained doctors care for ICU patients”).⁵ Throughout this report, I will refer to these four measures collectively as the “imputed measures.”

8. Five hospitals in Florida—Good Samaritan Medical Center, Inc., Delray Medical Center, Inc., Palm Beach Gardens Medical Center, St. Mary’s Medical Center, Inc., and West Boca Medical Center, Inc. (collectively “Plaintiffs” or “Plaintiff Hospitals”)—allege that, in Fall 2024, TLG changed its scoring methodology such that “any hospital declining to provide data [by declining to participate in TLG’s survey] would automatically fail” on the imputed measures.⁶

9. Specifically, prior to Fall 2024, Plaintiffs allege that TLG’s “imputation model” assigned non-participating hospitals “a score based on the average score applicable to similarly situated hospitals.”⁷ In Fall 2024, however, Plaintiffs allege that TLG modified its “imputation model” to instead “assign[] the lowest possible score to non-participating hospitals” (which I understand TLG refers to as a score reflecting “Limited Achievement”).⁸ I will refer to the practice of

⁴ See, e.g., Motion to Dismiss, Exhibit 28 (citing “Good Samaritan Medical Center,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/good-samaritan-medical-center>), PBHN000002641–3.

⁵ The listed names are the names of the measures that appear on TLG’s Hospital Safety Grade Pages. Plaintiffs refer to these four measures as “Computerized Order Entry (‘CPOE’), Bar Code Medication Administration (‘BCMA’), ICU Physician Staffing (‘IPS’), and Hand Hygiene Score” in their Complaint. As background, TLG relies on self-reported data for 12 of 22 measures to determine an overall letter grade. When a hospital does not participate in TLG’s survey, three measures are dropped, five measures use government data as a substitute, and the four remaining measures are assigned values through TLG’s imputation model. Complaint, ¶¶ 48–51. See also “Scoring Methodology: Fall 2024 Safety Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/media/file/Safety-Grade-Scoring-Methodology-Fall-2024.pdf> (“Fall 2024 ‘Scoring Methodology’”), pp. 5–8, PBHN000003044–69; “Scoring Methodology: Spring 2025 Safety Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/media/file/Methodology-Spring-2025.pdf> (“Methodology Document”), pp. 4–8, PBHN000003012–40. I understand identical copies of the Methodology Document exist at <https://www.hospitalsafetygrade.org/media/file/Methodology-Spring-2025-1.pdf> and <https://www.hospitalsafetygrade.org/media/file/Methodology-Spring-2025-2.pdf>.

⁶ Complaint, ¶¶ 3, 9–13.

⁷ Complaint, ¶ 50.

⁸ Complaint, ¶ 50 (“Beginning in Fall 2024, however, TLG modified its imputation model. It now assigns the lowest possible score to non-participating hospitals.”), ¶ 52 (“For the four imputed measures (CPOE, BCMA, IPS, and Hand Hygiene), if a hospital does not participate in TLG’s survey, TLG assigns ‘a point value that is equivalent to receiving ‘Limited Achievement’ for this measure’—its lowest possible score—without any factual basis. The result is that hospitals who elect not to participate in TLG’s survey receive only 60 out of 400 possible points in these four categories—resulting in artificially deflated overall grades with no basis in fact and no correlation to a hospital’s actual safety performance.”).

assigning the minimum score on the imputed measures as TLG's "imputation methodology." I understand that TLG purports to disclose the imputation methodology in notes and documentation on hospitalsafetygrade.org and leapfroggroup.org (together "TLG's websites"), which I will refer to as TLG's "imputation disclosures."⁹

10. According to the Plaintiffs, as a result of the change, Plaintiff Hospitals received "Ds and Fs ... for the first time."¹⁰ Specifically, TLG assigned the following grades for Plaintiff Hospitals in Fall 2024 and Spring 2025, respectively, and marketed and disseminated this information, including via its websites:¹¹

- Good Samaritan Medical Center: F, D
- Delray Medical Center: F, F
- Palm Beach Gardens Medical Center: F, F
- St. Mary's Medical Center: D, D
- West Boca Medical Center: D, F

11. Plaintiffs allege that TLG "deceives consumers by inventing negative data" about non-participating hospitals and fails to adequately disclose that its "D" or "F" Hospital Safety Grades for Plaintiff Hospitals are the result of the hospitals' decisions to not to respond to TLG's survey, not their actual performance on safety.¹² Plaintiffs further allege that TLG's Hospital Safety Grades have caused "severe, ongoing, and irreparable harm to Plaintiffs," including "harm to their

⁹ Defendant the Leapfrog Group's Motion to Dismiss Pursuant to Federal Rule of Civil Procedure 12(b)(2) And 12(b)(6) and Incorporated Memorandum of Law in Support of the Same, *Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group*, United States District Court for the Southern District of Florida, West Palm Beach Division, Case No.: 9:25-cv-80526-DMM, June 27, 2025 ("Motion to Dismiss"), pp. 8–9.

¹⁰ Complaint, ¶¶ 2–3.

¹¹ "Good Samaritan Medical Center", *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/good-samaritan-medical-center>, navigated to "Show Recent Past Grades," PBHN000007583–5; "Delray Medical Center", *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/delray-medical-center>, navigated to "Show Recent Past Grades," PBHN000007580–2; "Palm Beach Gardens Medical Center", *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>, navigated to "Show Recent Past Grades," PBHN000007588–90; "St. Mary's Medical Center", *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/st-marys-medical-center-west-palm-beach-fl>, navigated to "Show Recent Past Grades," PBHN000007595–7; "West Boca Medical Center", *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/west-boca-medical-center>, navigated to "Show Recent Past Grades," PBHN000007598–600; The Plaintiff Hospitals' Response in Opposition to the Leapfrog Group's Motion to Dismiss Pursuant to Federal Rules of Civil Procedure 12(b)(2) And 12(b)(6), *Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group*, United States District Court for the Southern District of Florida, West Palm Beach Division, Case No.: 9:25-cv-80526-DMM, July 11, 2025 ("Opposition to the Motion to Dismiss"), Exhibit D, p. 1 (citing "Follow-Up Statement from Leapfrog President and CEO Leah Binder on Tenet Healthcare Hospitals' Lawsuit to Suppress Poor Safety Grade Performance," *The Leapfrog Group*, May 2, 2025, <https://www.leapfroggroup.org/news-events/follow-statement-leapfrog-president-and-ceo-leah-binder-tenet-healthcare-hospitals%E2%80%99>), PBHN000002638–40.

¹² Complaint, ¶¶ 52, 54.

reputation,” and have “caused Plaintiffs’ patients to move their procedures from Plaintiffs to Plaintiffs’ competitors.”¹³

III. Assignment

12. I have been asked by counsel for Plaintiffs to assess whether, and in what ways, low or failing TLG Hospital Safety Grades may impact consumers’ perceptions of Plaintiff Hospitals and consumers’ decisions to seek care at Plaintiff Hospitals. I have also been asked to assess whether and how repeated publication of low or failing TLG Hospital Safety Grades (i.e., future grades using the same imputation methodology) could affect consumers’ perceptions of, and decisions to seek care at, Plaintiff Hospitals. Finally, I have been asked by counsel to assess the extent to which TLG’s imputation disclosures would be expected to affect consumers’ understanding of TLG’s imputation methodology (i.e., TLG’s practice of assigning the minimum score on the imputed measures and not basing it on hospital performance) and consumers’ understanding of the impact of TLG’s imputation methodology on TLG’s Hospital Safety Grades for non-participating hospitals, including Plaintiff Hospitals.

13. A list of materials I have considered to date in connection with this assignment is attached as **Appendix C**. I reserve the right to supplement or amend my opinions should new information become available.¹⁴

14. I am being compensated at my standard billing rate of \$1,200 per hour. I have been assisted in this matter by staff of Cornerstone Research, who worked at my direction. I receive compensation from Cornerstone Research based on its collected staff billings for its support of me in this matter. Neither my compensation in this matter nor my compensation from Cornerstone Research is in any way contingent or based on the content of my opinion or the outcome of this or any other matter.

¹³ Complaint, ¶¶ 103, 116.

¹⁴ I understand that TLG has the opportunity to present opinions from one or more experts in this matter and that the parties are continuing to produce documents and evidence in this case. For example, I have been informed that TLG produced more than 250,000 documents in the four days before this report was due, including 93,000 documents on Sunday, August 3 and 156,000 documents on Wednesday, August 6. As I have not yet had the opportunity to meaningfully review these documents, I reserve the right to adjust my opinions based on my review of documents recently produced or that will be produced in this litigation. I also reserve the right to supplement my analysis and conclusions set forth in this report to respond to the opinions of TLG’s expert(s) or based upon any additional discovery performed or disclosed by the parties.

IV. Summary of Opinions

15. TLG's "D" or "F" Hospital Safety Grades for Plaintiff Hospitals likely impact consumers' perceptions of Plaintiff Hospitals and deter consumers from choosing to receive care there. Moreover, if TLG continues to publish low or failing grades for Plaintiff Hospitals in the future, these effects are likely to be amplified. While TLG purports to disclose its imputation methodology to consumers, consumers are unlikely to understand that TLG assigns the minimum possible score on the imputed measures and the impact of the imputation methodology on the Hospital Safety Grades for non-participating hospitals.

16. TLG's "D" or "F" Hospital Safety Grades for Plaintiff Hospitals likely negatively impact consumers' perceptions of Plaintiff Hospitals' quality. Research has found that third-party ratings, like TLG's Hospital Safety Grades, can affect consumers' perceptions of a product or service's quality. Further, third-party ratings are likely to be particularly impactful for healthcare services and hospital choice because consumers are unlikely to effectively evaluate a hospital's quality by themselves. Moreover, the information TLG presents on its Hospital Safety Grade Pages, including its "A" through "F" letter grades and summaries of performance using a red, yellow, green color scale, are examples of evaluative categories and labels, which are a form of information presentation that indicates how information should be evaluated. Presenting evaluative categories and labels alongside information has been shown to increase the influence of that information on consumers' perceptions in many contexts, including in the specific context of information on hospital quality.

17. Beyond perceptions, TLG's "D" or "F" Hospital Safety Grades for Plaintiff Hospitals also likely affect consumers' *choices* and deter consumers from choosing Plaintiff Hospitals. Research has found that third-party ratings, like TLG's Hospital Safety Grades, impact consumers' decision-making across a variety of healthcare contexts. Indeed, TLG itself publicized a study on the effect that letter grades for hospital safety, modeled after TLG's Hospital Safety Grades, had on consumers' choices. The study found that respondents almost always chose a hospital rated as safer when presented with such information, even if it was more expensive. Such an effect would be consistent with research on consumer decision-making. Hospital choice is a complex decision, and consumers are more likely to rely on decision-making shortcuts, or heuristics, like TLG's

Hospital Safety Grades to make decisions. Moreover, “D” or “F” TLG Hospital Safety Grades are likely to evoke negative emotions from consumers about Plaintiff Hospitals. In such emotional states, consumers are less likely to seek out and more likely to disregard other information about Plaintiff Hospitals, including positive or contradictory information about the graded hospital. Finally, statements on TLG’s own website are consistent with the premise that Hospital Safety Grades can influence consumers’ hospital choices, and TLG presents the four imputed measures as fundamental aspects of medical care and frames its Hospital Safety Grades as essential inputs into consumers’ hospital choices.

18. The effects of TLG’s “D” or “F” Hospital Safety Grades for Plaintiff Hospitals would be intensified if TLG continues to repeatedly publish “D” or “F” Hospital Safety Grades in the future. Such a practice would be expected to have a long-term, negative impact on perceptions of, and choice for, Plaintiff Hospitals. In particular, consumers may be repeatedly exposed to low or failing grades for Plaintiff Hospitals through future publications, and research has found that consumers who are repeatedly exposed to information are more likely to be persuaded by that information.

19. TLG’s imputation disclosures are unlikely to help consumers understand that TLG assigns the minimum score on the imputed measures and the impact this has on the safety grades TLG assigns to non-participating hospitals. In fact, TLG does not directly disclose the relevant information on its Hospital Safety Grade Pages. Instead, TLG includes a disclosure in the footnote of its Hospital Safety Grade Pages for the imputed measures (“footnote disclosure”) that fails to explain that the minimum score is assigned for the imputed measure, or that such assignment lowers the hospital’s overall Hospital Safety Grade. The only disclosure that explains the imputation methodology is found on page 16 of TLG’s 28-page Spring 2025 “Scoring Methodology” document (“methodology document”), which requires multiple steps to access from a TLG’s Hospital Safety Grade Page. In fact, it is unlikely that many consumers would read either disclosure, because TLG’s footnote disclosure is located at the bottom of the Hospital Safety Grade Pages and because it takes multiple steps to access TLG’s methodology document. Finally, TLG’s imputation disclosures themselves use language that may lead consumers to place the responsibility for missing data on Plaintiff Hospitals and, thus, negatively impact consumers’ perceptions of Plaintiff Hospitals.

V. “D” or “F” TLG Hospital Safety Grades Likely Negatively Impact Consumers’ Perceptions of Plaintiff Hospitals’ Quality

A. Third-Party Ratings Have Been Found to Affect Consumers’ Hospital Quality Perceptions

20. Third-party ratings can influence consumers’ perceptions, especially in the context of healthcare. The academic literature has repeatedly shown that third-party ratings, such as TLG’s Hospital Safety Grades, can affect consumers’ perceptions of the quality of a product or service. These third-party ratings are likely to be particularly impactful for healthcare services and hospital choice because many consumers lack the requisite knowledge and expertise to effectively evaluate a hospital’s quality by themselves. As a result, third-party ratings, such as TLG’s Hospital Safety Grades, fill that vacuum and can significantly impact consumers’ perceptions of the quality of hospitals, including Plaintiff Hospitals.

21. The academic literature has found that, in a variety of contexts, consumer perceptions of a product or service’s quality can be influenced by third-party ratings. A 2022 study of consumers’ responses to product ratings, for example, found that consumers tended to perceive products with positive ratings as higher quality than products that had negative or ambiguous ratings.¹⁵ Similarly, a 2018 study, which presented participants with the description of a product and different reviews of the product, found that strongly negative reviews adversely affected participants’ attitudes toward the product manufacturer and lowered their product satisfaction.¹⁶

22. The effect of third-party ratings on perceived quality is likely to be particularly impactful on consumer perceptions of hospital quality because consumers often lack the knowledge and expertise necessary to evaluate hospital quality themselves. Healthcare, including hospital care, is a prototypical example of a “credence good,” which is a good or service whose quality can be difficult for consumers to reliably assess.¹⁷ Healthcare in general is such a good because consumers “can hardly determine the extent of the service that was required ... whether necessary treatments

¹⁵ Pascucci, F., et al. (2022), “Exploring the Relationships Between Perception of Product Quality, Product Ratings, and Consumers’ Personality Traits: An Eye-Tracking Study,” *Journal of Neuroscience, Psychology, and Economics*, 15, 2, 89–100 at p. 94, PBHN000004088–100.

¹⁶ Esmark Jones, C. L., et al. (2018), “Tell It Like It Is: The Effects of Differing Responses to Negative Online Reviews,” *Psychology and Marketing*, 35, 2, 891–901 at pp. 898–899, PBHN000003576–87.

¹⁷ Dulleck, U., et al. (2011), “The Economics of Credence Goods: An Experiment on the Role of Liability, Verifiability, Reputation, and Competition,” *American Economic Review*, 101, 2, 526–555 at p. 526, PBHN000003524–54.

were not performed ... [and] the quality of the services he has purchased.”¹⁸ Moreover, hospital care, specifically, is a credence good because many consumers lack the medical expertise necessary to identify and evaluate information about the quality of care a hospital offers.¹⁹ This is true even *after* consumers receive treatment, because health outcomes are not always indicative of quality of care.²⁰ Even assuming consumers *were* able to assess hospital quality based on experience alone, many consumers only consider or experience hospital care infrequently and are thus unlikely to have sufficient direct or recent experience, if any at all, to form a perception of hospital quality.²¹

23. Because many consumers are unable to assess hospital quality directly, they are more likely to rely on outside information sources, like TLG’s Hospital Safety Grades, to form their perceptions. Indeed, research has found that online reviews, rankings, and ratings can affect perceptions of credence goods, including healthcare services. For example, one study assessing physician reviews found that online reviews significantly influenced respondents’ perceptions of the physician’s technical skills.²² A 2019 study conducted by the consulting firm McKinsey found that when respondents were asked what information would give them the most confidence that they would receive high quality care, nearly 40% of respondents selected “a facility has a good

¹⁸ Emons, W. (1997), “Credence Good and Fraudulent Experts,” *RAND Journal of Economics*, 28, 1, 107–119 at p. 107, PBHN000003562–75; Kerschbamer, R., et al. (2023), “Credence Goods Markets, Online Information, and Repair Prices: A Natural Field Experiment,” *Journal Of Public Economics*, 104891, 1–14 at pp. 1–2, PBHN000003893–906; Lantzy, S., et al. (2021), “Online Reviews of Credence Service Providers,” *Journal of Public Policy and Marketing*, 40, 1, 27–44 at pp. 27–28, PBHN000003933–51.

¹⁹ Kahn, B. E., et al. (1997), “Examining Medical Decision Making from a Marketing Perspective,” *Marketing Letters*, 8, 3, 361–375 (“Kahn et al. (1997)”) at p. 362, PBHN000003833–48.

²⁰ Kahn et al. (1997), p. 362, PBHN000003833–48 (“...there is a stochastic relationship between health outcomes and the quality of care. For example, one cannot automatically assume a patient who died after being hospitalized for cancer was improperly treated. Because health outcomes are not always diagnostic about the quality of treatment, consumers may not know that they have received improper treatment even when they experience adverse health outcomes.”); Lantzy, S., et al. (2021), “Online Reviews of Credence Service Providers,” *Journal of Public Policy and Marketing*, 40, 1, 27–44 at pp. 27–28, PBHN000003933–51 (“For example, a patient may begin to feel better after treatment, but if she does not have medical training, she may never know whether her doctor correctly diagnosed her symptoms or whether she would have felt equally good without treatment. Or, a patient may not feel better after treatment and blame the doctor, even though he received state-of-the-art care.”).

²¹ Arrow, K. J. (1963), “Uncertainty and the Welfare Economics of Medical Care,” *American Economic Review*, 53, 5, 941–973 at p. 951, PBHN000003182–215. Less than 8% of people in the United States spend a night in a hospital each year. See, “Summary Health Statistic: National Health Interview Survey,” Table P-10a, *Centers for Disease Control and Prevention, National Center for Health Statistics*, 2018, PBHN000004188–96. The CDC also reported that in 2018, only 5.2% of the U.S. population aged 1–64 experienced a hospital stay in the last year and only 21.3% had visited an emergency department in the past year. See, “Hospitalization,” *Centers for Disease Control and Prevention, National Center for Health Statistics*, <https://www.cdc.gov/nchs/has/topics/hospitalization.htm>, PBHN000003751–60.

²² Li, S., et al. (2019), “Effects of Online Physician Reviews and physician Gender on Perceptions of Physician Skills and Primary Care Physician (PCP) Selection,” *Health Communication*, 34, 11, 1250–1258 at pp. 1250, 1256, PBHN000003952–61.

reputation for quality / scored well by publications.”²³ Similarly, in another 2019 survey of U.S. consumers, more than one third of respondents (34%) reported using hospital ranking websites to develop their impressions of a hospital’s reputation.²⁴ Further, a 2020 study found that negative comments left on physician-rating websites, even if exaggerated or untrue, can cause reputational harm for physicians because of “the limited ability of the readers ... to evaluate whether the accusation in the negative review corresponds to the truth or not.”²⁵ Overall, these findings suggest that TLG’s Hospital Safety Grades are likely to influence perceived hospital quality and low or failing Hospital Safety Grades likely negatively impact consumers’ perceptions of hospital quality.

B. TLG’s Hospital Safety Grades Present Hospital Performance Using Evaluative Categories and Labels, Which Can Increase the Influence of Hospital Safety Grades on Consumers’ Perceptions of Hospital Quality

24. TLG’s Hospital Safety Grades are also likely to have a strong influence on consumers’ perceptions of hospital safety because of how the grades are presented. Specifically, on each Hospital Safety Grade Page, TLG presents an overall letter grade for the hospital, on a scale of “A” to “F,” and, for each measure underlying the letter grade, a dial graphic with a red, yellow, green color scale indicating the hospital’s performance on that measure, as shown in the excerpt in Exhibit 1. Both the letter grade and the color-scaled dial graphic exemplify what research describes as “evaluative” categories or labels. Evaluative categories or labels refer to forms of information presentation that indicate how information should be evaluated or judged.²⁶ Numeric information (e.g., 5%), for example, can be presented alongside an evaluative label, such as “high”

²³ “Consumer Decision Making in Healthcare: The Role of Information Transparency,” *McKinsey & Company*, July 2020, Exhibit 3, <https://www.mckinsey.com/~/media/McKinsey/Industries/Healthcare/20Systems/20and/20Services/Our/20Insights/Consumer/20decision/20making/20in/20healthcare/Consumer-decision-making-in-healthcare-The-role-of-information-transparency.pdf>, PBHN000003405–16.

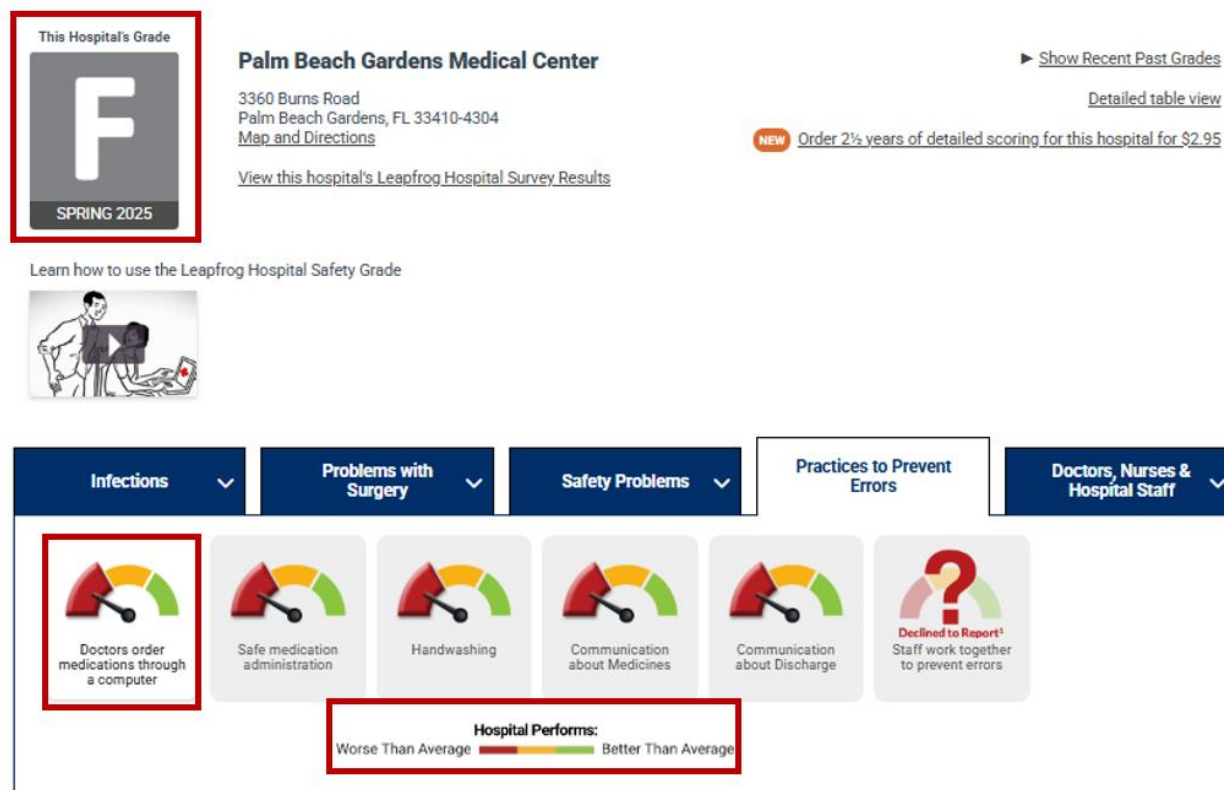
²⁴ Ziemba, J. B., et al. (2019), “Consumers’ Association of Hospital Reputation with Healthcare Quality,” *Journal for Healthcare Quality*, 41, 4, 251–258 at p. 257, PBHN000004354–61.

²⁵ Arendt, F., et al. (2020), “Dealing with Negative Reviews on Physician-Rating Websites: An Experimental Test of How Physicians Can Prevent Reputational Damage Via Effective Response Strategies,” *Social Science & Medicine*, 266, 113442, 1–9 at pp. 2, 6, PBHN000003158–66.

²⁶ Dieckmann, N. F., et al. (2012), “Making Sense of Uncertainty: Advantages and Disadvantages of Providing an Evaluative Structure,” *Journal of Risk Research*, 15, 7, 717–735 at p. 718, PBHN000003497–516; Peters, E., et al. (2009), “Bringing Meaning to Numbers: The Impact of Evaluative Categories on Decisions,” *Journal of Experimental Psychology: Applied*, 15, 3, 213–227 (“Peters et al. (2009)”) at p. 214–215, PBHN000004367–81; Cadario, R. and P. Chandon (2020), “Which Healthy Eating Nudges Work Best? A Meta-Analysis of Field Experiments,” *Marketing Science*, 39, 3, 465–486 at p. 468, PBHN000003368–90.

or “low” or “good” or “bad,” which helps consumers interpret the numeric information.²⁷ Similarly, letter grades (e.g., “A” to “F”) and color schemes (e.g., red, yellow, green scale) provide information on how information should be interpreted (i.e., positive, average, or negative performance).²⁸

Exhibit 1 Presentation of Information on TLG’s Hospital Safety Grade Page



Source: “Palm Beach Gardens Medical Center,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>

Note: This exhibit displays an excerpt of the Hospital Safety Grade Page for Palm Beach Gardens Medical Center, navigated to the “Practices to Prevent Errors” tab and “Doctors order medications through a computer” measure. Parts of the page marked by the red boxes show the overall letter grade, the measure currently being viewed and its associated color-scaled dial graphic, and the legend that defines the colors of the dial graphics.

²⁷ Dieckmann, N. F., et al. (2012), “Making Sense of Uncertainty: Advantages and Disadvantages of Providing an Evaluative Structure,” *Journal of Risk Research*, 15, 7, 717–735 at p. 718, PBHN000003497–516.

²⁸ Cadario, R. and P. Chandon (2020), “Which Healthy Eating Nudges Work Best? A Meta-Analysis of Field Experiments,” *Marketing Science*, 39, 3, 465–486 at p. 468, PBHN000003368–90; Moller, A. C., et al. (2009), “Basic Hue-Meaning Associations,” *Emotion*, 9, 6, 898–902 at p. 901, PBHN000004362–6; Lipnevich, A. A. and J. K. Smith (2009), “Effects of Differential Feedback on Students’ Examination Performance,” *Journal of Experimental Psychology: Applied*, 15, 4, 319–333 at p. 330, PBHN000004391–405.

25. Academic research finds that evaluative categories and labels not only help consumers make sense of information, but they also increase the influence such information has on consumers' perceptions. For example, in a 2009 study, researchers provided participants with three indicators of hospital quality: (1) percentage of pneumonia patients who survived while being treated; (2) percentage of heart attack patients given recommended treatment; and (3) percentage of patients who rated their care as very good or excellent. The indicators could take numeric values ranging from 80 to 100 for one of the indicators (i.e., percentage of pneumonia patients who survived while being treated) and 0 to 100 for the remaining two.²⁹ The researchers assigned evaluative categories to the numeric values for each indicator. For example, for the 0–100 indicators, the researchers labeled 0–60 “poor,” 60–70 “fair,” 70–80 “good,” and “80–100” excellent. Respondents were then presented with the three indicators in one of two formats: either only numerically (e.g., 93%) or numerically *and* evaluative categories (e.g., 93% and the evaluative category “excellent”).³⁰ The researchers then asked participants to rate the hospital’s “attractiveness”—how attractive the hospital was as an option based on the information provided.³¹ Results indicated that including the evaluative categories (i.e., category labels) led respondents to give the quality indicators greater weight in determining the hospitals’ “attractiveness.”³² In other words, pairing the numerical information with the evaluative category had a greater effect on consumers’ perceptions.

26. Similarly, in a 2021 study, researchers presented participants with consumer products and information about the products’ attributes, and asked them to rate attractiveness of each product.³³ The attribute information provided was either numeric only (e.g., the bike has battery power of 800 Wh) or numeric with evaluative categories (e.g., the bike has battery power of 800 Wh, which is “excellent”).³⁴ An attribute such as battery power should be more attractive when it has a higher numeric value. Results indicated that when participants were provided with evaluative categories in addition to numeric values, they were more likely to rate a product with a higher numeric value

²⁹ Peters et al. (2009), pp. 215–217, PBHN000004367–81.

³⁰ Peters et al. (2009), pp. 215–217, PBHN000004367–81.

³¹ Peters et al. (2009), pp. 215–217, PBHN000004367–81.

³² Peters et al. (2009), pp. 218, 225, PBHN000004367–81.

³³ Tiede, K. E., et al. (2022), “Numeracy, Numeric Attention, and Number Use in Judgment and Choice,” *Journal of Behavioral Decision Making*, 35, 3, e2264 (“Tiede et al. (2022)”) at p. 4, PBHN000004255–71.

³⁴ Tiede et al. (2022), p. 5, PBHN000004255–71.

for the attribute as attractive. That is, including evaluative labels alongside the numeric information significantly increased participants' reliance on the numeric information in their product ratings.³⁵

27. TLG's presentation of its Hospital Safety Grade Pages using evaluative categories, including overall letter grades, would therefore influence how consumers would react to the information. Specifically, TLG transforms the data about a hospital into an overall safety score with a prominently displayed letter grade, which is precisely the type of evaluative categorization that would increase consumers' reliance on those grades, especially in the healthcare context where many consumers lack the ability to assess hospital quality on their own. As a result, the "D" or "F" Hospital Safety Grades TLG assigned to Plaintiff Hospitals would be likely to both impact consumers' perceptions of the quality of care at these hospitals negatively and, as I will discuss below in Section VI, deter consumers from seeking care at Plaintiff Hospitals.

VI. "D" or "F" TLG Hospital Safety Grades Likely Deter Consumers from Choosing Plaintiff Hospitals

28. There are many reasons why TLG's Hospital Safety Grades can influence consumers' hospital choices.³⁶ First, studies have shown that third-party ratings, like TLG's Hospital Safety Grades, can impact consumers' hospital choices. Second, hospital choice is a complex decision in which consumers are likely to rely on decision-making shortcuts, such as prioritizing information that is simple to process (e.g., TLG's Hospital Safety Grades presented in the form of letter grades), and relying on emotional responses to information about available options (e.g., negative emotional responses to low or failing TLG Hospital Safety Grades). Third, consumers experiencing a negative emotional reaction to low or failing Hospital Safety Grades would be unlikely to seek out, and more likely to disregard, additional information about that hospital,

³⁵ Tiede et al. (2022), pp. 6–7, PBHN000004255–71.

³⁶ In some cases, consumers' hospital choices may be dictated by external factors, such as insurance coverage, doctor affiliation, or lack of availability of multiple hospitals. This section focuses on consumer decision-making when consumers are able to choose between multiple hospitals. See "Consumer Choice in U.S. Health Care: Using Insights from the Past to Inform the Way Forward," *The Commonwealth Fund*, November 30, 2021, <https://www.commonwealthfund.org/publications/fund-reports/2021/nov/consumer-choice-us-health-care-using-insights-from-past>, PBHN000003391–404; "Consumers in Health Care: The Burden of Choice," *California HealthCare Foundation*, October 2005, <https://www.chcf.org/wp-content/uploads/2017/12/PDF-ConsumersInHealthCareBurdenChoice.pdf>, pp. 8, 26, PBHN000003417–50.

including positive information about the hospital that may contradict TLG's Hospital Safety Grade. Finally, consistent with the premise that Hospital Safety Grades can influence consumers' hospital choices, TLG publicizes its Hospital Safety Grades and expressly instructs consumers to use both the imputed measures and its overall grades as critical inputs in their hospital decision-making processes.

A. Third-Party Ratings, Like TLG's Hospital Safety Grades, Have Been Found to Affect Consumer Decision-Making

29. Research in a variety of contexts has found that ratings from third-party organizations can affect consumers' choices. In the restaurant industry, for example, a 2002 study found that, after the introduction of mandatory hygiene grade rating disclosures using letter grades, consumer demand increased for restaurants that received higher grades. In particular, restaurants that received "A" and "B" grades experienced statistically significant increases in revenue after the introduction of the grades.³⁷ In the education context, a 2004 study found that, after the introduction of a statewide evaluation system for public schools in Florida using letter grades, the sales price of houses zoned for schools that received "A" grades increased 19.5% relative to the houses zones for schools that received "B" grades.³⁸

30. Similarly, studies have shown that third-party ratings impact consumers' choices in various healthcare contexts. For example:

- A 2022 study examining the effect of Yelp star ratings on hospital admissions in Florida found that "among admissions for elective, inpatient procedures, patients are willing to travel between 5 and 30 percent further to receive care from a hospital with a higher Yelp rating, relative to other hospitals in the market."³⁹

³⁷ In a 2014 interview, TLG CEO Leah Binder stated that the choice to present TLG's Hospital Safety Grades as letter grades was based, in part, on letter grades given to restaurants. See Jin, G. and P. Leslie (2002), "The Effect of Information on Product Quality: Evidence from Restaurant Hygiene Grade Cards," *Quarterly Journal of Economics*, 118, 2, 409–451 at p. 429, PBHN000003789–832; Wong, M., et al. (2015), "Impact of Letter-Grade Program on Restaurant Sanitary Conditions and Diner Behavior in New York City," *American Journal of Public Health*, 105, 3, e81–e87 at e84, PBHN000004332–8; "In Conversation With... Leah Binder, MA, MGA," *Agency for Healthcare Research and Quality*, April 1 2014, <https://psnet.ahrq.gov/perspective/conversation-leah-binder-ma-mga>, PBHN000003777–88.

³⁸ Figlio, D. N. and M. E. Lucas (2004), "What's in a Grade? School Report Cards and the Housing Market," *American Economic Review*, 94, 3, 591–604 at p. 598, PBHN000003599–613.

³⁹ McCarthy, I., et al. (2022), "Online Reviews and Hospital Choices," Economic Analysis Group, Antitrust Division, U.S. Department of Justice, 1–78 at p. 2, PBHN000004010–87. Yelp presents users with star ratings for hospitals which are an average of the prior user reviews, rounded to the nearest half-star. The study controls for hospital quality by including hospital characteristics including "total bed, nurse, and physician counts; indicators for teaching hospital status and system membership; payer mix [; and] ... hospital readmission rates." The authors additionally analyzed the effect of ratings on the price of hospital

- A nationally representative survey of parents published in 2014 regarding choice of children's physicians found that "about three-quarters (74%) of parents were aware of physician-rating sites, and about one-quarter (28%) had used them to select a primary care physician for their children." Among respondents who sought ratings online, 30% stated they had chosen not to visit a physician due to negative ratings, and 30% stated they had selected their children's physician based on positive ratings or reviews.⁴⁰
- A 2023 survey experiment examining the effect of star ratings on hospital choice found that respondents were willing to pay \$1,698 more, or travel 185 miles further, on average, for a hospital with a 1-star-higher rating on clinical outcomes and \$615 more on average or travel 62 miles further for a hospital with a 1-star-higher rating on safety outcomes.⁴¹ Additionally, the study found that "Medicare beneficiaries were willing to pay more or travel further to move from 1- to 2-star hospitals than from a 4- to 5-star hospital."⁴²
- A 2009 study examining the effect of the U.S. News and World Report hospital rankings on consumer choice found that a one spot drop in ranking was associated with a 6 to 7 percent decline in patient volume and revenue.⁴³ The author concluded that "[w]hile it can be argued whether changes in these rankings reflect true changes in hospital quality, at the very least, consumers are willing to respond to changes in *perceived* hospital quality."⁴⁴
- In the context of demand for physician appointments, a 2013 study of ratings and appointments data from ZocDoc found that a half star drop in ratings (on a 1 to 5 scale) was associated with a 10% average decrease in the likelihood that a doctor would fill an appointment.⁴⁵
- A 2018 survey experiment found that a physician rated two stars instead of four in government clinical ratings or commercial non-clinical ratings had significantly lower odds of being chosen.⁴⁶

services, which they defined as the average non-Medicare insurance payment to a hospital for an inpatient stay. According to the authors, the price of hospital services reflects patients' hospital choice so that a higher price is indicative of greater demand for the services of the hospital. The authors found that hospitals lacking online reviews were associated with higher prices compared to hospitals with negative reviews. See McCarthy, I., et al. (2022), "Online Reviews and Hospital Choices," Economic Analysis Group, Antitrust Division, U.S. Department of Justice, 1–78 at pp. 3, 21, 41, 47, PBHN000004010–87.

⁴⁰ Hanauer, D. A., et al. (2014) "Parental Awareness and Use of Online Physician Rating Sites," *Pediatrics*, 134, 4, e966–e975 at pp. e966, e968–e969, PBHN000003736–45.

⁴¹ Trenaman, L., et al. (2023), "What is a Star Worth to Medicare Beneficiaries? A Discrete Choice Experiment of Hospital Quality Ratings," *Health Affairs Scholar*, 2, 1, 1–7 at p. 4, PBHN000007630–6.

⁴² Trenaman, L., et al. (2023), "What is a Star Worth to Medicare Beneficiaries? A Discrete Choice Experiment of Hospital Quality Ratings," *Health Affairs Scholar*, 2, 1, 1–7 at p. 5, PBHN000007630–6.

⁴³ Hospital rankings are based on U.S. News and World Report's rank of U.S. hospitals. The study controls for hospital quality by incorporating the effect of a continuous quality score in the model. Pope, D. G. (2009), "Reacting to Rankings: Evidence from 'America's Best Hospitals'" *Journal of Health Economics*, 28, 6, 1154–1165 at pp. 1154–1155, 1163, PBHN000004101–12.

⁴⁴ Emphasis added. Pope, D. G. (2009), "Reacting to Rankings: Evidence from 'America's Best Hospitals'" *Journal of Health Economics*, 28, 6, 1154–1165 at p. 1164, PBHN000004101–12.

⁴⁵ Luca, M., and S. Vats (2013), "Digitizing Doctor Demand: The Impact of Online Reviews on Doctor Choice," American Economic Association Working Paper, p. 3, PBHN000003962–4009.

⁴⁶ Yaraghi, N., et al. (2018), "How Online Quality Ratings Influence Patients' Choice of Medical Providers: Controlled Experimental Survey Study," *Journal of Medical Internet Research*, 20, 3, 1–14 at pp. 1, 6, PBHN000004339–52.

31. The above examples from the academic literature demonstrate that consumers are less likely—and often much less likely—to choose hospitals and physicians with lower ratings. These studies also show that consumers are even willing to incur the extra cost of traveling farther away from their residence in order to visit higher ranked and rated hospitals. These findings demonstrate the significant influence of third-party ratings on consumers’ healthcare choices.

32. Further, in a study publicized on leapfroggroup.org,⁴⁷ researchers examined the effect of safety and cost information on consumers’ hospital choices in a discrete choice survey experiment, with safety information represented as letter grades modeled after TLG’s Hospital Safety Grades.⁴⁸ In each question, respondents were asked to choose between hospitals 1 and 2, where hospital 2 was always rated less safe but could be higher or lower cost than hospital 1.⁴⁹ Results indicated that consumers “chose safer hospitals in 97% of cost and safety scenarios,” and that “larger differences in safety resulted in greater preference [for the facility that was rated as safer].”⁵⁰

B. Hospital Choice is a Complex Decision Which Increases Reliance on Heuristic Cues like TLG’s Hospital Safety Grades

33. Choosing a hospital is often a complex decision. It can be difficult for consumers to evaluate the variety of attributes that differentiate hospitals (e.g., providers, availability, facilities, costs, quality, safety, the ability of the hospital to meet the individual consumer’s specific needs regarding care), some or all of which consumers may consider as part of their hospital selection process.⁵¹ While reviewing, processing, and evaluating all available information would be a time-consuming and difficult process, studies show that consumers typically engage in some level of research online, where TLG’s Hospital Safety Grades are easily accessible, as they make

⁴⁷ Duke, C. C., et al. (2017), “The Effects of Hospital Safety Scores, Total Price, Out-of-Pocket Cost, and Household Income on Consumers’ Self-Reported Choice of Hospitals,” *Journal Patient Safety*, 13, 4, 192–198, PBHN000003517–23 (“Duke et al. (2017)”), which is made available by TLG at

https://www.hospitalsafetygrade.org/media/file/JournalofPatientSafety_AltaurumReport.pdf; “The Altarum Institute Studies the Hospital Safety Score,” *The Leapfrog Group*, December 4, 2014, <https://www.leapfroggroup.org/news-events/altarum-institute-studies-hospital-safety-score>, PBHN000002644–50.

⁴⁸ Duke et al. (2017), pp. 192–193, PBHN000003517–23.

⁴⁹ Duke et al. (2017), p. 193, PBHN000003517–23.

⁵⁰ Duke et al. (2017), pp. 192, 197, PBHN000003517–23.

⁵¹ “Consumers in Health Care: The Burden of Choice,” *California HealthCare Foundation*, October 2005, <https://www.chcf.org/wp-content/uploads/2017/12/PDF-ConsumersInHealthCareBurdenChoice.pdf>, pp. 8–9, 26, PBHN000003417–50; “Consumer Choice in U.S. Health Care: Using Insights from the Past to Inform the Way Forward,” *The Commonwealth Fund*, November 30, 2021, <https://www.commonwealthfund.org/publications/fund-reports/2021/nov/consumer-choice-us-health-care-using-insights-from-past>, PBHN000003391–404; Kahn et al. (1997), p. 362, PBHN000003833–48.

healthcare decisions. For example, a 2019 U.S. nationwide survey found that 49% of patients used a review site or content site (e.g., Yelp or WebMD) to search for a provider.⁵² Similarly, a survey conducted by McKinsey in 2019 found that 37% of respondents searched online or used an app to “learn[] about the quality of a clinician or facility.”⁵³

34. TLG publicizes its Hospital Safety Grades widely, in public press releases, through coverage in print and television media, and some insurers present TLG’s Hospital Safety Grades to consumers, making it more likely consumers will see them during their research. For example, TLG widely publicized its Fall 2024 Hospital Safety Grades, including by issuing a press statement announcing their release.⁵⁴ According to TLG’s quarterly media report, the Fall 2024 Hospital Safety Grades generated “772 online articles from 435 different publications with a reach of 11.2 billion,” including in prominent outlets as the *Chicago Tribune*.⁵⁵ Of note, Florida, where Plaintiff Hospitals are all located, was the state with the highest number of articles covering the Fall 2024 Safety Grades.⁵⁶ TLG similarly publicized its Spring 2025 Hospital Safety Grades, issuing a press release on May 1, 2025⁵⁷ and generating “774 online articles from 486 different publications with a reach of ~59 million.”⁵⁸ Plaintiff Hospitals’ Safety Grades were covered in several news articles at the time of TLG’s press releases.⁵⁹ Similarly, TLG states that its Hospital Safety Grades are used by “dozens of national and regional health plans ... to educate their users on the importance of choosing a safer hospital.”⁶⁰

⁵² “Customer Experience Trends in Healthcare 2020,” *Doctor.com*, <https://cms.doctor.com/wp-content/uploads/2020/03/xtrends2020-report-final.pdf>, PBHN000003451–76.

⁵³ “Consumer Decision Making in Healthcare: The Role of Information Transparency,” *McKinsey & Company*, July 2020, https://www.mckinsey.com/~/media/McKinsey/Industries/Healthcare/Systems_and_Services/Our_Insights/Consumer_decision_making_in_healthcare/Consumer-decision-making-in-healthcare-The-role-of-information-transparency.pdf, PBHN000003405–16.

⁵⁴ “Fall 2024 Leapfrog Hospital Safety Grade Shows Significant Progress in Patient Safety Nationwide,” *The Leapfrog Group*, November 15, 2024, <https://www.leapfroggroup.org/news-events/fall-2024-leapfrog-hospital-safety-grade-shows-significant-progress-patient-safety>, PBHN000002416–7.

⁵⁵ LEAPFROG000000065–85 at LEAPFROG000000070–77.

⁵⁶ LEAPFROG000000065–85 at LEAPFROG000000070.

⁵⁷ “Leapfrog’s Spring 2025 Safety Grades Are In — New Trend Data Shows One in Eight Hospitals Sustained an ‘A’ for More Than Two Years,” *The Leapfrog Group*, May 1, 2025, <https://www.leapfroggroup.org/news-events/leapfrog%E2%80%99s-spring-2025-safety-grades-are-%E2%80%94new-trend-data-shows-one-eight-hospitals>, PBHN000002523–4.

⁵⁸ LEAPFROG000000122–40 at LEAPFROG000000126.

⁵⁹ See, e.g., “Tenet Hospitals at Bottom of Local Safety Grades,” *Stet News*, December 9, 2024, <https://stetnews.org/2024/12/09/tenet-hospitals-at-bottom-of-local-safety-grades/>, PBHN000002571–5; “Where Are Leapfrog’s 13 ‘F’ Hospitals,” *Beckers Hospital Review*, November 15, 2024, <https://www.beckershospitalreview.com/rankings-and-ratings/where-are-leapfrogs-14-f-hospitals.html>, PBHN000004328–31; “What Are the Best And Worst South Florida Hospitals for Patient Safety? See the Rankings,” *Miami Herald*, January 16, 2025, <https://www.miamiherald.com/news/health-care/article297048999.html>, PBHN000004319–27.

⁶⁰ “Leapfrog Hospital Safety Grade,” *The Leapfrog Group*, <https://www.leapfroggroup.org/data-users/leapfrog-hospital-safety-grade>, PBHN000004438–9.

35. TLG has even publicized Plaintiff Hospitals' grades in the context of this lawsuit. For example, in a TLG website post on May 2, 2025 about the lawsuit, TLG listed each hospital and its Hospital Safety Grade at the top of the article (e.g., "Delray Medical Center (Hospital Safety Grade: F)").⁶¹ Similarly, on June 30, 2025, TLG's President and CEO, Leah Binder, published an op-ed in *The Palm Beach Post* in which she stated, "the five [Plaintiff] [H]ospitals earn exceptionally poor grades: three Ds and two Fs."⁶²

36. When faced with complex decisions, like choosing a hospital, consumers often rely on heuristics, or "decisional shortcuts," to make choices.⁶³ Heuristics are strategies that can "provide[] an efficient means of finding an answer but cannot guarantee a correct outcome."⁶⁴ For example, a simple heuristic that people might use choosing between apartments is to first eliminate options with a high noise level, then choose the cheapest among the remaining options.⁶⁵

37. Consumers using heuristic decision-making strategies often place more weight on or rely on information that is simple to process, easy to recall, or easy to find, like TLG's Hospital Safety Grades.⁶⁶ TLG's Hospital Safety Grades and TLG's scores for each individual measure are presented in evaluative categories (e.g., letter grades, red/yellow/green dial graphics), and as explained in Section V.B, research has shown that presenting information in such evaluative categories can make it easier for consumers to comprehend the information, facilitate comparisons across options, and increase the weight of that information in decision-making.⁶⁷ Indeed, TLG's own website states that "[o]ne of the most significant problems with today's health care system is

⁶¹ Opposition to the Motion to Dismiss, Exhibit D, p. 2 (citing "Follow-Up Statement from Leapfrog President and CEO Leah Binder on Tenet Healthcare Hospitals' Lawsuit to Suppress Poor Safety Grade Performance," *The Leapfrog Group*, May 2, 2025, <https://www.leapfroggroup.org/news-events/follow-statement-leapfrog-president-and-ceo-leah-binder-tenet-healthcare-hospitals%E2%80%99>), PBHN000002638–40.

⁶² Opposition to the Motion to Dismiss, Exhibit B, p. 2 (citing "Leapfrog Gave Delray Medical an 'F' Grade. It Can Do Better," *Palm Beach Post*, June 30, 2025, <https://www.palmbeachpost.com/story/opinion/columns/your-voice/2025/06/30/leapfrog-gave-delray-medical-an-f-grade-it-can-do-better/84355159007/>), PBHN000003082–4.

⁶³ Blumenthal-Barby, J. and H. Krieger (2015), "Cognitive Biases and Heuristics in Medical Decision Making: A Critical Review Using a Systematic Search Strategy," *Medical Decision-Making*, 539–557 at pp. 539, 542–543, 545, PBHN000003334–52; Kahn et al. (1997), pp. 363, 365–366, PBHN000003833–48.

⁶⁴ "APA Dictionary of Psychology," *American Psychological Association*, <https://dictionary.apa.org/heuristic>, PBHN000003155–7.

⁶⁵ Svenson, O. (1979), "Process Descriptions of Decision Making," *Organizational Behavior and Human Performance*, 23, 86–112 at pp. 104–105, PBHN000004198–224.

⁶⁶ See, e.g., Tversky, A. and D. Kahneman (1974), "Judgment Under Uncertainty: Heuristics and Biases," *Science*, 185, 4157, 1124–1131 at pp. 1124, 1126–1128, PBHN000004272–9; Shah, A. K. and D. M. Oppenheimer (2007), "Easy Does It: The Role of Fluency in Cue Weighting," *Judgment and Decision Making*, 2, 6, 371–379 at pp. 371, 372, 374, PBHN000004382–90.

⁶⁷ Peters et al. (2009), pp. 214, 224–225, PBHN000004367–81; Kurtzman, E. and J. Green (2016) "Effective Presentation of Health Care Performance Information for Consumer Decision Making: A Systematic Review," *Patient Education and Counseling*, 99, 36–43 at p. 41, PBHN000003925–32.

the failure to make safety and quality information available to the public. ... The purpose of the Leapfrog Hospital Safety Grade is to bring this information to light in a way that is easy for you—the consumer—to use. ... Our letter grade scoring system allows consumers to quickly assess the safety of their local hospital, and choose the safest hospital to seek care.”⁶⁸

38. Consequently, consumers using heuristic decision-making strategies may rely on TLG’s Hospital Safety Grades as a key input into their hospital choice. Indeed, a 2021 study assessed the factors that affected consumers’ preferences in hospital choices, using both focus group interviews and a survey. In the focus group of consumers, “hospital reputation or ranking” was among the “[f]actors that patients most frequently identified as important drivers,” and in the survey, the Hospital’s ranking on a ratings website was considered “Very Important” or “Important” by nearly one-third of respondents.⁶⁹ This study underscores the role that simplistic heuristics often play in consumers’ hospital selection process.

39. As an example of how TLG’s Hospital Safety Grades may be used in consumers’ decision-making, some studies have documented a “lexicographic heuristic,” where consumers decide which aspect, feature, or piece of information about available options is most important to them and select the option that performs best based on it. If there are ties, the consumer then uses the second most important piece of information, and so on.⁷⁰ A consumer using such a decision-making strategy in this context may use a TLG Hospital Safety Grade as an initial criterion, choosing the hospital that scores the best or eliminating hospitals with low or failing Hospital Safety Grades. This decision-making strategy would be facilitated by the “search” feature on [hospitalsafetygrade.org](https://www.hospitalsafetygrade.org), in which consumers can search for hospitals in their zip code or city.⁷¹ On the “Search Results” page, TLG presents each hospital’s Safety Grade directly next to the hospital name, as shown in Exhibit 2. In such a setting, a consumer using a lexicographic heuristic could use TLG’s Hospital Safety Grades to narrow the set of hospitals for which they want to find

⁶⁸ Plaintiffs’ Motion for a Preliminary Injunction and Motion for Expedited Discovery, or, in the Alternative for an Expedited Trial and Incorporated Memorandum of Law, *Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group*, United States District Court for the Southern District of Florida, West Palm Beach Division, Case No.: 9:25-cv-80526-DMM, May 17, 2025 (“Motion for Preliminary Injunction”), Exhibit 6, p. 2, (citing “Why the Hospital Safety Grade Works,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/why-the-hospital-safety-grade-works>), PBHN000003079–81.

⁶⁹ Ellis, R., et al. (2020), “National Evaluation of Patient Preferences in Selecting Hospitals and Healthcare Providers,” *Medical Care*, 58, 10, 867–873 at p. 870, Table 2, PBHN000003555–61.

⁷⁰ Shah, A. K. and D. M. Oppenheimer (2008), “Heuristics Made Easy: An Effort-Reduction Framework,” *Psychological Bulletin*, 134, 2, 207–222 at 209, PBHN000004413–28.

⁷¹ LEAPFROG00000032–48 at LEAPFROG00000044.

additional information. According to TLG’s Q4 2024 Quarterly Media Report, the Search Results page was one of the most visited pages on hospitalsafetygrade.org.⁷²

Exhibit 2 Example of a Search Results Page on hospitalsafetygrade.org

How Safe is Your Hospital?

Search By City/State

3 Recent Searches

Hospital Matches
31 hospitals matching Delray Beach, FL

List Map Sort by Distance

This Hospital's Grade **Baptist Health Bethesda Hospital East**
2815 S. Seacrest Boulevard
Boynton Beach, FL 33435-7995
[View the full Score](#)

This Hospital's Grade **Delray Medical Center**
5352 Linton Boulevard
Delray Beach, FL 33484-6580
[View the full Score](#)

This Hospital's Grade **Baptist Health Boca Raton Regional Hospital**
800 Meadows Road
Boca Raton, FL 33486-2368
[View the full Score](#)

Source: “Hospital Matches: Delray Beach, FL,” *The Leapfrog Group*,
https://www.hospitalsafetygrade.org/search?findBy=city&zip_code=&city=Delray+Beach&state_prov=FL

Note: This exhibit displays an excerpt of the Search Results Page when searching for hospitals in Delray Beach, FL.

40. As another example, consumers may use an “affect heuristic,” in which they make such decisions based on their emotions or feelings about different available options.⁷³ Low or failing TLG Hospital Safety Grades are likely to evoke negative emotions from consumers, as I will discuss in the next section, and, thus, are likely to discourage consumers from choosing Plaintiff Hospitals.

⁷² LEAPFROG000000065–85 at LEAPFROG000000085.

⁷³ Kahn et al. (1997), p. 367, PBHN000003833–48; Blumenthal-Barby, J. and H. Krieger (2015), “Cognitive Biases and Heuristics in Medical Decision Making: A Critical Review Using a Systematic Search Strategy,” *Medical Decision-Making*, 539–557, Table 2, PBHN000003334–52.

C. “D” or “F” TLG Hospital Safety Grades Likely Evoke Negative Emotions about Plaintiff Hospitals, Which Can Lead Consumers to Be Less Likely to Seek Out Other, Potentially Positive Information about Plaintiff Hospitals

41. Consumers who view low or failing TLG Hospital Safety Grades are likely to experience negative emotions, which can lead them to disregard other, positive or contradictory information about the graded hospital. TLG’s Hospital Safety Grades purport to accurately measure hospital safety. Safety is not only an important factor in consumers’ healthcare decision-making, but research has also shown that when a product or service that consumers expect to be safe causes harm, they can experience strong negative emotions, like betrayal.⁷⁴ This can cause consumers to not seek out and to disregard other information about the hospital, including information that may contradict TLG’s low or failing Hospital Safety Grade.

42. TLG’s hospitalsafetygrades.org repeatedly states that TLG’s Hospital Safety Grades measure patient safety and quality of care. For example:

- On the page “About the Grade,” TLG states that “Leapfrog Hospital Safety Grades ... [are] the gold standard measure of patient safety” and “represent[] a hospital’s overall performance in keeping patients safe from preventable harm and medical errors.”⁷⁵
- On the page “Frequently Asked Questions About The Leapfrog Hospital Safety Grade,” TLG states that “[t]he Leapfrog Hospital Safety Grade is an ‘A,’ ‘B,’ ‘C,’ ‘D,’ or ‘F’ assigned to general hospitals in the U.S., the only such rating program focused exclusively on how safe they are for their patients.”⁷⁶
- On the page “How to Use the Grade,” TLG states that “not all hospitals prioritize their patient’s safety above all else. You deserve to know which hospitals do the best at protecting their patients from harm. That’s why we developed the Leapfrog Hospital Safety Grade. ... The Safety Grade rates hospitals on the very basics of medical care, such as handwashing, entering prescriptions through a computer, and the availability of highly-trained nurses.”⁷⁷
- On the page “Choosing the Best Hospital,” TLG states that “[y]our first step in finding the best care for yourself and your family is finding a safer hospital. Use the Leapfrog

⁷⁴ Koehler, J. J. and A. D. Gershoff (2003), “Betrayal Aversion: When Agents of Protection Become Agents of Harm,” *Organizational Behavior and Human Decision Processes*, 90, 244–261 at pp. 250–252, PBHN000003907–24; Gershoff, A. D. and J. J. Koehler (2011), “Safety First? The Role of Emotion in Safety Product Betrayal Aversion,” *The Journal of Consumer Research*, 38, 140–150 at pp. 143–144, PBHN000003674–85.

⁷⁵ Motion to Dismiss, Exhibit 4, p. 2 (citing “About the Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/about-the-grade>), PBHN000002619–25.

⁷⁶ Motion to Dismiss, Exhibit 3, p. 2 (citing “Frequently Asked Questions About the Leapfrog Hospital Safety Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/frequently-asked-questions>), PBHN000002423–7.

⁷⁷ Motion for Preliminary Injunction, Exhibit 15, pp. 2–3 (citing “How to Use the Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/your-hospitals-safety-grade/how-to-use-the-grade>), PBHN000003070–5.

Hospital Safety Grade search tool to find the safest hospital in your area, preferably one with an ‘A’ grade.”⁷⁸

43. Research has found that quality and safety are important attributes in healthcare decision-making.⁷⁹ A report by the Commonwealth Fund (a non-profit healthcare policy research group) found that “research supports the view that patients highly value information on health care ... quality,” and work on consumer healthcare decision-making observed that “[c]onsumer safety is a prerequisite for overall effectiveness.”⁸⁰ Consistent with these findings, in the study publicized on leapfroggroup.org described in Section VI.A, respondents faced with hypothetical choices between hospitals with different costs and safety scores were found to choose safer hospitals in 97% of cost and safety scenarios. The researchers concluded that “[c]onsumers perceived safety and differences in safety as important in their preferences ... very few respondents would sacrifice large differences in safety to save money.”⁸¹ Indeed, hospitalsafetygrade.org frames safety as a fundamental aspect of healthcare, stating “[a] hospital may have the best surgeons and greatest technology in the world, but unless it is preventing infections and eliminating errors, it is not delivering on a very basic premise: ensuring the safety of you and your loved ones.”⁸²

44. When consumers are informed that a product or service for which they expect safety actually *causes* harm, they can experience strong negative emotions, like feeling betrayed. Specifically, when the betrayal relates to a product or service involving “a duty or promise to protect,” the negative emotion is greater compared to that experienced from “identical bad acts that do not violate a duty or promise to protect.”⁸³ In safety-related environments, like healthcare,

⁷⁸ Motion to Dismiss, Exhibit 7, pp. 2–3 (citing “Choosing the Best Hospital,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/choosing-the-best-hospital>), PBHN000002626–8.

⁷⁹ Moore, G., et al. (2018), “Chapter 5: The Six E’s of Consumer Choice” in *Choice Matters: How Healthcare Consumers Make Decisions (and Why Clinicians and Managers Should Care)*, (Oxford, UK: Oxford University Press) pp. 148–149, PBHN000004442–75; Trenaman, L., et al. (2023), “What is a Star Worth to Medicare Beneficiaries? A Discrete Choice Experiment of Hospital Quality Ratings,” *Health Affairs Scholar*, 2, 1, 1–7 at pp. 3–4, PBHN000007630–6.

⁸⁰ “Consumer Choice in U.S. Health Care: Using Insights from the Past to Inform the Way Forward,” *The Commonwealth Fund*, November 30, 2021, <https://www.commonwealthfund.org/publications/fund-reports/2021/nov/consumer-choice-us-health-care-using-insights-from-past>, PBHN000003391–404; Moore, G., et al. (2018), “Chapter 5: The Six E’s of Consumer Choice” in *Choice Matters: How Healthcare Consumers Make Decisions (and Why Clinicians and Managers Should Care)*, (Oxford, UK: Oxford University Press) p. 149, PBHN000004442–75.

⁸¹ Duke et al. (2017), pp. 192, 197, PBHN000003517–23.

⁸² Motion for Preliminary Injunction, Exhibit 6, pp. 2–3, cited as (“Why the Hospital Safety Grade Works,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/why-the-hospital-safety-grade-works>), PBHN000003079–81.

⁸³ Koehler, J. J. and A. D. Gershoff (2003), “Betrayal Aversion: When Agents of Protection Become Agents of Harm,” *Organizational Behavior and Human Decision Processes*, 90, 244–261 at p. 244, PBHN000003907–24.

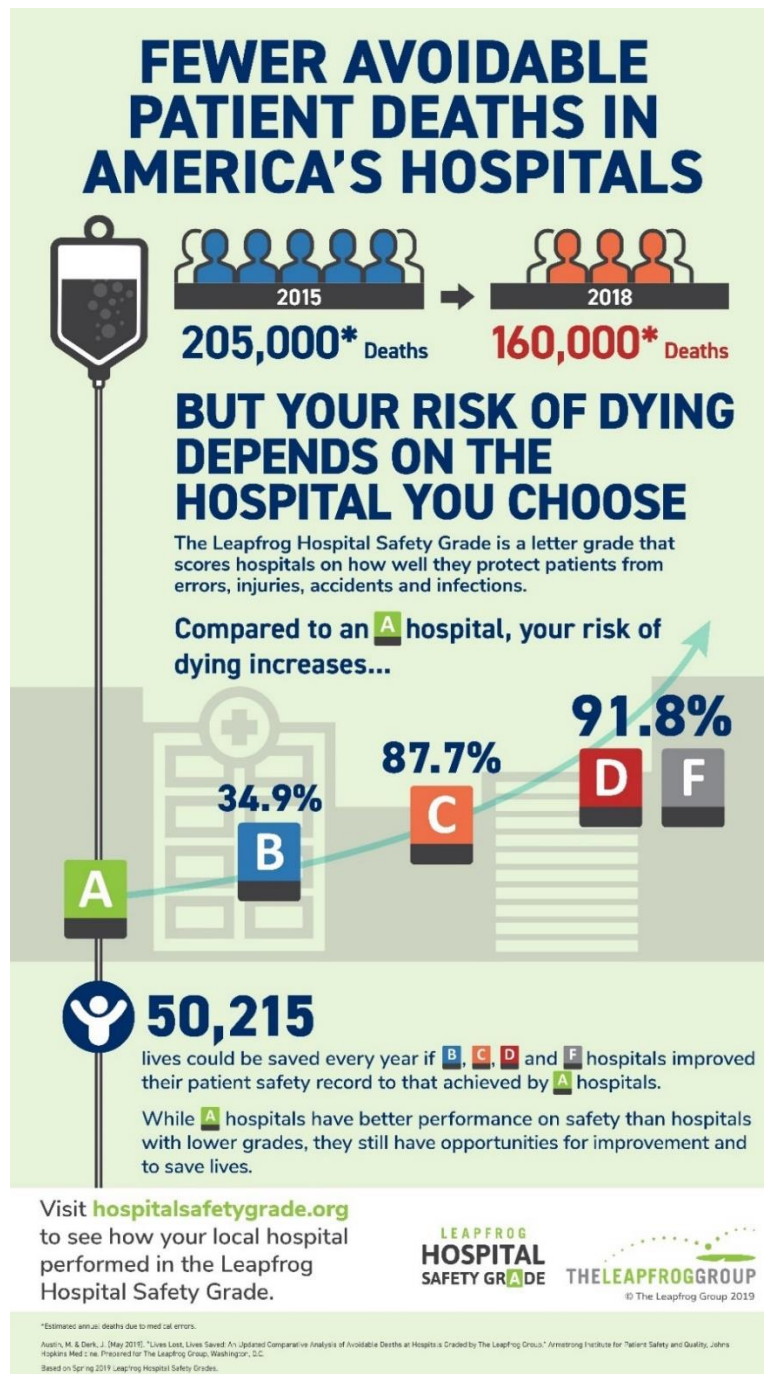
consumers are likely to experience these negative emotions even when they are faced with *the risk of harm*, and need not necessarily experience the actual harm.⁸⁴

45. Content on hospitalsafetygrade.org emphasizes both the risk of harm from choosing a “D” or “F” rated hospital and, for the imputed measures, the risk of choosing a hospital that is rated poorly on that measure. For example, on the page “Frequently Asked Questions About The Leapfrog Hospital Safety Grade,” TLG states that “It is critical to monitor safety before choosing a hospital. Preventable medical errors, accidents, injuries and infections in hospitals kill upwards of 200,000 people every year, the third leading cause of death in the United States” and “Johns Hopkins Medicine researchers estimate that patients are twice as likely to die of a preventable problem at a ‘C,’ ‘D,’ or ‘F’ hospital than an ‘A’ hospital, and over 50,000 lives would be saved if all hospitals performed the way A hospitals did.”⁸⁵ In the same vein, Exhibit 3 is an infographic from hospitalsafetygrades.org, which claims that a patient’s risk of dying increases by 90% when she chooses a “D” or “F” rated hospital instead of an “A” rated hospital.

⁸⁴ Gershoff, A. D. and J. J. Koehler (2011), “Safety First? The Role of Emotion in Safety Product Betrayal Aversion,” *The Journal of Consumer Research* 38, 140–150 at pp. 143, 145, PBHN000003674–85.

⁸⁵ Motion to Dismiss, Exhibit 3, p. 3 (citing “Frequently Asked Questions About The Leapfrog Hospital Safety Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/frequently-asked-questions>), PBHN000002423–7.

Exhibit 3 Example of Content on hospitalsafetygrade.org that Emphasizes Risk of Harm



Source: "Lives Lost and Lives Saved," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/your-hospitals-safety-grade/LivesLost>

Note: This exhibit shows an infographic displayed on-screen when a user navigates to the "Lives Lost and Lives Saved" page on hospitalsafetygrade.org.

46. TLG makes similar statements in content on leapfroggroup.org. For example, TLG provides “Patient Toolkits,” which it describes as “toolkits ... to empower patients with the knowledge and resources to make informed decisions about [their] medical care.”⁸⁶ In its toolkit titled, “Leapfrog Hospital Safety Grade Explained Toolkit,” under a heading “Why are Hospital Safety Grades Important?,” TLG includes statements like “[e]very year, one out of 31 patients develop an infection while in the hospital, and a Medicare patient has a one in four chance of experience, injury, harm or death when admitted into a hospital.”⁸⁷

47. Similarly, on TLG’s Hospital Safety Grade Page, a description of each measure is shown alongside the hospital’s score on that measure, as shown in Exhibit 4. For three of the four imputed measures at issue in this matter, the description includes language related to harm, as described below.⁸⁸ Thus, for each Plaintiff Hospital, TLG’s Hospital Safety Grade page displays harm-related language directly alongside a low imputed score on these measures.

- **Doctors order medications through a computer:** “Good CPOE [Computerized Physician Order Entry] systems alert the doctor if they try to order a medication *that could cause harm*...”⁸⁹
- **Specially trained doctors care for ICU patients:** “There are *higher death rates* in hospitals where ICU patients are not cared for by intensivists.”⁹⁰
- **Handwashing:** “When hospital staff does not carefully wash their hands, they can spread germs from one patient to another and cause someone to become *seriously ill*.”⁹¹

⁸⁶ “Judie Burrows Education Institute Patient Toolkits,” *The Leapfrog Group*, <https://www.leapfroggroup.org/judie-burrows-education-institute-patient-toolkits>, PBHN000004429–37.

⁸⁷ “Leapfrog Hospital Safety Grades Explained,” *The Leapfrog Group*, <https://www.leapfroggroup.org/sites/default/files/Files/Leapfrog%20Patient%20Toolkits%20%281%29.pdf>, PBHN000004440–1.

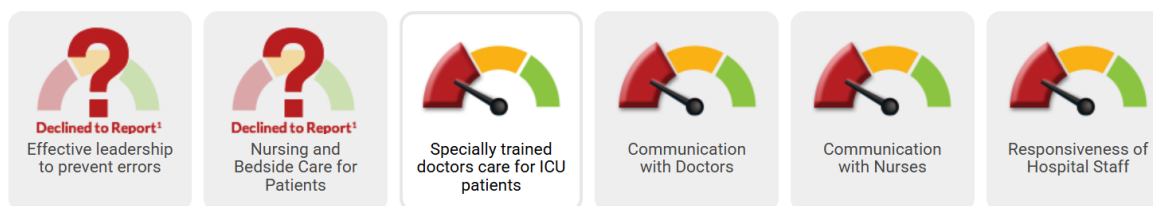
⁸⁸ The fourth measure, “Safe medication administration,” discusses “the risk that a hospital accidentally gives the wrong medication to a patient.” *See, e.g.*, “Palm Beach Gardens Medical Center,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>, excerpts from Hospital Safety Grade Page, PBHN000007591–4.

⁸⁹ Emphasis added. *See, e.g.*, “Palm Beach Gardens Medical Center,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>, excerpts from Hospital Safety Grade Page, PBHN000007591–4.

⁹⁰ Emphasis added. *See, e.g.*, “Palm Beach Gardens Medical Center,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>, excerpts from Hospital Safety Grade Page, PBHN000007591–4.

⁹¹ Emphasis added. *See, e.g.*, “Palm Beach Gardens Medical Center,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>, excerpts from Hospital Safety Grade Page, PBHN000007591–4.

Exhibit 4 Example of Description of the ICU Physician Staffing Measure on hospitalsafetygrade.org



Hospital Performs:
Worse Than Average ■ ■ ■ Better Than Average

This Hospital's Score:

5 *

Best Hospital's Score:

100

Average Hospital's Score:

65.15

Worst Hospital's Score:

5

Specially trained doctors care for ICU patients

A critical care unit or Intensive Care Unit (ICU) is a special part of the hospital that provides care for extremely ill patients. Hospitals should have special doctors called intensivists working in the ICU. Intensivists are physicians with advanced training in intensive or critical care. They learn to manage problems in the ICU and help to reduce errors. There are higher death rates in hospitals where ICU patients are not cared for by intensivists.

What safer hospitals do:

Hospitals staff ICUs with physicians who have training in critical care medicine.

Hospitals can earn up to 100 points for staffing their ICUs with intensivists. [For details on sources, click here.](#)

Source: "Palm Beach Gardens Medical Center," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>

Note: This exhibit displays an excerpt of the Hospital Safety Grade Page for Palm Beach Gardens Medical Center, navigated to the "Doctors, Nurses & Hospital Staff" tab and "Specially trained doctors care for ICU patients" measure.

48. While it is possible that the impact of low or failing TLG Hospital Safety Grades on a consumer's hospital choice may be reduced if the consumer is exposed to other, positive information about the hospitals she is considering, research has found that when consumers are exposed to negative information about a product, they are less likely to continue searching for additional information about it.⁹² Negative information about a product also leads consumers to seek out information about substitutes.⁹³ Further, studies show that when participants experience negative emotions, they are more likely to disregard additional information they receive.⁹⁴

⁹² Varga, M. and P. Albuquerque (2023), "The Impact of Negative Reviews on Online Search and Purchase Decisions," *Journal of Marketing Research*, 61, 5, 803–820 at p. 813, PBHN000004293–311.

⁹³ Varga, M. and P. Albuquerque (2023), "The Impact of Negative Reviews on Online Search and Purchase Decisions," *Journal of Marketing Research*, 61, 5, 803–820, at p. 813, PBHN000004293–311.

⁹⁴ Keller, P. A. (1999), "Converting the Unconverted: The Effect of Inclination and Opportunity to Discount Health-Related Fear Appeals," *Journal of Applied Psychology*, 84, 3, 403–415 at p. 413, PBHN000007601–16.

49. Consequently, when exposed to a “D” or “F” TLG Hospital Safety Grade, consumers are likely to experience negative emotions, like betrayal, and might limit their search for additional information about those hospitals, including positive information that could contradict a low or failing Hospital Safety Grade.

D. TLG Presents the Four Imputed Measures as Fundamental Aspects of Medical Care and Frames its Hospital Safety Grades as Essential Inputs into Consumers’ Hospital Choices

50. Consistent with the premise that Hospital Safety Grades can influence consumers’ hospital choices, TLG itself emphasizes the importance of using them in making such decisions. On [hospitalsafetygrade.org](https://www.hospitalsafetygrade.org), TLG repeatedly stresses that several specific imputed measures are determinative of hospital safety, the potential consequences of choosing an unsafe hospital, and the importance of using TLG’s Hospital Safety Grades to choose the safest hospital. Consequently, consumers who view this content, and view the low or failing TLG Hospital Safety Grades for Plaintiff Hospitals, may be persuaded to avoid Plaintiff Hospitals.

51. Specific to the imputed measures, [hospitalsafetygrades.org](https://www.hospitalsafetygrades.org) frames some as fundamental aspects of medical care and encourages consumers to weigh these measures more heavily when making their decisions. For example:

- **Handwashing:** TLG states that “[t]he Safety Grade rates hospitals on the very basics of medical care, such as handwashing, entering prescriptions through a computer...”⁹⁵ and lists Handwashing as one of three “most important” measures⁹⁶
- **Specially trained doctors care for ICU patients:** “If you’re concerned about a seriously-ill parent or family member, you can look at ICU staffing protocols and how the hospital uses computerized prescribing and bar-code technology to keep patients safe from medication errors.”⁹⁷

52. More broadly, multiple pages on [hospitalsafetygrade.org](https://www.hospitalsafetygrade.org) emphasize the importance of hospital choice in making healthcare decisions and, consequently, the use of TLG’s Hospital

⁹⁵ Motion for Preliminary Injunction, Exhibit 15, p. 3 (citing “How to Use the Grade”, *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/your-hospitals-safety-grade/how-to-use-the-grade>), PBHN000003070–5.

⁹⁶ Motion for Preliminary Injunction, Exhibit 15, p. 4 (citing “How to Use the Grade”, *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/your-hospitals-safety-grade/how-to-use-the-grade>), PBHN000003070–5.

⁹⁷ Motion to Dismiss, Exhibit 7, p. 3 (citing “Choosing the Best Hospital,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/choosing-the-best-hospital>), PBHN000002626–8.

Safety Grades. Specifically, the language used by TLG presents hospital choice not only as important to a consumer's safety, but as a matter of life or death. For example:

- "Your choice of hospital could be a life or death decision. Hospitals vary greatly on things like infection rates, surgical errors, and patient injuries—not to mention ER wait times, patient satisfaction, and other things we're just now starting to measure."⁹⁸
- "It is critical to monitor safety before choosing a hospital. Preventable medical errors, accidents, injuries and infections in hospitals kill upwards of 200,000 people every year, the third leading cause of death in the United States."⁹⁹
- "YOUR RISK OF DYING DEPENDS ON THE HOSPITAL YOU CHOOSE"¹⁰⁰

53. Finally, TLG's website presents TLG's Hospital Safety Grades to consumers as the primary piece of information they should use in choosing a hospital. For example:

- "When they have a choice, the Hospital Safety Grade is the first tool patients ***should*** use to select a hospital, because safety should come first."¹⁰¹
- "Choosing the best hospital for you doesn't have to be a daunting task—as long as you have the right tools. Your first step in finding the best care for yourself and your family is finding a safer hospital. Use the Leapfrog Hospital Safety Grade search tool to find the safest hospital in your area, preferably one with an 'A' grade."¹⁰²
- "Find a safer hospital. When you get to the list of hospital matches, look for hospitals with the highest grade. If there's more than one hospital with a good grade, then you can look at other things that are important to you."¹⁰³

54. Thus, across hospitalsafetygrade.org, TLG encourages consumers to rely on both its Hospital Safety Grades and some of its imputed measures as essential inputs into their hospital choices, while conveying to consumers that their choices can be a matter of life or death.

⁹⁸ Motion to Dismiss, Exhibit 7, p. 2 (citing "Choosing the Best Hospital," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/choosing-the-best-hospital>), PBHN000002626–8.

⁹⁹ Motion to Dismiss, Exhibit 3, p. 3 (citing "Frequently Asked Questions About the Leapfrog Hospital Safety Grade," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/frequently-asked-questions>), PBHN000002423–7.

¹⁰⁰ Motion to Dismiss, Exhibit 6, p. 5 (citing "Lives Lost and Lives Saved," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/your-hospitals-safety-grade/LivesLost>), PBHN000003004–8.

¹⁰¹ Emphasis added. Motion to Dismiss, Exhibit 3, p. 7 (citing "Frequently Asked Questions About the Leapfrog Hospital Safety Grade," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/frequently-asked-questions>), PBHN000002423–7.

¹⁰² Motion to Dismiss, Exhibit 7, pp. 2–3 (citing "Choosing the Best Hospital," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/choosing-the-best-hospital>), PBHN000002626–8.

¹⁰³ Transcribed from embedded video on page "Your Hospital's Safety Grade" on hospitalsafetygrade.org. See "Your Hospital's Safety Grade," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/your-hospitals-safety-grade>, PBHN000004353.

VII. Future, Repeated Publications of “D” or “F” Hospital Safety Grades Would Be Expected to Have a Long-Term, Negative Impact on Perceptions of and Choice for Plaintiff Hospitals

55. The previous sections discuss how low or failing TLG Hospital Safety Grades would likely negatively impact consumers’ perceptions of, and choices for, Plaintiff Hospitals. This section discusses why the negative impacts of low or failing Hospital Safety Grades would be expected to be long-lasting, and how these impacts would be further amplified by future, repeated publications of low or failing Hospital Safety Grades.

56. TLG’s low or failing grades for Plaintiff Hospitals will likely have negative long-term effects on many consumers’ perceptions of these hospitals, as consumers who are exposed to the grades share their perceptions with others through word of mouth.¹⁰⁴ For example, one TikTok video posted by user “True Stories,” uses TLG’s Fall 2024 Hospital Safety Grades to create a list of the “worst hospital in Florida.” The video lists four of the five Plaintiff Hospitals (West Boca Medical Center, Delray Medical Center, Good Samaritan Medical Center, and Palm Beach Gardens Medical Center) as among the top five worst hospitals in Florida.¹⁰⁵ Moreover, the video explicitly cites TLG’s assessment of each hospital’s performance on different measures, including the imputed measure for “Handwashing.” As of August 6, 2025, the video had over a million views, 43,000 likes, 3,000 comments, and almost 30,000 shares.

57. Moreover, the impact of TLG’s currently published Hospital Safety Grades for Plaintiff Hospitals may be long-lasting because negative impressions can be hard to overcome. Research shows that, compared to positive impressions, negative impressions can be slower to change or fade.¹⁰⁶ For example, in one study, the researcher asked participants to write first-person sentences with friendly, neutral, or hostile words.¹⁰⁷ The sentences using hostile words resulted in a longer

¹⁰⁴ Berger, J. (2014), “Word of Mouth and Interpersonal Communication: A Review and Directions for Future Research,” *Journal of Consumer Psychology*, 24, 4, 586–607 at pp. 587, 594, PBHN000003281–302.

¹⁰⁵ “@usamap55 Video,” *TikTok*, https://www.tiktok.com/@usamap55/video/7525460573430107405?_r=1&_t=ZP-8xwM4HOacsp, PBHN000002238.

¹⁰⁶ Baumeister, R. F., et al. (2001), “Bad is Stronger than Good,” *Review of General Psychology*, 5, 4, 323–370 at pp. 323, 325, PBHN000003216–63; Sanbonmatsu D. M., et al. (2022), “Perceived Changes in Trait Attributions to Others and the Self,” *Journal of Social Psychology*, 164, 5, 1–19 at p. 1, PBHN000004131–50.

¹⁰⁷ Ikegami, T. (1993), “Positive-Negative Asymmetry of Priming Effects on Impression Formation,” *European Journal of Social Psychology*, 23, 1, 1–16 at pp. 5–6, 8, PBHN000003761–76.

lasting effect on participants' emotional states than the sentences containing friendly or neutral words.¹⁰⁸

58. Additionally, future publication of low or failing Hospital Safety Grades for Plaintiff Hospitals may cause consumers who had already been exposed to this information to see it repeatedly, and research has shown that repeated exposure can increase the persuasiveness of information. For example, research has found that, in many circumstances, the act of being repeatedly exposed to information changes the way individuals perceive that information. Repeated exposure to information can result in the belief that the information is true (known as the "illusory truth effect").¹⁰⁹ The illusory truth effect describes the tendency of repeated information to be perceived as more true. In a 2023 study, researchers showed consumers 30 health-related statements, such as "[s]ugar-sweetened beverages decrease risk of heart disease."¹¹⁰ Afterwards, the researchers showed the same consumers 60 health-related statements, of which 30 were repeated. The researchers found that "repetition of information was associated with higher perceived accuracy."¹¹¹ In other words, respondents were more likely to believe that certain health information was true the more times they viewed it. A 2009 meta-analysis found that the illusory truth effect was robust across a variety of contexts and information presentation settings, including length of time between repetitions of information as well as the presentation of information (e.g., whether the information was presented visually or auditorily).¹¹² Similarly, a meta-analysis from 2019 found that the illusory truth effect was robust to the type of information (e.g., trivia, news, and consumer opinions), how motivated individuals are to assess the truthfulness of the information, and even the presence of other information about the accuracy of the statement.¹¹³

¹⁰⁸ Ikegami, T. (1993), "Positive-Negative Asymmetry of Priming Effects on Impression Formation," *European Journal of Social Psychology*, 23, 1, 1–16 at pp. 1, 11, PBHN000003761–76; Kensinger E. A. and S. Corkin (2003), "Effect of Negative Emotional Content on Working Memory and Long-Term Memory," *Emotion*, 3, 4, 378–393 at p. 388, PBHN000003877–92; Baumeister, R. F., et al. (2001), "Bad is Stronger than Good," *Review of General Psychology*, 5, 4, 323–370 at pp. 323, 325, PBHN000003216–63.

¹⁰⁹ Vellani, V., et al. (2023), "The Illusory Truth Effect Leads to the Spread of Misinformation," *Cognition*, 236, 105421, 1–7 ("Vellani et al. (2023)") at p. 2, PBHN000004312–8; Arkes, H. R., et al. (1989), "The Generality of the Relation between Familiarity and Judged Validity," *Journal of Behavioral Decision Making*, 2, 2, 81–94 at pp. 81–82, PBHN000003167–81.

¹¹⁰ Vellani, V., et al. (2023), "The Illusory Truth Effect Leads to the Spread of Misinformation," *Cognition*, 236, 105421, Appendix A: Supplementary Materials, PBHN000004476–83.

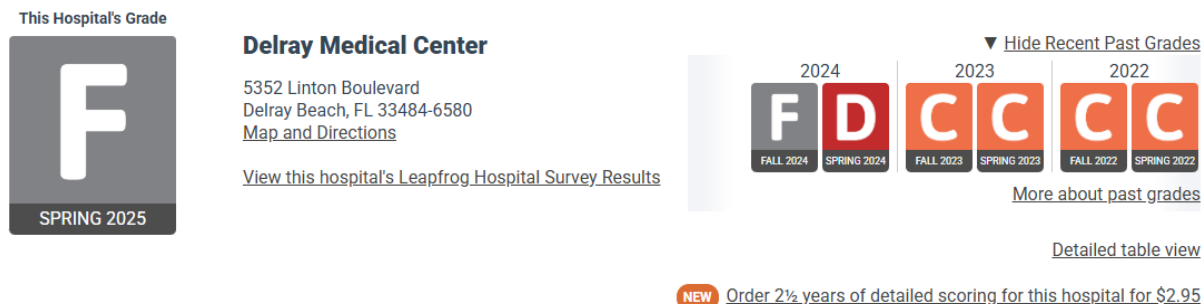
¹¹¹ Vellani et al. (2023), pp. 2, 4, PBHN000004312–8.

¹¹² Dechêne, A., et al. (2009), "The Truth About the Truth: A Meta-Analytic Review of the Truth Effect," *Personality and Social Psychology Review*, 14, 2, 238–257 at pp. 246–247, PBHN000003477–96.

¹¹³ Unkelback, C., et al. (2019), "Truth by Repetition: Explanations and Implications," *Current Directions in Psychological Science*, 28, 247–253 at p. 248, PBHN000004286–92.

59. The illusory truth effect would likely influence consumers' impressions of Plaintiff Hospitals if TLG continues to assign the hospitals low or failing Hospital Safety Grades in the future. Indeed, consumers who have already been exposed to TLG's existing "D" or "F" Hospital Safety Grades for Plaintiff Hospitals' may be exposed to future grades during future searches for information about hospitals. Moreover, on its Hospital Safety Grade Pages, TLG publishes not only the grade for the current period but also past grades, as shown in the excerpt in Exhibit 5.¹¹⁴ Thus, if TLG continues to publish low or failing Hospital Safety Grades for Plaintiff Hospitals in the future, the low or failing grades will be repeatedly published on each Plaintiff Hospital's TLG Hospital Safety Grade Page, deepening consumers' negative impressions of those hospitals.

Exhibit 5 Example of the Presentation of Past Grades on TLG's Hospital Safety Grade Pages



Source: "Delray Medical Center," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/delray-medical-center>.

Note: This exhibit displays an excerpt of the Hospital Safety Grade Page for Delray Medical Center, after clicking "Show Recent Past Grades."

VIII. Many Consumers Would Be Unlikely to Understand that TLG Assigns the Minimum Score on the Imputed Measures and the Impact of this Practice on the Safety Grades TLG Assigns to Non-Participating Hospitals, Based on TLG's Imputation Disclosures

60. I understand that TLG purports to display disclosures about its imputation methodology on pages of its websites, [hospitalsafetygrade.org](https://www.hospitalsafetygrade.org) and [leapfroggroup.org](https://www.leapfroggroup.org).¹¹⁵ Further, TLG claims that

¹¹⁴ A consumer can click "Show Recent Past Grades" on a TLG Hospital Safety Grade Page to see a hospital's past grades, as shown in Exhibits 7 and 8.

¹¹⁵ Motion to Dismiss, pp. 8–9.

the websites “encourage users to view its full grading methodology as well as the data and analysis used” and provide “full transparency in[to TLG’s] ratings programs.”¹¹⁶ However, TLG’s disclosures of its imputation methodology are unlikely to adequately inform consumers as to how it calculates its overall Hospital Safety Grade.

61. In addition to the overall letter grade shown on each Hospital Safety Grade Page, TLG also presents numeric scores and dial graphics for each measure underlying the letter grade. For the four imputed measures (i.e., “Doctors order medications through a computer,” “Safe medication administration,” “Specifically trained doctors care for ICU patients,” and “Handwashing”), TLG calculates scores using its imputation methodology, as explained in Section II.¹¹⁷ In Fall 2024, TLG changed its imputation methodology to assign the “lowest possible score” on the imputed measures for hospitals that did not participate in its survey and who did not have scores assigned in the two previous rounds of grades.¹¹⁸ TLG refers to this practice as assigning a score reflecting “Limited Achievement” on the measure. The score that is assigned can vary by imputed measure (e.g., 5 out of 100 for the measure “Specifically trained doctors care for ICU patients” and 15 out of 100 for the measure “Handwashing”), but it always represents the minimum possible score for the measure. I will refer to this practice as assigning the “minimum score” on the imputed measures.¹¹⁹

62. Plaintiffs allege that TLG fails to adequately disclose that its imputed measure scores do not represent Plaintiff Hospitals’ actual safety performance but instead their hospitals’ decisions not to respond to TLG’s hospital survey.¹²⁰ Plaintiffs also allege that TLG fails to adequately disclose the impact of its minimum score assignment on TLG’s overall “D” or “F” letter grades

¹¹⁶ Motion to Dismiss, p. 8.

¹¹⁷ The listed names are the names of the measures that appear on TLG’s Hospital Safety Grade Pages. Plaintiffs refer to these four measures as “Computerized Order Entry, Bar Code Medication Administration, ICU Physician Staffing, and Hand Hygiene Score” in their Complaint. See Complaint, ¶ 51.

¹¹⁸ Complaint, ¶ 50; Motion to Dismiss, Exhibit 38, p. 3, (citing “Final Updates to the Leapfrog Hospital Safety Grade Methodology for Fall 2024,” *The Leapfrog Group*, https://www.hospitalsafetygrade.org/media/file/Fall2024HospitalSafetyGrade_FinalMethodologyChanges.pdf), PBHN000002632–7.

¹¹⁹ For each measure, TLG places hospitals in one of several performance categories, which it translates to a numeric score for the purpose of calculating the letter grade. These categories range from the highest “Achieved the Standard” (which is assigned 100 numeric score) to the lowest “Limited Achievement,” which TLG translates into a different low numeric score for each measure. See Complaint, ¶ 50; Motion to Dismiss, Exhibit 5, pp. 11–12, 14, (citing Methodology Document), PBHN000003012–40.

¹²⁰ Complaint, ¶ 52.

for Plaintiff Hospitals, which are based, in part, on scores for the imputed measures.¹²¹ I understand that TLG purports to disclose the imputation methodology in its imputation disclosures, including in notes and documentation on hospitalsafetygrade.org and leapfroggroup.org.¹²² In this section, I analyze TLG's imputation disclosures to assess the extent, if any, to which these disclosures would be expected to affect consumers' understanding of TLG's practice of assigning the minimum score on the imputed measures and the impact of this assignment on TLG's overall Hospital Safety Grades.

A. TLG Does Not Directly Disclose Information on its Practice of Assigning the Minimum Score to Non-Participating Hospitals on TLG's Hospital Safety Grade Pages

63. As background on navigating TLG's Hospital Safety Grade Pages, Exhibit 6 shows the information a consumer would see on a Hospital Safety Grade Page for Plaintiff Hospital Palm Beach Gardens Medical Center when the consumer first navigates to the page. As shown in the exhibit, on each Hospital Safety Grade Page, TLG presents both the overall letter grade for the hospital and five "tabs." When a consumer arrives on the page, the leftmost tab "Infections" is selected by default. Within each tab, there are multiple measures (e.g., "MRSA Infection," "C. diff Infection," "Infection in the blood," etc.), and TLG summarizes its scores for each measure within the tab using dial graphics (e.g., the dial pointing to green for "MRSA Infection"). When a consumer arrives on the page, the leftmost measure "MRSA Infection" is selected by default. For the selected measure, TLG then presents the hospital's numeric score on that measure (e.g., 0.278 for "MRSA Infection") as well as summaries of the "Best," "Average," and "Worst" scores across all hospitals.

¹²¹ Complaint, ¶ 52.

¹²² Motion to Dismiss, pp. 8–9. I understand TLG also purports to disclose the imputation methodology on its website leapfroggroup.org.

Exhibit 6 The Default View When a Consumer First Navigates to the TLG Hospital Safety Grade Page for Palm Beach Gardens Medical Center

The screenshot displays the Leapfrog Hospital Safety Grade website. At the top, there is a navigation bar with links: "Join Our Mailing List", "Newsroom", and "Donate Now". Below this is a header section with the Leapfrog Hospital Safety Grade logo and a "Back to Results" button. The main content area shows the hospital's grade, "Palm Beach Gardens Medical Center", with a large "F" grade and a "Spring 2025" label. A red arrow points to the "F" grade with the text "Overall Grade ('F')". Below the grade, there is a "Tab ('Infections')" label pointing to the "Infections" tab in the navigation menu. The "Infections" tab is selected, and the "MRSA Infection" measure is highlighted. A red arrow points to the "MRSA Infection" measure with the text "Selected Measure ('MRSA Infection')". Below the measure, a "Dial Graphic for Measures" is shown, with a red arrow pointing to the "MRSA Infection" dial. The dial shows a score of 0.278, with a red arrow pointing to it and the text "Numeric Score for Selected Measure ('0.278')". The page also includes a "Notes and Definitions" section and a "Legal Disclaimer" at the bottom.

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This Hospital's Grade

Palm Beach Gardens Medical Center

3360 Burns Road
Palm Beach Gardens, FL 33410-4304
[Map and Directions](#)

[View this hospital's Leapfrog Hospital Survey Results](#)

Overall Grade ("F")

SPRING 2025

[Show Recent Past Grades](#)

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Tab ("Infections")

Infections Problems with Surgery Safety Problems Practices to Prevent Errors Doctors, Nurses & Hospital Staff

MRSA Infection

C. diff Infection

Infection in the blood

Infection in the urinary tract

Surgical site infection after colon surgery

Septic infection after surgery

Dial Graphic for Measures

Selected Measure ("MRSA Infection")

This Hospital's Score:
0.278

Best Hospital's Score:
0.000

Average Hospital's Score:
0.719

Worst Hospital's Score:
2.850

Numeric Score for Selected Measure ("0.278")

MRSA Infection
Staph bacteria are common in hospitals, but Methicillin-resistant Staphylococcus aureus (MRSA) is a type of staph bacteria that is resistant to (cannot be killed by) many antibiotics. MRSA can be found in bed linens or medical equipment and can be spread if providers do not properly wash their hands between patients. MRSA can cause life-threatening bloodstream infections, pneumonia and surgical site infections.

What safer hospitals do:
Doctors and nurses should clean their hands after caring for every patient. Hospital rooms and medical equipment should be thoroughly cleaned often. Safer hospitals will also keep MRSA patients separate from other patients and require providers and visitors to wear gloves and gowns around these patients.

Notes and Definitions

1. **Declined to Report:** The hospital was asked to provide this information to the public, but did not.

2. **Not Available:** "Not Available" means that the hospital does not have data for this measure. This could be because the measure is related to a service the hospital does not provide. For example, a hospital that does not have an ICU would not be able to report data about ICUs. It could also be because the hospital had too few patients or cases to report data for a particular condition or procedure. A "Not Available" result does not mean that the hospital withheld information from the public.

3. **Straight A:** The hospital has earned an A Grade for five consecutive grading rounds or more, qualifying it for recognition as a "Straight A" hospital.

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Source: "Palm Beach Gardens Medical Center," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>

Note: This exhibit displays the Hospital Safety Grade Page for Palm Beach Gardens Medical Center, navigated to the "Infections" tab and "MRSA Infection" measure, which is the default page view. The red arrows and text labels indicate different elements of the Hospital Safety Grade Page.

64. From this initial view, a consumer can then decide whether to leave the Hospital Safety Grade Page or to navigate to somewhere else on hospitalsafetygrade.org from the page. In particular, as shown in Exhibits 7 and 8, some of the places a consumer can click on include:¹²³

- “For details on sources, click here” within the description of the “MRSA Infections” measure, which takes the consumer to a table that includes the hospital’s numeric scores on each measure; the worst, average, and best scores across all hospitals; the data source for the measure; and the time period covered
- A different measure within the “Infections” tab
- A different tab and/or measure within that tab
- A link at the top of the Hospital Safety Grade Page, including:
 - “View this hospital’s Leapfrog Hospital Survey Results,” which takes the user to the hospital’s survey results on TLG’s website leapfroggroup.org
 - “Show Recent Page Grades,” which opens a dropdown of the hospital’s past six grades
 - “Detailed table view,” which takes the consumer to the same table view as the “For details on sources, click here” link
- A video, titled “Your Hospital’s Safety Grade”¹²⁴

¹²³ A consumer can also navigate to other pages on hospitalsafetygrade.org, using the dropdowns at the top of the page or the links at the very bottom of the page.

¹²⁴ When a consumer clicks on this link, they also have the option to view two other videos, with the titles “What is Patient Safety?” and “What You Can Do to Stay Safe.”

Exhibit 7 Examples of Navigation from a TLG Hospital Safety Grade Page

LEGEND

Goes to different tab and/or measure within that tab

Goes to different measures within the "Infections" tab

Goes to hospital's survey results

Goes to a TLG video titled "Your Hospital's Safety Grade"

Goes to hospital's past six grades

Goes to hospital's numeric scores for each measure

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This Hospital's Grade

F

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[Show Recent Past Grades](#)

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Infections | **Problems with Surgery** | **Safety Problems** | **Practices to Prevent Errors** | **Doctors, Nurses & Hospital Staff**

MRSA Infection

Hospital Performs:

Worse Than Average | Better Than Average

This Hospital's Score: 0.278

Best Hospital's Score: 0.000

Average Hospital's Score: 0.719

Worst Hospital's Score: 2.850

What safer hospitals do:

Doctors and nurses should clean their hands after caring for every patient. Hospital rooms and medical equipment should be thoroughly cleaned often. Safer hospitals will also keep MRSA patients separate from other patients and require providers and visitors to wear gloves and gowns around these patients.

Notes and Definitions

- Declined to Report:** The hospital was asked to provide this information to the public, but did not.
- Not Available:** "Not Available" means that the hospital does not have data for this measure. This could be because the measure is related to a service the hospital does not provide. For example, a hospital that does not have an ICU would not be able to report data about ICUs. It could also be because the hospital had too few patients or cases to report data for a particular condition or procedure. A "Not Available" result does not mean that the hospital withheld information from the public.
- Straight A:** The hospital has earned an A Grade for five consecutive grading rounds or more, qualifying it for recognition as a "Straight A" hospital.

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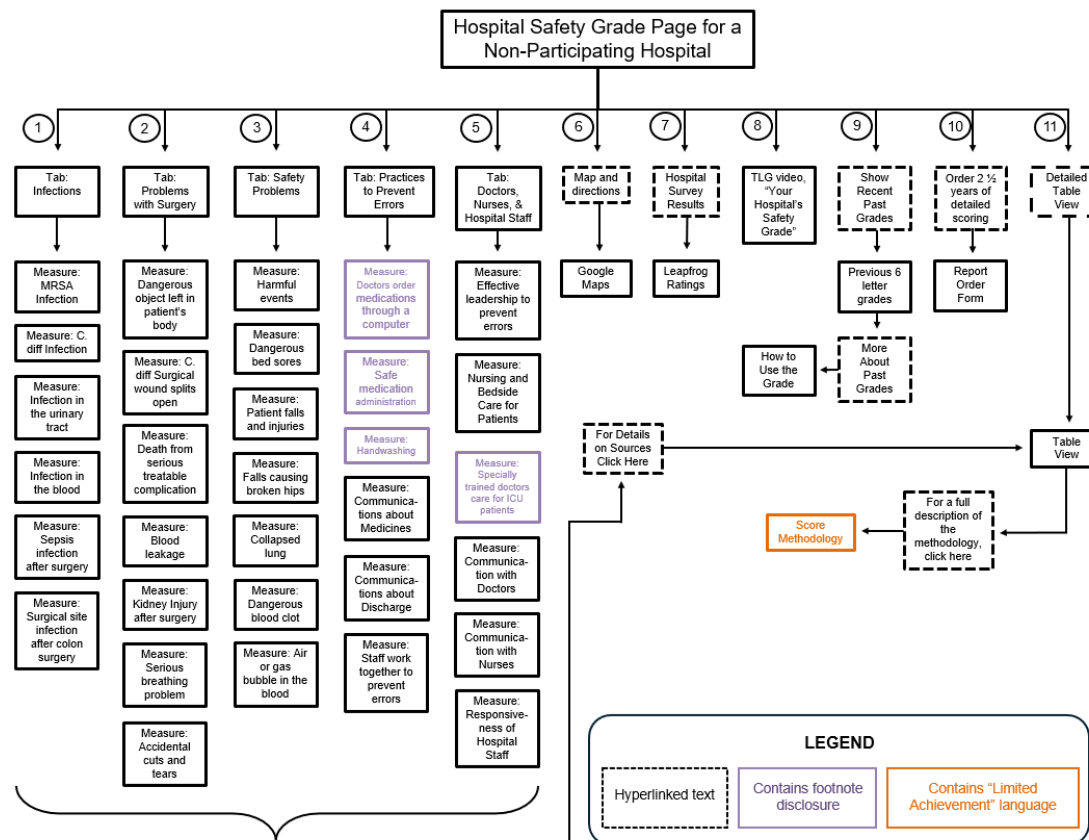
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Source: "Palm Beach Gardens Medical Center," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>

Note: This exhibit displays the Hospital Safety Grade Page for Palm Beach Gardens Medical Center, navigated to the "Infections" tab and "MRSA Infection" measure, which is the default page view. Color-coded boxes highlight places a user can click on the page to navigate to the locations defined in the legend.

Exhibit 8 TLG Hospital Safety Grade Page Navigation Structure



Source: "Palm Beach Gardens Medical Center," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>, PBHN000003151.

Note: This chart displays the possible routes a user could take from a Hospital Safety Grade Page. Routes are terminated at the point at which they either (1) lead to a page outside of the Hospital Safety Grade Page or (2) contain no more clickable links on the page. The route to reach the methodology document exceeds this criteria but is included to show the location of the "Limited Achievement" language. I have excluded routes navigable via the fixed dropdown menus in the navigation bar and the fixed hyperlinks in the sub-footer. I understand that it is possible to reach the methodology document via those routes.

65. TLG purports to disclose its imputation methodology on TLG's websites.¹²⁵ One such purported disclosure appears in the "Notes and Definitions" section underneath the "tabs" on the Hospital Safety Grade Page.¹²⁶ When a consumer navigates to one of the four imputed measures on a TLG Hospital Safety Grade Page, TLG presents the imputed numeric score on that measure and an asterisk, which points to a footnote ("footnote disclosure"), as outlined in the flowchart in Exhibit 8. Exhibits 9, 10, 11, and 12 below show four images of a TLG Hospital Safety Grade Page, navigated to each of the four imputed measures. The footnote disclosure appears in small font near the bottom of each page and states, "* The hospital declined to report their performance on this measure, so a score was assigned to reflect the lack of information available."¹²⁷ Thus, while the footnote disclosure states that "a score" was assigned by TLG, it does not convey that this assigned score was the minimum score for the imputed measure.

¹²⁵ Motion to Dismiss, p. 8.

¹²⁶ Motion to Dismiss, pp. 8–9.

¹²⁷ See, e.g., Motion to Dismiss, Exhibit 29, p. 3 (citing "Palm Beach Gardens Medical Center," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>), PBHN000003009–11.

Exhibit 9 The Footnote Disclosure on TLG’s Hospital Safety Grade Page for Palm Beach Gardens Medical Center, When Navigated to the Imputed Measure: *Doctors order medications through a computer*

The screenshot displays the Leapfrog Hospital Safety Grade website. At the top, there is a navigation bar with links like 'Join Our Mailing List', 'Newsroom', and 'Donate Now'. Below this, the hospital's name 'Palm Beach Gardens Medical Center' is shown along with its address and a 'View this hospital's Leapfrog Hospital Survey Results' link. The main section features a grid of safety measures, each with a circular gauge icon. The 'Doctors order medications through a computer' measure is highlighted with a red box and shows a score of 15. Below the grid, a 'Notes and Definitions' section contains four footnotes. Footnote 4, which is also highlighted with a red box, states: '* The hospital declined to report their performance on this measure, so a score was assigned to reflect the lack of information available.' The bottom of the page includes a 'Join Us' section with social media links and a 'Donate Now' button.

Doctors order medications through a computer

This Hospital's Score: 15 *

Best Hospital's Score: 100

Average Hospital's Score: 80.23

Worst Hospital's Score: 15

Notes and Definitions

1. **Declined to Report:** The hospital was asked to provide this information to the public, but did not.
2. **Not Available:** "Not Available" means that the hospital does not have data for this measure. This could be because the measure is related to a service the hospital does not provide. For example, a hospital that does not have an ICU would not be able to report data about ICUs. It could also be because the hospital had too few patients or cases to report data for a particular condition or procedure. A "Not Available" result does not mean that the hospital withheld information from the public.
3. **Straight A:** The hospital has earned an A Grade for five consecutive grading rounds or more, qualifying it for recognition as a "Straight A" hospital.
4. * The hospital declined to report their performance on this measure, so a score was assigned to reflect the lack of information available.

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Source: “Palm Beach Gardens Medical Center,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>

Note: This exhibit displays the Hospital Safety Grade Page for Palm Beach Gardens Medical Center, navigated to the “Practices to Prevent Errors” tab and “Doctors order medications through a computer” measure. Parts of the page marked by the red boxes show the imputed measure “Doctors order medications through a computer” and TLG’s footnote disclosure. The footnote disclosure states “* The hospital declined to report their performance on this measure, so a score was assigned to reflect the lack of information available.”

Exhibit 10 The Footnote Disclosure on TLG’s Hospital Safety Grade Page for Palm Beach Gardens Medical Center, When Navigated to the Imputed Measure: *Safe medication administration*

The screenshot displays the Leapfrog Hospital Safety Grade website. At the top, there is a navigation bar with links like 'Join Our Mailing List', 'Newsroom', and 'Donate Now'. Below this, the page header includes the Leapfrog Hospital Safety Grade logo and a list of navigation links: 'What is Patient Safety?', 'Your Hospital's Safety Grade', 'What You Can Do to Stay Safe', 'For Hospitals', 'Licenses & Permissions', 'About Our Movement', and 'THE LEAPFROG GROUP'.

The main content area shows the hospital's grade for Spring 2025, which is an 'F'. The hospital name is 'Palm Beach Gardens Medical Center', located at 3360 Burns Road, Palm Beach Gardens, FL 33410-4304. A link to 'View this hospital's Leapfrog Hospital Survey Results' is provided. Below this, there is a section titled 'Learn how to use the Leapfrog Hospital Safety Grade' with an illustration of a person using a computer.

The 'Practices to Prevent Errors' section is highlighted, showing various safety measures. The 'Safe medication administration' measure is specifically highlighted with a red box. It shows a gauge with a red needle pointing to the 'Not Available' section, indicating that the hospital did not report its performance on this measure. The text states: 'This Hospital's Score: 25 *', 'Best Hospital's Score: 100', 'Average Hospital's Score: 81.87', and 'Worst Hospital's Score: 25'.

Below the score, there is a 'Notes and Definitions' section. A red box highlights a footnote disclosure: '* The hospital declined to report their performance on this measure, so a score was assigned to reflect the lack of information available.' The full text of the footnote is: '1. Declined to Report: The hospital was asked to provide this information to the public, but did not. 2. Not Available: "Not Available" means that the hospital does not have data for this measure. This could be because the measure is related to a service the hospital does not provide. For example, a hospital that does not have an ICU would not be able to report data about ICUs. It could also be because the hospital had too few patients or cases to report data for a particular condition or procedure. A "Not Available" result does not mean that the hospital withheld information from the public. 3. Straight A: The hospital has earned an A Grade for five consecutive grading rounds or more, qualifying it for recognition as a "Straight A" hospital. 4. * The hospital declined to report their performance on this measure, so a score was assigned to reflect the lack of information available.'

The footer of the page includes the Leapfrog Hospital Safety Grade logo, a 'Join Us' section with social media links, and a 'Join Our Mailing List' and 'Donate Now' button. There is also a 'Legal Disclaimer' section at the bottom.

Source: “Palm Beach Gardens Medical Center,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>

Note: This exhibit displays the Hospital Safety Grade Page for Palm Beach Gardens Medical Center, navigated to the “Practices to Prevent Errors” tab and “Safe medication administration” measure. Parts of the page marked by the red boxes show the imputed measure “Safe medication administration” and TLG’s footnote disclosure. The footnote disclosure states “* The hospital declined to report their performance on this measure, so a score was assigned to reflect the lack of information available.”

Exhibit 11 The Footnote Disclosure on TLG's Hospital Safety Grade Page for Palm Beach Gardens Medical Center, When Navigated to the Imputed Measure: *Handwashing*

The screenshot displays the Leapfrog Hospital Safety Grade website. At the top, there's a navigation bar with links like 'Join Our Mailing List', 'Newsroom', and 'Donate Now'. Below this, the hospital's name 'Palm Beach Gardens Medical Center' is shown along with its address and a 'View this hospital's Leapfrog Hospital Safety Grade' link. A large 'F' grade is prominently displayed. The main content area features a grid of measures: Infections, Problems with Surgery, Safety Problems, Practices to Prevent Errors, and Doctors, Nurses & Hospital Staff. The 'Safety Problems' section is highlighted with a red box, and within it, the 'Handwashing' measure is also highlighted with a red box. Below the grid, the 'Handwashing' section provides a score of 15, which is marked with an asterisk (*). A footnote disclosure is visible at the bottom of the page, stating: '4. * The hospital declined to report their performance on this measure, so a score was assigned to reflect the lack of information available.' The footer contains the Leapfrog Group logo, contact information, and a disclaimer.

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SPRING 2025

Palm Beach Gardens Medical Center

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Palm Beach Gardens, FL 33410-4304
Map and Directions

View this hospital's Leapfrog Hospital Safety Grade

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Infections Problems with Surgery Safety Problems Practices to Prevent Errors Doctors, Nurses & Hospital Staff

Doctors enter medications through a computer Safe medication administration **Handwashing** Communication about Medicines Communication about Discharge **Declined to Report** Staff work together to prevent errors

Hospital Performs: Worse Than Average Better Than Average

This Hospital's Score: 15 *

Best Hospital's Score: 100

Average Hospital's Score: 74.40

Worst Hospital's Score: 15

Handwashing

Healthcare workers can help stop infection and illness by carefully cleaning their hands. When hospital staff does not carefully wash their hands, they can spread germs from one patient to another and cause someone to become seriously ill.

Hospitals can earn up to 100 points for having a handwashing policy and evaluating how hospital workers follow that policy. [Click here to learn more.](#)

What safer hospitals do:

Hospitals provide training and implement policies to make sure that all hospital staff clean their hands before touching a patient.

Notes and Definitions

1. Declined to Report: The hospital was asked to provide this information to the public, but did not.

2. Not Available: "Not Available" means that the hospital does not have data for this measure. This could be because the measure is related to a service the hospital does not provide. For example, a hospital that does not have an ICU would not be able to report data about ICUs. It could also be because the hospital had too few patients or cases to report data for a particular condition or procedure. A "Not Available" result does not mean that the hospital withheld information from the public.

3. Straight A: The hospital has earned an A grade for five consecutive grading periods or more, qualifying it for recognition as a "straight A" hospital.

4. * The hospital declined to report their performance on this measure, so a score was assigned to reflect the lack of information available.

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Source: "Palm Beach Gardens Medical Center," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>

Note: This exhibit displays the Hospital Safety Grade Page for Palm Beach Gardens Medical Center, navigated to the "Practices to Prevent Errors" tab and "Handwashing" measure. Parts of the page marked by the red boxes show the imputed measure "Handwashing" and TLG's footnote disclosure. The footnote disclosure states "* The hospital declined to report their performance on this measure, so a score was assigned to reflect the lack of information available."

Exhibit 12 The Footnote Disclosure on TLG’s Hospital Safety Grade Page for Palm Beach Gardens Medical Center, When Navigated to the Imputed Measure: *Specially trained doctors care for ICU patients*

The screenshot displays the Leapfrog Hospital Safety Grade website for Palm Beach Gardens Medical Center. The page shows the hospital's overall grade of 'F' for Spring 2025. A red box highlights the 'Specially trained doctors care for ICU patients' measure, which has a grade of 'D'. Below the measure, a footnote disclosure states: '* The hospital declined to report their performance on this measure, so a score was assigned to reflect the lack of information available.' The page also includes a 'Doctors, Nurses & Hospital Staff' tab and a 'Back to top' link.

Leapfrog Hospital Safety Grade

Palm Beach Gardens Medical Center

3360 Burns Road
Palm Beach Gardens, FL 33410-4304
Map and Directions

View this hospital's Leapfrog Hospital Survey Results

Doctors, Nurses & Hospital Staff

Specially trained doctors care for ICU patients

Hospital Performs:

Worse Than Average Better Than Average

This Hospital's Score: 5 *

Best Hospital's Score: 100

Average Hospital's Score: 65.15

Worst Hospital's Score: 5

Notes and Definitions

1. **Declined to Report:** The hospital was asked to provide this information to the public, but did not.

2. **Not Available:** "Not Available" means that the hospital does not have data for this measure. This could be because the measure is related to a service the hospital does not provide. For example, a hospital that does not have an ICU would not be able to report data about ICUs. It could also be because the hospital had too few patients or cases to report data for a particular condition or procedure. A "Not Available" result does not mean that the hospital withheld information from the public.

3. **Straight A:** The hospital has earned an A Grade for five consecutive grading rounds or more, qualifying it for recognition as a "Straight A" hospital.

4. * The hospital declined to report their performance on this measure, so a score was assigned to reflect the lack of information available.

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Note: This exhibit displays the Hospital Safety Grade Page for Palm Beach Gardens Medical Center, navigated to the “Doctors, Nurses & Hospital Staff” tab and “Specially trained doctors care for ICU patients” measure. Parts of the page marked by the red boxes show the imputed measure “Specially trained doctors care for ICU patients” and TLG’s footnote disclosure. The footnote disclosure states “* The hospital declined to report their performance on this measure, so a score was assigned to reflect the lack of information available.”

66. TLG introduced the footnote disclosure in response to feedback on its Fall 2024 methodology update. Specifically, TLG received feedback that its minimum score assignment misrepresented a hospital's performance to consumers and even acknowledged, itself, that consumers may "misinterpret" the scores on the imputed measures.¹²⁸ As a result, TLG decided to add a footnote disclosure.¹²⁹ While developing the language for the footnote disclosure, a TLG employee noted that TLG was "arbitrarily assigning [non-participating hospitals] points associated with the bottom scoring category."¹³⁰ Nonetheless, the footnote disclosure omits language about TLG's practice of assigning the minimum score on the imputed measures.

67. The footnote disclosure *only* appears on a TLG Hospital Safety Grade Page when a consumer has navigated to one of the four imputed measures on the measure's respective tab, as shown in Exhibit 8. Thus, upon first navigating to the TLG Hospital Safety Grade Pages for Plaintiff Hospitals, a consumer is exposed to TLG's overall "D" or "F" letter grade for the hospital without the footnote disclosure, because the default view of the "Infections" tab and "MRSA Infections" measure does not contain the footnote disclosure, as shown in Exhibit 6 above.

68. Similarly, when a consumer is viewing any of the non-imputed measures within the tabs that contain the four imputed measures (i.e., the tabs "Doctors, Nurses & Hospital Staff" and "Practices to Prevent Errors"), the footnote disclosure is not displayed. For example, Exhibit 13 shows the Hospital Safety Grade Page for Plaintiff Hospital Palm Beach Gardens Medical Center, navigated to the tab "Doctors, Nurses & Hospital Staff," and the measure "Effective leadership to prevent errors." The tab "Doctors, Nurses & Hospital Staff" also contains one of the four imputed measures, "Specially trained doctors care for ICU patients." In this view, a consumer would be exposed to both the "F" overall letter grade for the hospital as well as dial graphic for the imputed measure indicating that the hospital performed "[w]orse [t]han [a]verage" (i.e., red shaded region of the dial). However, the footnote disclosure does not appear. This would also be the case for consumers who navigated to the "Practices to Prevent Errors" tab (which contains the imputed measures "Doctors order medications through a computer," "Safe medication administration," and "Handwashing") and to the other, non-imputed measures in this tab.

¹²⁸ LEAPFROG00178628–633 at 629.

¹²⁹ LEAPFROG00178628–633 at 629.

¹³⁰ LEAPFROG00427863–633 at 863.

Exhibit 13 Example of TLG's Hospital Safety Grade Page, Navigated to a Non-Imputed Measure, where the Footnote Disclosure Does Not Appear

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Declined to Report?
Effective leadership to prevent errors

Declined to Report?
Nursing and Bedside Care for Patients

Specially trained doctors care for ICU patients

Communication with Doctors

Communication with Nurses

Responsiveness of Hospital Staff

Hospital Performs:
Worse Than Average | Better Than Average

This Hospital's Score:
Declined to Report

Best Hospital's Score:
120.00

Average Hospital's Score:
117.49

Worst Hospital's Score:
9.23

Notes and Definitions

1. **Declined to Report:** The hospital was asked to provide this information to the public, but did not.

2. **Not Available:** "Not Available" means that the hospital does not have data for this measure. This could be because the measure is related to a service the hospital does not provide. For example, a hospital that does not have an ICU would not be able to report data about ICUs. It could also be because the hospital had too few patients or cases to report data for a particular condition or procedure. A "Not Available" result does not mean that the hospital withheld information from the public.

3. **Straight A:** The hospital has earned an A Grade for five consecutive grading rounds or more, qualifying it for recognition as a "Straight A" hospital.

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Source: "Palm Beach Gardens Medical Center," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/palm-beach-gardens-medical-center>

Note: This exhibit displays the Hospital Safety Grade Page for Palm Beach Gardens Medical Center, navigated to the "Doctors, Nurses & Hospital Staff" tab and "Effective leadership to prevent errors" measure, as marked by the yellow box. Parts of the page marked by the red boxes show the imputed measure "Specially trained doctors care for ICU patients" and the location where TLG's footnote disclosure appears for the imputed measures (e.g., Exhibit 9).

69. Moreover, within the tabs that contain the imputed measures, TLG presents dial graphics for other, non-imputed measures that state the hospital “Declined to Report” on these non-imputed measures. For example, on TLG’s Hospital Safety Grade Page for Palm Beach Gardens Medical Center, the “Declined to Report” dial graphic appears in the tab “Practices to Prevent Errors” for the non-imputed measure “Staff work together to prevent errors,” as shown in Exhibit 9 and in the tab “Doctors, Nurses & Hospital Staff,” for the non-imputed measures “Effective leadership to prevent errors” and “Nursing and Bedside Care for Patients,” as shown in Exhibit 12. Notably, the non-imputed measures share a key similarity with the imputed measures: they are all measures whose scores are based on TLG’s voluntary hospital survey and, thus, for which TLG has no data for non-participating hospitals.¹³¹

70. Because of this presentation, many consumers would likely conclude that the dial graphics showing a low score for the imputed measures are based on more or stronger evidence than the “Declined to Respond” dial graphics for the non-imputed measures. Indeed, research has found that consumers make inferences about a product characteristic using not only the information provided about the characteristic but also using information that is omitted about that characteristic. For example, a study in the context of food product labels exposed consumers to product labels for three peanut oil products, and the study varied whether none, one, two, or all of the product labels contained the phrase “cholesterol free.” Consumers who saw only one or two of product labels with the “cholesterol free” phrase were more likely to believe that the *other* products, which did not display this label, contained cholesterol, compared to consumers who saw no product labels with the “cholesterol free” phrase.¹³² This is an example of inductive reasoning, where people draw general conclusions from specific examples.¹³³

¹³¹ Motion to Dismiss, Exhibit 5, p. 6–7 (citing Methodology Document), PBHN000003012–40. TLG refers to these measures by different names in its methodology document: “Safe Practice 1: Culture of Leadership Structures and Systems” for “Effective leadership to prevent errors”; “Safe Practice 2: Culture Measurement, Feedback & Intervention” for “Staff work together to prevent errors”; “Total Nursing Care Hours per Patient Day” for “Nursing and bedside care for patients”; “Hand Hygiene” for “Handwashing.” See “Public Reporting Website Measure Crosswalk,” *The Leapfrog Group*, Spring 2025, https://www.hospitalsafetygrade.org/media/file/PublicReportingWebsiteMeasureCrosswalk_Spring2025.pdf, PBHN000004116–8.

¹³² Burke, S. J., et al. (1997), “Displaying Common but Previously Neglected Health Claims on Product Labels: Understanding Competitive Advantages, Deception, and Education,” *Journal of Public Policy & Marketing*, 16, 2, 242–255 at pp. 248–249, PBHN000003353–67.

¹³³ Kardes, F. R., et al. (2004), “Consumer Inference: A Review of Processes, Bases, and Judgment Contexts,” *Journal of Consumer Psychology*, 14, 3, 230–256 at p. 230, PBHN000003849–76.

71. According to its Motion to Dismiss, TLG also purports to display imputation disclosures in 15 other locations (i.e., pages or documents) on the [hospitalsafetygrade.org](https://www.hospitalsafetygrade.org) and [leapfroggroup.org](https://www.leapfroggroup.org) websites, in addition to the footnote disclosure.¹³⁴ However, many of the examples TLG cites do not state that TLG assigns the minimum score on the imputed measures to hospitals that do not respond to its survey. For example:

- On the page “Frequently Asked Questions About The Leapfrog Hospital Safety Grade,” TLG states that “[i]f a hospital does not report to the Leapfrog Hospital Survey, other sources of data are used to calculate a Grade.”¹³⁵
- On the page “About the Grade,” TLG states that “[i]n some cases where a hospital’s information is not available for a certain measure, Leapfrog uses a supplemental data source. In cases where a hospital’s information is not available from any data source, Leapfrog has outlined a methodology for dealing with the missing data.”¹³⁶

72. In fact, analysis of not only the locations TLG explicitly cites as examples of disclosures, but also all locations cited as exhibits to either TLG’s Motion to Dismiss or Plaintiffs’ Motion for Preliminary Injunction, finds that only a small subset of such locations state TLG assigns the minimum score (i.e., a score based on “Limited Achievement”) on the imputed measures.¹³⁷ Specifically, of the 38 locations analyzed, only nine mention imputing data for non-participating hospitals at all, and only four say that hospitals will be given a score equivalent to “Limited Achievement” for imputed measures:¹³⁸ (1) TLG’s “Fall 2024 Methodology Updates” document, which first announced the Fall 2024 methodology change,¹³⁹ (2) the “2025 Leapfrog Hospital Survey,”¹⁴⁰ which is the survey form that hospitals fill out to provide data to TLG and is not directed

¹³⁴ Motion to Dismiss, pp. 8–9.

¹³⁵ Motion to Dismiss, Exhibit 3, p. 4 (citing “Frequently Asked Questions About The Leapfrog Hospital Safety Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/frequently-asked-questions>), PBHN000002423–7.

¹³⁶ Motion to Dismiss, Exhibit 4, p. 4 (citing “About the Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/about-the-grade>), PBHN000002619–25.

¹³⁷ Motion to Dismiss; Motion for Preliminary Injunction. For both the Motion to Dismiss and the Motion for Preliminary Injunction, I restricted my analysis to the set of exhibits that consist of pages from [hospitalsafetygrade.org](https://www.hospitalsafetygrade.org) or [leapfroggroup.org](https://www.leapfroggroup.org). I exclude from my analysis Motion for Preliminary Injunction, Exhibit 50, “June 22, 2012 Letter from the American Hospital Association’s then-President,” because although it is, or was at one point, available on [hospitalsafetygrade.org](https://www.hospitalsafetygrade.org), it consists of a letter to The Leapfrog Group rather than information published by The Leapfrog Group. See Workpaper 1.

¹³⁸ This analysis is at the location-level. Locations (i.e., pages or documents) on TLG’s website may contain many sentences or paragraphs of text. See Workpaper 1.

¹³⁹ Motion to Dismiss, Exhibit 38, p. 3 (citing “Final Updates to the Leapfrog Hospital Safety Grade Methodology for Fall 2024,” *The Leapfrog Group*, https://www.hospitalsafetygrade.org/media/file/Fall2024HospitalSafetyGrade_FinalMethodologyChanges.pdf), PBHN000002632–7 (“For hospitals that do not have historical data from the last two rounds of the Safety Grade ... hospitals will be assigned a point value that is equivalent to receiving ‘Limited Achievement’.”).

¹⁴⁰ Motion to Dismiss, Exhibit 21, p. 83 (citing “2025 Leapfrog Hospital Survey,” *The Leapfrog Group*, https://www.leapfroggroup.org/sites/default/files/Files/2025%20HospitalSurvey_20250502_v9.1%20%28version%20%29.pdf),

towards consumers of TLG's Hospital Safety Grades, (3) TLG's Fall 2024 "Scoring Methodology" document,¹⁴¹ and (4) TLG's Spring 2025 "Scoring Methodology" document ("methodology document"),¹⁴² which I understand is a newer version of TLG's Fall 2024 "Scoring Methodology" document.

73. Of these four documents, I understand that only one—the methodology document—can be accessed through TLG's Hospital Safety Grade Pages today.¹⁴³ I am not aware of any way that a user can navigate to the remaining three documents from a TLG Hospital Safety Grade Page today.

74. The only disclosure that can be accessed from TLG's Hospital Safety Grade Pages is a statement in found in TLG's 28-page methodology document.¹⁴⁴ On page 16 of this methodology document, TLG states, among other statements, that "If the hospital does not have historical data from the last two rounds (i.e., fall 2024, spring 2024) of the Safety Grade, the hospital is assigned a point value that is equivalent to receiving 'Limited Achievement' for this measure on the Leapfrog Hospital Survey."¹⁴⁵ This information is not displayed on TLG's Hospital Safety Grade Page. While it is possible to navigate to the methodology document from TLG's Hospital Safety Grade pages for Plaintiff Hospitals, navigating to the document and then navigating to the relevant information within the document both require multiple steps, such that it is unlikely that many consumers would view this information, as I discuss in Section VIII.D.

75. In addition, consumers may also be exposed to other statements about missing data on TLG's websites that are either irrelevant to the imputed measures or do not discuss TLG's imputation methodology. Thus, consumers seeking to understand the imputed measures' scores would need to evaluate these statements and understand to disregard them in their assessment of the imputed measures. In fact, of the 38 locations I analyzed, nearly half (16) mention missing data (in any context) and eight mention missing data related to any measure underlying the

PBHN000002651–3003 ("Hospitals that submit the Survey, but do not submit an Adult Inpatient Test via the CPOE Evaluation Tool, are scored and publicly reported as 'Limited Achievement' on the CPOE measure.").

¹⁴¹ Motion to Dismiss, Exhibit 31, p. 16 (citing Fall 2024 "Scoring Methodology"), PBHN000003044–69 ("Hospitals which do not have historical data from the two most recent rounds of the Safety Grade are assigned a point value that is equivalent to receiving 'Limited Achievement' for [the CPOE, BCMA, IPS, and Hand Hygiene] measure on the Leapfrog Hospital Survey.").

¹⁴² Motion to Dismiss, Exhibit 5, p. 18 (citing Methodology Document), PBHN000003012–40 ("Hospitals which do not have historical data from the two most recent rounds of the Safety Grade are "assigned a point value that is equivalent to receiving 'Limited Achievement' for [the CPOE, BCMA, IPS, and Hand Hygiene] measure on the Leapfrog Hospital Survey.").

¹⁴³ My understanding of which pages can be accessed from a TLG Hospital Safety Grade Page is based on a review of the website as of July 30, 2025.

¹⁴⁴ See Workpaper 1.

¹⁴⁵ Motion to Dismiss, Exhibit 5, p. 18 (citing Methodology Document, p. 16), PBHN000003012–40.

Hospital Safety Grade, all *without* reference to an imputation methodology or the minimum score assignment.¹⁴⁶ Thus, consumers would not only need to navigate to one of only four locations on TLG's website to be presented with information about its practice of assigning minimum scores to non-participating hospitals on the imputed measures, but consumers would also need to evaluate and understand to disregard additional, irrelevant information that TLG presents.

76. In sum, while TLG purports to disclose its imputation methodology on its Hospital Safety Grade Pages for Plaintiff Hospitals, the footnote disclosure does not state that the imputation methodology involves assigning the minimum score on the imputed measures. Moreover, while TLG purports to have many imputation disclosures on its website, the only one that is accessible from a TLG Hospital Safety Grade Page and in which TLG discloses that the imputation methodology involves assigning the minimum score on the imputed measures (which TLG refers to as "Limited Achievement") is found on page 16 of its 28-page methodology document. Finally, consumers seeking to understand the imputed measures' scores would also need to understand to disregard TLG's numerous other statements about missing data that are irrelevant to its imputation methodology or its practice of assigning the minimum score on the imputed measures.

B. TLG Does Not Directly Disclose that its Minimum Score Assignment Lowers Non-Participating Hospitals' Hospital Safety Grades

77. Plaintiffs also allege that TLG fails to adequately disclose that its practice of assigning the minimum score to non-participating hospitals on the imputed measures "result[s] in artificially deflated overall grades."¹⁴⁷ Indeed, consistent with Plaintiffs' allegations, staff at another hospital group, Allina Health, raised concerns that "[t]he public will not understand nor dig into the methodology of these grades, and hospitals will be falsely represented with a lower grade, because they chose not to complete a survey."¹⁴⁸ I understand that Professor Nicholson finds that, due to TLG's imputation methodology, Plaintiff Hospitals' Safety Grades were one to two letter grades lower than the grades they would have received had they participated in TLG's survey and responded as the average participating hospitals does.¹⁴⁹

¹⁴⁶ Workpaper 1.

¹⁴⁷ Complaint, ¶ 52.

¹⁴⁸ LEAPFROG00439030; LEAPFROG00178624–627 at 625.

¹⁴⁹ Expert Report of Professor Sean Nicholson, August 7, 2025, Section X.B.

78. I also analyzed content on TLG's websites to assess whether and to what extent they contained information on the impact of TLG's imputation methodology on TLG's Hospital Safety Grades for non-participating hospitals. Specifically, I analyzed the same 38 locations on TLG's websites as in Section VIII.A, which include not only the locations TLG explicitly cites as examples of disclosures but also all locations cited as exhibits to TLG's Motion to Dismiss and Plaintiffs' Motion for Preliminary Injunction. Of the 38 locations, only 23 even present a relationship between Hospital Safety Grades and underlying measures. Of these 23 locations, only four explicitly discuss TLG's minimum score assignment and only one of those four is accessible from the Hospital Safety Grade Pages, as I explained in VIII.A. For example, TLG presents the following language without any reference to the fact that some measures are imputed on its "Frequently Asked Questions About The Leapfrog Hospital Safety Grade" page:

- "The grade uses over 30 measures including rates of preventable errors, injuries and infections, and whether hospitals have systems in place to prevent them."¹⁵⁰
- "Leapfrog experts and advisors at the Johns Hopkins Armstrong Institute for Patient Safety and Quality regularly review all publicly available measures of safety and the methodology to determine a hospital's letter grade."¹⁵¹

79. Moreover, of the 23 locations that present a relationship between the Hospital Safety Grades and underlying measures, a majority indicate to consumers that TLG's Hospital Safety Grades have a basis in actual measurement of hospitals' performance. Specifically, 16 of these locations include statements that a hospital's Safety Grade is either based on data (e.g., from the Center for Medicare and Medicaid Services) or based on the hospital's performance on safety. For example, TLG's "About the Grade" page includes the statements:

- "***A hospital must have enough safety data available for our experts to issue them a letter grade.*** Hospitals missing more than six process measures, more than five outcome measures, or PS190 are not graded."¹⁵²

¹⁵⁰ Motion to Dismiss, Exhibit 3, p. 2 (citing "Frequently Asked Questions About The Leapfrog Hospital Safety Grade," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/frequently-asked-questions>), PBHN000002423–7.

¹⁵¹ Motion to Dismiss, Exhibit 3, p. 6 (citing "Frequently Asked Questions About The Leapfrog Hospital Safety Grade," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/frequently-asked-questions>), PBHN000002423–7.

¹⁵² Emphasis added. Motion to Dismiss, Exhibit 4, p. 6 (citing "About the Grade," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/about-the-grade>), PBHN000002619–25.

- “Taken together, those performance measures produce a single letter grade representing a hospital’s overall performance in keeping patients safe from preventable harm and medical errors.”¹⁵³

80. In fact, in some locations, TLG even explicitly downplays the impact of non-participation in its survey on a hospital’s letter grade. For example, TLG’s “Frequently Asked Questions About The Leapfrog Hospital Safety Grade” page states that “The Leapfrog Hospital Safety Grade is a letter grade Leapfrog biannually assigns to general hospitals in the United States, whether they voluntarily report data to Leapfrog or not. *If a hospital does not report to the Leapfrog Hospital Survey, other sources of data are used to calculate a Grade.*”¹⁵⁴ The majority of data used to calculate the Safety Grade comes from the Centers for Medicare and Medicaid Services (CMS).¹⁵⁴ The same page also tells consumers that a “Hospital Safety Grade reflects how well a hospital does on safety, *not whether they complete the Leapfrog Hospital Survey.*”¹⁵⁵ TLG’s websites include limited, and often even conflicting, information about its imputation methodology and the effect of non-participation on Hospital Safety Grades. It is unlikely that many consumers would understand that non-participation would lead to a minimum score assigned on the imputed measures and, in turn, a lower Hospital Safety Grade.

C. It Is Unlikely that Many Consumers Read TLG’s Footnote Disclosure Located at the Bottom of the Hospital Safety Grade Page

81. Even if the footnote disclosure stated that the imputation methodology involves assigning the minimum score to Plaintiff Hospitals, which it does not, many consumers are unlikely to read the footnote disclosure in this context. Specifically, the footnote disclosure is placed “below the fold” on TLG’s Hospital Safety Grade Pages for Plaintiff Hospitals, which requires consumers to scroll down to view the information, and research has found that, in a variety of contexts, consumers are unlikely to view information “below the fold.”¹⁵⁶ Such behavior may be particularly

¹⁵³ Motion to Dismiss, Exhibit 4, p. 2 (citing “About the Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/about-the-grade>), PBHN000002619–25.

¹⁵⁴ Emphasis added. Motion to Dismiss, Exhibit 3, p. 4 (citing “Frequently Asked Questions About The Leapfrog Hospital Safety Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/frequently-asked-questions>), PBHN000002423–7.

¹⁵⁵ Emphasis added. Motion to Dismiss, Exhibit 3, p. 4 (citing “Frequently Asked Questions About The Leapfrog Hospital Safety Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/frequently-asked-questions>), PBHN000002423–7.

¹⁵⁶ While the location of the footnote disclosure for an individual consumer may depend on how that consumer accesses TLG’s Hospital Safety Grade Pages (i.e., from a mobile device or computer), I observe that the footnote disclosure is below the fold in both the mobile and desktop views of the website. See, e.g., “Good Samaritan Medical Center,” *The Leapfrog Group*,

relevant in the context of TLG Hospital Safety Grade Pages that present low or failing grades, which are likely to elicit negative, emotional reactions from consumers. In this context, consumers are unlikely to search for more information, as explained in Section VI.C.

82. Studies, including my own research, have found that, in a variety of settings, information that is not visible without scrolling further down the page (i.e., information below the fold) can be less likely to be viewed.¹⁵⁷ Moreover, research has found that information further down the page can be less likely to be viewed compared to information conveyed earlier on the page.¹⁵⁸ For example, according to one study, “there was a dramatic drop-off in user attention at the position of the page fold” and that information just below the fold was less than half as likely to be viewed as information just above the fold.¹⁵⁹ Another study found that users spent less than 20% of their attention on information below the fold.¹⁶⁰ As an example, lower ranked results on search engine results pages receive dramatically less user engagement.¹⁶¹ Taken together, it is likely that many consumers would not have reviewed the footnote disclosure on TLG’s Hospital Safety Grade Pages.

<https://www.hospitalsafetygrade.org/h/good-samaritan-medical-center>, examples of desktop and mobile views, PBHN000007586–7. See also “For Display Ads, Being Seen Matters More than Being Clicked,” *ComScore*, April 24, 2012, <https://www.comscore.com/Insights/Press-Releases/2012/4/For-Display-Ads-Being-Seen-Matters-More-than-Being-Clicked>, PBHN000003671–3.

¹⁵⁷ “Scrolling and Attention (Original Research Study),” *Nielsen Norman Group*, March 21, 2010, <https://www.nngroup.com/articles/scrolling-and-attention-original-research/>, PBHN000004161–4; “The Fold Manifesto: Why the Page Fold Still Matters,” *Nielsen Norman Group*, February 1, 2015, <https://www.nngroup.com/articles/page-fold-manifesto/>, PBHN000004225–8; Ghose, A. and S. Yang (2009), “An Empirical Analysis of Search Engine Advertising: Sponsored Search in Electronic Markets,” *Management Science*, 55, 10, 1605–1622 at p. 1614, PBHN000003686–712; Ghose, A., et al. (2014), “Examining the Impact of Ranking on Consumer Behavior and Search Engine Revenue,” *Management Science*, 60, 7, 1–23 at pp. 16–17, PBHN000003713–35; Shi, S. W. and M. Trusov (2020), “The Path to Click: Are You on It?” *Marketing Science*, 40, 2, 344–365 at pp. 360, 363, PBHN000004165–87; Berger, J. and K. L. Milkman (2011), “What Makes Online Content Viral?” *Journal of Marketing Research*, 49, 2, 192–205, Table 4, PBHN000003264–80; Berger, J., et al. (2023), “What Holds Attention? Linguistic Drivers of Engagement,” *Journal of Marketing*, 87, 5, 793–809, Web Appendix, Figure W1, PBHN000003317–33.

¹⁵⁸ “The Importance of Being Seen: Viewability Insights for Digital Marketers and Publishers,” *Google*, November 2014, https://think.storage.googleapis.com/docs/the-importance-of-being-seen_study.pdf, pp. 9–13, PBHN000004229–54.

¹⁵⁹ “The Fold Manifesto: Why the Page Fold Still Matters,” *Nielsen Norman Group*, February 1, 2015, <https://www.nngroup.com/articles/page-fold-manifesto/>, PBHN000004225–8.

¹⁶⁰ “Scrolling and Attention (Original Research Study),” *Nielsen Norman Group*, March 21, 2010, <https://www.nngroup.com/articles/scrolling-and-attention-original-research/>, PBHN000004161–4.

¹⁶¹ Ghose, A. and S. Yang (2009), “An Empirical Analysis of Search Engine Advertising: Sponsored Search in Electronic Markets,” *Management Science*, 55, 10, 1605–1622 at p. 1614, PBHN000003686–712; Ghose, A., et al. (2014), “Examining the Impact of Ranking on Consumer Behavior and Search Engine Revenue,” *Management Science*, 60, 7, 1–23 at pp. 16–17, PBHN000003713–35.

D. It Is Unlikely that Many Consumers Read TLG's Disclosure in the Methodology Document

83. As explained in Section VIII.A, the methodology document is the only TLG imputation disclosure accessible from the Hospital Safety Grade page that states that the imputation methodology involves assigning the minimum score to non-participating hospitals. At least some consumers on TLG's Hospital Safety Grade Page for a Plaintiff Hospital would be unlikely to even open the methodology document, because reaching it from a Hospital Safety Grade Page requires multiple steps, as shown in Exhibits 14 and 15. Moreover, accessing the specific language which explains that TLG assigns the minimum score to non-participating hospitals requires even more steps, as shown in Exhibits 16 to 19. For example, one possible path a consumer could take is as follows:¹⁶²

- First, a consumer must click either the "Detailed table view" link on the top right of the page or the "For details on sources, click here" link below the descriptions of individual measures, which brings the consumer to a table with the hospital's scores on all measures (Exhibit 14). As explained in Section VIII.A, these actions are two of many, including navigating to different tabs, measures, and multiple different links, that a consumer can choose to undertake from a Hospital Safety Grade Page.
- Second, on the "Detailed table view" page, a consumer must scroll to the very bottom of this page, below the table, and click the link that reads, "For a full description of the methodology, click here" (Exhibit 15).
- Third, for those who click on this link, they would then access the 28-page methodology document (Exhibit 16).
- Fourth, consumers who scroll beyond the cover page of this document would then be presented with a Table of Contents, which includes the entry "Imputation Method for CPOE, BCMA, IPS, and Hand Hygiene" (Exhibit 17).¹⁶³ In this table of contents and the rest of the document, the names of the imputed measures are different than the names that appear on TLG's Hospital Safety Grade Pages (e.g., "Bar Code Medication Administration (BCMA)" in the methodology document is "Safe medication administration" on the Hospital Safety Grade Page) or even abbreviated (e.g., "BCMA").

¹⁶² Research has found that consumers are less likely to view information that is below the fold on a screen or requires scrolling, as explained in Section VIII.C. I understand that the methodology document is also reachable from a Hospital Safety Grade Page via routes navigable from the fixed dropdown menus in the navigation bar and the fixed hyperlinks in the sub-footer. I understand that reaching the methodology document via these routes requires the same number of clicks as the route described in the text.

¹⁶³ I understand that consumers can take multiple routes to reach the "Limited Achievement" language on the 16th page of this document. For example, some consumers may take more steps, such as navigating first to each measure under the "Process/Structural Measures" section of the Table of Contents, navigating to "Using Secondary Data Sources," and then scrolling to the 16th page of the document.

- Fifth, consumers who click on “Imputation Method for CPOE, BCMA, IPS, and Hand Hygiene” are then taken to page 15 of the methodology document, which describes the imputation methodology for non-participating hospitals that had a score assigned in the previous two rounds of grades (Exhibit 18).
- Finally, consumers must scroll down to page 16 of the methodology document, which describes, among other things, TLG’s imputation methodology for non-participating hospitals that did not have a score assigned in the previous two rounds of grades (Exhibit 19).

84. Research has found that consumers are less likely to navigate to pages that require more clicks to access in certain contexts. For example, a study of Wikipedia users’ search for information found that, for each click needed to navigate to information, “there is roughly a 10% chance of the user dropping out” from the navigation process.¹⁶⁴ Given the numerous steps involved, it is unlikely that a consumer would navigate to the methodology document in general, or the disclosure in this document about TLG’s practice of assigning the minimum score to non-participating hospitals on the imputed measures.

¹⁶⁴ Scaria, A. T., et al. (2014), “The Last Click: Why Users Give Up Information Network Navigation,” in Proceedings of the 7th ACM International Conference on Web Search and Data Mining, 213–222 at 215, PBHN000004151–60.

Exhibit 14 Steps to Navigate to TLG's Disclosure in the Methodology Document from a Hospital Safety Grade Page, Step 1

Step 1:
Consumer has to click either on "Detailed table view" or on "For details on sources, click here."

The screenshot displays the Leapfrog Hospital Safety Grade website. At the top, there is a navigation bar with links: "Join Our Mailing List", "Newsroom", and "Donate Now". Below this is a header section with the Leapfrog Hospital Safety Grade logo and a menu: "What is Patient Safety?", "Your Hospital's Safety Grade", "What You Can Do to Stay Safe", "For Hospitals", "Licensure & Permissions", "About Our Movement", and "THE LEAPFROG GROUP".

The main content area shows the hospital's grade: "Good Samaritan Medical Center" with a "D" grade for "SPRING 2025". A red box highlights the "Detailed table view" link. Below the grade, there is a section for "Infections" with a gauge for "MRSA Infection" showing a score of 0.000. A red box highlights the "For details on source, click here" link. The page also includes a "Notes and Definitions" section and a "LEGAL DISCLAIMER" at the bottom.

Notes and Definitions

- Declined to Report:** The hospital was asked to provide this information to the public, but did not.
- Not Available:** "Not Available" means that the hospital does not have data for this measure. This could be because the measure is related to a service the hospital does not provide. For example, a hospital that does not have an ICU would not be able to report data about ICUs. It could also be because the hospital had too few patients or cases to report data for a particular condition or procedure. A "Not Available" result does not mean that the hospital withheld information from the public.
- Straight A:** The hospital has earned an A Grade for five consecutive grading rounds or more, qualifying it for recognition as a "Straight A" hospital.

LEGAL DISCLAIMER: The Leapfrog Hospital Safety Grade scores hospitals on their overall performance in keeping patients safe from preventable harm and medical errors. The grades are derived from expert analysis of publicly available data using up to 37 evidence-based, national measures of hospital safety. No specific representation is made, nor shall be implied, nor shall The Leapfrog Group be liable with respect to any individual patient's potential or actual outcome as a result of receiving services performed at any of these hospitals. Leapfrog Hospital Safety Grades cannot be republished without expressed written permission from The Leapfrog Group.

Source: "Good Samaritan Medical Center," *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/good-samaritan-medical-center>

Note: This exhibit displays the Hospital Safety Grade Page for Good Samaritan Medical Center, navigated to the "Infections" tab and "MRSA Infection" measure, which is the default page view. Parts of the page marked by the red boxes show the "Detailed table view" link and the "For details on source, click here." link.

Exhibit 15 Steps to Navigate to TLG’s Disclosure in the Methodology Document from a Hospital Safety Grade Page, Step 2

Step 2:
Consumer has to
scroll to the
bottom of the
“Detailed table
view” page and
click on “For a full
description of the
methodology,
click here.”

The Leapfrog Hospital Safety Grade website for Good Samaritan Medical Center. The page displays a detailed table of patient safety measures. The table has columns for Measure, The Hospital's Score, Worst Performing Hospital, Avg. Performing Hospital, Best Performing Hospital, Data Source, and Time Period Covered. The measures listed include various clinical outcomes such as patient falls, infections, and surgical complications. A red box highlights a link at the bottom of the table that says "For a full description of the methodology, click here."

Measure	The Hospital's Score	Worst Performing Hospital	Avg. Performing Hospital	Best Performing Hospital	Data Source	Time Period Covered
Dangerous object left in patient's body What's This?	0.000	0.327	0.014	0.000	CMS	07/01/2021 - 06/30/2023
Air or gas bubble in the blood What's This?	0.000	2.890	0.002	0.000	CMS	07/01/2021 - 06/30/2023
Patient falls and injuries What's This?	0.769	1.926	0.384	0.000	CMS	07/01/2021 - 06/30/2023
Infection in the blood What's This?	0.588	2.762	0.601	0.000	CMS	01/01/2023 - 12/31/2023
Infection in the urinary tract What's This?	1.567	2.512	0.540	0.000	CMS	01/01/2023 - 12/31/2023
Surgical site infection after colon surgery What's This?	1.679	3.004	0.801	0.000	CMS	01/01/2023 - 12/31/2023
MRI infection What's This?	0.000	2.850	0.719	0.000	CMS	01/01/2023 - 12/31/2023
C. diff. infection What's This?	0.250	1.607	0.401	0.000	CMS	01/01/2023 - 12/31/2023
Death from treatable venous complications What's This?	156.08	235.51	177.45	84.66	CMS	07/01/2021 - 06/30/2023
Harmful Events What's This?	1.00	3.10	1.00	0.53	CMS	07/01/2021 - 06/30/2023
Surgical bed sores What's This?	0.42	7.50	0.64	0.05	CMS	07/01/2021 - 06/30/2023
Collapsed lung What's This?	0.36	0.65	0.25	0.10	CMS	07/01/2021 - 06/30/2023
Falls causing broken hips What's This?	0.05	0.56	0.29	0.15	CMS	07/01/2021 - 06/30/2023
Blood clots What's This?	3.03	5.53	2.42	1.01	CMS	07/01/2021 - 06/30/2023
Kidney injury after surgery What's This?	1.69	4.60	1.69	0.74	CMS	07/01/2021 - 06/30/2023
Serious breathing problem What's This?	9.96	57.80	10.53	1.54	CMS	07/01/2021 - 06/30/2023
Dangerous blood clot What's This?	4.95	8.15	3.95	1.56	CMS	07/01/2021 - 06/30/2023
Serious infection after surgery What's This?	5.51	12.56	5.63	1.95	CMS	07/01/2021 - 06/30/2023
Surgical wound splits open What's This?	1.70	4.00	1.87	1.13	CMS	07/01/2021 - 06/30/2023
Accidental cuts and tears What's This?	0.64	2.41	0.89	0.28	CMS	07/01/2021 - 06/30/2023

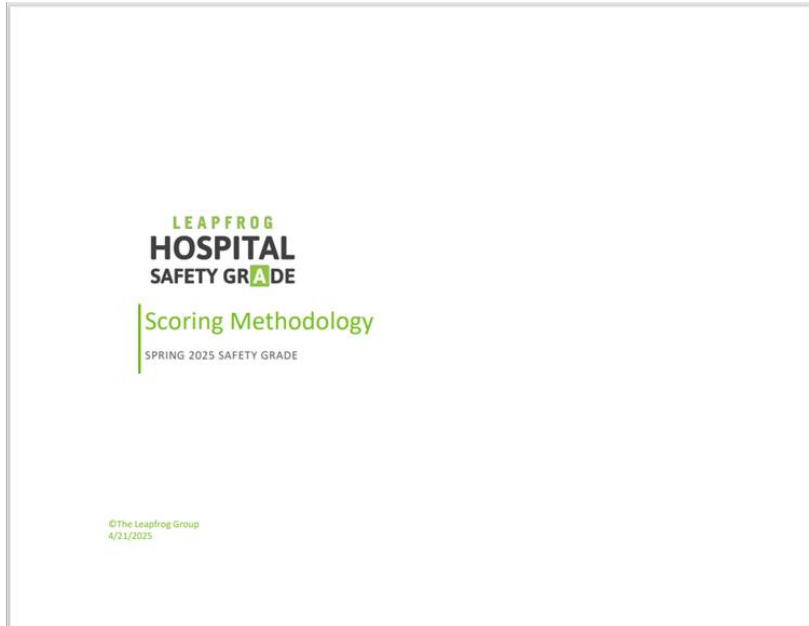
[For a full description of the methodology, click here.](#)

Source: “Good Samaritan Medical Center,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/table-details/good-samaritan-medical-center>

Note: This exhibit displays the “Detailed table view” page for Good Samaritan Medical Center. The part of the page marked by the red box shows the “For a full description of the methodology, click here.” link.

Exhibit 16 Steps to Navigate to TLG’s Disclosure in the Methodology Document from a Hospital Safety Grade Page, Step 3

Step 3:
Consumer has to
open the “Scoring
Methodology”
document.



Source: Methodology Document

Note: This exhibit displays the cover page of the methodology document.

Exhibit 17 Steps to Navigate to TLG’s Disclosure in the Methodology Document from a Hospital Safety Grade Page, Step 4

Step 4:
Consumer has to
click on
“Imputation
Method for CPOE,
BCMA, IPS, and
Hand Hygiene.”

LEAPFROG HOSPITAL SAFETY GRADE	
CONTENTS	
What is the Hospital Safety Grade?	3
Eligible Hospitals	3
Measures	4
Measure & Scoring Descriptions	9
Process/Structural Measures	9
Computerized Physician Order Entry (CPOE)	9
Bar Code Medication Administration (BCMA)	9
ICU Physician Staffing (IPS)	10
National Quality Forum (NQF) Safe Practices	11
Total Nursing Care Hours per Patient Day	11
Hand Hygiene	12
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Composites	12
Outcome Measures	13
Hospital-Acquired Conditions	13
Healthcare-Associated Infections	13
AHRQ Patient Safety Indicators (PSI)	14
Using Secondary Data Sources	15
Imputation Method for CPOE, BCMA, IPS, and Hand Hygiene	15
Step 1: Use a Hospital's Most Recent Score on the Measure (Applies to CPOE, IPS, and Hand Hygiene Only)	15
Step 2: Use Imputation Point Assignment (Applies to CPOE, BCMA, IPS and Hand Hygiene)	16
CMS Data For HAIs	17
Scoring Methodology	18
Weighting Individual Measures	18
Evidence	18
Opportunity	18
Impact	18

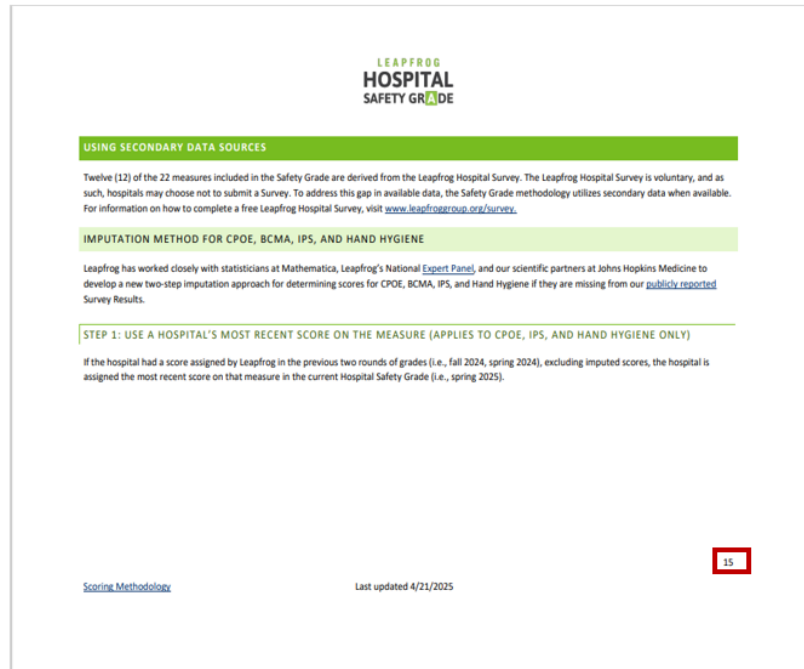
[Scoring Methodology](#) Last updated 4/21/2025 1

Source: Methodology Document

Note: This exhibit displays page 1 of the methodology document, which contains the Table of Contents. The part of the page marked by the red box shows the “Imputation Method for CPOE, BCMA, IPS, and Hand Hygiene” entry.

Exhibit 18 Steps to Navigate to TLG's Disclosure in the Methodology Document from a Hospital Safety Grade Page, Step 5

Step 5:
Consumer is taken to
page 15 of the "Scoring
Methodology" document.



Source: Methodology Document

Note: This exhibit displays page 15 of the methodology document. The part of the page marked by the red box shows the page number.

Exhibit 19 Steps to Navigate to TLG’s Disclosure in the Methodology Document from a Hospital Safety Grade Page, Step 6

Step 6:
Consumer has
to scroll down
to page 16 of
the “Scoring
Methodology”
document.



STEP 2: USE IMPUTATION POINT ASSIGNMENT (APPLIES TO CPOE, BCMA, IPS AND HAND HYGIENE)

If the hospital does not have historical data from the last two rounds (i.e., fall 2024, spring 2024) of the Safety Grade, the hospital is assigned a point value that is equivalent to receiving “Limited Achievement” for this measure on the Leapfrog Hospital Survey.

Note about IPS: Only hospitals that operate an adult or pediatric medical and/or surgical ICU or neuro ICU are eligible for Step 2 Imputation of the IPS measure. A hospital’s ICU designation (i.e., operating a medical ICU, surgical ICU, or pediatric ICU) is determined from the number of medical, surgical and/or pediatric ICU beds reported in Worksheet S-3 Part 1 of the hospital’s most recent CMS Cost Report. If your hospital does not operate an ICU, but shares a CMS Certification Number with a hospital that does, please [contact the Help Desk](#) immediately if an IPS score was imputed.

Step 2 Imputation Point Assignments

Measure	Leapfrog Hospital Survey Performance Category	Corresponding Safety Grade Measure Score
CPOE	Limited Achievement	15
BCMA	Limited Achievement	25
IPS	Limited Achievement	5
Hand Hygiene	Limited Achievement	15

[Scoring Methodology](#)

Last updated 4/21/2025

16

Source: Methodology Document

Note: This exhibit displays page 16 of the methodology document. The part of the page marked by the red box shows the page number.

E. TLG’s Imputation Disclosures May Negatively Impact Consumers’ Perceptions of Plaintiff Hospitals

85. To the extent consumers read TLG’s imputation disclosures, the language and framing of the disclosure content may cause consumers to form negative perceptions about Plaintiff Hospitals. Decades of research has found that the language used in, and framing of, a message, or the decisions of “what to say, what not to say, and how to say it,” impacts how consumers respond to that message.¹⁶⁵ In this matter, the footnote disclosure is framed such that “the hospital” is the actor or agent in the sentence: “[t]he hospital declined to report their performance on this

¹⁶⁵ Flusberg, S. J., et al. (2024), “The Psychology of Framing: How Everyday Language Shapes the Way We Think, Feel, and Act,” *Psychological Science in the Public Interest*, 25, 3, 105–161 at p. 105, PBHN000003614–70; Tversky, A. and D. Kahneman (1981), “The Framing of Decisions and the Psychology of Choice,” *Science*, 211, 4481, 453–458 at p. 457, PBHN000004280–5; Berger, J. and G. Packard (2023), “Wisdom from Words: The Psychology of Consumer Language,” *Consumer Psychology Review*, 6, 1, 3–16, PBHN000003303–16.

measure.”¹⁶⁶ Such framing is an example of “agentive language,” which includes the use of active voice with an agent, or actor, in the subject of a sentence.¹⁶⁷ Research studying agentive language in the context of accidents has shown that, compared to non-agentive language (e.g., in this case “the data were not available”) such framing can lead consumers to assign more blame to the subject of a sentence.¹⁶⁸ In other words, TLG’s use of agentive language may lead consumers to place the responsibility for missing data on Plaintiff Hospitals.

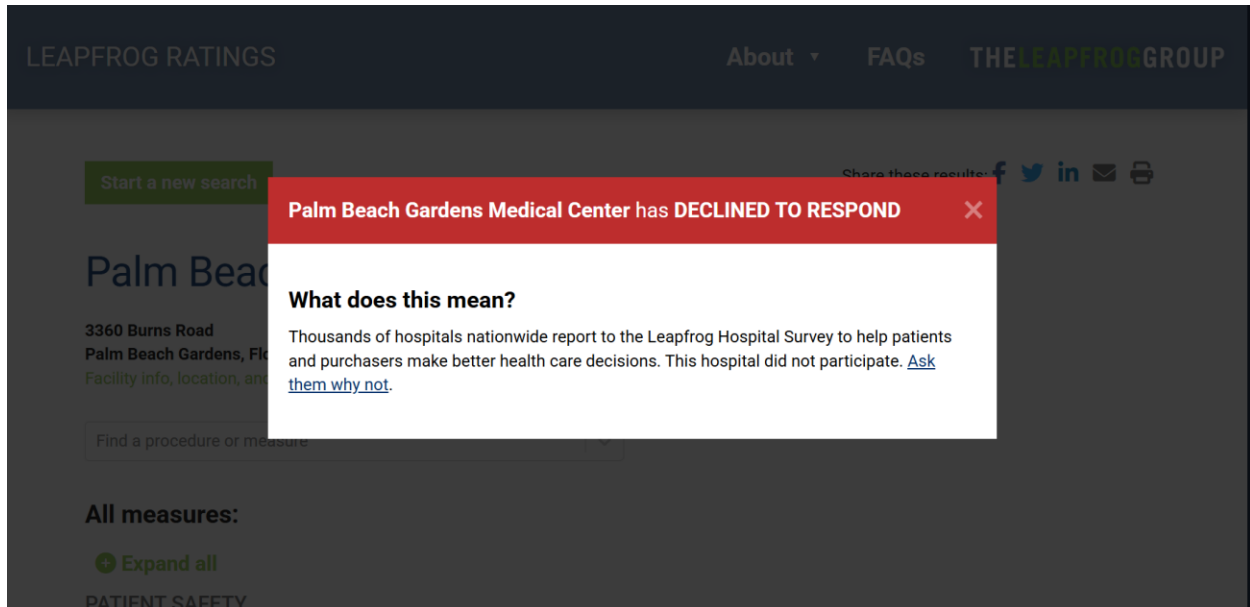
86. As another example, in a disclosure on its leapfroggroup.org, TLG uses even stronger language. A consumer on a Hospital Safety Grade Page can click on “View this hospital’s Leapfrog Hospital Survey Results” to navigate to the hospital’s page on leapfroggroup.org, as shown in Exhibit 8. Upon doing so, a consumer is immediately shown the pop-up in Exhibit 20. The pop-up language tells consumers that hospitals who participate in the survey do so “to help patients and purchasers make better health care decisions” but that “[t]his hospital did not participate.” From this language, consumers may infer that hospitals who choose not to participate are not interested in helping improve patients’ health care decisions. Moreover, TLG also prompts consumers to click on a link that says “[a]sk [the hospital] why not,” implying that the hospital failed to take an action it should have taken. TLG provides consumers who click on the link a draft of a letter requesting the hospital participate in TLG’s survey (Exhibit 21) and noting that hospitals should participate in the survey to “be transparent about its record on quality and safety.”

¹⁶⁶ Emphasis added. See, e.g., Motion to Dismiss, Exhibit 28 (citing “Good Samaritan Medical Center,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/h/good-samaritan-medical-center>), PBHN000002641–3.

¹⁶⁷ Fausey, C. and L. Boroditsky (2010), “Subtle Linguistic Cues Influence Perceived Blame and Financial Liability,” *Psychonomic Bulletin & Review*, 17, 5, 644–650 at p. 644, PBHN000004406–12.

¹⁶⁸ Fausey, C. and L. Boroditsky (2010), “Subtle Linguistic Cues Influence Perceived Blame and Financial Liability,” *Psychonomic Bulletin & Review*, 17, 5, 644–650 at p. 646, PBHN000004406–12.

Exhibit 20 Pop-Up Shown When the User Navigates from hospitalsafetygrade.org to leapfroggroup.org Using the “View this hospital’s Leapfrog Hospital Survey Results” Link



Source: “Palm Beach Gardens Medical Center,” *The Leapfrog Group*, <https://ratings.leapfroggroup.org/facility/details/10-0176/palm-beach-gardens-medical-center-palm-beach-gardens-fl>

Note: This exhibit displays the pop-up on leapfroggroup.org when the user navigates from the Hospital Safety Grade page for Palm Beach Gardens Medical Center using the “View this hospital’s Leapfrog Hospital Survey Results” link.

Exhibit 21 Draft of Survey Participation Request Letter Provided to Consumers who Click on “Ask them why not” Link on leapfroggroup.org

Date

Hospital CEO

Hospital Name

Hospital Address Line 1

Hospital Address Line 2

Dear [Hospital CEO],

In reviewing the results of the most recent Leapfrog Hospital Survey, I noticed that [Hospital Name] declined to participate. As an active member of this community, it's important to me that my local hospital be transparent about its record on quality and safety. Without that information, how can I determine if [Hospital Name] is the best hospital for me and my family?

I urge you to reconsider this decision and choose to participate in the Leapfrog Hospital Survey. You can visit www.LeapfrogGroup.org for more information.

I look forward to seeing the results of your hospital's performance on the Leapfrog Hospital Survey, and sharing that information with my friends and family.

Thank you for your time,

[Your name]

Source: “Survey Participation Request Letter,” *The Leapfrog Group*,
<https://www.leapfroggroup.org/sites/default/files/Files/Survey%20Participation%20Request%20Letter.docx>

Note: This exhibit displays the draft letter on leapfroggroup.org when the user navigates from the Hospital Safety Grade page for a non-participating hospital using the “View this hospital's Leapfrog Hospital Survey Results” link and then the “Ask them why not” link.

Executed this 7th of August, 2025



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Academic Positions

<i>The Wharton School, University of Pennsylvania</i>	
Associate Professor of Marketing (with tenure)	May 2013 –
James G. Campbell, Jr. Assistant Professor of Marketing	July 2010 – May 2013
Assistant Professor of Marketing	July 2007 – June 2010
<i>Cornell NYC Tech, Cornell University</i>	
Visiting Professor of Marketing	July 2014 – June 2015
<i>Fuqua School of Business, Duke University</i>	
Visiting Associate Professor of Marketing	July 2013 – Dec. 2013

Education

Ph.D., Marketing, Stanford University, Graduate School of Business, 2007
B.A., Human Judgment and Decision Making (with Distinction), Stanford University, 2002

Honors and Awards

Sheth Foundation Award, best article published in the *Journal of Marketing* that has made long-term contributions to the field of marketing, 2025
ISSEP General Best Paper Award, 2025
3rd most cited author in top marketing journals in 2024, SMU Analysis
Hunt/Maynard Award Finalist, most significant contribution to marketing theory and thought, *Journal of Marketing*, 2024
Sage 10-Year Impact Award (1 of the 3 most cited articles in all Sage journals in 2012), 2023
Wharton Teaching Excellence Award 2019, 2020, 2021, 2022, 2023
Most cited *Journal of Marketing* article, 2022
Berry-AMA Book Prize Finalist for Best Book in Marketing, 2022
AMA-Sheth Foundation Doctoral Consortium Fellow, 2019, 2020, 2021, 2022
MSI Scholar, 2020
William F. O'Dell Award, *Journal of Marketing Research*, 2017
Outstanding Reviewer Award, *Journal of Consumer Research* 2015–2016
Best 2012 Article Finalist, *Journal of Consumer Research*, 2015
Top 30 Leaders in Business, American Management Association, 2015
Emerald Citations of Excellence, article published in 2012, 2015
Berry-AMA Book Prize for Best Book in Marketing, 2014
Top 10 Most Productive Researchers in Marketing, AMA DocSig 2013–
Most Creative People in Business, Fast Company, 2013
Paul Green Award, *Journal of Marketing Research*, Finalist 2013
Early Career Award, *Association for Consumer Research*, 2013
Early Career Award, *Society for Consumer Psychology*, 2012
Dean's Research Grant, The Wharton School, 2012
Outstanding Reviewer Award, *Journal of Consumer Research* 2010–2011
Outstanding Reviewer Award, *Journal of Consumer Psychology*, 2010–2011
“Iron Prof” Award for “Awesome Faculty Research,” The Wharton School, 2011

MBA Teaching Commitment and Curricular Innovation Award, The Wharton School, 2011
 Dean's Research Grant, The Wharton School, 2011
 Young Scholars Program, Marketing Science Institute, 2011
 Alex Panos Research Grant, The Wharton School, 2011
Journal of Consumer Research Best 2007 Article Award Finalist, 2010
 James G. Campbell, Jr. Memorial Term Professorship, 2010
 Dean's Research Grant, The Wharton School, 2010
 AMA-Sheth Foundation Doctoral Consortium Fellow, 2006
 Society for Consumer Psychology, Best Student Paper Award (Honorable Mention), 2006
 Management Science Institute/JCP Research Competition (Honorable Mention), 2004
 Jaedeke Scholar, Stanford Graduate School of Business, 2003

Publications

1. Rocklage, Matt and Jonah Berger (2025), "The Trajectory of Confidence: Experience, Certainty, and Consumer Choice," *Conditionally Accepted, Journal of Marketing Research*.
2. "Casting a Wider Net," *forthcoming, Current Directions in Psychological Science*.
3. Berger, Jonah (2025), "What Gets Shared and Why? Interpersonal Communication and Word of Mouth," *Annual Review of Psychology*.
4. Packard, Grant, Yang Li, and Jonah Berger (2024), "When Language Matters," *Journal of Consumer Research*, 51(3), 634–653.
5. Packard, Grant, and Jonah Berger (2024), "The Emergence and Evolution of Consumer Language Research," *Journal of Consumer Research*, 51(1), 42–51.
6. Berger, Jonah, and Olivier Toubia (2024), "The Topography of Thought," *Proceedings of the National Academy of Sciences Nexus*, 3(5), 163.
 - Featured in *Nature*
7. Weingarten, Evan, and Jonah Berger (2024), "Discussing Proximal Pasts and Far Futures," *Journal of Consumer Psychology*, 34(1), 6–17.
 - Lead article
8. Oba, Demi and Jonah Berger (2024), "How Communication Mediums Shape the Message," *Journal of Consumer Psychology*, 34(3), 406–424.
9. Packard, Grant, Jonah Berger, and Reihane Boghrati (2023) "How Verb Tense Shapes Persuasion," *Journal of Consumer Research*, 50(3), 645–660.
 - Featured in HBR's IdeaWatch
10. Cascio-Rizzo, Giovanni Luca, Jonah Berger, Rumen Pozharliev, and Matteo De Angelis (2023), "How Sensory Language Shapes Consumer Responses to Influencer-Sponsored Content," *Journal of Consumer Research*, 50(4), 810–825.
 - Featured in HBR's IdeaWatch
11. Berger, Jonah, Wendy Moe, and David Schweidel (2023), "What Holds Attention? Linguistic Drivers of Engagement," *Journal of Marketing*, 87(5), 793–809.
 - Hunt/Maynard Award Finalist, Journal of Marketing 2024

12. Boghrati, Reihane, Jonah Berger, and Grant Packard (2023), “Style, Content, and the Success of Ideas,” Journal of Consumer Psychology, 33(4), 688–700.
13. Packard, Grant, Sarah G. Moore, and Jonah Berger (2023), “Consumer Insights from Text Analysis,” Journal of Consumer Psychology, 33(4), 615–620.
14. Boghrati, Reihane and Jonah Berger, (2023) “Quantifying Cultural Change: Gender Bias in Music”, Journal of Experimental Psychology: General, 152(9), 2591–2602.
15. Packard, Grant and Jonah Berger (2023), “Wisdom from Words: The Psychology of Consumer Language,” Consumer Psychology Review, 6(1), 3–16.
 - Lead Article
16. Berger, Jonah, Joshua Conrad Jackson, and Ceren Kolsarici (2023), “Catalyzing Social Change: Does Concentration Encourage Action?” PLOS ONE, 17(12), E0277934.
17. Berger, Jonah and Grant Packard (2023), “Using Language to Improve Health,” Journal of Service Research.
18. Rogers, Benjamin A., Herrison Chicas, John Michael Kelly, Emily Kubin, Michael S. Christian, Frank J. Kachanoff, Jonah Berger, Curtis Puryear, Dan P. McAdams, Kurt Gray (2023), “Seeing Your Life Story as a Hero’s Journey Increases Meaning in Life,” Journal of Personality and Social Psychology, 125(4), 752–778.
 - ISSEP General Best Paper Award
19. Berger, Jonah (2023), “Machines, Psychology, and Hypothesis Generation: Comment on “Banker, Chatterjee, Mishra, and Mishra (2024),” American Psychologist.
20. Berger, Jonah, Matt Rocklage, and Grant Packard (2022) “Expression Modalities: How Speaking Versus Writing Shapes Word of Mouth,” Journal of Consumer Research, 49(3), 389–408.
 - Editor’s choice
21. Berger, Jonah and Grant Packard (2022) “Using Language to Understand People and Culture,” American Psychologist, 77(4), 525–537.
22. Laurino Dos Santos, Henrique and Jonah Berger (2022), “The Speed of Stories: Semantic Progression and Narrative Success,” Journal of Experimental Psychology: General, 151 (8), 1833–1842.
 - Authors contributed equally
23. Berger, Jonah, Grant Packard, Reihane Boghrati, Ming Hsu, Ashlee Humphreys, Andrea Luangrath, Sarah Moore, Gideon Nave, Christopher Olivola, Matthew Rocklage (2022) “Marketing Insights from Text,” Marketing Letters, 33, 365–377.
24. Madan, Shilpa, Gita Venkataramani Johar, Jonah Berger, Pierre Chandon, Rajesh Chandy, Rebecca Hamilton, Leslie John, Aparna Labroo, Peggy J. Liu, John G. Lynch, Jr., Nina Mazar, Nicole Mead, Vikas Mittal, Christine Moorman, Michael I. Norton, John Roberts, Dilip Soman, Madhu Viswanathan, Katherine White (2002), “Reaching for Rigor and Relevance: Better Marketing Research for a Better World,” Marketing Letters, 34, 1–12.

25. Toubia, Olivier, Jonah Berger, and Josh Eliashberg (2021), “Quantifying the Shape of Stories Predicts Their Success,” Proceedings of the National Academy of Sciences, 118(26).
 - First two authors contributed equally
26. Berger, Jonah, Yoon Duk Kim, and Robert Meyer (2021) “What makes Content Engaging? How Emotional Dynamics Shape Success,” Journal of Consumer Research, 48(2), 235–250.
27. Packard, Grant and Jonah Berger (2021) “How Concrete Language Shapes Customer Satisfaction,” Journal of Consumer Research, 47(5), 787–806.
28. Rifkin, Jacqueline, Katherine Crain, and Jonah Berger (2021), “Penny for Your Preferences: Leveraging Self-Expression to Increase Prosocial Giving,” Journal of Marketing, 85(3), 204–219.
29. Jacqueline Rifkin and Jonah Berger (2021), “How Nonconsumption Can Turn Ordinary Items into Perceived Treasures” Journal of the Association of Consumer Research, 6(3), 350–361.
30. McDuff, Daniel and Jonah Berger (2021), “Why Do Some Advertisements Get Shared More than Others? Quantifying Facial Expressions to Gain New Insights,” Journal of Advertising Research, 60(4), 370–380.
31. Packard, Grant and Jonah Berger (2020) “Thinking of You: How Second Person Pronouns Shape Cultural Success,” Psychological Science, 31(4), 397–407.
32. Bellezza, Silvia and Jonah Berger (2020), “Trickle-Round Signals: When Low Status Is Mixed with High,” Journal of Consumer Research, 47(1), 100–127.
33. Berger, Jonah, Ashlee Humphreys, Stephen Ludwig, Wendy Moe, Oded Netzer, and David Schweidel (2020), “Uniting the Tribes: Using Text for Marketing Insight,” Journal of Marketing, 84(1), 1–25
 - Most cited Journal of Marketing article in 2022
 - Sheth Foundation Award, *Journal of Marketing* article that has made the biggest long-term contribution to the field of marketing
34. Van Zant, Alex and Jonah Berger (2019) “How the Voice Persuades,” Journal of Personality and Social Psychology, 118(4), 661–682.
35. Berger, Jonah and Grant Packard (2018), “Are Atypical Things More Popular?” Psychological Science, 29(7), 1178–1184.
36. Gullo, Kelley, Jonah Berger, Jordan Etkin, and Bryan Bollinger (2018), “Does Time of Day Affect Variety Seeking?” Journal of Consumer Research, 46(1), 20–35.
37. Berger, Jonah and Alixandra Barasch (2018) “A Candid Advantage? The Social Benefits of Candid Photos,” Social Psychological and Personality Science, 9(8), 1010–1016.
38. Buechel, Eva and Jonah Berger (2018), “Microblogging and the Value of Undirected Communication” Journal of Consumer Psychology, 28(1), 40–55.
39. Packard, Grant and Jonah Berger (2017), “How Language Shapes Word of Mouth’s Impact,” Journal of Marketing Research, 54(4), 572–588.

40. Sela, Aner Jonah Berger, and Joshua Kim (2017) “How Self-Control Shapes the Meaning of Choice” Journal of Consumer Research, 44(4), 724–737.
41. Weingarten, Evan and Jonah Berger (2017) “Fired Up for the Future: How Time Shapes Sharing,” Journal of Consumer Research, 44(2), 432–447.
42. Akpınar, Ezgi and Jonah Berger (2017), “Valuable Virality,” Journal of Marketing Research, 54(2), 318–330.
43. Berger, Jonah (2016), “Does Presentation Order Impact Choice After Delay?” Topics in Cognitive Science, 8(3), 670–684.
44. Chen, Zoey and Jonah Berger (2016) “How Content Acquisition Method Affects Word of Mouth,” Journal of Consumer Research, 43(1), 86–102.
45. Park, Minsu, Mor Naaman, and Jonah Berger (2016) A Data-driven Study of View Duration on YouTube, 10th International AAAI Conference on Weblogs and Social Media (ICWSM).
46. Gregory Park, Andrew Schwartz, Margaret Kern, Maarten Sap, Evan Weingarten, Johannes Eichstaedt, Jonah Berger, David Stillwell, Michal Kosinski, Lyle Ungar, and Martin Seligman (2016) “Living in the Past, Present, and Future: Measuring Temporal Orientation with Language,” Journal of Personality, 85(2), 270–280.
47. Akpınar, Ezgi and Jonah Berger (2015), “Drivers of Cultural Success: The Case of Sensory Metaphors,” Journal of Personality and Social Psychology, 109 (1), 20–34.
48. Schwartz, H. Andrew, Park, G., Sap, M., Weingarten, E., Eichstaedt, J., Kern, M., Stillwell, D., Kosinski, M., Berger, J., Seligman, M., & Ungar, L. (2015). Extracting Human Temporal Orientation from Facebook Language. NAACL-2015: Conference of the North American Chapter of the Association for Computational Linguistics.
49. Berger, Jonah (2014) “Word-of-Mouth and Interpersonal Communication: A Review and Directions for Future Research” Journal of Consumer Psychology, 24(4), 586–607.
50. Barasch, Alix and Jonah Berger (2014) “Broadcasting and Narrowcasting: How Audience Size Impacts What People Share,” Journal of Marketing Research, 51(3), 286–299.
51. Bhattacharjee, Amit, Jonah Berger and Geeta Menon (2014), “When Identity Marketing Backfires: Consumer Agency in Identity Expression,” Journal of Consumer Research, 41(2), 294–309.
52. Milkman, Katherine and Jonah Berger (2014), “The Science of Sharing and the Sharing of Science” Proceedings of the National Academy of Sciences, 111(4), 13642–13649.
53. Berger, Jonah (2014), “Beyond Viral: Interpersonal Communication in the Internet Age,” Psychological Inquiry, 24, 293–296.
54. Berger, Jonah and Raghuram Iyengar (2013), “Communication Channels and Word of Mouth: How the Medium Shapes the Message,” Journal of Consumer Research, 40(3), 567–579.
55. Chen, Zoey and Jonah Berger (2013), “When, Why, and How Controversy Causes Conversation,” Journal of Consumer Research, 40(3), 580–593.

56. Sela, Aner and Jonah Berger (2012) “How Attribute Quantity Influences Option Choice,” Journal of Marketing Research, December, 942–953.
57. McShane, Blakely, Eric T. Bradlow, and Jonah Berger (2012), “Visual Influence and Social Groups” Journal of Marketing Research, December, 854–871.
58. Berger, Jonah, Eric Bradlow, Alex Braunstein, and Yao Zhang (2012), “From Karen to Katie: Using Baby names to Study Cultural Evolution” Psychological Science, 23 (10), 1067–1073.
59. Chan, Cindy, Jonah Berger, and Leaf Van Boven (2012), “Identifiable but not Identical: Combining Social Identity and Uniqueness Motives in Choice” Journal of Consumer Research, 39(3), 561–573.
60. Berger, Jonah and Katy Milkman (2012), “What Makes Online Content Viral?” Journal of Marketing Research, 49 (2), 192–205.
 - **Sage 10-Year Impact Award (3 most cited articles in all Sage journals in 2012), 2023**
 - **William F. O’Dell Award, Journal of Marketing Research, 2017**
 - **Paul Green Award Finalist, Journal of Marketing Research, 2013**
 - **Emerald Citations of Excellence, 2015**
61. Sela, Aner and Jonah Berger (2012), “Decision Quicksand: How Trivial Choice Suck Us In” Journal of Consumer Research, 39(2), 360–370.
 - **Best 2012 Article Finalist, Journal of Consumer Research**
62. Berger, Jonah and Eric Schwartz (2011), “What Drives Immediate and Ongoing Word of Mouth?” Journal of Marketing Research, October, 869–880.
63. Berger, Jonah and Baba Shiv (2011), “Food, Sex, and the Hunger for Distinction.” Journal of Consumer Psychology, 21, 464–472.
64. Berger, Jonah (2011), “Arousal Increases Social Transmission of Information,” Psychological Science, 22(7), 891–893.
65. Berger, Jonah and Devin Pope (2011), “Can Losing Lead to Winning?” Management Science, 57(5), 817–827.
66. Berger, Jonah and Morgan Ward, (2010) “Subtle Signals of Inconspicuous Consumption,” Journal of Consumer Research, 37(4), 555–569. (Lead Article)
67. Berger, Jonah, Alan T. Sorensen, and Scott J. Rasmussen (2010), “Positive Effects of Negative Publicity: When Negative Reviews Increase Sales,” Marketing Science, 29(5), 815–827.
68. Berger, Jonah and Gael Le Mens (2009), “Key Considerations in Studying Cultural Abandonment Using Baby Names,” Proceedings of the National Academy of Sciences.
69. Berger, Jonah and Gael Le Mens (2009), “How Adoption Speed Affects the Abandonment of Cultural Tastes,” Proceedings of the National Academy of Sciences, 106, 8146–8150.
70. Sela, Aner, Jonah Berger, and Wendy Liu (2009), “Variety, Virtue, and Vice: How Assortment Size Influences Option Choice,” Journal of Consumer Research, 35(3), 941–951.

71. Berger, Jonah and Chip Heath (2008) "Who Drives Divergence? Identity Signaling, Outgroup Dissimilarity, and the Abandonment of Cultural Tastes," Journal of Personality and Social Psychology, 95(3), 593–607.
72. Berger, Jonah and Lindsay Rand (2008), "Shifting Signals to Help Health: Using Identity Signaling to Reduce Risky Health Behaviors," Journal of Consumer Research, 35(2), 509–518.
73. Berger, Jonah, Marc Meredith, and S. Christian Wheeler (2008), "Contextual Priming: Where People Vote Affects How They Vote," Proceedings of the National Academy of Sciences, 105 (26), 8846–8849.
 - **Featured in *Nature* (2008). 453, 1197.**
74. Berger, Jonah and Gráinne M. Fitzsimons (2008), "Dogs on the Street, Pumas on Your Feet: How Cues in the Environment Influence Product Evaluation and Choice," Journal of Marketing Research, 45(1), 1–14. (Lead Article)
75. Wheeler, S. Christian and Jonah Berger (2007), "When the Same Prime Leads to Different Effects," Journal of Consumer Research, 34(3), 357–368.
76. Berger, Jonah and Chip Heath (2007), "Where Consumers Diverge from Others: Identity-Signaling and Product Domains," Journal of Consumer Research, 34(2), 121–134. (Lead Article)
 - **Best 2007 Article Finalist, *Journal of Consumer Research***
 - **3rd highest cited JCR paper, 2011–2014**
77. Berger, Jonah, Michaela Draganska, and Itamar Simonson (2007), "The Influence of Product Variety on Brand Perceptions and Choice," Marketing Science, 26, 460–472. (Lead Article)
78. Pronin, Emily, Jonah Berger, and Sarah Molouki (2007), "Alone in a Crowd of Sheep: Asymmetric Perceptions of Conformity and Their Roots in an Introspection Illusion," Journal of Personality and Social Psychology, 92(4), 585–595.
 - **Featured in Editor's Choice section of *Science* (2007). 316, 1814.**
79. Heath, Chip, Ben Ho, and Jonah Berger (2006), "Focal Points in Coordinated Divergence," Journal of Economic Psychology, 27(5), 635–647.
80. Berger, Jonah and Chip Heath (2005), "Idea Habitats: How the Prevalence of Environmental Cues Influences the Success of Ideas," Cognitive Science, 29, 195–221. (Lead Article)

Books, Chapters, and Other Publications

81. Berger, Jonah (2023), *Magic Words: What to Say to Get Your Way*, Harper Collins.
 - **New York Times and Wall Street Journal Bestseller**
82. Berger, Jonah (2020), *The Catalyst: How to Change Anyone's Mind*, Simon & Schuster.
 - **New York Times and Wall Street Journal Bestseller**
 - **Berry-AMA Book Prize Finalist for Best Book in Marketing, 2022**
83. Berger, Jonah (2016), *Invisible Influence: The Hidden Forces that Shape Behavior*, Simon & Schuster.
 - **New York Times and Wall Street Journal Bestseller**
84. Berger, Jonah (2013), *Contagious: Why Things Catch On*, Simon & Schuster.

- **New York Times, Wall Street Journal Bestseller, Amazon Best Business Book of 2013, AMA-Berry Book Prize for Best Book in Marketing 2014**
- **Millions of copies in print in over 35 languages**

85. Berger, Jonah (2021), “Want Your Ad to Go Viral? Activate These Emotions,” Harvard Business Review. February 4
86. Berger, Jonah (2020), “How to Persuade People to Change Their Behavior,” Harvard Business Review. April 20
87. Berger, Jonah (2016), “The Goldilocks Theory of Product Success,” Harvard Business Review. July 7
88. Buechel, Eva C. and Jonah Berger (2015), “Motivations for Consumers Engaging with Social Media,” Consumer Psychology in a Social Media World.
89. Berger, Jonah (2015), “Word of Mouth and Interpersonal Communication,” Cambridge Handbook of Consumer Psychology
90. Berger, Jonah (2012), “Crafting Contagious,” Google Think Quarterly. August, 60–61.
91. Berger, Jonah (2012), “Bad Reviews Can Boost Sales. Here’s Why,” Harvard Business Review. March 28.
92. Berger, Jonah (2011), “Social Contagion and Word-of-Mouth,” in *Consumer Insights: Findings from Behavioral Research*, Ed Joseph Alba, Marketing Science Institute.
93. Berger, Jonah (2011), “If You Want to Win, Tell Your Team It’s Losing (a Little),” Harvard Business Review. October.
94. Rand, Lindsay and Jonah Berger (2010) “Using Identity Signaling to Improve Public Health” in *Leveraging Consumer Psychology for Effective Health Communications: The Obesity Challenge*, Eds. Rajeev Batra, Punam Anand Keller, and Victor J. Strecher, M. E. Sharpe.
95. Berger, Jonah (2008) “Identity-Signaling, Social Influence, and Social Contagion,” in *Peer Influence Processes among Youth*, Eds. Mitch Prinstein and Ken Dodge, Guilford Press.

Working Papers

96. Van Zant, Alex, Jonah Berger, Grant Packard, and Harry Wang, “The Power of Pausing,” *Under 3rd Review*.
97. A Machine Learning Approach to examine Originality of user-generated Content from TikTok. *Under 2nd Revision*. Best in track paper, Big Data, Analytics, AI & Machine Learning track, Winter AMA
98. Cascio-Rizzo, Giovanni Luca, Jonah Berger, and Mi Zhou, “How Hand Movements Shape Communication’s Impact,” *Under 2nd Review*.
99. Oba, Demi and Jonah Berger, How Hedges Impact Persuasion, *Under Revision*.
100. Cascio-Rizzo, Giovanni Luca, Jonah Berger, and Matt Rocklage “Speaking, Writing, and the Expression of Certainty,” *Under Review*.

101. Sepehri, Amir, Reihane Boghrati, and Jonah Berger, “Measuring and Mitigating Bias in Machine Learning,” *Under Review*.
Winner, EMAC-Sheth Foundation Sustainability Research Competition 2022
102. Cascio-Rizzo, Giovanni Luca, and Jonah Berger, “How Speaking Rate Shapes Consumer Response,” *Under Review*.
 - Featured in *Harvard Business Review*
103. What Drives Virtual Influencer’s Impact? *Under Review*
104. Visual Similarity to the Past, *Under Review*.
105. Boghrati, Reihane and Jonah Berger, “What Drives Longer Conversations?” *Under Review*.
106. Sepehri, Amir and Jonah Berger, “Passive Voice and Consumer Complaints,” *Under Review*.
107. Dore, Bruce and Jonah Berger, A Linguistic Signature of Sharing.
108. Sharing Comedy.
109. Cascio-Rizzo, Giovanni Luca and Jonah Berger, “Melodic Repetition Shapes Success,”
110. The Power of Preparation: Brainstorming Flexible Topics Before Conversations Begin
111. Reverse Diffusion.
112. Disposal in Response to Social Rejection
113. Aner Sela, Jonah Berger, and Gia Nardini “How Tradeoffs Shrink Attribute Hierarchy”
114. Iyengar, Raghu and Jonah Berger, “How the Quantity and Timing of Social Influence Impact Product Adoption”
115. Stephen, Andrew and Jonah Berger, “Creating Contagious: How Social Networks and Item Characteristics Combine to Spur Ongoing Consumption and Drive Social Epidemics.”
116. Berger, Jonah, Ben Ho, and Yogesh Joshi, “Identity Signaling with Social Capital: A Model of Symbolic Consumption.”
117. Berger, Jonah, “When Does Social Influence Attract versus Repel? Identity-Signaling, Conformity, and Divergence.”

Service

Global Youth Program Advisory Committee 2022–
MBA Curriculum Committee, 2021–
Organizer, Insights from Text Conference, 2017–
Wharton Digital Press Faculty Advisory Board
MBA Executive Committee, The Wharton School, July 2017–2020
Undergraduate Marketing Coordinator, The Wharton School, 2016–

Co-Founder, Technology and Behavioral Science Initiative, The Wharton School, 2015–
University of Pennsylvania Faculty Senate Executive Committee October 2018–2020
PhD Committee, The Wharton School, Sept 2009–July 2015
Curriculum Review Committee, The Wharton School, Sept 2015–July 2016
MBA Class of 2014 Convocation Speaker 2012
Dean’s Advisory Council, The Wharton School, Sept 2011–July 2012
Decision Process Seminar, Co-Organizer, The Wharton School, Sept 2008–July 2010
Course Development: MKTG 228/728 (Contagious: How Products, Ideas, and Behaviors Catch On)

Editorial Activities

Co-Editor, Special Issue of *Journal of Consumer Psychology* on Consumer Insights from Text Analysis, Oct 2023
Associate Editor, *Journal of Marketing*, June 2018 – Dec 2023
Associate Editor, *Journal of Marketing Research*, July 2012 - 2020
Associate Editor, Special Issue on Social Media, *Information Systems Research*, 2011
Guest Editor, *Journal of Marketing*
Guest Editor, *Proceedings of the National Academy of Sciences*

Editorial Review Boards: *Journal of Marketing Research*, *Journal of Marketing*, *Journal of Consumer Psychology*, *Research, Marketing Science*

Program Committees: *Association for Consumer Research* (2009, 2011, 2013, 2014, 2020, 2024, 2025, Knowledge Forum Chair, 2023), *Society for Consumer Psychology* (2008, 2013, 2014, 2020)

Selected Ad-Hoc Reviewing

Journal of Personality and Social Psychology, *Journal of Experimental Social Psychology*, *Journal of Personality*, *Journal of Decision Making*, *Organizational Behavior and Human Decision Processes*, *Trends in Cognitive Science*, *Journal of Experimental Psychology: Applied*, *International Journal of Research in Marketing*, *Psychological Science*, *Personality and Social Psychology Bulletin*, *Society for Judgment and Decision Making Conference*, *PLoS ONE*, *Social and Personality Psychology Compass*, *Management Science*, *Proceedings of the National Academy of Sciences*, *Evolution and Human Behavior*, *Journal of Behavioral Decision Making*, *Advances in Complex Systems*, *Nature: Human Behavior*, *Self and Identity*

Advising

Giovanni Luca Cascio-Rizzo (co-advisor)
Demi Oba (co-advisor)
Ike Silver (committee member)
Reihane Boghrati (post doc advisor)
Ezgi Akpinar (co-advisor) winner, 2014 McKinsey Dissertation Award
Zoey Chen (committee member)
Cindy Chan (committee member)
Amit Bhattacharjee (committee member)

Jonah Berger
Prior Testimony in the Last Four Years

I have given expert testimony at deposition and/or at trial in the following matters:

1. *In Re: Duramax Diesel Litigation*, United States District Court for the Eastern District of Michigan, Case No. 1:17-cv-11661-TLL-PTM, and related matters. Deposition testimony on March 18, 2022.
2. *JUUL Labs, In. Marketing, Sales Practices, and Products Liability Litigation*, United States District Court, Northern District of California, File No.: 19-md-02913-WHO. Deposition testimony on October 7, 2021, November 30, 2021, and May 19, 2022.
3. *J. Hart et al. v. TWC Product and Technology LLC*, United States District Court, Northern District of California, Case No. 4:20-cv-3842-JST. Deposition testimony on June 3, 2022.
4. *J. Ciccio et al. v. SmileDirectClub, Inc.*, United States District Court, Middle District of Tennessee, Nashville Division, Case No. 3:19-cv-00845. Deposition testimony on July 25, 2022.
5. *Walter Peters v. Apple, Inc.*, Superior Court of the State of California, County of Los Angeles, Case No. 19STCV21787. Deposition testimony on August 26, 2022.
6. *State of Minnesota, by its Attorney General, Keith Ellison vs. Juul Labs Inc.*, Fourth Judicial District Court, State of Minnesota, County of Hennepin, Court File No. 27-CV-19-19888. Deposition testimony on September 30, 2022.
7. *City of Chicago v. Juul Labs, Inc. et al.*, In the Circuit Court of Cook County, Illinois County Department, Chancery Division, Case No. 2020CH04183. Deposition testimony on October 19, 2022.
8. *Commonwealth of Kentucky, ex rel. Daniel Cameron, Attorney General v. Johnson & Johnson, et al.*, Commonwealth of Kentucky, Franklin Circuit Court, Civil Action No. 16-CI-867. Deposition testimony on November 2, 2022.
9. *District of Columbia v. Juul Labs, Inc. et al.*, In the Superior Court of the District of Columbia, Civil Division, Case No. 2019-CA-007795-B. Deposition testimony on February 7, 2023.
10. *Yuga Labs, Inc. v. Ripps, et al.*, United States District Court, Central District of California, Case No. 2:22-cv-04355. Deposition testimony on March 9, 2023. Trial testimony on July 31, 2023.
11. *Smartmatic USA Corp., Smartmatic International Holding B.V., and SGO Corporation Limited v. Newsmax Media, Inc.*, Superior Court of the State of Delaware, Case No. N21C-11-028 EMD. Deposition testimony on February 12, 2024.

12. *In Re: Qualcomm Incorporated Securities Litigation*, United States District Court, Southern District of California, Civil Action No. 3:17-cv-00121-JOMSB. Deposition testimony on February 20, 2024.
13. *Smartmatic USA Corp., Smartmatic International Holding B.V., and SGO Corporation Limited v. Fox Corporation, Fox News Network LLC, Lou Dobbs, Maria Bartiromo, Jeanine Pirro, and Rudolph Giuliani*, Supreme Court of the State of New York, County of New York, Index No. 151136/2021. Deposition testimony on May 22, 2024.
14. *Smartmatic USA Corp., Smartmatic International Holding B.V., and SGO Corporation Limited v. Michael J. Lindell and My Pillow, Inc.*, United States District Court, District of Minnesota, Case No. 22-cv-0098-WMW-JFD. Deposition testimony on August 12, 2024.
15. *Virtru Corporation v. Microsoft Corporation*, United States District Court for the Western District of Washington at Seattle, Case No. 2:23-cv-00872-JNW. Deposition testimony on November 19, 2024.
16. *Jane Doe, Janet Roe, and Janice Coe v. Netflix, Inc.; Netflix Worldwide Entertainment, LLC; and Realhouse Productions LLC*, United States District Court Southern District of Indiana, Indianapolis Division, Case 1:22-cv-01281-TWP-MJD. Trial testimony on December 4, 2024.
17. *In Re: Google Digital Advertising Antitrust Litigation*, United States District Court for the Southern District of New York, Case No. 1:21-md-3010 (PKC). Deposition testimony on March 6, 2025.
18. *In Re: Apple iPhone Antitrust Litigation*, United States District Court for the Northern District of California, Case No. 4:11-cv-06714-YGR. Deposition testimony on April 3, 2023 and July 1, 2025.

Documents Considered List

Academic Articles

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Exhibit 2

**UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION**

GOOD SAMARITAN MEDICAL CENTER
INC., DELRAY MEDICAL CENTER, INC.,
PALM BEACH GARDENS COMMUNITY
HOSPITAL, INC. D/B/A PALM BEACH
GARDENS MEDICAL CENTER, ST.
MARY'S MEDICAL CENTER, INC., AND
WEST BOCA MEDICAL CENTER, INC.,

Plaintiffs,

v.

THE LEAPFROG GROUP,

Defendant.

Case No. 9:25-CV-80526

Supplemental Expert Report of Jonah Berger, Ph.D.

August 21, 2025

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I. Background and Assignment

1. On August 7, 2025, I submitted an expert report (“Berger Report”) in the above-captioned matter.¹ A summary of my qualifications, my compensation in this matter, and a list of my prior testimony are included in the Berger Report. A list of additional materials I have considered since my initial report is attached as **Appendix A**.

2. In the Berger Report, I was asked to assess whether, and in what ways, the publication or repeated publication of low or failing TLG Hospital Safety Grades may impact consumers’ perceptions of and decisions to seek care at the five Plaintiff Hospitals.² I was also asked to assess the extent to which TLG’s imputation disclosures³ would be expected to affect consumers’ understanding of TLG’s imputation methodology and its impact on TLG’s Hospital Safety Grades for non-participating hospitals.⁴ In setting forth my opinions in the Berger Report, I noted that “the parties are continuing to produce documents and evidence in this case” and that “I reserve the right to adjust my opinions based on my review of documents recently produced or that will be produced in this litigation.”⁵ I understand that TLG produced excerpts of website analytics data from its Google Analytics account for hospitalsafetygrade.org on August 5, 2025 (“TLG’s Website Analytics Data”), such that I did not have the opportunity to meaningfully review the data prior to submission of the Berger Report. In this supplemental report, I have been asked to review and evaluate TLG’s recently produced data, including its Website Analytics Data.

3. I reserve the right to supplement or amend my opinions should new information become available.

¹ Expert Report of Jonah Berger, Ph.D., *Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group*, United States District Court for the Southern District of Florida, West Palm Beach Division, Case No.: 9:25-cv-80526, August 7, 2025 (“Berger Report”).

² Berger Report, ¶¶ 8, 12.

³ In the Berger Report, I define “imputation disclosures” as the notes and documentation on hospitalsafetygrade.org and leapfroggroup.org cited in TLG’s Motion to Dismiss, in which TLG purports to disclose its imputation methodology. In my analysis in Section VIII of the Berger Report, I also include exhibits to Plaintiffs’ Motion for Preliminary Injunction. *See* Berger Report ¶¶ 9, 72.

⁴ Berger Report, ¶ 12.

⁵ Berger Report, ¶ 13, footnote 14.

II. Summary of Opinions

4. In the Berger Report, I presented evidence that TLG has repeatedly presented its Hospital Safety Grades as measuring patient safety and has highlighted the potential harm that patients may experience from choosing a low-graded hospital, including with statements such as “patients are twice as likely to die ... at a ‘C,’ ‘D,’ or ‘F’ hospital than an ‘A’ hospital.”⁶ Among other things, I concluded that, while TLG purports to provide disclosures about its practice of assigning the minimum score on its imputed measures for non-participating hospitals,⁷ TLG’s purported disclosures are unlikely to help consumers understand what TLG does and the impact this practice has on non-participating hospitals’ Safety Grades.⁸ In fact, I showed evidence that, in some content on hospitalsafetygrades.org, TLG explicitly downplays the impact of this practice on the overall Hospital Safety Grades it assigns to hospitals.⁹

5. In the Berger Report, I analyzed TLG’s purported disclosures and found that only one—TLG’s Spring 2025 “Scoring Methodology” document”—both states that TLG assigns the minimum score on the imputed measures and can be accessed from TLG’s Hospital Safety Grade Pages.¹⁰ I also explained that many consumers are unlikely to see, let alone read, TLG’s Spring 2025 “Scoring Methodology” document.¹¹ TLG’s Website Analytics Data corroborates this conclusion. The data shows that only 3% of users who navigated to Plaintiff Hospitals’ Safety Grade Pages even downloaded, and thus were even *potentially* exposed to the disclosure in, either the Spring 2025 “Scoring Methodology” document or the Fall 2024 “Scoring Methodology” document (a previous version of the document). As discussed in the Berger Report, once these users downloaded the “Scoring Methodology” document, they would need to navigate to page 16 to access the language that discusses TLG’s practice of assigning the minimum score on the

⁶ Berger Report, ¶ 45.

⁷ I understand that Plaintiffs allege and Professor Nicholson finds that TLG’s Hospital Safety Grades for non-participating hospitals can be negatively impacted by TLG’s practice of assigning the minimum score on the imputed measures. *See* Berger Report, ¶ 77.

⁸ Berger Report, Section VIII.

⁹ Berger Report, ¶ 80.

¹⁰ Berger Report, ¶¶ 66, 72–73, Section VIII.D. My understanding of which pages can be accessed from a TLG Hospital Safety Grade Page is based on a review of the website as of July 30, 2025. *See* Berger Report, footnote 143.

¹¹ Berger Report, Section VIII.D.

imputed measures.¹² Consequently, it is unlikely that all 3% of users were exposed to, let alone read, the relevant language in these documents.

6. In the Berger Report, I also explained that TLG's "D" or "F" Hospital Safety Grades for Plaintiff Hospitals likely deter consumers from choosing the hospitals.¹³ As part of this conclusion, I explained that, when consumers are making healthcare decisions, it can be difficult for consumers to review, process, and evaluate available information on the variety of attributes that differentiate hospitals.¹⁴ However, consumers typically engage in some level of research online as they make healthcare decisions.¹⁵ I explained that TLG has widely publicized its Fall 2024 and Spring 2025 Hospital Safety Grades releases and that, among other publicity, each release was covered in over 700 online articles, making it more likely that consumers would see the grades, including TLG's "D" or "F" grades for Plaintiff Hospitals, during their research.¹⁶ TLG's Website Analytics Data is consistent with this conclusion. The data shows that views of Hospital Safety Grade Pages on hospitalsafetygrade.org increased sharply after TLG released its Fall 2024 and Spring 2025 Hospital Safety Grades. Indeed, compared to all other months between May 15, 2024 and July 14, 2025, views across all hospitals' Safety Grade Pages were four times higher, on average, in months when TLG released its Fall 2024 and Spring 2025 Hospital Safety Grades. Views across Plaintiff Hospitals' Safety Grade Pages, specifically, were five times higher during the same months.

III. The Vast Majority of Users who Visited Plaintiff Hospitals' Safety Grade Pages Did Not Download TLG's Fall 2024 or Spring 2025 "Scoring Methodology" Documents

7. I concluded in the Berger Report that while TLG purports to disclose its imputation methodology on its websites, TLG's imputation disclosures are unlikely to help consumers understand that TLG assigns the minimum score on the imputed measures and the impact this methodology has on non-participating hospitals' Safety Grades.¹⁷ In particular, I found that TLG's footnote disclosure omits language about TLG's practice of assigning the minimum score on the

¹² Berger Report, ¶ 83.

¹³ Berger Report, Section VI.

¹⁴ Berger Report, ¶ 33.

¹⁵ Berger Report, ¶ 33.

¹⁶ Berger Report, ¶ 34.

¹⁷ Berger Report, Section VIII.

imputed measures.¹⁸ I also concluded that many consumers are unlikely to see, let alone read, the Spring 2025 “Scoring Methodology” document, which is the only disclosure that both states TLG assigns the minimum score on the imputed measures and that can be accessed from TLG’s Hospital Safety Grade Pages.¹⁹ As discussed below, TLG’s Website Analytics Data corroborates this conclusion. Only a small proportion of users who visited Plaintiff Hospitals’ Safety Grade Pages even downloaded, and thus were even *potentially* exposed to the disclosure in, either the Spring 2025 “Scoring Methodology” document or the Fall 2024 “Scoring Methodology” document (a previous version of the document).

8. Website owners like TLG use website analytics data, including data from Google Analytics, to understand how users engage with and navigate through their sites.²⁰ This data may record measures such as the number of times a page is loaded, how often links are clicked, and the order in which users visit different pages on a website.²¹

9. TLG’s Website Analytics Data tracks how users interact with each Plaintiff Hospital’s Safety Grade Page on hospitalsafetygrade.org, including the total number of users who navigated to each page.²² TLG’s Spring 2025 “Scoring Methodology” document is accessible from a Hospital Safety Grade Page by navigating to the Detailed Table View of the hospital’s grade and then clicking on a link to download the document.²³ Accordingly, TLG’s Website Analytics Data not only shows the number of users who visited each Plaintiff Hospital’s Safety Grade Page, but also identifies how many of those users accessed the Detailed Table View or downloaded either

¹⁸ Berger Report, ¶¶ 65–66, Section VIII.C.

¹⁹ Berger Report, ¶¶ 72–74, Section VIII.D. I referred to the Spring 2025 “Scoring Methodology” document as the “methodology document” in the Berger Report. My understanding of which pages can be access from a TLG Hospital Safety Grade Page is based on a review of the website as of July 30, 2025. See Berger Report, footnote 143.

²⁰ “The Value of Digital Analytics,” *Google*, <https://support.google.com/analytics/answer/12159453>, PBHN000009892–3; “[GA4] Find Your Way Around Analytics,” *Google*, <https://support.google.com/analytics/answer/9367631>, PBHN000009919–20.

²¹ See “[GA4] Introducing the Next Generation of Analytics, Google Analytics 4,” *Google*, <https://support.google.com/analytics/answer/10089681>, PBHN000009921–2; “[GA4] About Events,” *Google*, <https://support.google.com/analytics/answer/9322688>, PBHN000009905–7; “[GA4] Automatically Collected Events,” *Google*, <https://support.google.com/analytics/answer/9234069>, PBHN000009908–14.

²² “Users” in TLG’s Website Analytics Data represent “active users,” where “active” indicates users who engaged with the page in the specified date range. “[GA4] Understand User Metrics,” *Google*, <https://support.google.com/analytics/answer/12253918>, PBHN000009923–4.

²³ Berger Report, ¶ 83. Clicking the link to the document represents a download. See “[GA4] Enhanced Measurement Events,” *Google*, <https://support.google.com/analytics/answer/9216061>, PBHN000009915–8.

the Spring 2025 “Scoring Methodology” document, which is the subject of my analysis in the Berger Report, or a previous version, the Fall 2024 “Scoring Methodology” document.²⁴

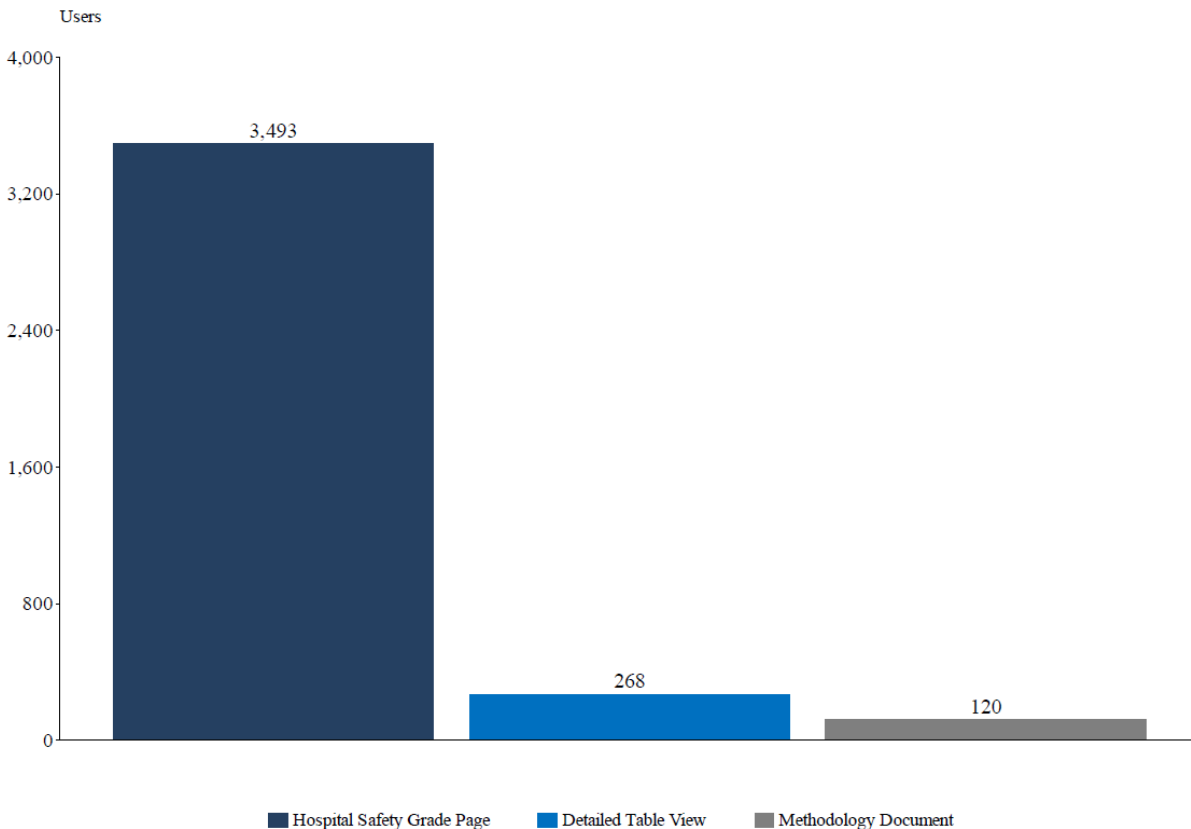
10. TLG’s Website Analytics Data shows that only a very small percentage of users who visited a Plaintiff Hospital’s Safety Grade Page downloaded the Fall 2024 “Scoring Methodology” or Spring 2025 “Scoring Methodology” document. Exhibit 1 presents the number of users who visited a Plaintiff Hospital’s Safety Grade Page between November 15, 2024 and August 4, 2025 (the end of the last month of data) and, of those, the number that accessed the Detailed Table View on that Plaintiff Hospital’s Safety Grade Page or downloaded either methodology document.²⁵ For example, if a user visited the Hospital Safety Grade Page for Delray Medical Center and, at some point after, visited the Detailed Table View Page for Delray Medical Center’s Hospital Safety Grade, that user would be counted in both the “Hospital Safety Grade Page” and “Detailed Table View” bars. While 3,493 users visited a Plaintiff Hospital’s Safety Grade Page, only 268 (8%) of these users also navigated to that Plaintiff Hospital’s Detailed Table View and only 120 (3%) downloaded either methodology document.²⁶

²⁴ The data records the number of active users who completed each action. The active users who downloaded either methodology document did not necessarily visit the Detailed Table View and vice versa.

²⁵ Users who viewed multiple Plaintiff Hospitals’ Safety Grade Pages are counted multiple times.

²⁶ TLG’s Website Analytics Data also records the total number of downloads for files on hospitalsafetygrade.org. The Fall 2024 “Scoring Methodology” and Spring 2025 “Scoring Methodology” documents were downloaded a total of 6,680 times sitewide from November 15, 2024 to August 5, 2025. *See* Workpaper 1. By comparison, Hospital Safety Grade Pages were viewed a total of 748,313 times sitewide across the same time period. *See* Workpaper 2. The Fall 2024 and Spring 2025 Methodology Documents were available at multiple URLs during this time period:
<https://www.hospitalsafetygrade.org/media/file/Methodology-Spring-2025.pdf>,
<https://www.hospitalsafetygrade.org/media/file/Methodology-Spring-2025-1.pdf>,
<https://www.hospitalsafetygrade.org/media/file/Methodology-Spring-2025-2.pdf>,
<https://www.hospitalsafetygrade.org/media/file/Safety-Grade-Scoring-Methodology-Fall-2024.pdf>,
<https://www.hospitalsafetygrade.org/media/file/Safety-Grade-Scoring-Methodology-Fall-2024-1.pdf>. *See* PBHN000003012–40; PBHN000009808–36; PBHN000009837–65; PBHN000003044–69; PBHN000009866–91. In the Berger Report, I also discuss two additional documents which contain language about TLG’s minimum score assignment: (1) The “Fall 2024 Methodology Updates” document and (2) the “2025 Leapfrog Hospital Survey.” *See* Berger Report, ¶ 72. The “2025 Leapfrog Hospital Survey” is not on the hospitalsafetygrade.org website and thus not included in TLG’s Website Analytics Data, which only captures hospitalsafetygrade.org analytics. In addition, the “Fall 2024 Methodology Updates” document does not appear in the data recording downloads for the November 15, 2024–August 5, 2025 period.

Exhibit 1 Number of Users who Navigated to Plaintiff Hospitals' Safety Grade Pages, the Detailed Table Views for Plaintiff Hospitals, and Downloaded the Methodology Document



Source: LEAPFROG02864707; LEAPFROG02864708; LEAPFROG02864711; LEAPFROG02864710; LEAPFROG02864714; LEAPFROG02864713; LEAPFROG02864716; LEAPFROG02864718; LEAPFROG02864721; LEAPFROG02864720

Note: This exhibit displays the total count of active users who visited a Plaintiff Hospital's Safety Grade Page between November 15, 2024, the day the Fall 2024 Hospital Safety Grades were released, and August 4, 2025, the end of the last day of the data underlying this analysis, and the proportion of those active users that navigated to the Detail Table Page for that Plaintiff Hospital or downloaded either the Fall 2024 or Spring 2025 "Scoring Methodology" document. Users who visited multiple Plaintiff Hospitals' Safety Grade Pages are counted multiple times.

11. Even after downloading the document, additional steps are required to view the language that discusses TLG's practice of assigning the minimum score on the imputed measures, which is on page 16 of the Spring 2025 "Scoring Methodology" document, as discussed in the Berger Report.²⁷ Consequently, it is unlikely that all of these 3% of users were exposed to, let alone read, the relevant language in these documents.

²⁷ Berger Report, Section VIII.D.

12. In sum, evidence in TLG's Website Analytics Data is consistent with my conclusions in the Berger Report that many consumers are unlikely to read TLG's Spring 2025 "Scoring Methodology" document. Indeed, TLG's Website Analytics Data shows that only a small proportion of users who visited Plaintiff Hospitals' Safety Grade Pages even downloaded, and thus were even *potentially* exposed to the disclosure in, either the Spring 2025 "Scoring Methodology" document or the Fall 2024 "Scoring Methodology" document.

IV. Views of Plaintiff Hospitals' Safety Grades Increased After TLG's Publicized the Releases of its Fall 2024 and Spring 2025 Hospital Safety Grades

13. In the Berger Report, I also explained that TLG's "D" or "F" Hospital Safety Grades for Plaintiff Hospitals likely deter consumers from choosing these hospitals.²⁸ As part of this conclusion, I explained that choosing a hospital is often a complex decision and, when making healthcare decisions, it can be difficult for consumers to review, process, and evaluate available information on the variety of attributes that differentiate hospitals.²⁹ However, consumers typically engage in some level of research online as they make healthcare decisions.³⁰ I explained that TLG has widely publicized its Fall 2024 and Spring 2025 Hospital Safety Grades releases and that, among other publicity, each grade release was covered in over 700 online articles, making it more likely that consumers would see the grades, including TLG's "D" or "F" grades for Plaintiff Hospitals, during their research.³¹

14. TLG's Website Analytics Data is consistent with this conclusion. According to this data, in the month immediately after TLG undertook its publicizing efforts for each release, views of individual hospitals' Safety Grade Pages on hospitalsafetygrade.org increased, both for all hospitals included in the data and for Plaintiff Hospitals specifically.

15. TLG's Website Analytics Data includes, among other things, the number of views of each hospital's Safety Grade Page on hospitalsafetygrade.org by month.³² The data records the number

²⁸ Berger Report, Section VI.

²⁹ Berger Report, ¶ 33.

³⁰ Berger Report, ¶ 33.

³¹ Berger Report, ¶ 34.

³² LEAPFROG02864692; LEAPFROG02864693; LEAPFROG02864689; LEAPFROG02864699; LEAPFROG02864690; LEAPFROG02864700; LEAPFROG02864691; LEAPFROG02864701; LEAPFROG02864702; LEAPFROG02864703;

of monthly page views for the period between November 15, 2023 and August 5, 2025, where a month is defined as the 15th of one month (e.g. November 15, 2024) to the 14th of the next month (e.g., December 14, 2024).³³

16. Exhibit 2 presents the total views of Hospital Safety Grade Pages on hospitalsafetygrade.org, summed across all hospitals in the data. The exhibit analyzes data from May 15, 2024, the start of the first full month of data after the Spring 2024 grades were released, to July 14, 2025, the end of the last full month of data. The exhibit shows that total views increased sharply after TLG's release and subsequent publicity of its Fall 2024 and Spring 2025 Hospital Safety Grades. Specifically, TLG released its Fall 2024 Hospital Safety Grades on November 15, 2024.³⁴ Views of TLG's Hospital Safety Grade Pages increased sharply from the month of October 15, 2024–November 14, 2024 to the month of November 15, 2024–December 14, 2024. TLG then released its Spring 2025 Hospital Safety Grades on May 1, 2025.³⁵ Views of TLG's Hospital Safety Grade Pages similarly increased sharply from the month of March 15, 2025–April 14, 2025 to the month of April 15, 2025–May 14, 2025. In fact, views in the months in which the Fall 2024 and Spring 2025 Hospital Safety Grades were released were approximately four times higher, on average, than views in other months between May 15, 2024 and July 14, 2025.³⁶

LEAPFROG02864694; LEAPFROG02864695; LEAPFROG02864683; LEAPFROG02864696; LEAPFROG02864684; LEAPFROG02864697; LEAPFROG02864685; LEAPFROG02864686; LEAPFROG02864687; LEAPFROG02864688; LEAPFROG02864698

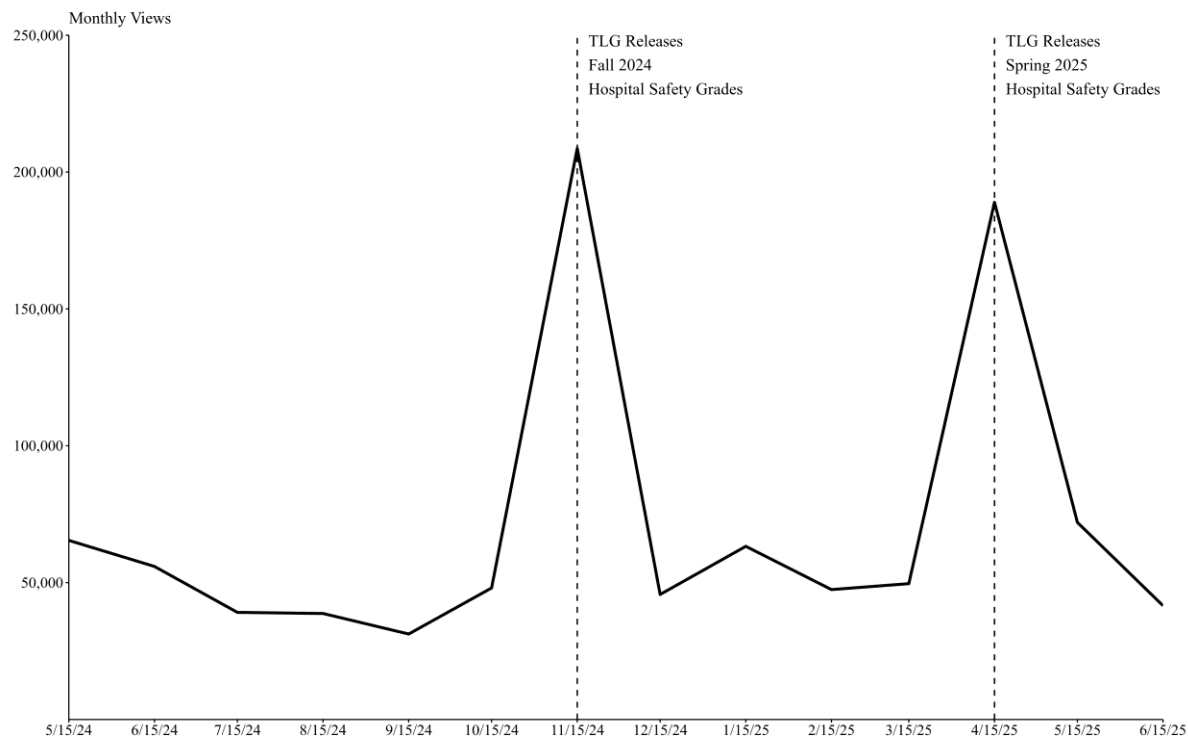
³³ See, e.g., LEAPFROG02864683. One user may view the same webpage multiple times, and each view is counted. See “[GA4] Enhanced Measurement Events,” *Google*, <https://support.google.com/analytics/answer/9216061>, PBHN000009915–8.

³⁴ Berger Report, ¶ 34, footnote 54.

³⁵ Berger Report, ¶ 34.

³⁶ Average views across the two months when TLG released its Fall 2024 and Spring 2025 Hospital Safety Grades (November 15, 2024–December 14, 2024 and April 15, 2025–May 14, 2025) were 198,798. Average views across all other months from May 15, 2024 to July 14, 2025 (the end date of the last full month of data) were 49,840. See Workpaper 3.

Exhibit 2 Total Monthly Views of Hospital Safety Grade Pages, Across All Hospitals



Source: LEAPFROG02864691; LEAPFROG02864701; LEAPFROG02864702; LEAPFROG02864703; LEAPFROG02864694; LEAPFROG02864695; LEAPFROG02864683; LEAPFROG02864696; LEAPFROG02864684; LEAPFROG02864697; LEAPFROG02864685; LEAPFROG02864686; LEAPFROG02864687; LEAPFROG02864698

Note: This exhibit displays the total monthly number of views that all Hospital Safety Grade Pages received on hospitalsafetygrade.org. The monthly views are recorded in periods beginning on the 15th of a month and ending on the 14th of the following month. The exhibit analyzes data from May 15, 2024, the start of the first full month of data after the Spring 2024 grades were released, to July 14, 2025, the end of the last full month of data. The dashed vertical lines indicate the start date for the months during which TLG released its Fall 2024 and Spring 2025 Hospital Safety Grades. TLG released its Fall 2024 Hospital Safety Grades on November 15, 2024 and its Spring 2025 Hospital Safety Grades on May 1, 2025.

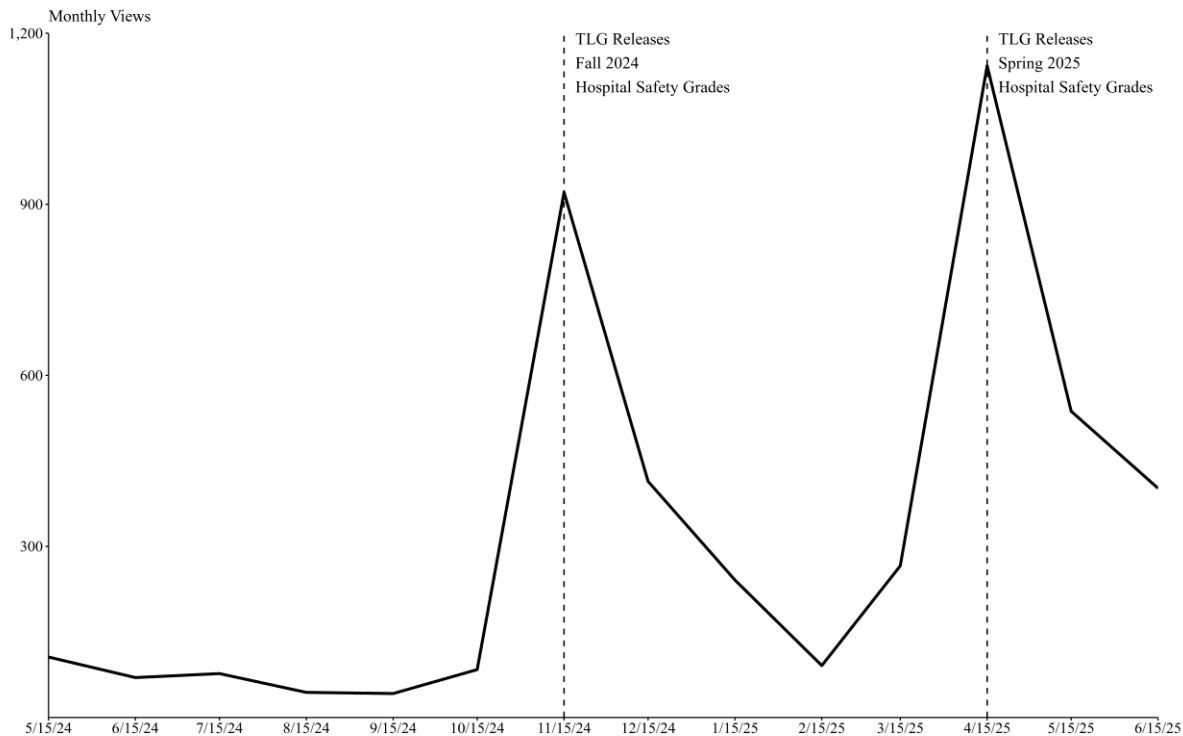
17. Exhibit 3 presents the total views of Plaintiff Hospitals' Safety Grade Pages on hospitalsafetygrade.org, summed across the five Plaintiff Hospitals. As the Exhibit shows, consistent with the results for all hospitals, the total views of Plaintiff Hospitals' Safety Grade Pages increased sharply after TLG's release and subsequent publicity of its Fall 2024 and Spring

2025 Hospital Safety Grades.³⁷ In fact, views for Plaintiff Hospitals' Safety Grade Pages in the months in which the Fall 2024 and Spring 2025 Hospital Safety Grades were released were almost five times higher, on average, than views in other months between May 15, 2024 and July 14, 2025.³⁸

³⁷ My conclusion does not change when I analyze the monthly average number of active users visiting Plaintiff Hospitals' Safety Grade Pages instead of total monthly views. *See* Workpaper 4.

³⁸ Average views for Plaintiff Hospitals across the two months when TLG released its Fall 2024 and Spring 2025 Hospital Safety Grades (November 15, 2024–December 15, 2024 and April 15, 2025–May 14, 2025) were 1,032. Average views for Plaintiff Hospitals across all other months from May 15, 2024 to July 14, 2025 (the end date of the last full month of data) were 198. *See* Workpaper 3. My conclusion does not change when I analyze the monthly average number of active users visiting Plaintiff Hospitals' Safety Grade Pages instead of total monthly views. *See* Workpaper 5.

Exhibit 3 Total Monthly Views of Hospital Safety Grade Pages, Across Plaintiff Hospitals



Source: LEAPFROG02864691; LEAPFROG02864701; LEAPFROG02864702; LEAPFROG02864703; LEAPFROG02864694; LEAPFROG02864695; LEAPFROG02864683; LEAPFROG02864696; LEAPFROG02864684; LEAPFROG02864697; LEAPFROG02864685; LEAPFROG02864686; LEAPFROG02864687; LEAPFROG02864698

Note: This exhibit displays the monthly number of views that Plaintiff Hospitals' Safety Grade Pages received on hospitalsafetygrade.org. The monthly views are recorded in periods beginning on the 15th of a month and ending on the 14th of the following month. The exhibit analyzes data from May 15, 2024, the start of the first full month of data after the Spring 2024 grades were released, to July 14, 2025, the end of the last full month of data. The dashed vertical lines indicate the start date for the months during which TLG released its Fall 2024 and Spring 2025 Hospital Safety Grades. TLG released its Fall 2024 Hospital Safety Grades on November 15, 2024 and its Spring 2025 Hospital Safety Grades on May 1, 2025.

18. In sum, TLG's Website Analytics Data shows that views of Hospital Safety Grade Pages on hospitalsafetygrade.org increased sharply after TLG widely publicized the release of its Fall 2024 and Spring 2025 Hospital Safety Grades. This is consistent with my opinion that TLG's publicity efforts made it more likely that consumers would see the grades.

Executed this 21st of August, 2025

A handwritten signature in black ink, appearing to read "Jonah Berger", with a long horizontal flourish extending to the right.

Jonah Berger

Documents Considered List

Expert Reports

- Expert Report of Jonah Berger, Ph.D., *Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group*, United States District Court for the Southern District of Florida, West Palm Beach Division, Case No.: 9:25-cv-80526, August 7, 2025
- Expert Report of Thomas Chakurda, *Good Samaritan Medical Center, Inc., et al. v. The Leapfrog Group*, United States District Court for the Southern District of Florida, West Palm Beach Division, Case No.: 9:25-cv-80526-DMM, August 7, 2025

Produced Documents

- LEAPFROG00140378–423
- LEAPFROG00147364–409
- LEAPFROG02864683
- LEAPFROG02864684
- LEAPFROG02864685
- LEAPFROG02864686
- LEAPFROG02864687
- LEAPFROG02864688
- LEAPFROG02864689
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- LEAPFROG02864707
- LEAPFROG02864708
- LEAPFROG02864710
- LEAPFROG02864711
- LEAPFROG02864713
- LEAPFROG02864714
- LEAPFROG02864716
- LEAPFROG02864718
- LEAPFROG02864720
- LEAPFROG02864721

Websites / Online Content

- “[GA4] About Events,” *Google*, <https://support.google.com/analytics/answer/9322688>, PBHN000009905–7
- “[GA4] Automatically Collected Events,” *Google*, <https://support.google.com/analytics/answer/9234069>, PBHN000009908–14
- “[GA4] Enhanced Measurement Events,” *Google*, <https://support.google.com/analytics/answer/9216061>, PBHN000009915–8
- “[GA4] Find Your Way Around Analytics,” *Google*, <https://support.google.com/analytics/answer/9367631>, PBHN000009919–20
- “[GA4] Introducing the Next Generation of Analytics, Google Analytics 4,” *Google*, <https://support.google.com/analytics/answer/10089681>, PBHN000009921–2
- “[GA4] Understand User Metrics,” *Google*, <https://support.google.com/analytics/answer/12253918>, PBHN000009923–4
- “Average Time on Page,” *AgencyAnalytics*, <https://agencyanalytics.com/kpi-definitions/average-time-on-page>, PBHN000009784–99
- “Average Time on Website Page Analysis,” *Umbrex*, <https://umbrex.com/resources/ultimate-guide-to-company-analysis/ultimate-guide-to-marketing-analysis/average-time-on-website-page-analysis>, PBHN000009800–7
- “Scoring Methodology: Fall 2024 Safety Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/media/file/Safety-Grade-Scoring-Methodology-Fall-2024-1.pdf>, PBHN000009866–91
- “Scoring Methodology: Spring 2025 Safety Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/media/file/Methodology-Spring-2025-1.pdf>, PBHN000009808–36
- “Scoring Methodology: Spring 2025 Safety Grade,” *The Leapfrog Group*, <https://www.hospitalsafetygrade.org/media/file/Methodology-Spring-2025-2.pdf>, PBHN000009837–65
- “The Value of Digital Analytics,” *Google*, <https://support.google.com/analytics/answer/12159453>, PBHN000009892–3
- “What is the Average Time on Page and How to Increase It,” *Nitropack*, <https://nitropack.io/blog/post/average-time-on-page>, PBHN000009894–904

Exhibit 3

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

GOOD SAMARITAN MEDICAL CENTER,)
INC., et al.,)
)
Plaintiffs,)
) Case No.
v.) 9:25-CV-80526-DMM
)
THE LEAPFROG GROUP,)
)
)
Defendant.)
)

Videotaped Deposition of JONAH BERGER, Ph.D.
(Given Remotely)
Thursday, August 28, 2025
9:33 a.m.

Reported by: Karen Kidwell, RMR, CRR

Magna Legal Services
866-624-6221
www.MagnaLS.com

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2

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17 Also Remotely Present:

18 Jason Dugmore, Videographer

19

20

21

22

23

24

25

1 I N D E X

2 WITNESS/EXAMINATION Page

3 JONAH BERGER, PH.D.

4 By Ms. Blair 4

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10 (No Exhibits Marked.)

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1 THURSDAY, AUGUST 28, 2025

2 P R O C E E D I N G S

3 - - -

4 VIDEOGRAPHER: This begins file Number 1.

5 We're now on the record for the deposition of

6 Jonah Berger, Ph.D., in the matter of Good

7 Samaritan Medical Center, Inc., et al., versus

8 The Leapfrog Group. Today's date is

9 August 28th, 2025. The time is 9:33 a.m.

10 Will counsel please introduce themselves.

11 MS. BLAIR: I guess I'll go first.

12 Kimberly Blair on behalf of the Defendant, The

13 Leapfrog Group.

14 MS. MALONEY: Mary Beth Maloney, and I'm

15 joined by my colleague Adam Garnick on behalf of

16 Plaintiffs.

17 MS. WOOD: And Courtney Wood on behalf of

18 Defendant, The Leapfrog Group.

19 VIDEOGRAPHER: Will the court reporter

20 please swear in the witness.

21 JONAH BERGER, PH.D.

22 being first duly sworn, testified as follows:

23 EXAMINATION

24 BY MS. BLAIR:

25 Q. Dr. Berger, as you probably know, my name

1 is Kim Blair, and I represent The Leapfrog Group in
2 connection with litigation brought by five different
3 hospitals for which you've been retained as an
4 expert. Correct?

5 A. That is correct, yes.

6 Q. And I just want the record to reflect that
7 this deposition is being taken pursuant to the
8 Federal Rules of Civil Procedure as well as the local
9 rules for the United States District Court for the
10 Southern District of Florida.

11 Have you ever provided expert witness
12 testimony in the Southern District of Florida
13 previously?

14 A. I'm not sure offhand.

15 Q. Okay. Could you please state and spell
16 your name for the record.

17 A. Sure. My name is Jonah, J-o-n-a-h,
18 Berger, B-e-r-g-e-r.

19 Q. And do you prefer Doctor, Professor,
20 Jonah? How do you prefer I address you during this
21 deposition?

22 A. Either Doctor or Professor is fine.

23 Q. Excellent.

24 I know that you've been deposed several
25 times before. And so I will quickly run through the

1 ground rules here, all of which you've heard multiple
2 times, but, of course, you know, this -- at any time
3 if you need to take a break, we're certainly amenable
4 to that. I only ask that if a question is pending,
5 you answer that question before we take a break. Is
6 that fine with you?

7 A. Totally fine, yes.

8 Q. If at any time you don't understand a
9 question I've asked, please ask me to rephrase it or
10 restate it; I will do my best. And to the extent
11 you've answered any of my questions, I'm going to
12 assume for purposes of this record that you
13 understood the question as asked. Is that fair?

14 A. Okay.

15 Q. And as you know, the court reporter can't
16 take down a shrug of the shoulders, an "uh-huh,"
17 "huh-uh," so all of your answers must be verbal.
18 Correct?

19 A. I understand.

20 Q. And I sometimes -- I'm from Chicago;
21 sometimes I'm a fast talker, so I'm going to do
22 everything I can to not talk over you and make sure
23 that I give you all the time you need to answer my
24 questions. And so for the courtesy of the court
25 reporter, I ask that we try not to crosstalk if

1 that's okay with you as well.

2 A. Makes sense. I appreciate that.

3 Q. Can you provide me just briefly, and I
4 know your -- your educational background is quite
5 extensive, but could you just provide a brief
6 background of your education as it relates to
7 marketing?

8 A. Sure. I have a Ph.D. in marketing from
9 the Stanford Graduate School of Business. And since
10 graduating with that Ph.D., I've been employed by the
11 Wharton School at the University of Pennsylvania in
12 the marketing department, and I am now a tenured

13 marketing professor in that department and have
14 published at this point over 80 articles, many of
15 them in top-tier marketing journals on issues related
16 to consumer behavior and things along those things.

17 Q. And just for the record when you say
18 "marketing department," you don't mean the department
19 that markets for the university, but rather the
20 marketing department being the department that
21 educates students to do marketing, correct?

22 A. Thank you for clarifying. Yes. So I am
23 the department that teaches marketing just like
24 there's an accounting department, a finance
25 department, a management department; not to do those

1 things for the school but to educate MBA
2 undergraduate and executives on those topics. And I
3 am a tenured faculty member in the marketing
4 department.

5 Q. Have you ever worked in what I will call
6 private practice in marketing?

7 A. I have frequently consulted for a variety
8 of companies and organizations on marketing issues.

9 Q. Okay. But have you ever been employed as
10 a marketing personnel in-house at a corporation as an
11 employee?

12 A. Yes, I have.

13 Q. Okay. And where -- where did you work?

14 A. A number of different places over the
15 years. I worked at a branding firm called Lexicon
16 Branding. I worked at Capital One in a brand
17 marketing-type role. Those are just some examples.

18 Q. Okay. And those -- those two roles that
19 you just mentioned were both in brand marketing,
20 correct?

21 A. No, they were in different aspects of
22 marketing.

23 Q. Oh.

24 A. Yeah. Those are just some examples.

25 Q. Okay. I thought you said in brand

1 marketing. So I just wanted to be clear.

2 In any of those outside employments that
3 you had -- well, let me ask this: When you -- what
4 year did you get your Ph.D.?

5 A. I believe it's 2007.

6 Q. Okay. And after receiving your Ph.D.,
7 what was your first employment after that?

8 A. With the Wharton School.

9 Q. Okay. So these jobs that you just told me
10 about -- Lexicon, Capital One -- they would have been
11 prior to getting your Ph.D. at the Wharton School?

12 A. That's correct. Prior to getting my Ph.D.
13 at the Stanford Graduate School of Business and prior
14 to my job at the Wharton School.

15 Q. Sorry. Yes. I misspoke. Thank you.

16 And so those jobs, roughly what time frame
17 would you have worked in, again, what I'm calling
18 nonacademic practice of marketing?

19 A. I -- I don't remember offhand. It's
20 been -- it's been a few years. I think more relevant
21 is my recent experience consulting for, you know,
22 hundreds of companies and organizations on issues
23 related to marketing. But I have been in-house at
24 individual companies, and you are correct that that
25 was before the time I got my Ph.D.

1 Q. Got it.

2 And what year did you graduate from
3 undergrad?

4 A. I believe 2002.

5 Q. And your current consulting work is with
6 the Cornerstone Group, correct?

7 A. I'm not sure what you mean.

8 Q. Well, as I understand it, and -- and
9 please correct me if I'm wrong, you were retained as
10 an expert in this case through the Cornerstone Group,
11 correct?

12 A. Oh, sorry. I thought you were referring
13 to when I said I consult for companies,
14 organizations, you were --

15 Q. Oh, no.

16 A. I thought you were referring to other --
17 other marketing consulting assignments. For this
18 case, yes, I am -- Cornerstone has worked at my
19 direction to carry out some of my ideas in this case.

20 Q. And what are some of the other consulting
21 companies that you have worked for let's just say in
22 the past two years?

23 A. I want to be careful, I don't remember
24 exactly within two years or not. But I --

25 Q. Oh, sure.

1 A. -- have done consulting work for companies
2 like Apple, Nike, Google, The Gates Foundation,
3 Moderna, Johnson & Johnson, a variety of different
4 companies and organizations.

5 Q. And have those engagements been in your
6 capacity as an expert?

7 A. No, in my capacity as a marketing
8 consultant.

9 Q. What kind of consulting services did you
10 provide for Apple?

11 A. I'd have to go back and look and make sure
12 I know what I'm allowed to talk about, but in general
13 across these projects, they usually relate in some
14 way to marketing. Often, though not exclusively, in
15 some way to consumer behavior. They often touch on
16 why consumers make the decisions they make and social
17 influence, word of mouth, digital marketing; those
18 are some of the topics they touch on.

19 Q. In any of your consulting that you've
20 performed since 2007 after receiving your Ph.D., have
21 you been involved with the creation of websites for
22 any companies?

23 A. I want to be a little careful there. So I
24 am not a -- I'm not a web designer by training. And
25 so I -- I'd have to go back and look, but I don't

1 know that I've done any design work on websites, for
2 example. But I've certainly helped companies think
3 about aspects of their websites and how those aspects
4 interact with consumers and consumer behavior.

5 Q. Do you consult with these companies
6 about -- when you're talking about websites and
7 providing your consulting services -- and I
8 understand you're not a website designer -- do you
9 consult with these companies about meeting FTC
10 regulations?

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

12 Q. Do you have any experience in consulting
13 with companies about meeting FTC standards?

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

15 Q. How many times have you served as an
16 expert in litigation?

17 A. I'm not sure of the exact number, but I
18 believe dozens of times.

19 Q. How many times have you testified at trial
20 as an expert?

21 A. Are we talking about deposition or trial?

22 Q. Trial. I thought I said trial. Sorry.

23 A. Yeah, I'm just making sure.

24 I'm not sure of the exact number.

25 Probably a handful of times. I don't remember the

1 exact number.

2 Q. A handful, so five or less probably? At
3 trial?

4 A. In the ballpark of five to seven. I don't
5 remember the exact number. But somewhere in the
6 ballpark of there.

7 Q. Has your expert testimony at trial ever
8 been limited by a court?

9 A. No.

10 Q. And just for clarity of record, I'm not
11 asking whether you've ever been barred as an expert
12 at court, I'm asking whether or not your testimony
13 has ever been limited by a court through a motion in
14 limine or otherwise?

15 A. I don't believe so. I'm not aware of
16 something like that.

17 Q. And I know you told me a minute ago that
18 you do not have expertise in website design.
19 Correct? You're not a web designer?

20 A. Yeah, I want to be careful. I'm not
21 putting myself forward as a person who designs

22 websites. But I do have expertise in marketing and
23 thinking about how aspects of branding, for example,
24 might shape consumers and consumer behavior. So I've
25 certainly helped companies think about those types of

1 contexts.

2 Q. Do you consider yourself to be a digital
3 low literacy expert?

4 A. I'm not sure what you mean by "digital low
5 literary."

6 Q. Sure.

7 Do you consider yourself to be an expert
8 in determining how websites should be designed in
9 order to properly provide information to low literacy
10 consumers?

11 A. I believe at some point in time I either
12 spoke to or briefly consulted for an organization
13 that thinks about those types of issues, but I myself
14 am not putting myself forward as an expert on those
15 types of issues for this particular case.

16 Q. Thank you.

17 And who retained you in this case?

18 A. What do you mean?

19 Q. Well, you have an engagement agreement in
20 this case, I assume?

21 A. Yes, it's with the plaintiffs.

22 Q. All five plaintiffs?

23 A. I -- I believe so. I'd have to go back
24 and look at the engagement, but I believe so.

25 Q. Okay. And in your own words, can you just

1 tell me what it is you believe that you were retained
2 to evaluate or opine on in this case.

3 A. Sure. I was asked to think about a couple
4 of different types of issues. One, for example, was
5 the degree to which hospital grades might -- whether
6 and how they might impact both consumer perceptions
7 of the plaintiff hospitals as well as whether or not,
8 for example, consumers might seek care at those
9 hospitals. I was also asked to think about whether
10 and how repeated publication of lower failing
11 hospital grades, so D and F grades, for example,
12 could affect consumer perception and decisions, both
13 now and into the future. And was also asked to think
14 about the degree to which TLG's imputation
15 disclosures would be -- or be expected to affect
16 consumers' understanding of the imputation
17 methodology. So the -- assign the minimum score,
18 whether consumers would understand what was going on,
19 as well as the impact of that imputation methodology
20 on the grades for the plaintiffs' hospitals.

21 Q. So when you say "the impact of the
22 imputation methodology on the grades of the
23 plaintiffs' hospitals," are you telling me you were
24 retained to look at the methodology itself and
25 determine whether or not the grade declined as a

1 result of the methodology?

2 A. No.

3 Q. Okay. I want to make sure I understood.

4 A. Yes. Sorry. When I say the impact of the
5 imputation methodology on the grades, it's consumers'
6 understanding of that impact. So it's consumers'
7 understanding both of the imputation methodology
8 itself and whether or not the imputation disclosures
9 in particular would affect consumers' understanding
10 of that imputation methodology, as well as the extent
11 to which the imputation disclosures would impact
12 consumers' understanding of the impact of the
13 methodology on hospital grades.

14 Q. Okay.

15 A. Particularly for the plaintiffs'
16 hospitals.

17 Q. Other than those four areas, were you
18 asked to do anything else that you declined to opine
19 on?

20 A. There was nothing I was asked to do that I
21 declined to opine on and these were the questions at
22 least in my initial report that I was asked to focus
23 on.

24 In the supplemental report, I examined,
25 among other things, examined some data that builds on

1 or connects to the work I did in that initial report,
2 but the general questions themselves are the same.

3 Q. Okay. And to put it another way, I just
4 want to make sure I'm closing the loop on this. You
5 were not asked by these plaintiffs to provide any
6 opinions that you determined you could not provide?

7 A. That's correct.

8 Q. And when were you retained by the
9 plaintiffs?

10 A. I don't remember the exact date. We are
11 sitting in the end of August now. I believe it was
12 sometime this summer, but I don't remember the exact
13 date.

14 Q. To the best of your memory, was it after
15 May 1st, 2025?

16 A. I want to be a little careful there
17 because May 1st, 2025, is not a magical date that is
18 embedded in my memory. I believe yes, it is -- it is
19 after that date, but I don't remember the exact date.

20 Q. But if we wanted to get an exact date,
21 we'd look at the engagement agreement, right, and you
22 could maybe figure that out?

23 A. I have not done that. But that would
24 certainly be a place to start, yes.

25 Q. Sure.

1 How much have you billed to date to the
2 plaintiffs?

3 A. I don't know.

4 Q. Can you give me a ballpark?

5 A. I -- I'm not sure what I billed, but I can
6 think about sort of a number of hours completed and
7 so I'll give you that estimate. I think I've done
8 between -- I'm guessing between 60 and 120 hours of
9 work on this case. I'm not 100 percent sure it's
10 within those bounds, but I'm -- something around
11 there in terms of the amount of work I've done on
12 this case.

13 Q. And if I take -- your rate is \$1200 an
14 hour. Correct?

15 A. That is correct, yes.

16 Q. So the fee is somewhere over \$100,000,
17 give or take?

18 A. Again, I -- you asked if I knew the
19 number. I told you I didn't --

20 Q. Okay.

21 A. -- know the exact number. I gave you an
22 estimate.

23 Q. I'll do the math. That's fine.

24 A. You can do the math. If it's the low end,
25 it's below 100. If it's the high end, it's above

1 100. But I don't -- I don't know for sure, and so I
2 can't definitely say it's above 100.

3 Q. And you employed some members of the
4 Cornerstone Group to aid you in your research,
5 correct?

6 A. That is correct, yes.

7 Q. The hours that you just gave me,
8 120 hours, does that include the hours worked by the
9 Cornerstone personnel or are those your personal
10 hours?

11 A. Those are my personal hours.

12 Q. Do you know what -- how many hours and/or
13 the fee that the Cornerstone Group has billed the
14 plaintiffs for these opinions?

15 A. I do not.

16 Q. Are you privy to that information?

17 A. No, I'm not privy to that information.

18 Q. Who at the Cornerstone Group aided you in
19 your -- in coming to your opinions?

20 A. Sorry. No one aided me in coming to my
21 opinions. All the ideas in this report are my own.
22 But --

23 Q. That's fair.

24 A. -- as is often the case, in my expert
25 work, I rely on the Cornerstone -- Cornerstone

1 Research to help me carry out some aspects of my
2 report and help me complete the work. And so in this
3 case, there was someone named Natasha as well as
4 someone named Austin, and those are the people I
5 worked with most frequently.

6 Q. And what services did they provide to aid
7 you in coming to your own opinions? I did not mean
8 to make it sound like they weren't your opinions. So
9 what services did they provide?

10 A. And I want to be careful again. They
11 didn't aid me in coming to my opinions.

12 Q. No.

13 A. They aided me in carrying out aspects for
14 the report, for example. So the document is nicely
15 formatted correctly; the figures look beautiful and
16 are easy to read, and all those types of things. So
17 as is often the case, they provide research support
18 to help me carry out the ideas.

19 Q. And we did and you mentioned this in your
20 supplemental report, we did two different sessions
21 for the Google Analytics site inspection I will call
22 it. And you were not there. Correct?

23 A. That is correct.

24 Q. And there were two members I believe of
25 the Cornerstone Group that were at that Google

1 Analytics site inspection. Correct?

2 A. I don't know offhand how many people were
3 there. But I did speak with members of Cornerstone
4 Research prior to the discussion, someone -- I don't
5 know if it was one or two people -- had with someone
6 else about the Google Analytics data, including what
7 type of data we might be interested in, as well as
8 how we might examine that data as it relates to the
9 assignment of this report.

10 Q. Okay. So you're kind of answering my next
11 question, so thank you.

12 So in terms of what Google Analytics data
13 would be important to your ultimate -- to your
14 ultimate opinions, you came up with what you wanted
15 to see from those Google Analytics inspections?

16 A. I want to be careful. It's not what I
17 want to see in terms of the conclusions but the type
18 of data --

19 Q. No, the type of data.

20 A. Yes.

21 Q. Correct.

22 A. The type of data that would be useful if
23 it existed, and I didn't necessarily know what would
24 exist, but if it existed, the type of data that would
25 aid us in examining some of the questions of the

1 assignment that I was asked.

2 Q. And do you have any expertise in Google
3 Analytics based on your many years of consulting
4 work?

5 A. I want to careful. I understand from both
6 my work as -- in consulting and academic work, I
7 understand some of the types of data that can be
8 tracked with online -- of consumers' or visitors'
9 online interactions and so certainly have some
10 expertise in that space.

11 Q. Okay. But just to make sure my record is
12 clear, the type of data that was culled from the
13 Google Analytics site inspection was done at your
14 direction and based on what you believed you would
15 need to see in order to formulate your opinions,
16 correct?

17 A. I want to be a little bit careful here.
18 So I had discussions with the Cornerstone team about
19 the types of data that would be useful for us. I did
20 not, however, attend that meeting, so I do not know
21 exactly what was discussed at that meeting or what
22 the options of things were, but I -- I thought about
23 what types of data might be helpful, and I discussed
24 that with the team before they discussed things with
25 whoever else was on that call.

1 Q. Sure. And I guess I think I may be being
2 really inarticulate, so I apologize, Dr. Berger.

3 I'm just curious, does Cornerstone tell
4 you, "Here's the type of Google Analytics data you're
5 going to want based on where we're trying to get with
6 the opinions," or do you, Dr. Berger, tell them,
7 "This is the type of Google Analytics data I want in
8 order to support my opinions"?

9 A. I have a sense of the types of data that
10 are available. I did not know exactly what type of
11 available -- data would be available in this
12 situation because I did not know what was captured.
13 But I had a sense of the types of data that are often
14 available. And I discussed ahead of time with the
15 Cornerstone team based on my expertise what types of
16 data we might be interested in that might speak to
17 the questions that I was asked to speak to.

18 Q. And what types of data did you tell the
19 Cornerstone Group would be important to your
20 opinions?

21 A. View data, for example. Of the
22 hospital pages, for example. Download of the
23 document that -- the methodology document or
24 documents like it. Those types of data.

25 Q. Okay. And did the Cornerstone Group

1 provide you with any of their own ideas about what
2 types of data might be useful?

3 A. This has been a few weeks now. I can't
4 remember every conversation that we had. But, again,
5 I want to stress that this report is my ideas. I
6 have a good degree of expertise in things like what
7 data is available online from websites, and so
8 provided direction about the types of data to look
9 for.

10 Q. In preparing your opinions, did you speak
11 to anybody directly associated with the plaintiff
12 hospitals?

13 A. I'm not sure what you mean.

14 Q. Sure. So I'm not talking about the
15 lawyers, right, and I'm not talking about the lawyers
16 at Gibson Dunn.

17 I'm asking in preparing your opinions, in
18 any sense of what that means to you, did you have
19 discussions with anyone from Good Samaritan, Delray,
20 West Boca, any of the five hospitals that are
21 plaintiffs, did you have any specific discussions
22 with them?

23 A. No, I did not.

24 Q. And I think we cleared this up earlier,
25 but I want to make sure.

1 You're not here to offer any opinions
2 today about whether or not the Leapfrog methodology
3 itself is unfair. Correct?

4 MS. MALONEY: Objection.

5 THE WITNESS: I want to be a little
6 careful here. I'm not sure what you mean by
7 "unfair."

8 BY MS. BLAIR:

9 Q. Well, so there's two things going on as I
10 understand it. There's whether or not the grades as
11 displayed deceive consumers who go onto the website
12 and look at it in some way. You understand that.
13 Correct?

14 A. I do.

15 Q. And, in fact, you've offered a lot of
16 opinions, 60 pages of opinions about how consumers
17 might likely view these grades. Correct?

18 A. The potential impact of these grades on
19 things like consumer perception and consumers
20 likelihood of choosing plaintiffs hospitals, yes.

21 Q. Right.

22 And you understand that the grade that may
23 or may not likely impact consumer choice, right, that
24 you're opining on, comes from a methodology that
25 Leapfrog has created to come to that ultimate grade.

1 Correct?

2 A. I want to be a little careful because I --
3 I don't want to agree or not agree about whether we
4 can call it a methodology or not.

5 Q. Sure.

6 A. Approach might be another word. I
7 understand that Leapfrog uses a certain approach.
8 I'm not saying I agree with that approach or
9 disagree.

10 Q. Of course.

11 A. But I understand they use a certain
12 approach. I'm opining, for example, what the
13 imputation disclosures related to that approach would
14 be expected to affect consumers' understanding of the
15 methodology or consumers' understanding of the impact
16 of that methodology on grades.

17 Q. Right.

18 So your opinions are about the consumers'
19 understanding or impact on consumers of that grade.

20 Correct?

21 A. My opinions are how the D and F grades
22 might impact consumer perception and consumer care at
23 plaintiffs' hospitals, for example, how repeated
24 republication of such grades could affect perceptions
25 and decisions to seek care and, as we just discussed,

1 the extent to which the imputation disclosure would
2 be expected to affect consumers' understanding of the
3 methodology, the imputation methodology, and their
4 understanding of the impact of that methodology on
5 safety grades.

6 Q. I understand that.

7 And you have done no mathematical analysis
8 on the methodology alone. Correct?

9 A. Yes, correct.

10 Q. Okay. That's all I'm trying to get to.

11 So you say in your report that you rely on
12 a report by Dr. Sean Nicholson. Correct?

13 A. I want to be careful. So I certainly --
14 there's one place in my report where I cite to the
15 Nicholson report, but I do cite to it in -- at a
16 place in my report, yes.

17 Q. And you read that report?

18 A. I have read that report, yes.

19 Q. Okay. And do you have an understanding
20 that Dr. Nicholson has opinions about the mathematics
21 and the statistical analysis that is used in
22 Leapfrog's approach? We'll use your word "approach."

23 A. I want to be a little careful here. I am
24 not Nicholson.

25 Q. I understand.

1 A. I have no reason to doubt what Nicholson
2 does in his report. But I also don't feel
3 comfortable characterizing his report in one way or
4 another. And so in my report, I note in paragraph
5 77, for example, that I understand Professor
6 Nicholson finds due to the imputation methodology
7 Plaintiffs' hospital safety grades were one or two
8 grades lower than grades they would have received had
9 they participated in the survey and responded as the
10 average participating hospital does, and that is the
11 understanding I took away from the Nicholson report.

12 Q. Correct.

13 And I'm just trying make sure, Dr. Berger,
14 you don't have an opinion about whether or not these
15 hospital grades are one or two grades lower than they
16 should have been because of Leapfrog's methodology,
17 correct?

18 A. I was not asked to examine that specific
19 question in the context of this case and so I have
20 not.

21 Q. Thank you. That's all I'm trying to get
22 to.

23 A. No problem.

24 Q. I want to make sure that I understand what
25 your opinions are and what your opinions are not.

1 A. I understand. No problem.

2 Q. And so I don't want to ask you a bunch of
3 questions about whether you're a quantitative
4 mathematician if you're not here to give that
5 opinion.

6 A. Okay. I understand.

7 Q. Excellent. Thank you.

8 I have a list, I believe it's Exhibit C,
9 of all of the materials that you reviewed in
10 connection with your -- at least -- I want to talk
11 about your first report. I want to be careful. With
12 respect to your first report, Exhibit C is called
13 "Documents Considered List." Correct?

14 A. That is correct, yes.

15 Q. And I just want to make sure, I've never
16 seen it called that before, but what do I know. Are
17 these -- when you say "documents considered," are
18 these documents you relied on or does -- does it mean
19 you didn't rely on them, you just considered them?

20 Do you understand the distinction?

21 A. I don't understand the -- I'm not a
22 lawyer.

23 Q. Sure.

24 A. And so I don't know that I understand the
25 fine points of that distinction. And when one would

1 use a considered versus a relied upon list.

2 Q. Okay. I don't either. I'm just -- I'm
3 just asking what -- when you wrote that, "documents
4 considered," what was your understanding of what you
5 were trying to communicate to me, the reader, the
6 consuming public of this -- of this report by using
7 that word?

8 A. Sorry. This is a standard section I have
9 I believe in almost every report I've ever done. And
10 so I have not gone ahead and questioned the exact
11 meaning of -- of the words in that title. Again, I'm
12 not a lawyer. But I believe this is content that I
13 considered when forming my opinions contained in this
14 report.

15 Q. Okay. And when you say "these are things
16 I considered," you went and read them in conjunction
17 with the preparation of this report?

18 A. Let's be a little careful here. Some of
19 these articles are content that I am -- was familiar
20 with or at least --

21 Q. Okay.

22 A. -- portions of that content before I was
23 asked to get -- I was given this assignment. I'm --
24 I've been in this field of marketing, academic field
25 of marketing for over 20 years now. I have a great

1 deal of expertise in different areas. Some of these
2 papers are my own papers that I've written on topics
3 related to issues discussed here. Others are papers
4 written by people I know or papers I have reviewed or
5 taught in my classes. And so I did not necessarily
6 go ahead and reread every word of every paper
7 contained in this list, for example, for the purposes
8 of this litigation. But these were things that I
9 considered or the parts of these papers were things
10 that were useful in forming my opinions.

11 Q. And I know you told me that the
12 Cornerstone Group, you know, formats this and makes
13 it all look nice and everything, but do they -- do
14 they provide you any information, synopses with
15 respect to what's listed in Exhibit C of your initial
16 report?

17 MS. MALONEY: Objection to form.

18 THE WITNESS: I'm not -- I'm not sure what
19 you mean.

20 BY MS. BLAIR:

21 Q. Sure.

22 So you told me that the Cornerstone Group
23 people like kind of put this together and make it
24 look nice for you, correct, at the end of the day?

25 A. Parts of it, yes.

1 Q. Yeah.

2 And do you provide them with that
3 documents considered list to put in the back of your
4 report or is that something they create on their own?

5 A. So just to give you an example, you know,
6 some of these articles were things when I got the
7 initial set of questions that we were interested in,
8 I said, oh, this is a paper I'm familiar with. So
9 the Jin and Leslie, for example, 2002 "Effective
10 Information on Product Quality" about restaurant
11 grades, that's a paper I became aware of I think
12 decades ago now at this point. And it's a paper I'm
13 familiar with in this space and so used that paper to
14 find other papers, and so I suggested that paper. I
15 went back and looked at at least part of that paper
16 to remind myself of what I found. That's how it got
17 here.

18 Q. And when you say "I suggested that paper,"
19 who did you suggest it to?

20 A. Oh, when I had a discussion with
21 Cornerstone, I said, "You know I think this
22 literature would be worth including. There's -- this
23 is a literature I know on grades. This is one of the
24 papers I know. I think it would be worth including
25 in the report."

1 Q. And does that conversation with
2 Cornerstone work the other way where Cornerstone
3 says, "Hey, what about these papers? I think they
4 would be worth considering in connection with your
5 opinion"?

6 A. I can't remember whether they found any
7 additional papers beyond the set of things I
8 suggested initially or whether I found all of these
9 papers myself. But again, the ideas of the types of
10 papers that I was looking for and the literatures I
11 wanted to examine I suggested initially.

12 And so, for example, whether, when I
13 suggested this Jin and Leslie paper, whether the
14 Cornerstone folks read it, noticed a citation in it
15 that we discussed and asked me whether that might
16 also be relevant, I said yes, I can't remember.

17 Q. Okay. And when you use terms like "they"
18 or "the Cornerstone folks," are we referring just to
19 Natasha and Austin or are there other folks we're
20 referring to?

21 A. Those are the people I talked to most
22 frequently. There may have been one or two other
23 people at one point in time that may have been on an
24 individual phone call, but I -- I'm not sure.

25 Q. When you completed your opinion, does

1 Cornerstone provide any edits or revisions to the
2 content?

3 A. We talked together to determine whether
4 the way -- the way my ideas are expressed accurately
5 reflect the opinions and are formatted and
6 communicated in a way that is appropriate for this
7 setting.

8 Q. Okay. Do they offer any substantive
9 revisions to your opinions?

10 A. I wouldn't say so, no. There are cases
11 where they suggest, you know, this way of phrasing
12 this particular idea is more consistent with the way
13 an expert report might look compared to an academic
14 article, for example, or say, you know, reporting
15 this particular thing might be appropriate for an
16 academic article, but I don't know that we need that
17 in an expert report, but I wouldn't describe them as
18 substantive, no.

19 Q. Okay. And the only names you can think of
20 right now are Natasha and Austin, right, from the
21 Cornerstone Group?

22 A. Those are the folks I worked with most
23 directly.

24 Q. Okay. But you can't remember any other
25 names?

1 A. Not offhand, no.

2 Q. Okay. And we talked about your opinions
3 or lack thereof with respect to the mathematical part
4 of the methodology.

5 With respect to your opinions that are
6 contained in both the report and the supplemental
7 report, it appears to me, and I want to make sure I'm
8 understanding it, that you do not provide any
9 opinions about the content or the display of the
10 Leapfrog website prior to May of 2024?

11 A. Would you mind asking that question one
12 more time?

13 Q. Sure.

14 You have -- let me ask it another way just
15 so we're all on the same page. I'll lay a little
16 foundation.

17 In your report, you -- you have a "Factual
18 Background" section where you discuss that at least
19 you gleaned from the complaint, motion to dismiss,
20 and other pleadings that you've read that these five
21 hospitals that have retained you have an issue with
22 the imputation model that was implemented for the
23 fall 2024 grade -- Leapfrog grading period. Correct?

24 A. Yes, I understand that in fall 2024 TLG
25 changed its scoring methodology.

1 Q. And the website that you reviewed, as I
2 understand your opinions and I want to know from you,
3 was the website that was in place at the time of or
4 after Leapfrog changed its imputation methodology in
5 2024. Correct?

6 A. I believe so, yes.

7 Q. In other words, to put it a different way,
8 you didn't go back and look at any cached versions of
9 the website from 2023, let's just say?

10 A. I don't -- I don't believe -- I don't
11 believe so.

12 Q. Okay. So as you sit here today, you don't
13 know whether the Leapfrog website with respect to
14 reporting grades looked different prior to the
15 Leapfrog's imputation change in the fall of 2024
16 versus after the imputation change in 2024, correct?

17 A. I don't believe that that was a question
18 that I was asked to opine on. I focused on the
19 degree to which D and F hospital grades, TLG's D and
20 F hospital grades would affect consumer perception,
21 consumer choice; repeated publication of such grades
22 would -- and future repeated publication of such
23 grades would impact things; and the degree to which,
24 based on the information provided by TLG, their
25 imputation disclosures, for example, how that might

1 impact consumers' understanding of the imputation
2 methodology and the impact of that methodology on
3 hospital grades.

4 There may be places in my report, for
5 example -- just one second.

6 So when I talk about repeated grades, for
7 example, in paragraph 5 of my report, I show a
8 screenshot of the version of the website that also
9 shows grades from 2023 and 2022.

10 Q. Correct.

11 A. But I was not asked to examine the
12 methodology, the prior methodology itself, and so
13 that's not something I considered. But I do, for
14 example, note that here's an example where prior
15 grades are being shown even though it's not maybe the
16 prior version of the website.

17 Q. Right.

18 But that -- that screenshot that shows the
19 prior grades, that's from 2024 or from current 2025?

20 A. Correct.

21 Q. You didn't go back and look at what that
22 would have looked like in 2023. Correct?

23 A. Correct.

24 Q. Now, your opinions are all couched with
25 the -- with the term "likely." Correct?

1 MS. MALONEY: Objection.

2 THE WITNESS: I'm not sure what you're
3 referring to.

4 BY MS. BLAIR:

5 Q. Sure.

6 Let's just look at the table of contents.
7 Page Roman numeral small i of your report.

8 A. Okay.

9 Q. And this -- this lays out starting in
10 Roman numeral V your opinions. Correct?

11 A. It does, yes.

12 Q. And the first one is "'D' or 'F' TLG
13 Hospital Grades Likely Negatively Impact Consumers
14 Perceptions."

15 Do you see the word "likely" there?

16 A. I do, yes.

17 Q. Yeah. And if we go to Roman numeral
18 number VI is another opinion you have, "'D' or 'F'
19 TLG Hospital Safety Grades Likely Deter Consumers
20 From Choosing Plaintiffs' Hospitals."

21 Correct --

22 A. Yes.

23 Q. -- it says that?

24 And then if we go to Roman numeral number
25 VII, it says "Future, Repeated Publications of 'D' or

1 'F' Hospital Grades Would Be Expected" -- I guess it
2 doesn't say likely -- "Would Be Expected to Have a
3 Long-term, Negative Impact on Perceptions."

4 Correct?

5 A. I do see that, yes.

6 Q. And number VIII, again you use the
7 "likely" word, but it's "unlikely" here. You say
8 "Many Consumers Would be Unlikely to Understand that
9 TLG Assigns the Minimum Score on the Imputed Measures
10 and Impact of the Practice on the Safety Grades TLG
11 Assigns to Non-participating Hospitals Based on TLG's
12 Imputation Disclosures."

13 Correct?

14 A. I believe that's correct, yes.

15 Q. So let's just talk then about Roman
16 numeral V on this page where you say "'D' or 'F' TLG
17 Hospital Safety Grades Likely Negatively Impact
18 Consumers' Perceptions."

19 And my question is, as an expert in the
20 field of marketing, what is the significance, if any,
21 of using the word "likely" in this opinion?

22 A. I don't know -- I'm not sure exactly what
23 you're getting at. This is my opinion. And so I've
24 stated it in the way I felt was most accurate to
25 state it.

1 Q. Based on the way that you state that
2 opinion, again Roman numeral V on the table of
3 contents, is your opinion to a reasonable degree of
4 professional certainty if you're using the word
5 "likely"?

6 A. Can you repeat the second half of that
7 question one more time?

8 Q. Sure.

9 As we read Roman numeral III -- or sorry,
10 V on the table of contents, is your opinion, that
11 opinion, Roman numeral V, is that opinion to a
12 reasonable degree of professional certainty if you're
13 using the word "likely"?

14 MS. MALONEY: Objection.

15 THE WITNESS: Yes, yeah, this opinion is
16 based on my decades' worth of experience in
17 marketing and consumer behavior, understanding
18 how grades impact consumer perceptions and
19 consumer choice, and I'm suggesting that I think
20 that D and F TLG hospital safety grades likely
21 negatively impact consumers' perceptions of
22 plaintiffs' hospital quality.

23 BY MS. BLAIR:

24 Q. Okay. But likely isn't -- likely -- would
25 you agree with me that likely is different than

1 saying it does impact consumer -- consumers?

2 A. I agree that those are two different
3 words. This is my opinion based on my decades' worth
4 of expertise in this space. And so I don't -- I
5 don't know what else to say.

6 Q. Okay. So your opinion is that it's
7 likely, but you don't know for certain?

8 MS. MALONEY: Objection.

9 THE WITNESS: That's not what I said.

10 BY MS. BLAIR:

11 Q. Okay.

12 A. I --

13 Q. Let me ask it this way, Dr. Berger.

14 MS. MALONEY: Oh, wait, if you could let
15 him finish the question.

16 MS. BLAIR: Oh, yeah, sure.

17 MS. MALONEY: And I haven't spoken up
18 about that before, but if we could just try a
19 little harder to let him finish his answers,
20 that would be great.

21 MS. BLAIR: Absolutely.

22 THE WITNESS: So as I discuss in both of
23 these seconds -- sections, there are decades'
24 worth of academic literature that support these
25 points including, for example, as I talk about

1 down in paragraph 32, you know, even something
2 that was directly modeled or designed after
3 TLG's hospital grades showing that they impact
4 hospital choice and that the grades impact
5 hospital choice and that lower grades make
6 people less likely to choose hospitals.

7 And so I'm expressing with a strong degree
8 of certainty that these grades likely impact
9 both perceptions and choice of the plaintiffs'
10 hospitals.

11 BY MS. BLAIR:

12 Q. Okay. So your opinion is to a strong
13 degree of certainty something is likely. Is that a
14 fair characterization?

15 A. I believe so, yes.

16 Q. And in coming to your conclusions in the
17 160 to 120 hours' worth of work that you did to come
18 to these opinions, did you examine any consumer
19 feedback specifically related to the Leapfrog
20 website?

21 MS. MALONEY: Objection.

22 THE WITNESS: So I want to be careful
23 here. A couple things. First, the question
24 misstated an earlier answer of mine. I'm sure
25 it was not intentional, but --

1 BY MS. BLAIR:

2 Q. Oh, no, I'm not trying to be intentional.

3 A. -- between 60 and 120 hours. That's not
4 important, but that was the first half of that.

5 Q. I thought that's what I said. If I
6 misspoke I apologize.

7 A. Second, more generally, though, I did the
8 work for this case that I felt would be most helpful
9 in answering the questions that were asked. Looking
10 at what one individual consumer said, for example,
11 may not in this particular instance provide much
12 insight into what is happening across a broad set of
13 people. If one person says, for example, oh, the
14 grades didn't impact my decision, does that mean it
15 impacted no ones' decision? Not necessarily. It
16 means that that consumer at that point in time said
17 that they didn't think it impacted them.

18 And so what I did here similar to what I
19 would do in my academic work is I looked to the
20 literature to see what the literature had to say
21 about these questions. I also analyzed data that the
22 TLG Group provided on their own website, for example,
23 looking at the percentage of visitors that actually
24 downloaded this methodology document which include
25 not just one consumer's opinion of what happened, but

1 what a large number of consumers actually did. And
2 so I thought that these approaches were the best way
3 in this situation to address the questions asked.

4 Q. Okay. But my question was, did you
5 examine any consumer feedback directly related to the
6 Leapfrog website in coming to your conclusions?

7 A. I think what I said is in my answer to the
8 prior question was I didn't feel like individual
9 consumer feedback would be the best or most
10 appropriate way to answer this question and so that
11 is not what I considered. Given the large amount of
12 literature, including work modeled actually after
13 TLG's hospital safety grades, given the data
14 available about actual consumer behavior on the site,
15 I chose to rely on those types of data because they
16 seemed most appropriate here.

17 Q. So is the answer no? I mean, did you rely
18 on any consumer feedback related to the Leapfrog
19 website in coming to your conclusions?

20 A. I --

21 Q. Yes or no?

22 A. Sorry. Go ahead.

23 Q. I just want yes or no, did you or did you
24 not. I just want to make sure I'm checking these
25 things off.

1 A. I answered your question already. I'm
2 happy to give you the same answer I just gave you.
3 But I detailed the reasons why I did -- I detailed
4 both what I did as well as why I did what I did.

5 Q. Right. And I -- I totally get that. I
6 understand why -- what you did and why you did it.
7 Just want to make sure, in doing all the things you
8 did, did you look at consumer feedback related to the
9 Leapfrog website?

10 A. As I already said, as I often do in
11 situations like this, before deciding what type of
12 data to use, I thought about what type of data would
13 be most appropriate to analyze this type of question
14 and address this type of question. I did not feel
15 like data on individual consumer's feedback would be
16 the most appropriate type of data and so that is not
17 the type of data that I considered.

18 In particular, given there's decades of
19 literature showing how things like hospital grades
20 impact consumer choice, and there is also data
21 available from the website about consumers' actual
22 downloading of the document that details the
23 methodology, those types of data seemed more
24 appropriate to answer this type of question.

25 Q. Okay. And you didn't ask any individual

1 consumer, fine.

2 Did you perform any focus group research
3 related to the Leapfrog website in coming to your
4 conclusions?

5 A. I'm going to give you a very similar
6 answer to what I gave for the last question, which is
7 that I did not feel that focus groups would be the
8 most appropriate way to address the questions
9 outlined in my assignment and so I did not do focus
10 groups. Instead, given the decades' worth of
11 academic literature on these topics that clearly show
12 that these type of hospital grades would be expected
13 to impact consumer perception and choice as well as
14 the data available on actual consumer behavior on
15 their website including downloads and methodology
16 document, that is what -- or some of the things I
17 relied on in drawing -- in forming my opinions.

18 Q. Did you examine any usability data in
19 coming to your conclusions?

20 A. Very similar answer. I did not examine
21 usability data because I did not feel that that was
22 the most appropriate data to answer these questions.
23 Given the other data available which I felt was more
24 relevant, I focused on that other data.

25 Q. Did you do any empirical testing related

1 to the Leapfrog website to come to your conclusions?

2 A. Yes, I analyzed data on website views and
3 downloads of the methodology document, for example.

4 Q. And we'll get to that in a few minutes.

5 And is it -- so is it your testimony,
6 Dr. Berger, that usability data, consumer feedback,
7 focus groups, user surveys were not important to you
8 in coming to your conclusion that's stated? And,
9 again, I'll just refer to the table of contents Roman
10 numeral number VIII that "Many Consumers Would be
11 Unlikely to Understand that TLG Assigns the Minimum
12 Score on the Imputed Measures and the Impact of the
13 Practice on the Safety Grades TLG Assigns to
14 Non-participating Hospitals Based on TLG's Imputation
15 Disclosures"?

16 A. I'm sure we'll discuss this more in a few
17 minutes, but as I detail in my report, only a very,
18 very small portion of website visitors downloaded the
19 methodology document which is the only place I'm
20 aware of that provides any information indicating
21 that the minimum score was applied -- was imputed for
22 hospitals that did not complete the survey.

23 Given that, not only are the most website
24 visitors not seeing that information -- and by the
25 way that information on page 16 of that document, so

1 just because 3 percent of people downloaded it
2 doesn't mean that 3 percent of people read it. It
3 means that at a high only up to 3 percent of people
4 could even potentially have been exposed to it, let
5 alone the case that many individuals may not have
6 decided or ended up reading all the way through to
7 page 16 to actually seeing that, let alone the people
8 who saw the hundreds of articles that included these
9 hospital grades that were published across hundreds
10 of publications.

11 And so that data gives us a quite good
12 sense at least of the upper bound which is quite
13 small who would have been exposed to those important
14 methodology details. And so that seemed to be the
15 best way I could think of, and I was not aware of any
16 better way of getting at that question.

17 Q. The Google Analytics data that you just
18 spoke about doesn't tell you who the people were that
19 looked at those pages, does it?

20 A. I'm not sure what you mean "who the people
21 were."

22 Q. Sure.

23 For all we know, every single one of those
24 clicks was a neurosurgeon from one of the plaintiffs'
25 hospitals. You can't rule that out, can you?

1 A. Sorry. 3 percent is the percentage of
2 people that downloaded that methodology document. So
3 if what you're saying is a portion of those 3 percent
4 were whatever type of doctors that you just
5 mentioned, it means an even smaller number of
6 patients actually saw those methodology details about
7 the imputation methodology. And so you're right. I
8 don't know whether some of the individuals that
9 downloaded that document were doctors and, thus, if
10 the number of consumers or potential patients we can
11 call them might be even lower. I don't know that.

12 But, if anything, that suggests that
13 3 percent is a -- a generous or a conservative
14 estimate of the number of people that saw it.

15 Q. I guess my question was really, forget
16 about the downloads and methodology. You don't know
17 who the people were that even clicked on the hospital
18 survey grade website at all. You don't know whether
19 they were consumers, whether they were journalists,
20 whether they were doctors, whether they were the
21 lawyers in this case. You don't know who the users
22 were that clicked on that by looking at the Google
23 Analytics data, do you?

24 A. Sorry. The Google -- I am not aware of
25 the exact person who either viewed the website or

1 downloaded that document. I'm not sure how that
2 impacts any of the conclusions of my report, though.
3 I use that data in the supplemental report, for
4 example, to show that when the grades came out and
5 when TLG engaged in I believe sort of PR and
6 announcement efforts around the grades, views to the
7 website went up, consistent with the notion that the
8 attention came -- was more likely to come around
9 those times. That's one way I'm using that data, but
10 I'm not sure -- I'm not sure how what you mentioned
11 would change any of my conclusions.

12 Q. In your expert opinion, what would be the
13 best way to determine whether or not a consumer of
14 health care services understands that Leapfrog Group
15 assigns the minimum score on the imputed measures?
16 What would be the best way to test that in your
17 expert opinion?

18 A. Give me just a second. I'm just going to
19 go to that place in my report. Would you mind
20 repeating the question?

21 Q. Sure.

22 In your expert opinion, what would be the
23 best way to determine with certainty whether
24 consumers understand that Leapfrog assigns the
25 minimum score on imputed measures when looking at the

1 website?

2 A. Well, sorry. TLG does not directly
3 disclose that information on the hospital safety
4 grade pages, as I detail. Further, it doesn't
5 disclose that the minimum score assignment lowers
6 non-participating hospitals' safety grades as I
7 discuss. And further, not only is it unlikely that
8 consumers read that general footnote disclosure
9 located at the bottom of the pages; but the
10 methodology document, which I've already mentioned,
11 I'm not aware of any other place beyond that
12 methodology document where consumers can get the
13 details about the minimum score being assigned.

14 Consequently, the number of individuals
15 who -- or the percentage of website viewers who
16 downloaded that document in my mind is a good measure
17 of the upper bound of the number of people exposed to
18 that information. As I mentioned already and detail
19 in my report, the number may be lower because not
20 everybody who downloaded the document necessarily got
21 to page 16 whereas the -- whereas that -- where the
22 information is detailed in that document. So some
23 people may have downloaded it and not done anything
24 with it. Some people may have read the first couple
25 of pages, but not made it to page 16.

1 And so I'm not aware of any other data
2 that would be better than -- available data that
3 would be better than the data I've analyzed in my
4 supplemental report to examine this particular
5 question.

6 Q. You don't think the best data would be to
7 ask the users of the website themselves whether they
8 understand it?

9 A. No.

10 Q. And why is that?

11 A. In this instance, consumers may think they
12 understand the information, but they may not
13 actually, as I -- as I detail in my report, for
14 example, there are many pieces of information on the
15 site that may confuse consumers or make consumers
16 feel like they understand what information -- or the
17 way that things are imputed when they may not
18 actually understand it. And so given the only place
19 that I'm aware of that they could gain that
20 understanding of the methodology is this document.
21 And that's the only place they could find it.

22 Then the number of -- the percentage of
23 people, number of people that downloaded that
24 document provide a good sense of the upper bound, not
25 the absolute number, but the upper bound, a

1 conservative estimate, of the number of people who
2 could have such an understanding.

3 Q. And, Dr. Berger, is it your position
4 that -- that that document, the 16-page -- you know
5 on page 16 that you just discussed, that a reasonable
6 website user of The Leapfrog Group would understand
7 that document and they need to see that document to
8 understand their grade?

9 A. Sorry. You bring up a really good point,
10 which is I'm not sure that a reasonable website
11 visitor would be able to understand that document,
12 even if they chose to download it which most of them,
13 a huge proportion chose not to do, even if they read
14 it, I'm not sure that all of those individuals would
15 understand it. And, thus, that is even more cause
16 for concern about whether consumers actually
17 understand both the fact that -- that the minimum
18 score was used as well as how that impacts the
19 grades. But that only furthers the conclusions of my
20 report. It does not undermine them.

21 Q. Wouldn't the best way to figure out
22 whether consumers are confused or can understand the
23 information on this website to be -- to conduct a
24 consumer survey to make that determination? Or you
25 believe you, by reading articles, can determine

1 whether consumers understand something without
2 putting them in a focus group?

3 MS. MALONEY: Objection.

4 THE WITNESS: Sorry, you've -- I think
5 you've been chosen to mischaracterize what I'm
6 saying there. I'm not suggesting based simply
7 on academic articles. I'm making this point, as
8 we've already discussed, based on actual data,
9 the actual number of people who visited the
10 website who viewed this document. That doesn't
11 mean they read the document. That doesn't mean
12 they understood the document.

13 And so I certainly agree, as you've
14 already laid out, that it may be a conservative
15 estimate. The number may be 1 percent. It
16 might be less than 1 percent. It might be a
17 half, a quarter. It might be even smaller; I
18 don't know how much smaller exactly, but I
19 certainly have not seen anything to suggest that
20 the number is higher than 3 percent.

21 And a focus group would not give us as
22 precise an understanding in this context as this
23 data does. And so I'm not aware of any data
24 better than this data to answer this question.

25

1 BY MS. BLAIR:

2 Q. But, Doctor, the data from the Google
3 Analytics doesn't even tell you whether those clicks,
4 and I'm talking about the initial clicks, forget
5 about the methodology clicks, you don't even know
6 whether those initial clicks are by consumers or
7 whether they're by sophisticated doctors, or whether
8 they're by press, or whether they're by internal
9 Leapfrog. You don't know who clicked on that at all.

10 So you're making -- is it true that you're
11 making assumptions that the clicks that you're
12 looking at in Google Analytics are of consumers of
13 health care services? That's an assumption you're
14 making, is it not?

15 A. You know --

16 MS. MALONEY: Objection.

17 THE WITNESS: -- as we've already
18 discussed, if what you're saying is you're
19 concerned that of the 3 percent of people who
20 downloaded this document, some of them are not
21 patients or caregivers, they're doctors or
22 hospital employees, or folks engaged in this
23 litigation, then I agree that number could be
24 even lower. But, again, that doesn't undermine
25 my conclusion. That only bolsters the

1 conclusion.

2 I'm not assuming --

3 BY MS. BLAIR:

4 Q. Did you --

5 A. -- I'm not assuming that all those
6 visitors are those types of individuals. I'm being
7 generous and conservative in suggesting that
8 3 percent is the higher end. I agree it could be
9 lower. But that would only bolster my conclusions,
10 not undermine them.

11 Q. And just so I understand your testimony,
12 as an expert in the field of marketing, you disagree
13 that the best data or evidence to determine whether
14 or not the Leapfrog website is able to be understood
15 by a consumer is not asking the consumers themselves?

16 MS. MALONEY: Objection.

17 THE WITNESS: Sorry. That's not what we
18 were just talking about. What we were just
19 talking about, and I put forward my expertise
20 on, shared my expertise on, is the number of
21 people who viewed -- first of all, downloaded,
22 let alone viewed, let alone understood the
23 details in the methodology document that would
24 allow consumers to understand the scoring
25 methodology, and in particular that the minimum

1 score assignment -- that minimum score
2 assignment was what was done in the first place,
3 and that that minimum score assignment lowers
4 non-participating hospitals' safety grades.

5 Understanding that minimum -- the minimum
6 assignment is what occurred, the only place they
7 can do that is this document. And so given
8 that, looking at the percentage or the number,
9 if you prefer, is to me the most appropriate way
10 to understand that.

11 For example, that data, Exhibit 1 of my
12 supplemental report, shows that the high end is
13 120 people that downloaded this methodology
14 document. And so if you're agreeing or
15 supporting the notion that some portion of the
16 people that downloaded that document weren't
17 actually patients, then the number of patients
18 that actually understand that the minimum score
19 was assigned is even lower than that. And
20 that -- all of that supports and is consistent
21 with my opinions. It does not undermine my
22 opinions.

23 BY MS. BLAIR:

24 Q. Okay. I don't want to -- I'm talking
25 about something totally different.

1 I asked you earlier about whether or not
2 you conducted any focus groups or consumer surveys
3 related to consumers' understanding of the Leapfrog
4 website. Do you recall that?

5 A. You've asked a number of questions today.
6 I don't -- I don't recall --

7 Q. We'll do it again.

8 Did you perform any focus group research
9 with respect to the Leapfrog website to come to your
10 conclusions today?

11 A. Yes, so that question I do remember. And
12 as we discussed, I said I did not think focus groups
13 was the best -- among the available ways in this
14 case, the best way to answer the questions I was
15 asked, and so I chose a different way, based on my
16 expertise -- decades' worth of expertise in the
17 space, academic work in these types of questions.
18 Using that expertise and knowledge and understanding
19 and given the data available, I used other sorts of
20 information to draw my conclusions because those were
21 accessible and better able to answer the relevant
22 questions.

23 Q. And you believe that the Google Analytics
24 that appear in your supplemental report that tell you
25 nothing about the identity of the users of this

1 website is a better source of data in coming to your
2 conclusions than a focus group or a consumer survey.
3 Correct?

4 A. Again, I don't know what question, you are
5 suggesting a specific question, you're suggesting a
6 focus group would be better to answer or a specific
7 question that you are suggesting a survey would be
8 better to answer. As I've noted already, my opinion
9 about whether consumers are likely to understand that
10 the minimum -- and let me go back to the exact
11 language here. Give me just a second.

12 My opinion that many consumers would be
13 like -- unlikely to understand that TLG assigns the
14 minimum score on the imputed measures, for example,
15 that opinion, I'm not sure how a focus group or
16 consumer survey would be better than the actual data
17 on how many people downloaded the only document I'm
18 aware of that provides information on the minimum
19 score assignment. I'm not -- I'm not aware of how a
20 focus group or a consumer survey would provide more
21 insight than the fact that only 120 people, as I
22 discuss in my supplemental report, even downloaded
23 the document that has the information in it that
24 would allow a consumer to understand that the minimum
25 score was assigned.

1 Q. But you don't know whether or not
2 consumers know about the Leapfrog methodology from
3 other sources like media communications or press
4 releases or public comment or discussing this with
5 friends and family about the -- how the methodology
6 works. You're just assuming that the only source
7 that consumers would figure out about the imputation
8 model is from reading the methodology document on
9 website. Correct? That's an assumption you're
10 making?

11 A. Sorry, I'm not aware of any news article
12 that detailed the methodology of assigning the
13 minimum score. I'm not aware of any press release
14 that detailed the methodology about the minimum
15 score. And I'm not aware of any consumer-to-consumer
16 word of mouth, for example, that details the
17 methodology of assigning the minimum score. If you
18 would like to show that information to me, I'm happy
19 to consider it. But I have not seen any such
20 information, and I looked at a good deal of
21 information in this case, for example. I'm not aware
22 of any such information.

23 And further, given the small number of
24 people that even downloaded this document to begin
25 with, the likelihood of such things existing seems

1 quite, quite low. And indeed I haven't seen any.

2 And so if you'd like to put some in front of me I'm
3 very happy to look at it.

4 Q. I'll probably do that at trial. But in
5 terms of consumer-to-consumer --

6 A. I'm still answering.

7 Q. Oh, I'm sorry.

8 MS. MALONEY: Objection.

9 THE WITNESS: I'm happy to look at that if
10 you have it. But in the absence of such
11 information, I'm not aware of any information
12 better than the data that I relied on.

13 BY MS. BLAIR:

14 Q. And when you talk about
15 consumer-to-consumer word of mouth, wouldn't you have
16 to interview consumers to determine whether or not
17 they were -- they gleaned that information from
18 another source?

19 A. Not necessarily, no.

20 Q. What types of information could you look
21 at to make the determination as to whether or not
22 consumer-to-consumer word of mouth existed?

23 A. I'd need to think about it a little bit
24 more in this exact instance. But in this report, for
25 example, I provide an example of a social media post

1 that shared the negative grades, the negative
2 hospital grades. And so that might be a place to
3 consider. I'm not saying there's only one way to
4 glean such insights or that there's one right way to
5 do it. But it's certainly possible to -- one could
6 imagine looking there.

7 Q. But you never asked any consumers -- in
8 connection with your opinions, you never interviewed
9 any consumers about their impressions or use of the
10 Leapfrog hospital safety grade website. Correct?

11 A. As we've talked about already, I have a
12 great deal of expertise in this space. I treat every
13 case differently, analyzing the issues of the case
14 and thinking about the available data. In this case,
15 given that there was good data on something like the
16 number of downloads, that seemed to be the most
17 useful type of data compared to interviewing
18 individual consumers.

19 Q. And what literature do you rely on to come
20 to the conclusion that this type of Google Analytics
21 data is good data for an expert to rely on to come to
22 his conclusions?

23 A. I'm not sure what you mean.

24 Q. Well, sure.

25 You said in your years of expertise, you

1 came to the conclusion that the Google Analytics data
2 that's included in your supplemental report is the
3 best data available to come to your conclusions.

4 Correct?

5 A. On this specific issue, given this data is
6 available, this data seemed more appropriate to me
7 than asking some small set of consumers their
8 opinions about the website.

9 Q. Well, did I say it had to be a small set
10 of consumers? What would you consider to be a small
11 set of consumers?

12 A. I'm just -- you talked about a focus
13 group, for example. A focus group is usually a small
14 set of consumers. And so given this data's available
15 and given this is the only place I'm aware of that
16 details the methodology. I'm not aware of another
17 place. Again, if you're aware of other places feel
18 free to put them in front of me. I'm happy to
19 discuss them.

20 But given it is my -- I'm not aware of any
21 other places where the methodology is detailed,
22 understanding the actual people -- the actual number
23 of people that downloaded the document that contains
24 the methodology, provides a really good estimate of
25 at least the upper bound of the number of people

1 exposed to this information in this specific context.

2 Q. Okay. And in -- and in making that
3 determination that these Google Analytics data is the
4 data that should be relied on in coming to this
5 conclusion in this particular case, are you relying
6 on any specific academic or industry literature that
7 says you should rely on Google Analytics data in
8 circumstances like this?

9 A. Sorry. There is a good bit of academic
10 research on data like Google Analytics, whether it's
11 Google Analytics per se or something else, data on
12 individuals interacting with websites. I myself have
13 done such research on analyzing individuals'
14 interactions with websites. And so given my own
15 research in this space, given research that I've
16 looked at in doing research on this space, and given
17 my decades' worth of academic research in consumer
18 behavior, this data is quite appropriate to examine
19 this type of question.

20 Q. And so my question is, because I'm not an
21 expert in marketing or Google Analytics, what
22 academic or marketing materials should I look at that
23 would tell me that relying on this type of Google
24 Analytics data is appropriate in coming to an expert
25 opinion like the one you came to? You just

1 referenced many journals and academia. I'm asking
2 for which ones.

3 A. Sorry. Google Analytics data tells you --
4 can tell you, I should be careful there, can tell you
5 what people did on a website. So given we're
6 interested in understanding whether people understand
7 information that is only contained in one document
8 that one has to download from this website to get,
9 downloads of that information, that document is a
10 good initial estimate, again, a high estimate -- it
11 would be lower -- but a high estimate of how many
12 people are likely able to reach that understanding.

13 There's not one particular academic
14 article I'm relying on when using that. I'd have to
15 go back to the literature and look and see what might
16 be most appropriate, but I didn't -- I didn't think I
17 needed to cite something. This is data. And this
18 data is of the people who did the thing, at least a
19 thing that one has to do before one gets to what I
20 was interested in.

21 And so given that they have to do this
22 thing first, download this document, before most
23 people would be able to gain such understanding, this
24 data's quite useful in addressing that question.

25 MS. MALONEY: Counsel I don't want to

1 interrupt your flow, but if there's a time
2 that's appropriate coming up to take a break, I
3 need a break.

4 MS. BLAIR: Absolutely. Just a couple of
5 follow-up questions while I'm on this thing,
6 Mary Beth, and yes, for sure.

7 MS. MALONEY: No worries.

8 BY MS. BLAIR:

9 Q. What is it that you believe as an expert a
10 consumer of the Leapfrog website must get to to
11 understand? I mean, we're using these kind of
12 general phrases, and so I want to make sure, what is
13 it that you think by looking at this score a user of
14 the Leapfrog website cannot understand unless they
15 look at the methodology document?

16 A. Sorry. As I detail in a section of my
17 report, they're unlikely to understand that TLG
18 assigns the imputed score on the measures.

19 Q. Okay.

20 A. Why are they unlikely to have that
21 understanding? Because as I detail in my report, TLG
22 does not directly disclose information on its
23 practice of assigning the minimum score on hospital
24 safety grade pages. They don't -- they don't
25 disclose that information.

1 Further, my understanding is the place
2 where that information is disclosed, the only place
3 where it disclosed, and indeed, by the way, note that
4 TLG received feedback that its minimum score
5 assignment misrepresented a hospital's performance to
6 consumers and even acknowledged itself that consumers
7 may misinterpret the scores on the imputed measures,
8 and I -- that's a document I cite to in paragraph 66
9 of my report in paragraph 128.

10 And so there's a discussion there even a
11 TLG employee noted that arbitrarily assigning
12 non-participating hospitals points associated with
13 the bottom scoring category was -- noted that they
14 were arbitrarily assigning that. So TLG's own
15 employees have recognized that.

16 And so I discuss throughout this section
17 of my report why consumers are unlikely to have this
18 understanding and the fact that only one document,
19 the methodology document, can be accessed through
20 TLG's hospital safety grade pages today, and I've
21 gone ahead and looked at in my supplemental report
22 the number of people that have downloaded that
23 document.

24 Q. Okay. And before we take this break,
25 because I think this is a good time, I just want to

1 make sure I understood your answer; that it is your
2 expert opinion that consumers looking at the Leapfrog
3 hospital safety grades are unlikely to understand
4 that the hospital is assigning the minimum score on
5 imputed measures. Correct? Did I write that down
6 right?

7 A. My opinion as detailed in my report is
8 that TLG does not directly disclose information on
9 its practice of assigning the minimum score to
10 non-participating hospitals on TLG's hospital safety
11 grade pages.

12 Q. Perfect.

13 MS. BLAIR: I think this would be a good
14 time to take a break. How long do you want to
15 take, Mary Beth, 15 minutes?

16 MS. MALONEY: 10 minutes.

17 MS. BLAIR: 10.

18 MS. MALONEY: 10, 15, whatever, I'll speak
19 to the court reporter.

20 THE WITNESS: Great. That sounds good.

21 MS. MALONEY: Is 10 okay?

22 THE WITNESS: 10's great.

23 MS. BLAIR: Yep.

24 MS. MALONEY: Okay. Thanks so much.

25 MS. BLAIR: All right. Thank you.

1 VIDEOGRAPHER: Going off the record at
2 10:53.

3 (A recess transpired from 10:53 a.m. until
4 11:05 a.m.)

5 VIDEOGRAPHER: One moment.

6 We're back on the record at 11:05.

7 BY MS. BLAIR:

8 Q. Dr. Berger, now I can't find my notes.

9 Okay. So right before the break, we were
10 talking about -- and this is specifically with
11 respect to Section VIII of your report, that when you
12 say consumers would be likely -- unlikely to
13 understand that TLG assigns the minimum score on the
14 imputed measures, that is your opinion based --
15 again, I just want to make sure, based on the Google
16 Analytics data that you reviewed, you -- it is your
17 expert opinion that consumers would be unlikely to
18 understand that Leapfrog Group assigns the minimum
19 score on the imputed measures, correct?

20 A. Sorry. That is Section VIII of my report.

21 Q. Yes.

22 A. I believe maybe I misheard, but I think
23 the beginning of your question was beyond
24 Section VIII of your report. But Section VIII of my
25 report is the section where I discuss this. So I'm a

1 little confused.

2 Q. Oh, I didn't mean to say "beyond," if I
3 did.

4 A. Ah, okay.

5 Q. I'm just trying to pick up where we left
6 off.

7 When we left off we were talking about
8 your expert opinion is that based on the Leapfrog
9 website as currently constructed, consumers are
10 unlikely to understand that Leapfrog assigns the
11 minimum score on the imputed measures. Correct?

12 A. My opinion, in Section VIII, is that many
13 consumers would be unlikely to understand that TLG
14 assigns a minimum score on the imputed measures. I
15 also go on to detail the impact of that practice, but
16 it seems like you're just interested in the first
17 half of that sentence. So unlikely that TLG assigns
18 a minimum score.

19 Q. And your expert opinion is based not only
20 on the academic literature that you reviewed, but
21 also on the Google Analytics data that you reviewed
22 that is part -- or that is in your supplemental
23 report. Correct?

24 A. Yes, in addition to sections of my initial
25 report, Section VIII(a), for example, noting that TLG

1 does not directly disclose information on its
2 practice of assigning the minimum score on TLG
3 hospital grade safety pages. I detail in that
4 section a variety of sources of evidence that I use
5 to reach that conclusion in that section, for
6 example. And so that's one place where I discuss
7 this issue.

8 Another place where I discuss this issue,
9 as you noted, is in my supplemental report where I
10 use Google Analytics data to speak to this question
11 about whether consumers are likely to understand the
12 minimum grade assignment.

13 Q. And so asking that question sort of in the
14 reverse way, is it your expert opinion that if the
15 website stated clearly that it was assigning the
16 lowest possible score to a non-participating
17 hospital, that would be likely to properly inform a
18 consumer of the website?

19 A. I appreciate that you're asking me to
20 hypothesize about what would happen in a different
21 situation than the situation that is observed. I --
22 there are a number of assumptions, though, that I
23 would need to make to answer that question. And I
24 don't know the answer to those assumptions. I don't
25 know the way in which that information would be

1 conveyed, where it would appear on the site, how it
2 would appear, the exact language that would be used,
3 among other things. And so without that information,
4 I can't -- I can't provide an expert -- an
5 appropriate expert answer on that question.

6 What I can say is given the reality that
7 existed and the information that was provided on the
8 website and the way in which it was provided, many
9 consumers would be unlikely to understand that TLG
10 assigns the minimum score on the imputed measures
11 based on the -- TLG's imputation disclosures.

12 Q. Understood. Let me ask it a different
13 way, then.

14 As a marketing expert, do you have an
15 opinion as to what the website would need to show in
16 order to make sure that consumers are likely to
17 understand that TLG assigns the minimum score on
18 imputed measures?

19 A. Yeah, that's not something I was asked to
20 consider in my assignment and so it's not something
21 I -- I considered here and -- or I'd need to think
22 about it more to give you a fulsome answer.

23 Q. Okay. So you don't have an opinion about
24 whether -- if the website had some bigger, bolder
25 disclaimer that said, "We are just assigning this

1 hospital the lowest score because it didn't
2 participate," whether that would be enough to
3 properly educate a consumer of this website as to
4 TLG's methodology? You don't have an opinion about
5 that?

6 A. Exactly of what type of new, different
7 disclosure moving forward might either be appropriate
8 or might make consumers -- give them a better
9 understanding was not a question I was asked to opine
10 on, and so it's something I'd need to consider in
11 greater detail.

12 Q. Okay. So you don't have an opinion about
13 whether if the website said, "We are just going to
14 assign this hospital the worst grade possible because
15 it didn't participate," if it was that specific, you
16 don't have an opinion about whether or not that would
17 then make consumers likely to understand that
18 Leapfrog assigns the minimum score on imputed
19 measures? You don't have an opinion one way or the
20 other?

21 A. Again, I wasn't asked to opine on that
22 issue. And further, while I respect that what you
23 said seems simple, there are a variety of ways that
24 what you said might be operationalized that might
25 potentially have different impacts. And so I would

1 need to have a better understanding of exactly the
2 way in which what you're talking about is
3 operationalized and the time to consider that issue
4 to put forward an expert opinion on it.

5 Q. Okay. And I'm sorry to keep beating this
6 horse, but I just want to make sure I'm clear and I
7 close the loop.

8 So you don't have an expert opinion
9 about -- well, let me just ask it this way: Your
10 upper bound is the way that -- and I'm talking just
11 about your opinion in number VIII, Roman numeral VIII
12 of your initial report that the way in which the
13 grades are displayed today makes it unlikely that
14 consumers will understand that TLG assigns the
15 minimum score on imputed measures. Correct? That's
16 one of your many opinions. But that's part of your
17 opinion in Section VIII. Correct?

18 A. One of my opinions in Section VIII is that
19 based on TLG's imputation disclosures, many consumers
20 would be unlikely to understand that TLG assigns the
21 minimum score on the imputed measures.

22 Q. And you cannot offer opinions -- an
23 opinion today about what would suffice to make sure
24 that consumers are likely to understand that TLG
25 assigns the minimum score on imputed measures? I

1 know I've asked it 17 different times, 17 different
2 ways. I'm just closing the loop, Doctor, thank you.

3 A. I'm going to try to be helpful here, but I
4 feel like I've answered this question, but I'll try
5 again. I am aware that this matter is ongoing. I
6 reserve the right to augment my opinions should new
7 things become available. At the moment, however, I
8 was not asked to answer the additional question that
9 you mentioned in your question. And, thus -- and I
10 do not have the information necessary at the moment
11 to put forward -- because I was not asked, I do not
12 have the necessary information to put forward an
13 expert opinion on that question. But yeah, so that's
14 what I can say at the moment.

15 Q. No, understood.

16 And as an expert in the field of
17 marketing, what information would you need to come to
18 that opinion?

19 MS. MALONEY: Objection.

20 THE WITNESS: I would need to think about
21 it more. There are a variety of ways one could
22 imagine providing such information, a variety of
23 places on the website, for example, a variety of
24 ways of providing that information beyond
25 placing it on the website. I have not --

1 because I was not asked in this matter, I have
2 not considered exactly what I would need to
3 answer that question and so I would need more
4 time to do so.

5 BY MS. BLAIR:

6 Q. Thank you, Doctor. I appreciate that.

7 In the expert area of marketing, is there
8 a percentage of consumers that must be confused
9 before a website rises to the level of deceptive?

10 MS. MALONEY: Objection. Calls for a
11 legal conclusion.

12 THE WITNESS: Sorry, I couldn't hear what
13 you said. Would you mind saying that one more
14 time? Both -- both the question and the
15 objection. I heard neither, I'm sorry.

16 BY MS. BLAIR:

17 Q. Sure. I'll let Mary Beth make her
18 objection again because it's a good objection, but
19 I'm just curious.

20 Is there anything in the academic
21 literature that establishes some sort of percentage
22 cutoff of consumers that must be confused by a
23 website's layout in order for it to rise to the level
24 of being deceptive?

25 MS. MALONEY: Objection. Lacks

1 foundation. Vague. Calls for a legal
2 conclusion.

3 THE WITNESS: Okay. Thank you. I think I
4 heard both of those.

5 So I was not asked to opine on this
6 specific question. And so I would -- I would
7 need to think about it more.

8 BY MS. BLAIR:

9 Q. Okay. And going back to all of my myriad
10 of questions about focus groups and consumer surveys,
11 have you ever provided expert testimony where you
12 did, in fact, conduct a consumer survey or a focus
13 group?

14 A. I believe so, but I'd have to go back and
15 look to be sure.

16 Q. Do you have any specific recollection of
17 what that might have been?

18 A. You know, just to be clear, I often do
19 surveys in my academic research. At this point, I've
20 probably done over a thousand surveys in combination
21 of my academic and expert work. I don't -- I wasn't
22 studying this question going in so I don't know a
23 specific case offhand, but I believe I've certainly
24 used, you know, different types of methodologies in
25 different cases including things like surveys.

1 Q. And in your expert opinion -- well, strike
2 that.

3 In your academic research, why do you
4 conduct consumer surveys?

5 MS. MALONEY: Objection.

6 THE WITNESS: That's a very broad question
7 so I want to be a little bit careful. In some
8 cases, that is the best type of data that I'm
9 aware of that is available to answer a relevant
10 question. And so in cases where it is the best
11 type of data I am aware of being available to
12 answer a relevant question, it is sometimes a
13 method that I use.

14 BY MS. BLAIR:

15 Q. And what kind of cases are those cases
16 where it's the best type of data to use?

17 A. I'd have to go back and think about it
18 more and look at the specific instances.

19 Q. Do you have any recollection of using
20 consumer surveys in connection with analysis of
21 websites in any of your academic or expert research?

22 A. I've certainly done work related to
23 websites. I'd have to go back and look at the exact
24 methods used and the exact ways in which they were
25 used.

1 Q. Okay. And so my question was, like, do
2 you have any specific recollection of doing a
3 consumer survey in connection with a website in your
4 academic or expert research?

5 A. I believe I have done surveys in papers
6 where I've examined, along with surveys, data of
7 consumers interacting with websites, but I'd need to
8 go back and look to figure out exactly which paper.

9 Q. Okay. And your -- your expert opinion
10 references I think 72 or 76, sorry, I don't remember,
11 on different articles that you've written. It would
12 be one of those? Is that where I should look?

13 A. Sorry, when you say my expert opinion
14 references 76 articles that I've written, what do you
15 mean by that?

16 Q. Yeah, so when I look at page 1 of your
17 initial report, you say -- oh, it's 75. See I was
18 wrong on all accounts. You say, "I have published
19 over 75 peer-reviewed articles."

20 And I'm just trying -- if I wanted to find
21 which article it was where you did a consumer study
22 related to website, would it be one of these 75?

23 A. It should be, yes. Unless there's some
24 paper that is a working paper, an unpublished paper
25 that had done that, I've done a number of academic

1 papers over a number of years and so I have not
2 reviewed the details of all of them for the purposes
3 of this case. Further, many papers contain multiple
4 studies, you know, multiple surveys or both field
5 data and surveys. And so I don't remember all the
6 details of all of them. But my CV would certainly be
7 the best place to look to find the work that I've
8 done in general.

9 Q. Excellent.

10 And then -- but as you sit here today, you
11 can't specifically recall what article or what type
12 of consumer survey that was?

13 A. Again, I've done a lot of consumer surveys
14 across my papers, and, you know, expert work and
15 consulting work. Over a thousand at this point. I
16 am well familiar with survey methodology. I use it
17 often. Exactly what I used it for in a given paper I
18 don't have at the tip of my memory.

19 Q. That's fair. It's not a memory test. I
20 was just trying to make my life easier. So I
21 appreciate that.

22 But it's your position as you sit here --
23 well, is it your position as you sit here today that
24 a website -- that you can from an expert vantage
25 point make the determination as to whether or not a

1 disclaimer on a website is confusing to consumers
2 without any consumer testing or comparison to
3 industry benchmarks? Let me break that up because
4 that was a confusing question. So sorry.

5 Is it your expert opinion in this case
6 that you can to a reasonable degree of professional
7 certainty opine that the asterisks and disclaimer on
8 the Leapfrog website is -- I don't want to misstate
9 your words. I'm going to be careful -- makes it
10 unlikely that consumers understand that Leapfrog
11 assigns the minimum score? You can make that expert
12 determination without consumer testing in this case?

13 A. Let me quote the footnote disclosure. It
14 says, "The hospital declined to report their
15 performance on this measure, so a score was assigned
16 to reflect the lack of information available."

17 Q. Correct.

18 A. And so while that footnote disclosure
19 states that a score was assigned by TLG, it does not
20 say anything about how that score was assigned, what
21 that score is, or convey the fact that this assigned
22 score was the minimum score for the imputed measure.
23 And so in this instance, one can tell by reading this
24 sentence that it does not say anything about a
25 minimum score. The word "minimum," the word "score,"

1 none of that information is contained in -- in this
2 sentence.

3 Q. Well, it does say "score."

4 A. Sorry. My fault. Minimum, thank you.
5 Sorry. My mistake. You are right. You are
6 100 percent right. It says "score." It says "a
7 score was assigned." It doesn't say whether that's
8 the minimum score, the maximum score, the average
9 score, a random number, says nothing about the nature
10 of that score that was assigned.

11 And so given that this sentence does not
12 convey that information, I'm concluding that it does
13 not convey this assigned score was the minimum score
14 for the imputed measure.

15 Q. But you don't have an opinion about
16 whether or not if that said, this is the minimum
17 score for this measure, whether that would be enough
18 to unconfuse, my word, consumers reading this
19 website?

20 A. Again, I wasn't asked about alternate -- I
21 wasn't asked to form an opinion about whether a given
22 or which of a number of given or something like that,
23 you know, alternate language things, what those
24 alternate language things would do. I analyzed what
25 the language was on the website as well as where

1 there is language that discusses the minimum score
2 assignment.

3 Q. Okay. And so when you look at that
4 asterisks footnote, it's your expert opinion that
5 there is nothing in that disclaimer that provides
6 context to the reader that this hospital's being
7 assigned the worst score it can get for that measure?

8 A. Well, to be precise, that's not just my
9 opinion. So even -- let me look to the right
10 information here. So even TLG itself received
11 feedback, as I discuss in paragraph 66, that its
12 minimum score assigned misrepresented a hospital's
13 performance to consumers and even acknowledged itself
14 that consumers may misinterpret the scores on the
15 measure. I believe there was a time where they
16 responded to public comments or something like that,
17 and some commentators expressed concerns about the
18 imputation misrepresenting the procedures of what
19 is -- of what is going on.

20 Further, as I note in paragraph 66, when
21 developing the language for the footnote disclosure,
22 a TLG employee noted that TLG was arbitrarily
23 assigning things in this regard. And I think that's
24 detailed in footnote 30. "'Arbitrarily assigning
25 [non-participating hospitals] points associated with

1 the bottom scoring category.' Nonetheless, the
2 disclosure omits any language about TLG's practice of
3 assigning the minimum score on imputed measures."

4 Q. Right. And I guess just kind of
5 summarizing.

6 So your opinion is there's nothing in this
7 disclosure or on this page that properly advises a
8 consumer that a -- this non-participating hospital is
9 being assigned the worst score it can be assigned,
10 and that's your problem with this disclaimer?

11 A. I want to be a little careful here. My
12 opinion in this section of the report is that TLG
13 does not directly disclose information on its
14 practice of assigning the minimum score to
15 non-participating hospitals on TLG's hospital safety
16 grade pages.

17 And to reach that conclusion, I have
18 looked at where disclosures appear, and the language
19 that appears in those disclosures. And I note not
20 only does language not appear about a minimum score
21 being assigned or the imputed measure as I discuss in
22 paragraph 65, but I note that TLG itself received
23 feedback that its minimum score --

24 Q. And I get that.

25 A. -- misrepresented a hospital's performance

1 to consumers and even acknowledged itself that
2 consumers may misinterpret the scores.

3 Q. Right.

4 So, again, my question is, your problem
5 with this disclaimer is it does not tell a consumer
6 of these digital services that this hospital got the
7 worst grade it could get for this measure? That's
8 your problem. We should be telling people that.

9 A. I want to be a little bit careful.

10 Q. Sure.

11 A. So I'm -- I don't believe I was asked,
12 as -- as we discussed already, I was not asked to
13 prescribe solutions. I was asked to analyze the
14 language and the likely inferences that consumers
15 would draw from the language and whether they would
16 understand what is going on with the minimum score
17 being assigned. That's what I was asked to do and
18 that's what I did.

19 Q. Okay. And so when you say, "Consumers
20 would be unlikely to understand that TLG assigns the
21 minimum score," that is because that -- that dis- --
22 is that -- let me ask this question:

23 Is that because this disclaimer and this
24 page that we just were discussing do not tell a
25 consumer that a non- -- this non-participating

1 hospital is being given the worst grade it can get
2 for this imputed measure?

3 A. I want to be a little bit careful here.
4 So I am noting what occurred, and while the footnote
5 disclosure states a score was assigned, it does not
6 convey that it was the minimum score.

7 Q. Okay.

8 A. I'm not prescribing one solution. I'm not
9 suggesting that adding a particular word would or
10 would not solve everything. I've not been asked to
11 do that. And I also want to be careful, I'm not
12 saying that this is the only problem with what is
13 going on and there are no others.

14 I am merely suggesting in this section of
15 the report that while TLG purports to disclose its
16 imputation methodology on TLG's websites, if you
17 actually look at what's going on, this is what's
18 actually happening with the imputation disclosure.
19 It's small. It's near the bottom of the page. What
20 it says does not say anything about minimum score
21 being assigned, among other things.

22 Q. Okay. And so you make a great point.

23 So we've talked about you got a problem
24 with -- I'm calling it the disclaimer, the asterisks,
25 whatever we're going to call it on this page -- and

1 that is -- is it your opinion that that's only one
2 thing that makes it confusing to consumers in
3 understanding that TLG assigns the minimum score?

4 A. So I want to start by saying this is not
5 my problem. I did not create this problem. There is
6 a problem.

7 Q. Okay.

8 A. I am merely highlighting what the problem
9 is.

10 Q. Right.

11 A. But I did not create the problem. I am
12 not --

13 Q. I'm not suggesting that.

14 A. The language is what it is. And I, using
15 my expertise and literature and other things, are
16 discussing what's going on with that.

17 What was, though, the second part of your
18 question? The second part of your question was
19 whether this is the only thing that what?

20 Q. Yeah. You said -- I thought you said in
21 your answer to me, that I just want to be very
22 careful that this is one of many things that you
23 think is problematic with the Leapfrog website. And
24 I want to make sure I understood that answer or maybe
25 I didn't.

1 A. Oh, what I was just saying, you were
2 focusing on the language?

3 Q. Yes.

4 A. And I was noting that the footnote
5 disclosure is also small font. It appears near the
6 bottom of pages. It only appears on certain pages.
7 And so it's not just that.

8 My conclusion is not solely based on the
9 fact that this sentence does not contain a specific
10 word. It is also based on what the disclosure looks
11 like and where it appears among potentially other
12 things.

13 Q. Got it.

14 And when you talk about, you know, it
15 being small, it's not -- it's on the bottom of the
16 page -- I think your report uses the phrase "below
17 the fold," which I had to explain to some of my
18 younger associates that's a newspaper reference which
19 they could not understand. No joke. We had that
20 conversation last night.

21 Does that come from any set of standards
22 that you reviewed to make the determination as to --
23 it is too small, it's not conspicuous enough, it's
24 not in the right places. Does that come from a
25 specific set of standards?

1 A. Well, sorry. So the notion that it's
2 below the fold is based on where it appears.

3 Q. Correct.

4 A. That discusses that, similar to newspaper,
5 you see what's on the top of the page; you don't
6 necessarily see what's below the fold or the folded
7 bottom half of the page. Similarly on a website, you
8 see what's on a website when you get there; but if
9 you have to scroll down to see information, you don't
10 see it immediately.

11 What that means is that if someone doesn't
12 scroll, they don't see that information. There's no
13 way someone could be exposed to that information
14 unless they scrolled. And further, depending on how
15 far down on the page it is, they may need to scroll
16 further to see it.

17 Similarly, the more pages something
18 appears on, the more likely people will be, in
19 general, controlling for all else, more pages in this
20 context should in general probably help people see it
21 more. In this case, it was not on that many pages.
22 The font is relatively small and far down the page
23 and not appearing on all the pages.

24 And so I'm not using one particular cutoff
25 for any of these things to say, yes or no, it makes

1 it or it doesn't. All these things in combination,
2 in addition to the language used, all support the
3 point that it is unlikely that consumers read this
4 footnote disclosure. And further, given that TLG
5 does not directly disclose that its minimum score
6 assignment -- does not directly disclose that the
7 method is the minimum score, it is unlikely that
8 consumers would understand that.

9 Q. Yeah, and I guess my question was a little
10 more specific, but maybe it made no sense, so I
11 apologize.

12 I'm just curious in somebody who does what
13 you do -- which is not what I do clearly by this
14 deposition -- is there a set of guidelines? Like, do
15 you look at -- or this particular professor put out a
16 set of guidelines that is the industry standard, and
17 this is what you look at to determine whether or not
18 this disclaimer is -- and I'm just talking about the
19 conspicuous nature of it, right, how small it is,
20 whether it's bold enough, whether it's big enough, or
21 whether it's above the fold, is there an academic --
22 piece of academic literature someone like me could
23 look at and say, these are sort of the checklists
24 that you need to look at that are industry-accepted
25 standards to make the determination as to whether or

1 not, not the content, but whether or not the
2 disclaimer itself is conspicuous enough?

3 A. There --

4 MS. MALONEY: Objection.

5 THE WITNESS: Sorry. Go ahead.

6 MS. MALONEY: Just objection. Form.

7 THE WITNESS: There is certainly
8 literature that speaks to some of these things,
9 if not all of them. I do not at the tip of my
10 memory have a particular paper in mind. That
11 said, just as a general thought, I've certainly
12 done work, done research myself that speaks to
13 this and may cite some of the literature in this
14 space.

15 And so I'm not -- but some of it is also
16 common sense, right? So if -- if you can't see
17 something unless you scroll, then you can't see
18 it unless you scroll. And so if someone doesn't
19 scroll, they don't see it; and thus, they can't
20 read it; and thus, they can't be exposed to that
21 information. And so some of this is just basic
22 principles of exposure, psychological principles
23 of exposure.

24 I'm sure that there are many academic
25 papers that speak to that. I have not reviewed

1 all those papers for the purpose of this
2 deposition so I can't suggest to you one paper.
3 But there's a large academic literature on the
4 psychology of exposure.

5 BY MS. BLAIR:

6 Q. Do you recall what paper it was that, or
7 papers it was, that you wrote that would have spoken
8 to this issue?

9 MS. MALONEY: Objection to form.

10 THE WITNESS: I would need to go back and
11 look to be sure.

12 BY MS. BLAIR:

13 Q. So as you sit here today, off the top of
14 your head, you just don't recall?

15 A. I don't recall exactly which paper. I'd
16 have to look.

17 Q. But, again, if I looked at those 75
18 different peer-review articles that you discuss in
19 your opinion, it's most likely in one of those?

20 A. I've certainly done research related to
21 issues we've just discussed, and I believe there are
22 citations in those papers to some related literature,
23 but I'd have go look to be sure.

24 Q. And do you -- did you employ any sort of
25 readability analyses with respect to the Leapfrog

1 website?

2 MS. MALONEY: Objection to form. Vague.

3 THE WITNESS: I'm not sure exactly what
4 you mean.

5 BY MS. BLAIR:

6 Q. Sure.

7 I guess we talked earlier about whether or
8 not you had any expertise in digital low literacy.
9 And I -- I don't want to put words in your mouth. I
10 think you said you are not an expert -- or you're
11 not -- you're not here to provide expert opinions on
12 that. Correct?

13 A. For the purposes of this case, I was not
14 asked to provide expert opinions on that, yes.

15 Q. And so would it be fair to say that you
16 didn't perform any digital low literacy readability
17 analyses with respect to the Leapfrog website?

18 A. I'm not sure exactly what type of analyses
19 you have in mind. But I don't believe I performed
20 any such analyses in this instance because I was not
21 asked to -- not asked to do such a task.

22 Q. Understood.

23 In coming to your conclusions, did you
24 review -- or I'm sorry. In coming to your opinions,
25 did you review any patient surveys from any of the

1 five hospitals?

2 A. I don't believe that I reviewed patient
3 surveys. But I'm not sure that such surveys would
4 necessarily be the best source of data to answer the
5 questions here. And I was not aware of any surveys
6 that would provide a fulsome sense of what's going
7 on. One would probably need a specific type of
8 survey answering certain questions potentially over
9 time, and I'm not aware of any such data that exists
10 in this instance.

11 Q. But you do opine in your initial opinions
12 that a hospital's reputation can be impacted by many
13 different sources, including patient perceptions,
14 correct?

15 A. Is there a specific place in my report
16 you're referring to? If so --

17 Q. Well, sure. Let's just -- we'll just
18 start at the top and we'll go through it
19 systematically. Maybe that's the easiest way.
20 Because it's very lengthy and I want to make sure I
21 don't miss anything.

22 Let's just start -- I'm going to start
23 with Section V of your report on page 8. And
24 Section V is entitled "'D' or 'F' TLG Hospital Safety
25 Grades Likely Negatively Impact Consumers'

1 Perceptions of plaintiffs' Hospital Quality."

2 Correct? Are you on that page?

3 A. Yes.

4 Q. Okay. I just want to make sure we're on
5 the same place.

6 Would you agree with me that the purpose
7 of the Leapfrog hospital safety grade is to provide
8 transparency in patient safety to consumers of this
9 information?

10 A. I think your question is asking me to
11 speak to the intent of the hospital safety grades,
12 and I don't feel comfortable speaking to that intent.

13 Q. Okay.

14 A. There may be a couple places in my report
15 where I quote specific TLG language, and I'm happy to
16 go there, if useful. They make at certain points
17 certain statements that I cite to. But I'm not sure
18 that I can speak to intent. I don't -- I don't have
19 access -- I don't know their intent.

20 Q. Okay. And in coming to your opinions,
21 and, again, I'm just talking about the initial
22 opinions in your first report, did you review any
23 other health care ratings websites to determine
24 whether or not those websites also contained any
25 information that would be likely to confuse

1 consumers?

2 A. I was not asked to analyze whether other
3 websites may or may not have information that may or
4 may not be confusing to consumers. But regardless of
5 whether other websites may or may not have
6 information that is confusing to consumers, that
7 doesn't change my conclusions that contained in this
8 report, for example, that "The 'D' and 'F' TLG
9 hospital safety grades likely negatively impact
10 consumers' perceptions of hospital quality and likely
11 deter consumers from choosing plaintiff hospitals."

12 Q. And I guess my question is, do you have an
13 opinion about whether other hospital safety grade
14 websites are likely to deter consumers from going to
15 hospitals that received poor ratings?

16 MS. MALONEY: Objection. Vague. Calls
17 for a hypothetical.

18 THE WITNESS: I wasn't asked --

19 MS. MALONEY: Lacks foundation.

20 THE WITNESS: Sorry.

21 MS. MALONEY: Go ahead.

22 THE WITNESS: I wasn't asked to in detail
23 examine other hospital safety grade pages --
24 other hospital safety grade websites. And so
25 I'm not putting forth an opinion on what is

1 going on on other hospital safety grade web
2 pages.

3 BY MS. BLAIR:

4 Q. Understood.

5 A. I am merely, for example, in this section
6 that we're talking about here noting what the D and F
7 TLG hospital safety grades likely did in terms of
8 consumer perception of Plaintiffs' hospital quality.

9 Q. Okay. And so you did no benchmarking, my
10 word, between let's just say like Healthgrades or
11 U.S. News World Report, which are mentioned in your
12 report, and the Leapfrog disclosures about their
13 methodology? You did no kind of benchmarking in
14 coming to your opinions. Correct?

15 A. I wasn't asked to do such benchmarking,
16 and further, I'm not sure why that benchmarking is
17 necessarily relevant in this instance. Whether other
18 hospital safety grade pages or other hospital safety
19 grade websites did or did not negatively impact
20 consumers' perceptions of plaintiffs' hospital
21 quality does not speak to whether or not the D or F
22 TLG hospital safety grades themselves based on what
23 TLG did on TLG's own website have such an impact.
24 And so I --

25 Q. Well -- I'm sorry.

1 A. -- focused on what TLG did, not what other
2 hospitals have done.

3 Q. Yeah, and I'm just asking because in
4 paragraph 22, for example, in your report you say,
5 "the effect of third-party ratings." Not "Leapfrog,"
6 but "third-party ratings." And you do go on in other
7 parts of this report to talk about other types of
8 third-party ratings.

9 And you say in paragraph 22, "The effect
10 of third-party ratings on perceived quality is likely
11 to be particularly impactful on consumer
12 perceptions."

13 And so I'm just asking, you're using that
14 obviously generally, not referring just to Leapfrog.
15 And so I'm just asking if you looked at any of the --
16 the impact of any of the other third-party ratings on
17 the consumer perceptions of these five hospitals in
18 coming to your opinions?

19 A. Yeah. And so I -- so I want to be careful
20 here. The language I used in my report is the
21 language I used in my report, and I stand by that
22 language.

23 And so I'm not saying that other -- other
24 third-party ratings beyond TLG's rating did not also
25 impact consumer perceptions. I did not look or

1 analyze other such sites. But regardless, even if
2 those sites did, or if those sites did not have an
3 impact on consumer perception, that doesn't change my
4 opinion that TLG's grades, D and F grades, both
5 likely impacted perceptions and hospital choice.

6 Q. Understood.

7 But you offer no opinion about how much
8 reputational damage, for example, could be
9 attributable to Leapfrog versus a one star CMS rating
10 or versus a one star patient perception rating by
11 U.S. News and World Report. Correct? You didn't do
12 that?

13 A. I was not asked to specifically quantify
14 the exact amount of reputational damage that might
15 have been attributable to one source versus the
16 other. And so I'm not putting forth an expert
17 opinion on that.

18 Q. And you're also not putting forth any
19 expert opinions about the quality of patient safety
20 at any of these five hospitals. Correct?

21 A. I'm not putting forth an opinion about the
22 actual quality of these hospitals.

23 Q. Going to page 9, same section, same
24 paragraph 22. Your report says -- and this is -- it
25 starts on the second line on page 9, that many

1 consumers act -- I'm sorry, "Many consumers lack the
2 medical expertise necessary to identify and evaluate
3 information about the quality of care a hospital
4 offers."

5 Do you see that, where you say that?

6 A. I do.

7 Q. Is it your expert opinion that a consumer
8 must have medical expertise to determine whether --
9 to evaluate whether or not they received quality care
10 at a hospital?

11 A. No. My -- my opinion is simply that many
12 consumers lack the medical expertise necessary to
13 identify and evaluate information about the quality
14 of care a hospital offers.

15 Q. Why would a consumer need medical
16 expertise to determine whether or not from their
17 perspective they received good quality care from a
18 hospital?

19 A. Well, first of all, not all consumers have
20 been to a specific hospital. And so if they have not
21 been, they have not themselves received care. And so
22 they can't evaluate the care from their own -- the
23 quality of care from their own personal experience if
24 they haven't been. They would have to evaluate it
25 another way. And they may not have the expertise

1 necessary to identify and evaluate such information.

2 Further, even after someone receives
3 treatment, while consumers may have access to health
4 outcomes, health outcomes themselves are not always
5 indicative of quality of care. And so even, assuming
6 consumers were able to assess quality based on
7 experience alone, many consumers only consider or
8 experience care infrequently and are unlikely to have
9 sufficient direct or recent experience to form a
10 perception of hospital quality.

11 Q. But what you just discussed was not
12 medical expertise, was it?

13 A. I'm not sure what you mean.

14 Q. Well, not my sentence. But you say -- I
15 mean, this sentence says that they lack medical
16 expertise, and the things you just described weren't
17 medical expertise. I mean, you don't need to know
18 how to perform a -- you know, a spleen removal to
19 make a determination as a patient whether or not
20 staff was responsive when you hit the button or there
21 were enough nurses on the night shift to take care of
22 your need. Correct? That's not medical expertise?

23 A. I want to be careful. I'm not saying that
24 lacking medical expertise is the only challenge that
25 consumers have when evaluating quality of care. That

1 is one challenge.

2 More generally, this is a credence good
3 where even after experience, health outcomes are not
4 always indicative of quality of care. And so even if
5 I had some experience, which not everybody does, and
6 further, they -- many people only experience hospital
7 care infrequently and are unlikely to have either
8 sufficient direct or recent experience. Even if they
9 have experience, they may not be able to correctly
10 evaluate quality of care simply from health outcomes.

11 Q. And you agree with me that most hospitals
12 provide patient safety -- or I'm sorry, patient
13 satisfaction surveys to their patients, correct?

14 A. I can't speak to whether most hospitals do
15 or do not provide such surveys.

16 Q. Do you know if these five hospitals do?

17 A. I don't know offhand, no.

18 Q. And you were never told about whether they
19 do or do not provide patient satisfaction surveys?

20 A. I don't know whether they do or they do
21 not.

22 Q. Would it be important to you as an expert
23 to have reviewed those patient satisfaction surveys
24 to make the determination as to whether or not these
25 patients at these five hospitals could in fact

1 evaluate information about the quality of care they
2 received?

3 A. I want to be careful here. I don't
4 know -- this wasn't a question I was asked to do in
5 the context of this case. And so I don't know
6 whether patient satisfaction, how well correlated
7 that is, for example, with quality of care, offhand.
8 I don't know whether surveys exist, what exactly they
9 asked, and so this is not an area I can speak to in
10 any depth at the moment.

11 Q. Okay. But my question is, if they exist
12 and let's just use that, because I don't know either.
13 If they exist, is that something that you as an
14 expert would have liked to have seen in the context
15 of formulating your opinions?

16 A. I asked for any things relevant to forming
17 these opinions. Anything I asked for I was given.
18 Given I'm not aware of such surveys, I am -- I have
19 no reason to believe and have seen no information to
20 suggest that relevant surveys existed that would have
21 helped me form my opinion.

22 Q. Right.

23 But my question was in a hypothetical. If
24 they existed, is that something you would have like
25 to have seen to come to your conclusions? I don't

1 know if they exist or not.

2 A. I appreciate the question, but it's not
3 just whether such surveys existed. It's what
4 questions were asked on those surveys, the nature of
5 those questions, the potentially -- you know, when
6 those questions were asked, a variety of other
7 things. And so I can't say without more detail
8 whether such information would have been useful or
9 not.

10 Q. Right. But you would have needed to see
11 those surveys to know whether the questions on them
12 would have been helpful. Correct?

13 A. Not -- not necessarily. I asked for
14 information that was relevant to forming my opinions.
15 And I trust that I was given anything that was
16 relevant to forming my opinions.

17 Q. Did you specifically ask for patient
18 satisfaction surveys?

19 A. I asked for any information including data
20 that would be relevant to forming my opinions.

21 Q. And you asked for that information from
22 whom?

23 A. I believe I asked counsel for that
24 information.

25 Q. Okay. And so you left it up to counsel to

1 make the determination as to what would be relevant
2 to your opinions?

3 MS. MALONEY: Objection.

4 THE WITNESS: This is the standard process
5 I follow in every case I'm involved in. When
6 I'm given my assignment, I always ask for any
7 relevant information that would help me in
8 forming my opinion. And I trust that I'm given
9 any information that would be relevant.

10 BY MS. BLAIR:

11 Q. Okay. So you didn't provide, like -- "As
12 an expert, I would need to see these -- I would like
13 to see these following things on this checklist if
14 they exist." You didn't provide anything like that
15 to counsel to provide you with information?

16 A. I don't -- this is a while ago now. I
17 don't remember exactly. I don't believe I provided a
18 specific checklist. I simply asked for information
19 that would be relevant.

20 Q. Okay. In paragraph 23, the second full
21 sentence you said, "Research has found that online
22 reviews, rankings, and ratings can affect perceptions
23 of credence goods, including health care services."

24 Do you see that?

25 A. I do.

1 Q. What online reviews, rankings, and ratings
2 would affect a consumer's perception of a hospital's
3 quality of care? What other services exist other
4 than Leapfrog that you know of?

5 A. All I'm saying here is that research has
6 found what I say that research has found. And then I
7 go on to detail studies that show what I'm saying in
8 that sentence.

9 Q. Do you have any, in your -- you know, in
10 your expertise and specifically with respect to this
11 case, do you have any opinion about what rankings or
12 rating services a consumer would find most impactful
13 to the least impactful?

14 A. I wasn't asked to perform that analysis.
15 I don't have an expert opinion on it.

16 Q. If we go to page 14 and 15 of your report,
17 Section A, "Third-party Rankings, like TLG's Hospital
18 Safety Grades Have Been Found To Affect Consumer
19 Decision-Making."

20 Do you see that in your report? That's
21 page 14, Roman numeral VI(a), I believe?

22 A. I see that, yes.

23 Q. Okay. And if you look at paragraph 30,
24 you have some bullet points that go on to page 15.
25 Correct?

1 A. Yes. Correct.

2 Q. And you talk about different types of
3 ratings that could affect consumer decision making.
4 Correct?

5 A. I discuss studies that have examined and
6 shown third-party ratings and their impact on
7 consumers' choices in health care context.

8 Q. And the first bullet point is a 2022 study
9 of Yelp star ratings. Correct?

10 A. That's correct.

11 Q. Okay. And did you look at the Yelp star
12 ratings for these five hospitals in coming to your
13 opinions?

14 A. The Yelp star ratings of these hospitals
15 are not necessary to help me form my opinions.

16 Q. Okay. But my question was, did you look
17 at them?

18 A. No. Given I didn't think they were
19 relevant to understanding what TLG did, I did not --
20 did not look at them.

21 Q. But you talk about here, at least in this
22 bullet point, that this study talks about the fact
23 that patients are willing to travel 5 to 30 percent
24 further to receive care from a hospital with a higher
25 Yelp rating. Correct? That's what that bullet point

1 says?

2 A. I believe that's correct, yes.

3 Q. And in your expert opinion, did you
4 perform any analysis of whether or not patients are
5 willing to travel any percentage further to receive
6 care from a hospital with a higher Leapfrog rating?

7 A. I'm not relying on any one individual
8 study here to make my point. There are a variety of
9 studies across a variety of data sources that all
10 show consistent evidence that third-party ratings
11 like Leapfrog's D and F grades impact consumer
12 choices in various health care context. So there was
13 no need to, in Leapfrog's context, measure exactly
14 how far consumers were or were not willing to travel
15 for hospitals with different grades.

16 In particular, in paragraph 32, I also
17 cite to a study directly modeled with grades directly
18 modeled after TLG's hospital safety grades that show
19 that people choose safer hospitals based on these
20 grades in 97 percent of cost and safety scenarios.
21 So I'm not relying on any one piece of evidence here.
22 But this is quite strong evidence across a variety of
23 contexts all showing consistent things and -- and
24 shaping my opinion in this context.

25 Q. But you reviewed the complaint in this

1 matter, correct?

2 A. Yes.

3 Q. It's on your list?

4 And you understand that these five
5 hospitals are making the assertion that their
6 patients do travel farther based on Leapfrog hospital
7 safety grades, correct?

8 A. I don't remember all the words of the --
9 of the complaint. I'd have to look at it again.

10 Q. Okay. So my original question was, yes or
11 no, did you perform any analysis of whether or not
12 patients are willing to travel any percentage further
13 to receive care from a hospital with a higher
14 Leapfrog grade? Did you perform that analysis? Is
15 that part of your opinion?

16 A. That was not a question I was asked to
17 answer. So I did not undertake such an analysis.
18 That said, that analysis by itself is not necessary
19 to support any of the opinions in my expert report.

20 Q. Okay. And if we look on page 15, the
21 second bullet point on 15, you talk about "A 2023
22 survey experiment examining the effect of star
23 ratings on hospital choice found that respondents
24 were willing to pay \$1,698 more or travel 185 miles
25 further, on average, for a hospital with a

1 1-star-higher rating on clinical outcomes," and then
2 it goes on.

3 Do you see that?

4 A. I do, yes.

5 Q. And in that survey, were they not
6 referring to CMS star ratings?

7 A. I would have to look to be sure. I don't
8 have all the details of all these studies at the tip
9 of my memory.

10 Q. And do you believe this survey to be a
11 valid survey, this 2023 survey that you talk about in
12 bullet point 2 on page 15 of your report?

13 A. I haven't seen anything that causes me to
14 doubt this survey in general. I'm not -- I'm not
15 relying on all aspects of this survey, though.

16 Q. Sure.

17 A. I'm simply relying on the aspect I talk
18 about here, and I'd have to go back and look at it in
19 further detail. But I hadn't seen anything that
20 causes me to doubt it.

21 Q. Okay. And I'm only talking about what you
22 cited here. I didn't read the whole academic article
23 either.

24 But are you aware of what these five
25 hospitals' CMS star ratings are?

1 A. I'm not aware offhand, no.

2 Q. And so you don't have an opinion about
3 whether or not these five hospitals' low CMS star
4 rating would have an impact on whether or not
5 patients are willing to go to their hospital?
6 Correct?

7 A. I haven't analyzed that exact question.

8 Q. And the next bullet point here, it says,
9 "A 2009 study examining the effective of U.S. World
10 and News Report hospital rankings on consumer choice
11 found that a one stop drop in ranking" -- I think,
12 one spot drop; sorry, I can't read today -- "a one
13 spot drop in ranking was associated with a 6 to
14 7 percent decline in patient value."

15 Do you see that?

16 A. "In patient volume," yes, I see that.

17 Q. Okay. And as you sit here today, you have
18 no reason not to rely on that 2009 study, correct?

19 A. I'm relying on this 2009 study for exactly
20 what I cite it for. I have no reason to doubt that
21 study, but I have not gone back and looked at every
22 aspect of it.

23 Q. And are you aware as you sit here today
24 what the U.S. News rankings are for the five
25 hospitals that are plaintiffs in this litigation?

1 A. No, I'm not.

2 Q. And so as you sit here today, you don't
3 have any opinions about the impact of these hospitals
4 Yelp ratings, their CMS ratings, or their U.S. News
5 and World Report ratings on their perception in the
6 consumer marketplace, do you?

7 A. So I'm going to try to give an answer here
8 that we don't have to do for each type of data to
9 save us both time, but I'm happy to if you need.
10 Both for Yelp, for CMS, for U.S. News and World
11 Report, for any of the types of data that may be
12 talked about here, whether or not -- first of all, I
13 was not asked to specifically analyze these five
14 hospitals' scores on those types of data. And
15 further, was not asked to analyze whether those
16 sites -- scores on those sites shaped patients'
17 perceptions and patients' decisions.

18 That said, whether or not other sites'
19 data ratings things, whether they did or did not
20 shape consumers' perceptions or choices, does not
21 negate the fact that I am suggesting, based on all
22 this data and academic literature, that TLG's D and F
23 grades would be expected to damage both perceptions
24 and consumer choice of plaintiffs' hospitals.

25 And so I'm not saying that these other

1 things might not also potentially have an effect.
2 They might. But that doesn't change that TLG's
3 grades likely had an impact as well.

4 Q. And so I've said this a million times
5 today. But I'm not an expert in this area so I'm
6 just curious how this works.

7 If a consumer goes first to the CMS
8 website and sees that a hospital has a one star
9 rating and then goes, "I'm going to double-check
10 that's true." And they go then to Leapfrog and
11 see -- and they see that this hospital has a D, is
12 it -- in your expertise as a marketing expert, is it
13 your opinion that it is the Leapfrog grade that has
14 the impact on consumers' perceptions of the
15 plaintiffs' hospital's quality and not the CMS star
16 rating where they started their -- their journey?

17 A. I don't know exactly what this
18 hypothetical person did, what information they saw on
19 those sites, and a variety of other assumptions I
20 would need to make to answer that specific question.
21 And so I'm uncomfortable putting forward an expert
22 opinion without having more detail on that specific
23 situation.

24 More generally, though, what I'm quite
25 comfortable doing is given the data that's been

1 provided here, given the things we know from academic
2 research on the impacts of third-party ratings as
3 well as the other things that I detail throughout
4 this report, I'm comfortable making the opinions,
5 comfortable putting forth the opinions that I'm
6 putting forth in this report.

7 Q. And you're comfortable putting forth those
8 opinions even though you never gathered any direct
9 data by speaking to a consumer of the Leapfrog
10 website about how they view the website or their
11 perceptions from the website or their perceptions
12 from the hospital safety grade. Correct?

13 A. I'm not clear that asking one consumer
14 what they believe their perception to be about the
15 website and where they believe that perception came
16 from would be the most appropriate method to answer
17 the questions asked here. Given the number of
18 academic papers, for example, showing that
19 third-party ratings impact consumer choices in
20 various health care contexts and specifically showing
21 the grades modeled after TLG's hospital safety grades
22 shape consumer decision making, that's more than
23 enough evidence to support the points that I'm making
24 here.

25 Q. And you keep referring to talking to one

1 consumer. What if you talked to 5,000 consumers in a
2 survey, would that be enough? Or the academic
3 literature still outweighs that?

4 MS. MALONEY: Objection.

5 THE WITNESS: Again, you're asking me to
6 answer a bit of a hypothetical question. I
7 could imagine -- I could imagine that going
8 different ways potentially depending on the
9 specific questions that were asked and the ways
10 they were asked, and so I'm not -- so I -- I
11 can't answer that question without more detail.

12 BY MS. BLAIR:

13 Q. Okay. But an expert like you would be
14 able to put together some sort of consumer survey
15 that could answer these questions. Correct?

16 A. As we've --

17 MS. MALONEY: Objection.

18 THE WITNESS: -- talked about already, if
19 I thought a survey was the most appropriate
20 method to answer this specific question in this
21 specific case, I would have done so. I did not
22 think that that was the best method based on my
23 decades' worth of expertise in this space, did
24 not think that that was the best method to
25 answer the questions asked here.

1 BY MS. BLAIR:

2 Q. Right. Because the best method -- I'm
3 sorry. I didn't mean to cut you off. The best
4 method is to look at the Google Analytics that you
5 looked at; that's the best method?

6 MS. MALONEY: Objection to form. Asked
7 and answered. Argumentative. Lacks foundation.
8 Go ahead and answer.

9 THE WITNESS: When we talked about the
10 Google Analytics data, we talked about a
11 different part of the report. I did not say the
12 Google Analytics data was the best data.

13 In all theory, to answer this question,
14 it's the best data I was aware of to answer the
15 question. I wasn't aware of any better data in
16 this instance to answer that question which is
17 not the question we're talking about here. This
18 is a different section in my report.

19 And your question was how many
20 participants in a survey would have been enough,
21 would a 5,000-person survey have been enough.
22 And my answer, as I've already said, was that
23 without knowing more details about the survey
24 that you're talking about, I can't give an
25 expert answer because there are too many

1 assumptions involved that I don't know the
2 answers to.

3 BY MS. BLAIR:

4 Q. Okay. Going back to page 12 of your
5 report, paragraph 25, the first sentence there, you
6 say, "Academic research finds that evaluative
7 categories and labels not only help consumers make
8 sense of information, but they also increase the
9 influence such information has on consumer
10 perceptions."

11 Do you see that, first line, paragraph 25?

12 A. I do, yes.

13 Q. So as an expert in the area of marketing,
14 is it appropriate for Leapfrog to use, I think you
15 called them dials, measure dials on their websites to
16 help consumers make sense of information? Do you
17 have an issue with that part of it?

18 A. I was not asked to opine on the
19 appropriateness or not --

20 Q. Okay.

21 A. -- things like dials, for example. I am
22 merely noting that things like letter grades or dials
23 with a red, yellow, and green color scale are
24 examples of evaluative categories and labels which
25 can increase the influence of information, in this

1 case, hospital safety grades; and thus, TLG's choice
2 to do so can increase the influence of hospital
3 safety grades on consumers' perception of hospital
4 quality.

5 Q. Okay. So you're saying that when somebody
6 sees an F, they automatically think bad; or when they
7 see dial that's in the red, they think bad. Is that
8 a way of dumbing down what you're trying to tell me?
9 I'm not an academic.

10 A. I think --

11 MS. MALONEY: Objection.

12 THE WITNESS: -- compared to numeric
13 information, evaluative categories like A to F
14 grades; red, yellow, green scales can shape the
15 way consumers interpret information and can
16 increase the influence of such information on
17 consumers' perceptions.

18 BY MS. BLAIR:

19 Q. In -- the area of marketing, you know, in
20 your expertise, can too much data cause consumer
21 confusion?

22 A. That's a quite general question.

23 Q. Sure.

24 A. And one that I was not asked to opine on
25 in the context of this case. And so I would need

1 both more detail about the specific information
2 you're talking about and the context and a variety of
3 other things. I would need to have more detail on
4 those assumptions. And more time to think about it
5 to be able to answer that question.

6 Q. Okay. And I ask that question because we
7 talked a little bit earlier about you're like, well,
8 it takes all these clicks to get to the methodology,
9 this multipage methodology. And in your expertise as
10 a marketing expert, flooding -- is it true that
11 flooding a consumer with too much information can
12 cause consumer confusion?

13 A. That seems different than our conversation
14 about the number of clicks --

15 Q. Okay.

16 A. -- increasing the likelihood people are
17 exposed to information. More generally, while I
18 appreciate the broad nature of that statement, there
19 are a variety of assumptions I would need to have
20 answered to be able to answer it. And so I can't
21 answer that question in any detail without more, more
22 information.

23 Q. Okay. And I just want to make sure I
24 understand your opinion. And I really just am trying
25 to understand.

1 You talk a lot in your opinion about the
2 fact that you believe the only place for a consumer
3 to figure out that a non-participating hospital was
4 assigned the worst possible score is by clicking to
5 the methodology itself and reading through the
6 methodology. Correct?

7 A. Give me a second.

8 Q. Sure.

9 A. I'm just going to go down to that section
10 of the report again because we were somewhere else.

11 Q. And if you want to tell me what page you
12 are on, I'll read it with you. I just want to follow
13 along.

14 A. Give me a second.

15 Q. If it's helpful, it might be your chart on
16 page 37. That's what I'm thinking of, but you tell
17 me.

18 A. Give me -- give me one second.

19 Yeah, so I think the most relevant section
20 might be Section 72. And so --

21 Q. Wait, paragraph 72 or Section --

22 A. Sorry, sorry, yes, paragraph.

23 Q. No, no.

24 A. And so only a small subset of locations
25 state that TLG assigns the minimum score on the

1 imputed measure. Of the 38 locations analyzed, only
2 four say that hospitals would be given a score
3 equivalent to limit achievement from imputed
4 measures. And I detail what those four are there.

5 And then I note that, of these four
6 documents, I understand that only one, the
7 methodology document which we discussed already, can
8 be accessed through TLG's hospital safety grade pages
9 today. And so I'm not aware of any other way today,
10 any other way that consumers can navigate to the
11 remaining three documents on the page today.

12 And so that is the section, and maybe I
13 should have been either more precise or gone here
14 earlier, where I discuss where TLG states that they
15 assign the minimum score on the imputed measure.
16 And -- and consumers' ability to access that
17 information today.

18 Q. Okay. And I forget my question, but I'm
19 going to ask it again, so I apologize.

20 So it's your position that -- you tell me.
21 Is it your position that because the only place that
22 a consumer can figure out that a non-participating
23 hospital is being assigned the worst possible grade
24 is in the scoring methodology, the website is
25 confusing to consumers?

1 A. I think you're mischaracterizing what I
2 said.

3 Q. Okay. I may be.

4 A. First of all, I didn't use the word
5 "confusing." Second, and I was reading directly from
6 my report, and so it's in paragraph 72.

7 Q. Uh-huh.

8 A. Only 9 of the 38 locations mention
9 imputing data at all. Only four say that hospitals
10 would be given a score equivalent to limited
11 achievement from imputed measures, and so I think
12 that's what we were taking about, where TLG says that
13 hospitals be given a score equivalent to limited
14 achievement.

15 And then while there are four places, I'm
16 only aware -- I understand that only one of those
17 places, the methodology document, can be accessed
18 through TLG's hospital safety grade pages today.

19 And so my understanding is that this is
20 the only place today where consumers can access the
21 information. I've not seen any other places today
22 that consumers can access the information that says
23 that hospitals will be given a score equivalent to
24 limited achievement from imputed measures.

25 Q. Okay. And is this the only place you know

1 of today where the Leapfrog hospital safety grade
2 website says that a non-participating hospital will
3 receive the worst possible score for an imputed
4 measure? Are you aware of anywhere elsewhere it says
5 that?

6 A. I'm not sure what you mean by "worst
7 possible score." If what you mean is, is this the
8 only place there it says that hospitals be given a
9 score equivalent to limited achievement for the
10 imputed measures, then as I note, of these 38
11 locations, only four say that hospitals will be given
12 a score equivalent to limited achievement. And
13 further, of these four, I understand that only one,
14 the methodology document, can be accessed through
15 TLG's hospital safety grade pages today.

16 Q. And do you understand that "Limited
17 Achievement" means the worst possible score for that
18 measure?

19 A. I'm not sure what you mean exactly by
20 "worst possible score." And so I'm going to stick
21 with the language of "limited achievement" that I use
22 in my report which I -- I do have an understanding
23 of.

24 Q. Okay. And what's your understanding of
25 "limited achievement"?

1 A. Let me just go to the exact language I use
2 in my report because I want to be precise here.

3 Okay. So I note in paragraph 61, "In fall
4 2024, TLG changed its imputation methodology to
5 assign the 'lowest possible score' on the imputed
6 measure for hospitals that did not participate in its
7 survey and who did not have scores assigned in the
8 two previous rounds of grades. TLG refers to this
9 practice as assigning a score reflecting 'Limited
10 Achievement' on the measure." And it goes on to
11 provide more detail. So that is my understanding
12 of limited.

13 Q. Okay. And you're saying "lowest possible
14 score." I'm saying "worst score." Do you understand
15 those two things to be the same? If it's the lowest
16 possible, it's the worst? I am just using that same
17 language more colloquial than you are.

18 A. I'm just -- I'm just trying to be careful
19 here --

20 Q. Sure.

21 A. -- and make sure I understand what you're
22 saying. So I'm going to stick with the language that
23 was actually used if that's all right with you.

24 Q. Okay. So when you say lowest -- "limited
25 achievement," we both understand that to mean per

1 paragraph 61 of your report to be lowest possible
2 score, correct?

3 A. The lowest possible score on the imputed
4 measures for hospitals that did not participate in
5 its survey.

6 Q. And so to circle back -- you can tell
7 you're super precise and I'm not -- so I'm trying to
8 move it along, but I want to make sure.

9 A. I'm trying to do my job, so . . .

10 Q. No, you're doing great. I just want to
11 make sure that we're all using the same words.

12 And so just to circle back. Your position
13 is per paragraph 61 combined with paragraph 72 of
14 your report, that the only place today that you can
15 find on the Leapfrog hospital safety grade website
16 that a non-participating hospital is being assigned
17 limited achievement, which equates to the lowest
18 possible score, is in that methodology document that
19 you discuss on paragraph -- in paragraph 72 of your
20 report? Correct?

21 A. There were a lot of pieces in there.

22 Q. Sure.

23 A. And so I'm going to try to answer your
24 question. I don't think this is any different,
25 though, than what I've already said, which is my

1 understanding is that the only document of the four
2 documents that says that hospitals will be given a
3 score equivalent to limited achievement for imputed
4 measures, the only document that can be accessed
5 through TLG's hospital safety grade pages today is
6 the methodology document. And so that is the only
7 place I'm aware of through TLG's hospital safety
8 grade pages today that discuss how hospitals will be
9 given a score equivalent to limited achievement for
10 imputed measures that is accessible today through
11 TLG's hospital safety grade pages.

12 Q. And limited achievement we just saw in
13 paragraph 61 means lowest possible score from your
14 report, that's in paragraph 61 of your report, that
15 it is the lowest possible score. Correct?

16 A. That is in quotes "lowest possible score."
17 I want to make sure we agree on what we mean by
18 "lowest possible score." So --

19 Q. Yeah, it's your words.

20 A. -- lowest can vary by imputed measure.
21 For example, on specifically trained doctors care for
22 ICU patients, it's 5 out of 100. So I just want to
23 be clear. It may not be zero.

24 Q. Right.

25 A. It's 15 out of 100 for the measure hand

1 washing. That is the minimum possible score for this
2 measure, and so it's being assigned -- the lowest
3 possible score is being assigned reflecting limited
4 achievement on that measure.

5 Q. And do you know whether in paragraph 51
6 when you put "lowest possible score" in quotes, is
7 that -- does that come from somewhere on the Leapfrog
8 website or is that just your interpretation of
9 "limited achievement"?

10 MS. MALONEY: Objection.

11 THE WITNESS: Give me a second here. Let
12 me just go back to this paragraph.

13 I'm not going to be able to do this
14 without digging a little bit more, but I cite to
15 footnote 118 for this sentence. So either of
16 the two documents there may be using this
17 language "lowest possible score." I would need
18 to look.

19 BY MS. BLAIR:

20 Q. Okay. And if it's not in those documents,
21 which I think it is, but if it's not in those
22 documents, then the only explanation would be that
23 that's your interpretation of it; but if it's in the
24 documents, it probably comes from something that
25 Leapfrog has said somewhere. Correct?

1 A. I would want to go to the first place that
2 "lowest possible score" is discussed in this document
3 to get a better sense of where it comes from.

4 Q. Okay.

5 A. So that would probably take more time than
6 you're interested in me doing right now. But at
7 least for a cursory look for this particular
8 sentence, I'm citing to these two documents. And so
9 those --

10 Q. That's fine.

11 A. -- as well as, sorry, as well as -- yes.
12 And so that's -- I want to look there first.

13 Q. That's fine. And I'm just asking. I
14 mean, you're the expert. So I'm just wondering if
15 that's how you interpret it or it comes from some
16 sort of documentary evidence, so I'll look at the
17 documentary evidence that you cite.

18 A. Okay.

19 Q. Paragraph 42 on page 21 of your report
20 states that "TLG's hospitalsafetygrade.org repeatedly
21 states that TLG's Hospital Safety Grades measure
22 patient safety and quality of care."

23 Do you see that sentence?

24 A. I do.

25 Q. Do you dispute that that is what TLG's

1 hospital safety grades are attempting to measure?

2 A. I don't think I'm putting forward an
3 opinion about TLG's intent here, whether they're
4 intending to measure one thing or another. I am
5 merely noting that this website, TLG's -- one of
6 TLG's websites repeatedly states that hospital safety
7 grades measure patient safety and quality of care.

8 Q. Okay.

9 A. And so they are -- they are saying that.
10 I am noting that they are saying that. I am not
11 saying anything beyond that in this sentence.

12 Q. Okay. Perfect, thank you.

13 Do you know whether or not any of the five
14 hospitals that are plaintiffs in this litigation have
15 been A hospitals in the past five years?

16 A. I don't know that offhand.

17 Q. Have you performed any perception surveys
18 about how patients perceive a C hospital versus a D
19 hospital?

20 A. Again, there is very good data that
21 already exists on things like the question that you
22 asked. In paragraph 32, for example, I discuss a
23 study where participants were asked to make choices
24 between hospitals with different safety grades. And
25 there participants choose safer hospitals in

1 97 percent of the cost and safety scenarios which
2 gives us a good sense of how people would behave in
3 the situation that you asked. And so given that,
4 there's already such strong data out there including
5 studies modeled directly after TLG's hospital safety
6 grades and publicized on leapfrog.org. So the --
7 leapfrog.org is putting this information out there
8 and publicizing it, indicating that these types of
9 grades influence choices.

10 Q. And I understand that. But I guess my
11 question was a little more specific.

12 And we can talk about that Duke article as
13 well. I mean, if that's where it comes from. But
14 are you aware of what impact being a C hospital
15 versus a D hospital has on patient perception of a
16 hospital?

17 A. There is a good deal of literature that
18 shows and supports my suggestion, my opinion that D
19 and F hospital safety grades are likely to deter
20 consumers from both -- both negatively impact
21 consumer perceptions and deter consumers from
22 choosing plaintiffs' hospitals. I don't remember

23 offhand exactly what the difference is between a C
24 and a D in these studies. I would have to go look at
25 that to be sure.

1 But there's a lot of very strong data
2 including studies in exactly this context, including
3 studies modeled directly after TLG's own hospital
4 safety grades that demonstrate the impact of such
5 grades on both consumer perceptions and consumer
6 choice.

7 Q. Okay. And you say, you continue to use
8 "likely deter," and I'm just curious whether you have
9 any empirical data about how much the difference
10 between a C and a D hospital impacts consumer
11 perception?

12 A. I wasn't asked to answer that specific
13 question. And so I did not answer that specific
14 question.

15 But I did answer the specific questions I
16 would ask -- I was asked, and that analysis leads me
17 to conclude -- leads to -- my expert opinion to
18 conclude that D and F grades deter consumers from --
19 shape -- negatively impact consumer perceptions and
20 deter consumers from choosing plaintiffs' hospitals.

21 Q. And if I look at paragraph 32 that you
22 just talked about, you rely heavily on this Duke
23 article from 2017. Correct?

24 MS. MALONEY: Objection.

25 THE WITNESS: I don't think I rely heavily

1 on it. I think in that paragraph, that
2 paragraph is about that article, and so that
3 paragraph discusses that article. In the two
4 paragraphs prior to that, I think I cite -- I
5 don't know whether it's six or more articles
6 that show similar things using slightly
7 different data. So I don't heavily rely on this
8 article one way or another. It's just what I
9 discuss in paragraph 32.

10 BY MS. BLAIR:

11 Q. Okay. But what -- if you're not heavily
12 relying on these articles, what are you relying on to
13 come to the conclusion then in paragraph -- well, to
14 your conclusions in section -- I think it's VI(a),
15 right, that third-party ratings have been found to
16 affect consumer decision making? You're relying on
17 these articles, are you not, that you cite?

18 A. I'm relying on the set of articles that --
19 and anything else I discuss in this section to make
20 the point of that section. I'm not heavily relying
21 in particular on one study versus another. And there
22 isn't only one study. There are, you know,
23 potentially over ten different studies discussed in
24 this section that show very similar things. And so I
25 was just pointing out you said "heavily relying" in

1 paragraph 32. Paragraph 32 is about that particular
2 study, but it's not the only study I cite in this
3 section.

4 Q. True. And I just want to make sure that
5 how -- in your field of expertise, at what point in
6 time does a study or academic literature become
7 stale? In other words, some of these articles go
8 back to 2004 about surveys that were conducted. Is
9 there some sort of standard in your economic -- not
10 economic -- academic world where a study becomes
11 stale and shouldn't be relied on any more?

12 A. That's a hard question to answer in
13 general. Because while in some cases things might
14 change over time, in other cases they don't. And so
15 there's not a statute of limitations per se on
16 studies in general. It depends on the specific
17 context one is considering.

18 And in this context, many of these studies
19 are quite recent. Some of them are less recent, but
20 still quite recent compared to older literature one
21 could look to. And I have seen nothing in more
22 recent literature to cast doubt on the findings of
23 any of these papers that I'm citing to make this
24 point.

25 And so given all that, all of them seem

1 both relevant and useful to answering this question.

2 Q. Okay. But none of these conclusions that
3 we find in, you know, paragraph -- well, you referred
4 to paragraph 32, but it's Section VI(a) of your
5 report, none of those ultimate conclusions for your
6 expert opinion come from any focus group or consumer
7 survey that you conducted with respect to the likely
8 impact of hospital safety grades on consumer choice.
9 Correct?

10 A. I think we've already tread this ground a
11 number of times.

12 Q. I know.

13 A. No, I did not conduct a survey or focus
14 group. These studies did whatever they did. If
15 you'd like me to focus on a specific one, I'm happy
16 to dig into it and discuss it with you, but these
17 studies are more than sufficient to make -- given --
18 given these studies, how many studies there are, how
19 strong the analyses are in these studies, the
20 journals they're published in, the quality of the
21 work, there isn't a need to do an additional survey
22 or focus group to make this point. The studies
23 already make the point, and I summarize those points
24 in my -- my opinions in the bold sections like VI and
25 VI(a).

1 But yes. So given that, I didn't see the
2 need to conduct an additional focus group or survey.

3 MS. MALONEY: Again, not to interrupt your
4 flow, but if you want to figure out when to take
5 a break since it's 12:30?

6 MS. BLAIR: Oh, it's only 11:30 here.
7 Sorry. I'm in Chicago.

8 MS. MALONEY: Right, but it's also been
9 over an hour I think.

10 MS. BLAIR: Yeah, yeah, yeah. We can take
11 a break now. Is now -- I mean, I don't care.
12 That's fine. How does everyone else --

13 MS. MALONEY: Do you want to take a short
14 break or does the court reporter want a lunch
15 break now or what? We've been going for about,
16 you know.

17 THE WITNESS: My preference would be for a
18 relatively short break, but if someone else
19 wants more, that's fine, but ten minutes is
20 enough for me.

21 MS. MALONEY: Okay. And the court
22 reporter?

23 COURT REPORTER: Yes, that's fine.

24 MS. BLAIR: Can we go back on the record
25 at your time at 12:45? I have to make some

1 calls in other cases, and I can't promise they
2 will be only 10 minutes, but I can promise --

3 THE WITNESS: Sure. Sounds good. See you
4 at 12:45.

5 MS. BLAIR: 12:45. Thank you.

6 VIDEOGRAPHER: We're off the record at
7 12:31.

8 (A recess transpired from 12:31 p.m.
9 until 12:51 p.m.)

10 VIDEOGRAPHER: I'm going to do a short
11 read on. One moment.

12 This begins file number 2. We're back on
13 the record for the deposition of Dr. Jonah
14 Berger. The time is 12:51 p.m.

15 BY MS. BLAIR:

16 Q. Hi, Dr. Berger. Kim again. Again, if you
17 need to take a break at any other time, please just
18 let me know. I'm not trying to make this an
19 endurance test, and I'm hopefully getting to the end
20 here, so. It's just a dense report.

21 I think we talked about this earlier and I
22 just wanted to circle back to it so I want to make
23 sure I understand.

24 You're not providing any opinions about
25 whether or not Leapfrog's hospital safety grade

1 website display is any more or less transparent than
2 its peer safety grade or rankings websites. Correct?

3 A. That is not a question I was asked to
4 opine on and so I'm not putting forth an opinion on
5 that matter.

6 Q. Perfect.

7 Turning to page 27 of your initial report.
8 And this is Subsection D. "TLG Presents the Four
9 imputed Measures as Fundamental Aspects of Medical
10 Care."

11 Do you see that?

12 A. I do, yes.

13 Q. Are you offering any opinions as to
14 whether or not those measures are in fact fundamental
15 aspects of medical care?

16 A. I was not asked to opine on whether they
17 are fundamental measures of medical care or not. I'm
18 merely noting that TLG presents them as such.

19 Q. Excellent. Thank you.

20 A. And frames its hospital safety grades as
21 essential inputs to consumers' hospital choices.

22 Q. Can you repeat that answer? I don't think
23 I understood it.

24 A. It's just -- it's just the second half of
25 D. So "TLG Presents the Four Imputed Measures as

1 Fundamental Aspects of Medical Care and Frames its
2 Hospital Safety Grades as Essential Inputs into
3 Consumers' Hospital Choices."

4 Q. Right. And so when we look at that
5 title -- and I'm just making sure I understand your
6 report.

7 When we look at that title D, that's not
8 an opinion; you're just stating that's what Leapfrog
9 says? Is that a fair assessment?

10 A. Leapfrog presents the imputed measures as
11 fundamental aspects of medical care and frames the
12 grades as essential inputs, and I detail the support
13 for that point below.

14 Q. Okay. And when you say "frames the grades
15 as essential inputs into consumers' hospital
16 choices," what do you mean as "essential inputs"?

17 A. Give me a second to look at the exact
18 details of these paragraphs.

19 Q. Sure.

20 A. So as I note in paragraph 52, for example,
21 "TLG presents hospital choice not only as important
22 to consumer safety, but as a matter of life," and I
23 provide quotes that TLG -- things that TLG said like,
24 "Your choice of hospital could be a life or death
25 decision."

1 "Your risk of dying depends on the
2 hospital you choose," in all capital letters.
3 Further, they present TLG's hospital safety grades as
4 the primary piece of information consumers should use
5 in choosing a hospital, for example. And this is
6 reading from a TLG quote, "When they have a choice,
7 the Hospital Safety Grade is the first tool patients
8 should use to select the hospital, because safety
9 should come first."

10 And so across hospitalsafetygrade.org, TLG
11 encourages consumers to rely on both its grades and
12 some of its imputed measures as essential inputs into
13 their hospital choices.

14 Q. Okay. But would you agree with me that
15 Leapfrog believes all of the measures that go into
16 its grades are essential inputs into consumers'
17 hospitals choices?

18 A. Can you ask that question one more time?
19 I want to make sure I --

20 Q. Sure. Well, let me lay a little
21 foundation. So if we look at the website, there are
22 32 measures, correct, that are displayed on the
23 Leapfrog hospital safety grade website, and you
24 mention in your report on multiple occasions it's in
25 the categories of infections, problems with surgery,

1 safety problems, practices to prevent errors, and
2 doctors, nurses, and hospital staff, right? There
3 are 32 measures if we count those up. Correct?

4 A. So in addition to the overall grade that
5 appears at the top of the page and thus everyone
6 should see it when they open a given page, in
7 addition, there are a variety of submeasures that
8 make up that overall score.

9 Q. Right.

10 A. Yes.

11 Q. And I just want to make sure in this
12 Section D that it's not your position that only the
13 four imputed metrics are essential inputs, but all of
14 those measures would be essential inputs to the
15 Leapfrog safety grade?

16 A. Let's split up the sentence that's --

17 Q. Sure.

18 A. -- listed in D. "TLG Presents the Four
19 imputed Measures as Fundamental Aspects of Medical
20 Care." So I'm noting that TLG presents those four
21 measures as fundamental aspects of medical care. I
22 am not speaking in that sentence about the other
23 measures and saying whether or not they are also
24 fundamental. I'm merely noting that TLG presents the
25 four imputed measures as fundamental aspects of

1 medical care.

2 And the second half of that sentence
3 "frames its hospital safety grades as essential
4 inputs into consumers' hospital choices." Those are
5 about the grades themselves rather than about
6 individual measures.

7 Q. Okay. And my question is, in coming to
8 your conclusions or opinions that the safety grade
9 impacts consumer perception, is it your position, and
10 I'm just making sure I'm reading this correctly, that
11 Leapfrog puts an undue emphasis on these four imputed
12 grades? Is that why you drafted it this way?

13 A. Sorry. I am -- thank you. Fair question.

14 Q. Yeah.

15 A. I am not either suggesting they do -- do
16 or do not have. I'm not speaking about whether they
17 have undue impact compared to the other measures --

18 Q. Okay.

19 A. -- one way or another. That is not what
20 I'm saying.

21 What I'm saying in this whole broader
22 section, of which D is a subsection of, is that these
23 grades, D and F grades, that TLG provides likely
24 deter consumers from choosing patient hospitals.

25 One reason, as we've talked about already,

1 is that third-party ratings, like these grades, have
2 been found to affect consumer decision making. But
3 another reason, as I'm detailing in Section D, which
4 we are discussing now, is that in addition to the
5 other subsections, I've discussed already, TLG
6 presents these imputed measures as fundamental
7 aspects of medical care and framed safety grades as
8 essential inputs into consumers' hospital choices
9 which should encourage consumers to rely on this
10 information when making decisions, in addition to
11 what we already know from the literature and other
12 things that I discussed previously.

13 Q. Okay. Do you have an opinion about
14 whether or not consumers should be dissuaded from
15 going to F hospitals or not?

16 A. I was not asked to opine about whether
17 consumers should or should not be dissuaded from
18 choosing F hospitals. And so I don't have an expert
19 opinion on that issue.

20 Q. Okay. Your opinion is just consumers are
21 dissuaded from going to D and F hospitals?

22 A. TLG's D and F hospital grades likely deter
23 consumers from choosing plaintiff hospitals.

24 Q. Okay. But you have no opinion about
25 whether that's reasonable to dissuade consumers from

1 going to D and F hospitals or not?

2 A. That question -- I want to be a little
3 careful there. That question presumes that these
4 hospitals deserve to be D or F hospitals which is not
5 a question that I was asked to opine on and so is not
6 one I'm putting forth an expert opinion on. I'm
7 merely noting that these D and F hospital grades that
8 TLG gave plaintiffs' hospitals are likely to deter
9 consumers from choosing plaintiff hospitals.

10 Q. Okay. And would you agree with me that
11 when you look at this website, that Leapfrog does not
12 emphasize any one or subset of measures over other
13 measures that it's looking at to make the
14 determination of the hospital safety grade?

15 A. That wasn't a question that I was asked to
16 opine on and so I'm not putting forward an opinion
17 one way or the other on that issue I don't think.

18 Q. Okay. Well, I'm looking at, for example,
19 I just want to make sure I'm clear.

20 So paragraph 51 you say --

21 A. Uh-huh.

22 Q. Oh, sorry. Are you there?

23 A. Yes.

24 Q. 51. Okay. It says, "Specific to the
25 imputed measures, hospitalsafetygrades.org frames

1 some as fundamental aspects of medical care and
2 encourages consumers to weigh these measures more
3 heavily when making their decisions."

4 Do you see that?

5 A. Just a second.

6 I see what you're saying, yes.

7 Q. Okay. And did -- well, my first question
8 is, which ones of these measures are consumers
9 encouraged to weigh more heavily than the others?

10 A. Sorry. I think the way -- I think the
11 confusion is around the way the word "more" here,
12 what work the word "more" is doing. So I believe the
13 way that I'm using the word "more" here, which I
14 think is different than the way you're interpreting
15 it --

16 Q. Okay.

17 A. -- is for hand washing, for example, TLG
18 states that "The safety grade rates hospitals on the
19 very basics of medical care such as hand washing,
20 entering prescriptions through the computer," and so
21 on. And lists hand washing as one of three most
22 important measures.

23 So this is just what TLG is doing. I'd
24 have to go -- I'd have -- I do not have the full
25 language in front of me, the hospital website in

1 front of me as it discusses this. So I want to be
2 careful about saying more without looking at it. But
3 this is what TLG says about hand washing.

4 Similarly, for specifically trained doctor
5 care for ICU patients, it says, "If you're concerned
6 about a seriously-ill patient -- parent or family
7 member, you can look at ICU staffing protocols and
8 how the hospital uses computerized prescribing and
9 bar-code technology to keep patients safe from
10 medication errors."

11 And so what I'm saying, for example, for
12 that specific statement is they're saying this is
13 important. It should impact your decision making and
14 here's why.

15 Q. And are you aware that when you click on
16 any one of these measures, it has a blurb like that
17 about why that measure is important, whether it's an
18 imputed measure or not?

19 A. I'm sorry. So I want to be a little
20 careful here. I don't have everything in front of
21 me --

22 Q. Of course.

23 A. -- and I can't speak to other measures
24 that are not in front of me at the moment.

25 VIDEOGRAPHER: Dr. Berger, your camera

1 went off.

2 THE WITNESS: Me?

3 MS. BLAIR: Yeah.

4 VIDEOGRAPHER: Yes, sir.

5 THE WITNESS: Oh, sorry. I must have
6 moved this little icon over to scroll down. I'm
7 sorry.

8 Is it back on?

9 MS. BLAIR: Yes.

10 THE WITNESS: Yes. Okay. Great.

11 Sorry, give me one second. What was I
12 doing here? I was take a looking paragraph 51.
13 Hold on.

14 So I'm aware that for the hand washing
15 discussion, for example, hand washing is listed
16 as one of the three most important measures on
17 this page that I cite to in footnote 96. And I
18 believe it's titled, you know, "What Measures
19 Are Most Important?" And it lists hand washing
20 under those.

21 And so I don't remember the language that
22 describes every single page. I'm simply noting
23 that for the imputed measures,
24 hospitalsafetygrade.org frames them as
25 fundamental aspects of medical care and

1 encourages consumers to weigh them more heavily
2 when making their decisions.

3 BY MS. BLAIR:

4 Q. Okay. And so did you have the occasion
5 when you were putting together these opinions to look
6 at the content on the Leapfrog website with respect
7 to the other measures and the description of those
8 measures and why they're important to patient safety
9 or did you only look at the four imputed measures?

10 A. I have certainly considered some of the
11 other measures. I don't remember the specific
12 language of all the measures. There are a lot of
13 them and there's a lot of language on the site.

14 Q. Of course. But would you agree with me
15 that each measure has a blurb advising consumers as
16 to why that measure is important in reviewing patient
17 safety?

18 A. I'm sorry. I -- I think that every
19 measure has a blurb. I don't remember exactly what
20 each of those blurbs says. And so I -- I can't speak
21 to what all of them say. I can only speak to what
22 the ones in front of me say.

23 Q. Okay. And just so we're clear on that use
24 of "more," you were referring to the hand washing
25 blurb which says, "Hand washing as one of the three

1 most important measures," but when you look at the
2 next bullet point "Specifically trained doctors care
3 for ICU patients," it does not say that's one of the
4 most important measures. Correct?

5 A. Correct.

6 Q. Okay. So when we use --

7 A. I don't believe so from the quote that's
8 in front of me. I'm happy to look more, if there's
9 other language you want me to look at, but at least
10 from in front of me, I don't -- I don't see that.

11 Q. Okay. And so I'm just making sure that we
12 understand the use of "more." It's not your position
13 that the website is deceptive because Leapfrog has --
14 is telling consumers that the four measures with
15 imputed grades are the most important measures?

16 A. I want to be careful. I don't believe I
17 used the word "deceptive" in my report.

18 Q. Oh, sorry. My word.

19 A. That specific word. I can look and check,
20 but I don't believe I used the word "deceptive" in my
21 report.

22 And in this particular section, I'm merely
23 noting that TLG is encouraging consumers to pay
24 attention and potentially weigh this information when
25 making their choices. As we've talked about already,

1 they're saying that this is a life-or-death decision.
2 Hospital safety grades are important. You should use
3 these grades to rely on to choose hospitals. And
4 thus given that, it's not surprising that D and F
5 grades, TLG's D and F grades likely deter consumers
6 from choosing plaintiffs' hospitals.

7 Q. And you make a good point that you don't
8 use the word "deceptive." And you pointed out
9 earlier to one of my questions that you don't use the
10 word "confusing."

11 So what word would you use, if any, to
12 describe Leapfrog's website and the way in which it
13 communicates information to a consumer?

14 A. I'm not completely sure how to answer that
15 question. We've already gone over what my opinions
16 are. I have told you what my four main opinions are.
17 I don't know what else I have to say based on that.

18 Q. Sure. And I guess -- so if we look at
19 Roman numeral VIII, you say, "Many consumers would be
20 unlikely to understand." Right? This is the
21 heading. "Unlikely to Understand that TLG Assigns
22 the Minimum Score on Imputed Measures." That's the
23 first half of that heading.

24 And so I understand "unlikely to
25 understand." But you said it's not confuse -- you

1 wouldn't use the word "confused." And you wouldn't
2 use the word "deceptive." And so I guess I'm just
3 trying to figure out like where we land on this
4 spectrum of your opinion?

5 MS. MALONEY: Objection to form.

6 THE WITNESS: I'm just trying to be
7 precise here. I want to make sure that when you
8 use words, even if unintentionally, to state
9 things that I'm saying in my report, I'm using
10 the exact words I'm using in my reports because
11 I used those words likely for a reason. And so
12 opinion VIII is that many consumers would be
13 unlikely to understand both the TLG
14 understands -- assigns the minimum score on the
15 imputed measures and the impact of this practice
16 on safety grades that they assign to
17 non-participating hospitals.

18 BY MS. BLAIR:

19 Q. In your expert opinion, if a consumer is
20 unlikely to understand something, are they confused
21 by it or not necessarily?

22 A. I don't know the way in which you're using
23 the word "confused." I don't know the standard, the
24 legal standard that is applied to confusion and what
25 counts as confusion and does not. I -- my expert

1 opinion is based on the things I feel like I can
2 opine on. And so I have used the language that I
3 understand based on my area of knowledge to best
4 characterize what I understand to be going on.

5 Q. Okay. And so then it was your intention
6 to not use the word "deceptive." Correct?

7 A. I don't know that it was my intention not
8 to use the word "deceptive." I just used language
9 that reflected what I thought accurately reflected my
10 opinion.

11 Q. Okay. But you didn't use the word --
12 you're a very precise man, Dr. Berger, so I want to
13 make sure. You did not use the word "confused" in
14 this report. Correct? You corrected me on that
15 earlier.

16 A. I certainly didn't think that for the
17 thing we were talking about, I had used that word.
18 And I can try to look throughout the whole report to
19 see. I know, for example, when we discussed earlier
20 what TLG's -- the feedback TLG received regarding its
21 minimum score assignment, they acknowledged
22 themselves that consumers might misinterpret the
23 scores.

24 Q. Right, right, right.

25 A. Measures.

1 Q. In your opinion. In your opinion you
2 don't use the word "confused"?

3 A. I don't -- I don't believe so. But I'd
4 have to look to be sure.

5 Q. And then you just corrected me, rightfully
6 so, when I used the word "deceptive" because you
7 don't use that word in your opinion either. Correct?

8 A. I don't believe so. I'd have to look to
9 be sure, but I certainly don't use it in regards to
10 the sentence that I think you were using it regarding
11 one of my opinions.

12 So, again, I -- what I'm not saying is
13 that I avoided using those words necessarily. But I
14 chose words that I thought were reflective of my
15 opinion, and so those were the words that I chose.

16 Q. Okay. And so if you didn't use words like
17 "deceptive" or "misleading," those were not words
18 that you chose at the time you wrote your opinion to
19 accurately reflect your opinions, correct?

20 A. I want to be very careful here. Saying
21 that something the website did was not deceiving, I
22 am not saying that consumers were not misled or
23 confused. I am saying that I used the language that
24 I used because I felt that the language accurately
25 reflected my opinions; and whether those opinions are

1 used more broadly in this case to speak to issues of
2 the case on legal definitions or measures or lines, I
3 can't speak to that. But I'm not saying these aren't
4 those things. These opinions don't speak to those
5 questions.

6 But I was asked to opine on the issues I
7 was asked to opine on. And this is the language I
8 used to express those opinions.

9 Q. Okay. And this is the language you're
10 going to use to express these opinions in this case
11 at the time of trial, correct?

12 MS. MALONEY: Objection.

13 THE WITNESS: I think we've gone through
14 this at least one round already, and I think
15 what I said at that point, which I will say
16 again here, which is that I am aware that this
17 matter is ongoing and reserve the right to
18 adjust or augment things based on things that
19 occur moving forward. I don't have intentions
20 one way or another, but if asked to speak at
21 trial, I would certainly be willing to. And I
22 don't have anything else to add.

23 BY MS. BLAIR:

24 Q. Okay. But I should take the language in
25 this report for what it is, that you used this

1 language because you felt it was the right language
2 for your opinions when you wrote this report.

3 Correct?

4 A. I think more precisely than that, it is
5 language that I am familiar with and familiar with
6 the meaning of in my area of expertise to represent
7 what I think occurred in relation to the questions I
8 was asked to speak to. Whether or not the way I
9 phrased this opinion is similar to other things in
10 legal definitions or speak to legal questions in this
11 broader case, I am not intending to speak to at the
12 moment.

13 That's not -- I'm not a lawyer. That's
14 not my expertise. I'm not saying these -- these
15 opinions don't speak to those broader questions. I'm
16 merely suggesting that I use the words I used in my
17 report.

18 Q. Okay. So paragraph 29 -- I'm sorry.
19 Page 29 of your report, and this is heading VII,
20 "Future, Repeated Publications of 'D' or 'F' Hospital
21 Safety Grades Would Be Expected to Have" --

22 A. Hold on.

23 Q. Can you not hear me?

24 A. Can you just give me a paragraph number so
25 I can go there?

1 Q. Oh, I'm sorry. It starts with paragraph
2 55 is the first paragraph in that section. Page 29.

3 A. Okay. Great, go for it. Paragraph 59.

4 Q. Yeah.

5 So I just want to talk kind of this
6 overall opinion you have that "Future, Repeated
7 Publications of 'D' or 'F' Hospital Safety Grades
8 Would be Expected to Have a Long-term, Negative
9 Impact on Perceptions of and Choice for Hospitals."

10 That's your opinion. Correct?

11 A. Correct.

12 Q. Okay. And do you -- would you agree with
13 me that a hospital has the ability to improve its
14 grade in the future?

15 A. That's a general question that I can't
16 speak to. I don't know whether the methodology is
17 going to be the same or different. There's a variety
18 of assumptions underlying that question. So I -- I
19 can't answer that one way or the other.

20 Q. Well, let me ask it this way: If these
21 five hospitals got As in the fall safety grade, would
22 you agree with me then that your opinion at Roman
23 numeral VII would no longer be applicable?

24 A. I'm not sure that's the case.

25 Q. Okay. And why are you not sure that's the

1 case?

2 A. If they got an A next time but then got D
3 and Fs after that forevermore, those long-term --
4 those future repeated publication of D and F grades
5 would still be expected to have long-term negative
6 impacts.

7 Q. Okay. And so one of the things you talk
8 about in this report is like going back and you can
9 see like the last five grades. Right? When you go
10 in on the hospital safety website and you click on
11 the grade, you can see past grades. You talk about
12 that in your report. Correct?

13 A. Exhibit 5, yes.

14 Q. Yes.

15 And one of the things you talk about in
16 this section is that seeing those past grades, right,
17 either continually decline or, you know, stay the
18 same as Ds and Fs can have a long-term future impact
19 on perceptions of and choice of plaintiffs'
20 hospitals. Correct?

21 A. I say that "Future, Repeated Publication
22 of 'D' or 'F' Safety Grades Would be Expected to Have
23 a Long-term, Negative Impact on Perceptions of and
24 Choice of Plaintiffs Hospitals."

25 Q. Okay. And so I'm just trying to figure

1 out, if the plaintiffs' hospitals got As in the
2 future, would that not have an impact, a positive
3 impact on perceptions of and choice for the
4 plaintiffs' hospitals?

5 A. I think -- you just asked me a version of
6 that question.

7 Q. Yeah.

8 A. I would need to understand more of the
9 specific circumstances that you're talking about
10 before I would be able to provide an expert opinion
11 there. Here I am merely suggesting that future
12 repeated replications of D or F grades would be
13 detrimental in the way I'm discussing.

14 Q. Okay. So you're not offering any opinions
15 about whether or not these five plaintiff hospitals
16 could avoid future injury? You're just saying if
17 they continue to get Ds and Fs, they will have a
18 future repeat -- future impact on perceptions of and
19 choice for patient hospitals? Is that a fair
20 assessment?

21 A. I think the most fair assessment is that
22 future repeated publications of D or F hospital
23 safety grades would be expected to have a long-term
24 negative impact on perceptions of and choice of
25 plaintiff hospitals.

1 Q. Do you have any opinions about whether or
2 not these five hospitals could improve their
3 performance such that their grades of D and Fs could
4 be avoided in the future? Do you have any opinions
5 on that?

6 A. That's not a question I was asked to
7 consider, and so I -- I have not thought enough about
8 it to put forward an expert opinion.

9 Q. So you have no opinion on that?

10 A. I think, as I just said, I was not asked
11 to consider that question, and so it's not something
12 I've thought about it in detail and would need to
13 think about it more to provide an expert opinion.

14 Q. But as we sit here today, you don't have
15 an expert opinion. Correct?

16 MS. MALONEY: Objection to form.

17 THE WITNESS: As we sit here today, I was
18 not asked to opine on the specific question, and
19 so I've not thought about it in detail, and so I
20 would need to think about it in detail to
21 provide an expert opinion.

22 BY MS. BLAIR:

23 Q. Are you planning on thinking about it in
24 detail in the future to provide an expert opinion?
25 I'm not trying to be clever. I'm just trying to

1 close the loop.

2 A. I understand. Again, as I've tried to say
3 already, and I understand you're doing your job; I'm
4 trying to do mine. I do not have plans one way or
5 the other. I'm aware that things are ongoing at the
6 moment. I have no plan to conduct or put forward
7 such an opinion. But I am aware that things in this
8 matter are ongoing, and so I reserve the right to
9 update or augment my opinions based on, you know,
10 things that happen in the future.

11 Q. Fair enough.

12 Paragraph 56, you talk about TikTok videos
13 posted by user True Stories. Correct?

14 A. I talk in particular about one TikTok
15 video posted by True Stories, yes.

16 Q. Okay. And you've watched that video I
17 presume?

18 A. Yeah, I have consumed a lot of content
19 related to this case. I don't remember all the
20 details of this video, but I believe I have watched
21 it, yes.

22 Q. Do you know -- would you agree with me
23 that there's no specific reference to Leapfrog in
24 that video?

25 A. I have -- I do not remember, sorry, one

1 way or the other.

2 Q. Did you read any of the comments that are
3 attached to that TikTok video?

4 A. I don't remember. But just to be clear,
5 whether or not the video mentions Leapfrog in
6 particular, I believe this video uses TLG's fall '24
7 hospital safety grades to create a list of the worst
8 hospitals in Florida, lists four of the five
9 plaintiff hospitals among the top worst hospitals in
10 Florida and gets some views, likes, comments, and
11 shares that diffuse this information to a broader set
12 of people.

13 Q. And you believe that they use the Leapfrog
14 hospital safety grades based on what?

15 A. I -- I don't remember. I have not watched
16 the video in preparation for this deposition. I
17 would have to go back and watch it to remind myself.

18 Q. And when you go through the comments of
19 this TikTok video, do you see any mention of Leapfrog
20 to your recollection?

21 A. I don't remember.

22 Q. And do you remember reading any of the
23 comments -- well, let me put it this way: You talk
24 earlier in this -- in this opinion about the fact
25 that -- you know, Yelp reviews, we talked about that.

1 Yelp reviews and things like that can have an impact
2 on consumer perception. Correct?

3 A. Uh-huh.

4 Q. And would you agree with me that comments
5 on social media --

6 A. Can you hold on one second? Sorry. Can
7 you hold on one second? I should be -- I should be
8 precise here. Give me one second.

9 Q. Yeah, sure.

10 A. I think I said yes to something where I
11 should have been a little more careful. Give me one
12 second. Because you asked about the Yelp -- Yelp
13 study specifically, right?

14 Q. Yeah, it's 30 --

15 A. Yeah. And so if that's in paragraph 30,
16 that was a study that talked about decision making
17 and choices. That's what that study focused on.
18 Impacts on patients' willingness to travel to receive
19 care from hospitals with a higher Yelp rating.

20 Q. Right.

21 And in this report, though, you talk in
22 other places about -- I'll find it -- about the
23 impact that patient perceptions can have in reviews
24 on the perception of the hospital. And I will
25 attempt to find that.

1 A. I do have a section in my report which
2 talks about how hospital safety grades likely impact
3 consumer perceptions. That's Section V. And I talk
4 about how third-party ratings can influence consumer
5 perceptions, yes.

6 Q. Okay. And are other patients' ratings of
7 hospital considered third-party ratings in your mind,
8 or in this report I should say?

9 A. I'm not sure what you're referring to when
10 you say "other patients' ratings of hospitals."

11 Q. Well, Yelp review. "I went to this
12 hospital, I give it a one star. It's terrible." Is
13 that considered a third-party ranking in your report?
14 I'm just trying to understand what we mean by
15 "third-party rankings."

16 A. Yeah. So in paragraph 30, I discuss a
17 2022 study examining the effect of Yelp star ratings
18 which are made by individuals on hospital admissions
19 in Florida.

20 Q. Okay. And so if you look at the TikTok
21 comments to this video, are you aware that people are
22 commenting about specific hospitals and their patient
23 experience?

24 A. Again, I don't remember the exact details
25 of all the comments.

1 Q. As an expert in marketing, what impact do
2 social media comments like that have on a consumer's
3 perception of a good or service?

4 A. I don't know what these comments said. I
5 don't know how many people chose to read the
6 comments. So I want to be a little bit careful about
7 answering with more detail than I have available to
8 me. The only point I'm making here is that things
9 like this negative -- this review, I'm sorry, or
10 video I should say, about the list of the worst
11 hospitals in Florida, which uses TLG's hospital
12 safety grades includes a number of plaintiffs'
13 hospitals, had over a million views, and so exposes
14 people to information about these hospital grades.

15 Q. Yeah, and I guess my question is a little
16 more like general in terms of -- in terms of in the
17 world in which you operate, you know, the expertise
18 of marketing, a world I do not operate, which I
19 assume the landscape today in 2025 looks
20 significantly different than it did in, say, 2000
21 when I graduated from law school in that we didn't
22 have all this social media and individual commentary
23 that could, you know, explode on the scene and be
24 seen by millions of viewers.

25 And so I'm curious as to whether or not

1 the academic marketing literature takes a position
2 about the impact of social media comments and reviews
3 on perceptions of consumer goods and services?

4 A. Well, let's be careful. Consistent with
5 what we've talked about already, it's not just about
6 whether reviews and comments in general do or don't
7 have an impact. It depends on whether people see
8 those reviews or comments.

9 This video was -- had over a million views
10 suggesting that a decent number of people, at least
11 some number of people, saw it, was exposed to this
12 information.

13 Your original question was about the
14 comments and whether the comments had an impact. And
15 my answer then, consistent with what my answer is
16 now, is the first question is, did anyone see those
17 comments? And that's a question I don't know the
18 answer to, and so I can't speak about in detail in
19 this context.

20 Q. Okay. And I guess my question is just
21 generally how has the academic literature and science
22 around marketing developed with respect to the impact
23 of social media comments on the perception of
24 consumer goods and services?

25 A. I'm going to answer this question the same

1 way I just did, which is not it's not whether
2 comments always have an impact or not. It depends on
3 whether people see them.

4 Q. Okay.

5 A. So if nobody sees something, it's going to
6 be hard for that to have an impact. If more people
7 see something, there's more opportunity for that
8 thing to have an impact. But it still may or may not
9 have an impact. And so without knowing the specific
10 thing we're talking about and having specific details
11 to help us, I can't speak on that in detail here.

12 Q. Okay. And I guess it's sort of like the
13 hospital safety grades. It would depend on how many
14 people see them, and even if they see them, if it had
15 an impact at all on their perception. Right? I
16 mean, isn't that the same about viewing a website as
17 you just told me about viewing comments on social
18 media?

19 A. Well, let's be careful here. So people
20 not only saw these hospital safety grades on the
21 website. There were also hundreds of articles in
22 hundreds of different publications with a reach of
23 around 59 million people who saw TLG hospital -- or
24 sorry. I should say TLG publicized its hospital
25 grades issuing press releases that generated hundreds

1 of articles in hundreds of publications with a reach
2 of 59 million people.

3 And so my only point there is that the
4 grades are not only being seen potentially by
5 visitors to the website, they may be seen through
6 videos that people post about the grades as we just
7 discussed on TikTok that got them a million views, or
8 news articles that discuss the grades, which, as I
9 discuss in a prior paragraph of my report, the
10 hospital safety grades generate a number of online
11 articles in many publications with reaches of tens of
12 millions of people.

13 Q. Right. And just like a comment on TikTok,
14 it may have been the ability to reach 54 million
15 people, but that doesn't mean that actually
16 54 million people saw it or were influenced in any
17 way by it. Correct?

18 A. I'm not saying that 59 million people
19 necessarily saw the grades of each of these
20 hospitals. I'm just pointing out that even beyond
21 the website, there are other channels through which
22 information can diffuse.

23 Q. Right.

24 And do you know this TikTok video, do you
25 understand it was AI generated?

1 A. I do not remember exactly what the video
2 looked like. I can't speak to the content of the
3 video without having it in front of me one way or the
4 other.

5 Q. Okay. And did you look at or analyze in
6 any way the number of views and how many of those
7 were bots versus actual real consumers?

8 A. I wasn't asked to analyze that question in
9 particular and so that's not something I did here.

10 Q. Okay. On page 30 of your report,
11 paragraph 58, you have a line, I guess it's the third
12 full sentence. And it starts, "Repeated exposure to
13 information can result in the belief that the
14 information is true (known as the 'illusory truth
15 effect')."

16 Can you explain to me sort of in your own
17 words what the "illusory truth effect" is?

18 A. As I state here, it describes the tendency
19 of repeated information to be perceived as more true.

20 Q. Okay. But what if it is true? Is it
21 illusory if it's actually true? I mean, I guess
22 that's where I fell off the understanding the
23 sentence. Illusory means it's not really true, but
24 people are perceiving it as true. Right? The word
25 "illusory."

1 A. Just the point that a tendency of repeated
2 information is perceived as more true, and so
3 repeating information can make it seem more true.

4 Q. Okay. So you don't have an opinion about
5 whether or not it's true that any of these hospitals
6 are unsafe. You're just commenting that in the
7 science of marketing, this illusory truth effect
8 exists. Is that a fair analysis?

9 A. My point here in this section or
10 subsection is that a "Future publication of lower or
11 failing Hospital Safety Grades for Plaintiffs
12 Hospital may cause consumers who had already been
13 exposed to this information to see it repeatedly, and
14 research has shown that repeated exposure can
15 increase the persuasiveness of information."

16 Q. Okay. But it has nothing to do with
17 whether or not it's actually true. This analysis is
18 just, if you hear it enough times, you will accept it
19 as true, whether it is or isn't. Is that a fair
20 statement?

21 A. I'm not opining in this section about the
22 truthfulness of the information one way or the other.
23 I'm merely highlighting that repeated exposure can
24 increase the persuasiveness of information and make
25 it seem more true.

1 Q. When we look at Section VIII of your
2 report which is about -- and we spent a lot of time
3 on it already, so I won't belabor the point. But
4 Section VIII is that consumers would be unlikely to
5 understand that TLG assigns a minimum score on the
6 imputed measures. That's the section I'm referring
7 to which starts on page 31 of your report at
8 paragraph 60.

9 And we talked earlier about the fact that
10 you've read Dr. Nicholson's report. Correct?

11 A. I have read the Nicholson report, yes.

12 Q. And do you understand that Nicholson
13 opines that the Leapfrog methodology is not
14 scientifically based, my words?

15 A. I want to be careful. I do not have the
16 Nicholson report in front of me. I have indeed read
17 that report, but it's been a little while since I've
18 read it. I don't remember all the details of that
19 report. I am -- understand from Nicholson the part
20 of the report where I note to Nicholson, and I can
21 find that if that's useful. But beyond that, I
22 don't -- I don't have an opinion on Nicholson's
23 report one way or the other.

24 Q. Right. And I'm just trying to lay some
25 foundation before I ask my next question. I want to

1 understand what your understanding is of Nicholson's
2 opinion.

3 A. I'm not -- I'm not saying that Nicholson
4 only has one opinion. If you'd like me to consider
5 the Nicholson report, I would need to look at that,
6 have it in front of me, see what specific part of his
7 report you're asking me to respond to. I can't just
8 do that.

9 Q. Then let me ask it this way: One of the
10 things we talked a lot about this morning was the
11 fact that a consumer of the Leapfrog website can't
12 easily or readily get to the description of the
13 Leapfrog methodology. Correct? We discussed that
14 this morning.

15 A. I want to be careful to agree to a
16 specific characterization of what we discussed this
17 morning, but, in general, we talked about how there
18 is -- or I'm only aware of one place concurrently
19 today where consumers can get to the information
20 about limited achievement from the safety grades.
21 And so we discussed that, yes.

22 Q. Okay. So do you have an opinion as a
23 marketing expert about whether if Nicholson is
24 correct and the methodology is not scientifically
25 based and is unreliable, how is displaying that

1 unreliable methodology to a consumer helpful to a
2 consumer?

3 A. I'm not sure I understand.

4 Q. Sure.

5 A. You seem to be saying that the methodology
6 and thus the grades on which they're based are
7 unreliable. I -- if that's what you're stating --

8 Q. I'm saying Nicholson says that. And
9 you've read that report. So I'm just curious.

10 A. As I already said, if you'd like me to
11 speak to something specifically that Nicholson says,
12 I would need to have the report in front of me to do
13 so.

14 Q. Okay. But you haven't married your
15 opinions with Nicholson's in that regard? And by
16 that I mean, you don't have a position about
17 whether -- or an opinion about whether displaying the
18 methodology more prominently to a consumer would help
19 a consumer understand the methodology and how that
20 would have an impact, if any, on the fact that
21 Nicholson says the methodology is wrong? You haven't
22 done that sort of opinion making, correct?

23 A. I'm not sure I understand that question.

24 Q. Sure.

25 A. It was a little longer. Can you repeat

1 it?

2 Q. Do you have an opinion about whether or
3 not consumers should be exposed to a methodology that
4 is allegedly scientifically unsound?

5 A. That's not a question I was asked to opine
6 on, so I don't have an opinion on that.

7 Q. Turn to page 45, paragraph 69 of your
8 report.

9 A. Okay.

10 Q. The last sentence of paragraph 69, you say
11 "Notably, the non-imputed measures share a key
12 similarity with the imputed measures: they are all
13 measures whose scores are based on TLG's voluntary
14 hospital survey and, thus, for which TLG has no data
15 for non-participating hospitals."

16 Do you see that, that statement?

17 A. I do.

18 Q. And in that statement, if we look up in
19 that paragraph, you're discussing some measures
20 where -- where Leapfrog will tell the viewer that
21 they have no score for a measure because it's a
22 decline to report in contrast to other measures where
23 the hospital declined to report, but Leapfrog has
24 assigned it a grade. Correct?

25 A. I'm just saying that for -- for some

1 measures, TLG notes that the hospital declined to
2 report. That's what -- that's what TLG says.

3 Q. Okay. But you understand that there are
4 12 measures for which the hospital declined to report
5 that are part of the hospital safety grade
6 methodology. Correct?

7 MS. MALONEY: Objection to form.

8 THE WITNESS: Sorry. Would you mind
9 repeating that question?

10 BY MS. BLAIR:

11 Q. Sure.

12 Do you have a -- just a basic
13 understanding of how many measures Leapfrog includes
14 in its 32 measures that come from the hospital survey
15 that's sort of at the epicenter of what we're talking
16 about here today? And I think -- it's in your report
17 so I can -- I can show you where you say that, where
18 you talk about it. It's in the beginning. If I can
19 find it.

20 Well, it would be from the complaint,
21 but . . . I thought you said it in here.

22 Well, regardless, do you have an
23 understanding of how the methodology works?

24 A. I have a general understanding of how the
25 methodology works, yes.

1 Q. Okay.

2 A. I don't remember exactly how many
3 statements fell into certain categories, beyond in
4 particular the four that I focus on. I'm happy to
5 refer to something if you'd like me to refer to it,
6 but I don't have the details of the exact number that
7 do different things committed to memory.

8 Q. Okay. When I focused on that sentence on
9 page 45, paragraph 69, the last sentence, you say
10 "Notably, the non-imputed measures share a key
11 similarity with the imputed measures," and I guess
12 I'm asking, which non-imputed measures are you
13 referring to? First and foremost.

14 A. Give me a second just to look at paragraph
15 69 again.

16 Yeah, so as I discuss in paragraph 69,
17 "TLG presents dialed graphics -- dial graphics for
18 other non-imputed measures that state the hospital
19 'Declined to Report' on these non-imputed measures."

20 Q. Okay. And is that the only key similarity
21 is that the decline to report measures and the
22 imputed measures are decline to report? Is that what
23 you're referring to when you say "notably"?

24 A. I think my point in this broader section,
25 I'm not sure if this is your question, but I'll do my

1 best here --

2 Q. No, that's great.

3 A. -- is that in some cases, TLG provides
4 something that says "decline to respond" graphics.
5 In other cases they don't say "decline to respond."
6 Yet, in both cases, their measures of scores are
7 based on TLG's voluntary hospital survey and, thus,
8 scores for which TLG has no data for
9 non-participating hospitals. And, thus, given the
10 research I discuss later in paragraph 70, many
11 consumers would likely conclude that the dial
12 graphics showing a low score for the imputed measures
13 are based on more or stronger evidence than the
14 decline to respond dial graphics for non-imputed
15 measures.

16 Q. Do you understand that the decline to
17 respond measures are procedural measures versus the
18 imputed measures that are structural measures?

19 A. I'm not sure I understand your question.

20 Q. Okay. Do you know why in the methodology
21 that I know you've seen because you've navigated to
22 it -- do you know why in the methodology there is a
23 difference between the decline to report and imputed
24 data?

25 A. I don't remember all the details of the

1 methodology. I focused in particular on page 16
2 which discussed this low achievement score and what
3 occurred based on that given that that was the focus
4 of my expert report. I think what I'm saying more
5 generally is regardless of the reason why some of
6 these are marked decline to respond and others are
7 not, the fact that some are marked decline to respond
8 may lead consumers to conclude that ones that are not
9 marked decline to respond are based on more stronger
10 evidence even though they have no data on that
11 measure as well. TLG has no data for
12 non-participating hospitals on that measure as well.

13 Q. And you come to that conclusion even
14 though if you go to one of those imputed measures, it
15 says, "The hospital declined to report their
16 performance on this measure, so a score was assigned
17 to reflect the lack of information available."

18 You think a consumer is confused -- I'm
19 using the word "confused" -- unlikely to understand
20 the difference? Is that your position?

21 A. Sorry, are you referring to the footnote
22 that --

23 Q. Yeah.

24 A. -- occurs much lower down on the page?

25 Q. Yeah.

1 A. It's not clear that consumers -- that's
2 not at the same place at which it says "decline to
3 respond." There's decline to respond, and near that
4 there's something that said -- does not say "decline
5 to respond."

6 Let me make this a little larger. So I
7 think that 13, Exhibit 13 is illustrative here.

8 And so on 13, clearly says "decline to
9 respond" on a couple measures, and it doesn't say
10 that --

11 Q. Well, to be careful for the --

12 MS. MALONEY: Let him finish, please.

13 MS. BLAIR: But it says "decline to
14 report," and I know you want to be careful, and
15 I put that word in your mouth, and I just wanted
16 to clear that for you.

17 THE WITNESS: Oh, okay.

18 MS. BLAIR: Sorry.

19 THE WITNESS: Sorry.

20 MS. MALONEY: He can correct himself or I
21 can correct it on cross.

22 Go ahead.

23 THE WITNESS: Okay, sorry. I'm not -- it
24 is too small on my screen to see exactly what it
25 declined to, but that is the place I believe --

1 thank you for mentioning that -- that is the
2 place, though, on that line I believe where and
3 I can see if I have a picture of it in here --
4 and otherwise I would need to refer to the
5 website -- where I believe it lists decline to
6 report or the hospital declined to report these
7 things. And so -- yes.

8 BY MS. BLAIR:

9 Q. Okay. So you don't have any understanding
10 in your field of marketing whether there's any
11 difference between a process measure and a structural
12 measure in terms of imputing data. Is that fair?

13 A. I'm not sure what you're asking.

14 Q. Sure.

15 Do you have any mathematical expertise
16 that would lead you to provide an expert opinion
17 today about whether or not it is proper to assign an
18 imputed score to a structural measure versus a
19 process measure?

20 A. Again, I'm going to try to answer what I
21 think is the intent of your question in case that's
22 helpful, but if not, I'm happy to answer it again
23 obviously.

24 My point here is that some measures are
25 showing up as decline to respond. And -- and so

1 compared to seeing something that says decline to do
2 what it is, consumers may infer that the other ones
3 are based on more stronger evidence.

4 Q. Okay. On page 48 of your report,
5 paragraph 77, you state that -- and this is the first
6 sentence. "Plaintiffs also allege that TLG fails to
7 adequately disclose that its practice of assigning
8 the minimum score to non-participating hospitals on
9 the imputed measures 'result[s] in artificially
10 deflated overall grades.'" "

11 Do you see that?

12 A. I do, yes.

13 Q. Are you offering any opinions here today
14 to a reasonable degree of professional certainty
15 about whether or not the scores are, in fact,
16 artificially deflated?

17 A. My opinion here is that TLG does not
18 directly disclose that its minimum score assignment
19 lowers non-participating hospitals' hospital safety
20 grades. I am noting here that, for example, staff at
21 another hospital group raised concerns that the
22 public will not understand nor dig into the
23 methodology's grades, and hospitals will be falsely
24 represented with a lower grade because they chose not
25 to complete the survey.

1 I also have the understanding from
2 Professor Nicholson, which I detail here. But the
3 focus of my opinion here is that TLG does not
4 directly disclose that its minimum score assignment
5 lowers non-participating hospitals' hospital grades.

6 Q. Okay. So is it your opinion that the
7 Leapfrog website should disclose that not
8 participating in the hospital safety grade lowers the
9 letter grade score for a non-participating hospital?

10 A. As -- as was the case with similar
11 questions here, I was not asked to provide
12 prescriptive recommendations about what they should
13 do. And given I did not spend time considering that,
14 I'm not going to put forward an expert opinion on
15 that at the moment.

16 Q. Thank you. And I appreciate your
17 indulgence. I know you've done this before, and I'm
18 just trying to close out these questions.

19 A. It's okay. I understand.

20 Q. Do you have an opinion as to whether or
21 not a consumer of health care services would be
22 likely to understand the methodology document that is
23 in your report at Exhibit 17 if read?

24 A. Would you mind repeating the beginning of
25 the question? I heard you say "if," but I wasn't

1 sure who that actor was.

2 Q. Oh, I'm sorry. I didn't hear what you
3 just said.

4 A. I think at the beginning of your question
5 you said "if a," and you described some type of
6 person or --

7 Q. Oh.

8 A. -- but I didn't hear what it was. Would
9 you mind repeating the question?

10 Q. Of course.

11 Do you have an opinion as to whether or
12 not a consumer of the Leapfrog website would be
13 likely to understand the methodology that is
14 described or set forth in Exhibit 17, referred to in
15 Exhibit 17 of your report?

16 A. Well, I think that's part of the challenge
17 I allude to in this section. So not only does TLG
18 not directly disclose that its minimum score
19 assignment lowers non-participating hospital safety
20 grades, the disclosures on the bottom of the page
21 don't provide information about exactly what is
22 occurring about the limited achievement scoring. And
23 so does not directly disclose its practice of
24 assigning a minimum score to non-participating
25 hospitals on TLG's hospital safety grade pages.

1 But further, even if consumers went to
2 this methodology page, which many do not as we talked
3 about in my supplemental report, thus are unlikely to
4 be exposed to this information.

5 You bring up another important question
6 which is even whether -- if they were exposed to that
7 information, would they understand that information?

8 All of these questions together highlight
9 the fact that I make in my broader opinion which is
10 many consumers would be unlikely to understand both
11 that TLG assigns the minimum score on the imputed
12 measures and the impact of this practice on the
13 safety grades TLG assigns to non-participating
14 hospitals based on the imputation disclosures that
15 are -- that are out there.

16 Q. Okay. So -- but you're offering no
17 opinions about what Leapfrog should be putting on its
18 website to make certain that consumers are likely to
19 understand the imputation model. Correct?

20 A. I'm not putting forward an opinion about
21 what I was not asked to and thus I'm not putting
22 forward an opinion about what they should do in this
23 instance.

24 Q. Would you consider it -- from a marketing
25 expert standpoint, would you consider it consumer

1 friendly for Leapfrog to conceal the fact that
2 hospitals are not participating in the survey?

3 MS. MALONEY: Objection.

4 THE WITNESS: I'm not able to answer that
5 question. I don't know exactly what you mean by
6 "consumer friendly." I don't know what you mean
7 exactly by "conceal." I'm not -- I can't -- I
8 don't know how to answer that question.

9 BY MS. BLAIR:

10 Q. Sure.

11 So a lot of your opinions or some of your
12 opinions are about -- well, specifically, the opinion
13 that we find in Roman numeral number VIII about
14 consumers -- what consumers are likely to understand
15 from viewing this website.

16 A. Uh-huh.

17 Q. From an expert marketing standpoint,
18 should a rankings organization like Leapfrog conceal
19 the fact that some hospitals are not participating in
20 the survey?

21 A. That's not a question I was asked to
22 consider for the purposes of my expert report, and so
23 it's -- I haven't -- not a question I've thought
24 about in detail and am not putting forward an expert
25 opinion on at the moment.

1 Q. And I ask that because if we turn to
2 paragraph 85 on your initial report on page 59 which
3 is entitled "TLG's Imputation Disclosures May
4 Negatively Impact Consumers' Perceptions of
5 plaintiffs' Hospitals."

6 Do you see that section?

7 A. I do.

8 Q. You talk about "The language and framing
9 of the disclosure content may cause consumers to form
10 negative perceptions about Plaintiffs Hospitals."

11 Do you see that sentence?

12 A. I do.

13 Q. Okay. And then two sentences later, you
14 say, "In this matter, the footnote disclosure is
15 framed such that 'the hospital' is the actor or agent
16 in the sentence." And then you quote, and emphasis
17 added "[t]he hospital declined to report their
18 performance on this measure."

19 Do you see where you say that?

20 A. I do, yes.

21 Q. And then you go on to say, "Such framing
22 is an example of agentive language" --

23 Am I using that right, saying that right?
24 Agentive?

25 A. Yes.

1 Q. -- "which includes the use of active voice
2 with an agent or actor in the subject of this
3 sentence."

4 So my question is, is it your expert
5 opinion that hospital ratings groups like Leapfrog
6 should not disclose to consumers that the hospital
7 declined to report their performance on the measure?
8 Is that the criticism that you're setting forth in
9 paragraph 85?

10 A. No, that's not the criticism I'm setting
11 forth. I'm not suggesting in 85 that necessarily
12 that -- that this information could be concealed or
13 something like that. I'm merely suggesting in this
14 section that the language being used to discuss this
15 is a -- is a choice. And that choice may impact,
16 negatively impact consumers' perception of the
17 plaintiffs' hospitals. There may be other ways one
18 could note that this information was not available,
19 and this particular choice of language which includes
20 active voice with the hospital as the agent of the
21 sentence may lead consumers to blame the hospitals in
22 particular.

23 Q. Is there any way in the marketing --
24 academic marketing literature that a sentence like
25 that could be positively perceived by consumers so

1 that they know this hospital is not engaging in this
2 grading system?

3 A. There are a number of assumptions in that
4 question, and so I -- I don't -- I'm not -- I don't
5 know how to answer it without having more detail.

6 Q. Okay. So let me ask it this way:
7 Agentive language as I understand this -- and again,
8 I'm not an expert -- is negative to the consumer.
9 Correct?

10 A. My point here is that they are using the
11 hospital as the actor in this sentence. "The
12 hospital declined to report their performance." And
13 so if one was to read this, one might be more likely
14 to place the responsibility for missing data on the
15 plaintiffs' hospital.

16 Similarly later, the pop-up says, you
17 know, hospitals who participated in the survey do so
18 to help patients and purchasers make better health
19 care decisions but that this hospital did not
20 participate, right, which is a specific way of
21 framing what has occurred that may shape the
22 inferences consumers draw.

23 This is not the only way to provide such
24 information. And this particular way of providing
25 information may negatively impact consumer

1 perceptions of plaintiffs' hospitals.

2 Q. Is there a way in the marketing academic
3 expertise that you possess to frame this type of
4 language, i.e., the hospital didn't do the survey in
5 language that would not have a negative impact on the
6 hospital?

7 A. That's not a question I was asked to
8 answer and so that's not something I considered in
9 detail. But I imagine -- there's certainly alternate
10 ways of framing this. And I imagine that it's
11 possible to come up with a framing that would be less
12 likely to negatively impact consumer perceptions of
13 hospitals.

14 Q. And I guess asking a different way, is
15 there a corollary in the marketing academic
16 literature to agentive language? Right? Like
17 there's agentive language, and there's the opposite
18 of agentive language; and, if so, what is that?

19 A. I'm not sure exactly what you're asking.

20 Q. Well, sure. So I read this agentive
21 language, right, which you say "'agentive language,'
22 which includes the use of active voice with an agent,
23 or actor, in the subject of a sentence." So I
24 suspect, I don't know, that -- is there an opposite
25 type of language that would include the use of

1 passive voice where it would not be imputed to the
2 agent or actor? And is that called something in the
3 marketing literature? I'm literally just
4 intellectually curious about this.

5 A. Yeah, I mean, so you refer to passive
6 voice. Passive voice is different than active voice.
7 I would need to think about this some more to see if
8 there's an opposite in the way you're using it. But
9 as you're highlighting there, active voice is a
10 choice, and that choice may have consequences in this
11 setting.

12 Q. And if passive voice was used, would that
13 have a consequence in this setting?

14 A. I would need to have better sense of
15 exactly what you're asking, specifically what
16 language is being used and would need to analyze it
17 to come to a conclusion to put forward an expert
18 opinion on that.

19 Q. And you end this sentence, this paragraph
20 85 by saying, "In other words, TLG's use of agentive
21 language may lead consumers to place the
22 responsibility for missing data on Plaintiffs
23 Hospitals."

24 Correct?

25 A. That's the sentence, yes.

1 Q. Do you disagree that the data is missing
2 because we don't have -- we -- Leapfrog does not have
3 survey results?

4 MS. MALONEY: Objection to form.

5 THE WITNESS: I'm not sure what you're
6 asking.

7 BY MS. BLAIR:

8 Q. Well, it's sort of a strange opinion.
9 Right? That it leads consumers to place the
10 responsibility for missing data on plaintiffs'
11 hospitals. But do you understand that those four
12 imputed measures, the only way to get that data at
13 this point in time is from a hospital participating
14 in the survey?

15 A. All I'm saying in this section is that the
16 language used by TLG, which is TLG's choice -- they
17 have a choice about what language to use -- may
18 negatively impact consumers' perception of
19 plaintiffs' hospitals.

20 They are repeatedly saying this hospital
21 didn't participate. They are characterizing
22 participation in a particular way. They're even
23 drafting the survey as I note in Exhibit 21, survey
24 participation request letter provided to consumers
25 who click on "Ask them why not" to encourage

1 consumers to reach out to hospitals and ask them to
2 participate.

3 All of these are choices. All these
4 choices may have consequences.

5 Q. Right.

6 And everybody's choices have consequences.
7 Right?

8 A. That's a general statement. I'm here
9 speaking on something specific in this specific case.

10 Q. Understood.

11 Paragraph 86 is -- you've already
12 referenced this, but you refer to this pop-up that
13 comes up that says to help patients and purchasers
14 make -- or I'm sorry, the pop-up language that say
15 the "hospitals who participate in the survey do so
16 'to help patients and purchasers make better health
17 care decisions' but that '[t]his hospital did not
18 participate.'"

19 Do you see that?

20 A. I do, yes.

21 Q. Yeah.

22 And do you have an understanding that that
23 pop-up refers to the survey which is separate and
24 distinct from the hospital safety grade?

25 A. Give me one second.

1 Q. Sure.

2 Oh, I apologize. My question was bad.

3 I'm referring to Exhibit 20. Not paragraph 86. I

4 apologize. I'll withdraw that question.

5 If we look at Exhibit 20, which is on

6 page 61 of your report. My apologies.

7 A. Okay.

8 Q. There's a pop-up. And you have a

9 screenshot of it. And I think you're referring to

10 something different in 86, so that was my bad.

11 And you say -- see, it says, "Palm Beach

12 Gardens Medical Center has declined to respond."

13 Do you see that pop-up on Exhibit 20 in

14 your report on page 61?

15 A. I do, yes.

16 Q. Okay. And it says, "What does this mean?"

17 And it goes on to say, "Thousands of hospitals

18 nationwide report to Leapfrog Hospital Survey to help

19 patients and purchasers make better health care

20 decisions. This hospital did not participate."

21 You see that, correct?

22 A. I do, yes.

23 Q. Okay. And you understand this pop-up

24 refers to the hospital survey. Correct?

25 A. What hospital survey are you referring to?

1 Q. The Leapfrog hospital survey.

2 A. That the hospitals declined to respond to
3 the survey?

4 Q. Correct.

5 A. I'm not entirely sure what we're talking
6 about here. In this -- in this section, I note we've
7 been talking about -- I believe we've been talking
8 about -- the hospitals and how the language is framed
9 around the hospital's decision whether to participate
10 or not. And so the language, TLG's imputation
11 disclosures may negatively impact consumers'
12 perception of plaintiffs' hospitals. I'm not sure
13 what you're asking me beyond what we have already
14 talked about.

15 Q. You -- do you understand that there is a
16 Leapfrog hospital survey that is 300 questions, and
17 12 of those questions find their way in to the
18 hospital safety grade methodology? Do you understand
19 that's how it works?

20 A. I don't remember the exact numbers of
21 different things, so I want to be careful, but I
22 understand that TLG asks hospitals -- Leapfrog asks
23 hospitals to complete a survey, and that survey is
24 used to compute some of the measures we've been
25 discussing today.

1 Q. Okay. And the -- the leapfrog.org website
2 has a place where you can go and see this pop-up that
3 a hospital declined to respond to the 300-question
4 survey, which is separate and distinct from the
5 health -- the hospitalsafetygrade.org website which
6 is the safety grade.

7 Do you understand that distinction?

8 A. I believe so, yes.

9 Q. Okay. And so am I right that this pop-up
10 that you display in Exhibit 20 is on a different
11 website and is related to the survey and not the
12 safety grade?

13 A. I would have to go back and follow the
14 links in the notes to refresh my memory on exactly
15 where this different language appears. My broader
16 point, though, is that the language being used here
17 is similar to the language being used other places
18 which characterizes the actions in a particular way.

19 Q. Okay. And regardless of where it comes
20 from, this type of language, is this also agentive
21 language on Exhibit 20?

22 A. Give me one second.

23 "Palm Beach Gardens Medical Center has
24 declined to respond." I believe that, yes, Palm
25 Beach Gardens is the subject of that sentence.

1 Q. Okay. So this is just another example of
2 agentive language. Correct?

3 A. The hospital is -- yes, the hospital is
4 the actor in that sentence. Or the agent or actor or
5 subject of that sentence, yes.

6 Q. Okay. And for the record, when I say
7 "this is," I mean Exhibit 20 is another example of
8 agentive language, correct?

9 A. The sentence "Palm Beach Gardens Medical
10 Center has declined to respond" is another example of
11 where the hospital is the subject of the sentence.
12 And the fact that they're saying "did not respond"
13 can lead consumers to assign blame to the hospital
14 and place the responsibility for missing data on
15 plaintiffs' hospitals.

16 Q. And placing responsibility on the
17 hospitals for missing data like we see in Exhibit 20,
18 it's your expert marketing opinion that that may have
19 a negative impact on consumer perception of, at least
20 for Exhibit 20, Palm Beach Gardens. Correct?

21 A. That -- this type of language may
22 negatively impact consumer perceptions of plaintiffs'
23 hospitals. That's what I talk about in Subsection E
24 of this report.

25 Q. Okay. When we look at Exhibit C again,

1 the documents considered list -- and full disclosure,
2 I tried to look at them all -- do any of the -- these
3 academic literature, whether they're journal articles
4 or whatnot, do any of these papers measure the user
5 interpretation of asterisks plus a footnote
6 disclosure?

7 A. I don't know offhand whether any --

8 Q. Would it have been important to you in
9 coming to your expert conclusions, specifically those
10 that we discussed at length today in Roman numeral
11 number VIII to read and review articles that talk
12 about website interpretations or media --
13 interpretations of media that use an asterisk plus a
14 footnote?

15 A. As we discussed already, more generally,
16 the question is not just whether there are articles
17 that discussed asterisks or footnotes, but the way in
18 those asterisks or footnotes are used. And the
19 information contained in those footnotes.

20 As we've talked about already, not only
21 are there very few places where those footnotes
22 appear, not only are those footnotes below the fold
23 and thus more people are unlikely to see them and
24 appear on not every page that someone goes to, but
25 further, the information contained in those footnotes

1 does not provide information that the minimum scores
2 applied. It merely says that a score is applied.

3 And so it is unlikely even if consumers
4 were exposed to those footnotes, which they may not
5 be because they may not see them because they don't
6 appear everywhere and require scrolling; but even if
7 they saw them, they may not understand from them,
8 unlikely to understand from them that a minimum score
9 was assigned because that's not what the footnote
10 says.

11 Q. Yeah.

12 So my question was: Do any of the
13 articles listed in Exhibit C to your initial report
14 discuss in any way the marketing impact of the
15 interpretation of an asterisk plus a footnote?

16 A. I'm not sure. I would need to go through
17 the articles again. I'm not sure offhand.

18 Q. Would it have been important to you in
19 coming to your conclusions to at least review the
20 academic literature specific to interpretation of
21 asterisks plus footnote in coming to your opinions in
22 this case?

23 MS. MALONEY: Objection to form.

24 THE WITNESS: Even if a paper showed that
25 an asterisk and footnote does something in

1 particular, the information contained in that
2 footnote would have to give people the
3 information needed for people to be aware of
4 that information.

5 And so even in this case, if people saw
6 the footnote, which as we've discussed there are
7 reasons to believe that didn't happen or few
8 people saw it, many people might not have seen
9 it. Even if they saw it, the information
10 contained in it doesn't tell people that the
11 minimum score was assigned, and, thus, there's
12 no way from reading the footnote -- it's
13 unlikely from reading the footnote by itself
14 that consumers would come to that conclusion.

15 BY MS. BLAIR:

16 Q. But if that academic literature existed,
17 is that something you would have considered, whether
18 you disregarded it or accepted it, is it something
19 that you would have reviewed and considered to come
20 to your conclusions in this litigation?

21 A. I'm not aware of a paper offhand that
22 examines exactly that question. And further, I
23 didn't feel -- I didn't think that -- I didn't -- I
24 don't believe a paper like that is necessary for me
25 to reach my conclusion that I reach. There are a

1 variety of other pieces of academic literature that
2 all support the broader point that I'm making here.
3 And as we've talked about already, data from the
4 website also support points I'm making in these
5 sections. And so they all point to a consistent
6 conclusion, even without discussing whether there is
7 or is not a paper that mentions exactly what you
8 mentioned.

9 Q. In your academic research, have you ever
10 had the occasion to consider the interpretation of an
11 asterisk plus footnote?

12 A. Again, to me in this case, the -- this
13 instance, the bigger question is not an asterisk or
14 footnote. It's where that information appears.
15 Right?

16 So there could be a footnote, and the
17 footnote could be very close to the top of the page.
18 There could be footnote, and it could be 17 pages
19 down. And so the footnote by itself isn't the only
20 thing that matters.

21 Further, the information contained in the
22 footnote, even if someone sees it, it has to -- it
23 has to contain the relevant information.

24 Q. Yeah.

25 And my question is, have you ever in your

1 academic research had the occasion to consider the
2 interpretation of an asterisk in a footnote?

3 A. I don't remember whether I've considered
4 exactly those things together, but my academic
5 research has certainly touched on the larger question
6 of what leads people to be exposed to information.
7 And that is the expertise that I put forward here in
8 reaching my conclusions.

9 Q. Have you ever had occasion to testify as
10 an expert -- or not testify. Have you ever had the
11 occasion to provide expert opinions on the
12 interpretation of an asterisk plus a footnote other
13 than this litigation?

14 A. Again, whether I've specifically opined on
15 an asterisk or a footnote, uniquely, to me is not the
16 only relevant question. The question is information
17 exposure and what is exposure to that information
18 likely to lead consumers to understand.

19 And so I've certainly opined in a variety
20 of cases on access to information, the degree to
21 which people were exposed to information, the degree
22 to which whether that exposure might shape their
23 understanding, and have certainly done academic work
24 on those topics as well.

25 Q. Right.

1 And so I think my question was just much
2 simpler, which is, have you ever had the occasion to
3 provide expert opinions about the interpretation of
4 an asterisk plus a footnote ever?

5 A. I'm not sure offhand. I'd have to look
6 back and see for sure.

7 Q. You talk a little bit in your report about
8 betrayal aversion. Can you just tell me in your own
9 words what betrayal aversion is?

10 A. Sure. And we've been going I think --

11 Q. Oh, sorry.

12 A. I'm happy to answer this question, no
13 problem. But then maybe soon, 15, 20 minutes from
14 now.

15 Q. I'm almost done.

16 A. And we can take a break.

17 Betrayal aversion. Give me just a second
18 here.

19 Is there a particular part of my report --
20 I have a sense of where it is, but if you're looking
21 at a paragraph, certainly, please let me know.

22 Q. I knew you were going to ask me that, and
23 I did not write in my notes what part of your report
24 it was. So give me one second.

25 A. Just a second. I will -- I have a sense

1 of where it is. Give me just a second.

2 Q. Oh. Sorry.

3 A. Okay, I think I have a sense of where
4 you're talking about. So I think this is around
5 paragraph 44, for example. So "When consumers are
6 informed that a product or service which they expect
7 safety actually causes harm, they can experience
8 strong, negative emotions, like feeling betrayed."
9 And people don't like feeling betrayed.

10 Q. Okay. And so that's what betrayal
11 aversion means, is you feel betrayed by the -- who do
12 you feel betrayed by or what do you feel betrayed by?

13 A. I would have to go back to look at those
14 specific papers to refresh my memory on the exact
15 detail of what -- what they studied. But in general,
16 people can feel negative emotions like betrayal when
17 they're informed that something which they expect
18 safety like a hospital, for example, actually causes
19 harm.

20 Q. Okay. And so particularly your footnote
21 84, which is the Gershoff article "Safety First? The
22 Role of Emotion in Safety Product Betrayal Aversion."

23 A. Okay.

24 Q. Do you know whether -- and I'm sorry, I
25 just don't know. Do you know whether or not that was

1 specific to health care services?

2 A. I would -- I would need to go back to the
3 paper to be sure. I don't -- I don't have that
4 detail off the tip of my memory.

5 Q. Do you know whether these papers that you
6 cite on betrayal aversion rely on physiological or
7 survey evidence to come to their conclusions that
8 betrayal aversion exists in these circumstances?

9 A. I reviewed a lot of literature for this
10 expert report. I don't remember that specific detail
11 of this specific paper.

12 Q. Would that be important to you as an
13 expert to know whether or not these -- this academic
14 literature that you rely on comes to its conclusions
15 based on physiological or survey evidence from
16 consumers to prove betrayal aversion?

17 A. I have no reason to doubt the conclusions
18 of this specific paper. I don't happen to remember
19 all the method details at this moment, but nothing I
20 read in this paper gave me reason to -- or nothing
21 I'm aware of gave me reasons to doubt the conclusions
22 of this paper.

23 Q. And I'm asking this question because I
24 obviously don't live in the world in which you live,
25 and so I'm trying to make a determination.

1 Is that how it works? Like in order for
2 somebody to say, betrayal aversion is real and it
3 exists, do scientists in the world that you live in
4 do physiological or -- or, you know, surveys to
5 confirm that or how does it work?

6 A. I'm not sure what you mean by
7 "physiological survey."

8 Q. Yeah, I guess maybe I don't either. I'm
9 trying to figure out.

10 So we have these articles, and I skimmed
11 these in the betrayal aversion. And they do come to
12 the conclusion that you rely on that betrayal
13 aversion is real. And it is people feel betrayed
14 when they see a bad grade.

15 And I guess I'm asking, in your world --
16 in your world of, you know, marketing Ph.D.s and
17 academic literature, how do we get to the conclusion
18 that that is really happening? Is it based on some
19 sort of surveying people who are seeing this type of
20 information or is it based on -- what is it based on
21 when you do these types of things?

22 MS. MALONEY: Objection.

23 THE WITNESS: I want to be a little
24 careful here. You're asking a quite general
25 question. It usually depends on the specific

1 situation and the specific data that's best
2 suited to answer the question that the
3 researcher is interested in, or that data is
4 available in that -- in that situation. But
5 without more detail on, you know, exactly what
6 you're talking about, I don't offhand, for
7 example, remember what they did in this paper.

8 BY MS. BLAIR:

9 Q. Okay. Yeah, and I guess I was just asking
10 generally how it works. Like how does the science of
11 marketing work. Is it usually validated through
12 consumer surveys or -- I just don't know generally
13 how the science of marketing works, and I'm just
14 asking you as an expert, how do we in the marketing
15 expert academic community validate these theories?

16 A. That's a very broad question.

17 Q. I know.

18 A. Experts use data that the authors feel
19 like is most appropriate in a given situation to --
20 to try to speak to a certain question.

21 Q. And when that data is used, do other
22 academics opine on -- wow, you didn't use the right
23 data; you should have used other data? Is that how
24 it sort of works in your line of work?

25 A. I don't -- I don't know how to answer that

1 question.

2 Q. Okay. Just curious.

3 Turning to your supplemental report.

4 A. Okay.

5 MS. MALONEY: Is now a good time for a
6 break --

7 MS. BLAIR: I'm sorry. You wanted a
8 break.

9 MS. MALONEY: Before you turn to the
10 supplemental report?

11 THE WITNESS: If we're at the place where
12 we're like five to ten minutes from finishing --

13 MS. MALONEY: Let's take a ten-minute
14 break.

15 MS. BLAIR: Yes. Sorry, sorry. I forgot.

16 THE WITNESS: -- I am happy to five or
17 ten-minutes and keep going.

18 MS. BLAIR: Ten minutes is great. I'm at
19 the end, I promise you.

20 THE WITNESS: Okay. If you think you're
21 close to the end, like five or ten minutes, I'm
22 happy to keep going. If it's going to be more
23 like a half hour, I'd love to take a break at
24 some point. But if it's only five or ten
25 minutes, I'm happy to continue.

1 MS. BLAIR: No, let's just -- let's just
2 take a break now because I'll go and confer with
3 Courtney about my notes and see, and so then
4 I'll just finish the whole thing after the
5 break.

6 THE WITNESS: Okay. Sounds good. Does a
7 ten-minute break work?

8 MS. BLAIR: Works for me.

9 THE WITNESS: Okay. Great. I'll see guys
10 back at 30 after the hour. Thank you.

11 MS. BLAIR: Thank you.

12 VIDEOGRAPHER: Going off the record at
13 2:21.

14 (A recess transpired from 2:21 p.m. until
15 2:32 p.m.)

16 VIDEOGRAPHER: This begins file Number 3.
17 We're back on the record for the deposition of
18 Dr. Jonah Berger. The time is 2:32 p.m.

19 BY MS. BLAIR:

20 Q. Dr. Berger, I want to now just turn to
21 your supplemental report, and I know we talked about
22 it at least a little bit earlier this morning. And I
23 just want to turn back to it for just a little bit.

24 A. Okay.

25 Q. The supplemental report was supplemented

1 after the Google Analytics site inspections were
2 completed. Correct?

3 A. I believe that's the case, yes.

4 Q. Right. And, in fact, your report contains
5 the Google Analytics data that you received.
6 Correct?

7 A. Yes, that is correct.

8 Q. So it would be safe to say you
9 supplemented this report after you got the data which
10 was from the Google Analytics site inspection, great.

11 What were your -- what were the opinions
12 in your own words that you supplemented after
13 reviewing the Google Analytics data?

14 A. Well, I think I list the opinions in the
15 supplemental report. For example, consistent with
16 the discussion in the main report of the fact that
17 people might not be likely to see some of the
18 content, the -- for example, the imputation
19 disclosures, or the methodology document, for
20 example. The vast majority of users who visited
21 Plaintiffs' hospital safety grade pages did not
22 download the 200 -- 2024 or spring 2025 scoring
23 methodology document.

24 So here I'm using data that we talked
25 about already quite a bit today that just provides

1 more confirmatory evidence, more evidence consistent
2 with my suggestion that individuals would be unlikely
3 to understand the exact way that the --

4 I should read the language. Give me one
5 second here so I'm precise.

6 Q. Sure.

7 A. Unlikely to understand that the imputation
8 methodology, specifically the practice of assigning
9 the minimum score on the imputed measures. Given
10 that very few people are downloading and thus even
11 potentially exposed to page 16 of this document,
12 that's consistent with the opinion I expressed in the
13 initial report.

14 Q. Okay. And I want to ask the question
15 about the download. What do you mean by "download"?

16 A. I'm not sure what you mean.

17 Q. Well, there's clicking on the methodology
18 and reading it. And in the vernacular, right,
19 download means you hit the "download" button, and you
20 save it to your desktop. So I'm just curious in your
21 report, I didn't understand how you were using the
22 word "download."

23 A. Let me go back to the supplemental report.
24 Give me a second.

25 Q. Sure.

1 A. So the scoring methodology document is
2 accessible from the hospital safety grade page, as I
3 state in my supplemental report, how you get there.
4 And you have to -- you have to navigate to a specific
5 table view of the hospital safety grade. And then
6 click on the link to download the document.

7 Q. Okay.

8 A. This is speaking to the number of people
9 that both viewed the detailed table view as well as
10 downloaded the methodology document.

11 Q. Okay. So when you use the word "download"
12 in this supplemental report, you mean they actually
13 downloaded it and saved to their desktop?

14 A. I don't know whether they saved it to
15 their desktop or not. But they clicked "download."

16 Q. They clicked "download." Okay.

17 And if we look at the table on page 6 of
18 your supplemental report, Exhibit 1, "Number of Users
19 who Navigated to Plaintiffs Hospitals' Safety
20 Grade Pages, the Detailed Table Views for Plaintiffs
21 Hospitals and the -- and Downloaded the Methodology
22 Document."

23 Correct?

24 A. Correct.

25 Q. Okay. And as I understand, this is --

1 this is the total number of people who viewed these
2 five hospitals' safety grades between November 15th,
3 2024, and August 4th, 2025. Correct?

4 A. No.

5 Q. No.

6 Okay. What is it, then?

7 A. It's the number of people who viewed the
8 safety grade pages over that time. As we discussed
9 already, the grades themselves may have also diffused
10 through a variety of other methods. So this is the
11 number of people simply who viewed the hospital grade
12 safety -- hospital grade safety page.

13 Q. Oh, got it. Okay. I see what you're
14 doing there. Okay.

15 So just for my clarification, the -- let
16 me break it down this way: The time frame that
17 you're looking at on this Google Analytics page is
18 between November 15th, 2024, and August 4th, 2025.
19 Correct?

20 A. Correct.

21 Q. And it would be the number of users who
22 navigated to these five hospitals' patient safety
23 grade pages. Correct?

24 A. Correct.

25 Q. Did you break down and analyze how many

1 went to each of the five plaintiff hospitals' safety
2 grade pages?

3 A. I don't remember offhand whether I broke
4 it up by each individual hospital safety grade, each
5 individual hospital.

6 Q. Okay. But you would agree with me that
7 when I look at your report at page 6, Exhibit
8 Number 1, I can't tell how many users went to which
9 specific hospital's safety grade webpage. Correct?

10 A. Just to be clear, this is your side's
11 data. So I believe you have access to this data as
12 well, and you're welcome to look at it or your
13 experts are welcome to look at it. But I agree from
14 Exhibit 1, Exhibit 1 is just looking at the total
15 number navigated to the safety grade pages,
16 Plaintiffs' hospital safety grade pages.

17 I should mention by the way, just in
18 answer to a prior question, the -- even on the
19 website, the plaintiffs' hospital safety grade pages
20 are not the only place where these grades could be
21 viewed. So if I search, for example, among a
22 variety -- not for a specific hospital, but for
23 hospitals in the area, for example, I may see a
24 number of hospitals that come up. I may see the
25 grades associated with each of those hospitals. But

1 I'm seeing the grade not on the plaintiffs' hospital
2 safety grade page itself.

3 Q. Understood.

4 But the -- for purposes of your
5 supplemental report, you analyzed the Google
6 Analytics for navigation to the plaintiffs' specific
7 hospital safety grade pages. Correct?

8 A. Well, I was interested in this particular
9 analysis on the proportion of people that downloaded
10 the methodology document or even got to the detailed
11 table view, and so that's why I looked at it in this
12 way. But yes, as a first place to start here, I'm
13 starting with the people who navigated to plaintiff
14 hospital grade pages.

15 Q. And couldn't it be true that a user of
16 this website could have been looking at Jupiter
17 Hospital, downloaded the methodology there, and then
18 went over and looked at West Boca and didn't need to
19 download the methodology again? Couldn't that be
20 true?

21 A. I believe -- and I would need to check to
22 be sure, but I believe that this is -- well, sorry.
23 Let me -- give me a second.

24 Yeah, so as I discuss in paragraph 10, if
25 a user visited the hospital safety grade page for

1 Delray Medical Center and at some point after visited
2 the detailed table view page for Delray, that would
3 be counted both in the hospital safety grade page and
4 the detailed table view bars. And so in your
5 example, as long as someone visited a hospital safety
6 grade page at some point in time, one of these five
7 plaintiffs' hospitals, and at some point in time
8 downloaded the methodology document, I believe they
9 would show up in the gray bar in Exhibit 1.

10 Q. Right. And so my question was a little
11 different.

12 My question is: What if I'm looking at a
13 hospital unrelated to these five hospitals and in
14 that search I download the methodology. Right? And
15 I have it. I downloaded it. I've saved it to my
16 desktop, and now I'm looking at other hospitals. But
17 I have the methodology. That's possible, is it not?

18 A. Sorry. As long as -- in that example, if
19 you both downloaded the methodology document and
20 visited a plaintiffs' hospital safety page at some
21 point, I believe you would be counted in that gray
22 bar.

23 Q. Okay. So you believe if in week one I
24 went to another hospital safety page or just to the
25 Leapfrog safetygrades.org and I downloaded the

1 methodology on week one, and on week five I go to
2 Delray Medical Center and I just click on their
3 safety grade web page, you believe you're capturing
4 the fact that I downloaded the methodology five weeks
5 before?

6 A. I would need to go -- again, there are a
7 lot of details in both of my reports. And in this
8 case, we had to pull together the supplemental report
9 quite quickly because the data was not provided in
10 enough time to do it for the main report. We had to
11 turn around things quite quickly. I would have to go
12 back and refresh my memory on exactly the details.
13 But I believe, as I said already, that if someone
14 both visits one of the plaintiffs' hospital safety
15 grade pages and downloads the methodology document,
16 at any point in time both of those individuals --
17 that individual would be counted in the gray bar.

18 Q. Right.

19 But I don't think that answers my
20 question, which is, is it not possible that a user of
21 the Leapfrog website could download the methodology
22 and then weeks later visit one of these five
23 hospitals and just click on their safety grade and
24 still have an understanding and a download of the
25 methodology?

1 A. I'm sorry. I'm not sure how what you're
2 saying is different than mine. Are they visiting the
3 hospital safety grade page?

4 Q. Five weeks later.

5 A. Or the plaintiff hospital?

6 Q. Correct.

7 A. Both things happened within the time range
8 we're talking about?

9 Q. Correct.

10 A. Then I believe they would be counted in
11 the gray bar as I said previously.

12 Q. Okay. So you believe it's tracking a
13 specific IP user and the fact that they downloaded a
14 methodology in week one and on week five when they go
15 to the plaintiffs' hospital, the Google Analytics is
16 showing this IP user downloaded the methodology
17 five weeks before? That's my question.

18 A. I have nothing --

19 MS. MALONEY: (Simultaneous speaking)

20 Objection.

21 THE WITNESS: -- that we haven't said
22 already.

23 I'm sorry. Go ahead.

24 MS. MALONEY: No, that's okay.

25 It's objection to form with respect to

1 this hypothetical.

2 THE WITNESS: As we said already, this is
3 stretching the depths of my memory. I have said
4 all I have to say here about what I believe is
5 the case about if someone both went to a
6 plaintiffs' hospital safety page and downloaded
7 the methodology document.

8 I don't have anything else to add at this
9 point. I'm happy to try to -- I don't have
10 anything else to add at this point.

11 BY MS. BLAIR:

12 Q. Sure. So let me ask it a different way:
13 Is it not possible that someone could have
14 the methodology document from another source and not
15 download it when between these dates on your
16 Exhibit 1 they click and navigate to the hospital
17 safety website for this particular -- these
18 particular five hospitals?

19 MS. MALONEY: Objection to form.

20 THE WITNESS: Again, you're asking me a
21 hypothetical. There are a number of assumptions
22 underneath that. I think more generally I
23 haven't seen any case where someone shared this
24 methodology document. If the other side
25 would -- would like to put forth evidence that

1 this is the case, I'm certainly happy to
2 consider that evidence. But I have not seen
3 that occur. I'm not aware of that occurring.

4 BY MS. BLAIR:

5 Q. Let me ask it a different way: Are you
6 not assuming in Exhibit 1 that the 120 people that
7 downloaded the methodology could only have downloaded
8 the methodology by first visiting one of the five
9 plaintiffs' safety grade pages? Is that not the
10 assumption in this graft -- graph?

11 A. I don't know what else to add. I've said
12 that my memory of the method is not perfect. But you
13 guys have the data, and so you're welcome to look at
14 the data yourself.

15 But I believe as long as someone visited
16 one of the hospital safety grade pages and at some
17 point in time downloaded the methodology document,
18 they would be counted in this gray bar. I don't have
19 anything else to add. But, again, feel free to
20 analyze the data on -- yourself, if there's something
21 you'd like to check or you're interested in some
22 different analysis than the one I did.

23 Q. Well, I'm just -- I'm just interested in
24 how I interpret this chart. So I want to make sure.
25 So why don't we go through it. So -- because you

1 talked about it earlier.

2 So in Exhibit 1, during this time frame,
3 November 15th, 2024, through August 4th, 2025, there
4 were 3,493 navigations to these five hospitals'
5 safety grade pages. Correct? That's what the navy
6 blue bar represents in Exhibit 1.

7 A. The number of users who navigated to
8 plaintiffs' hospital grade pages.

9 Q. Okay. And when we say "plaintiffs," we
10 mean the -- all five of the plaintiffs in this
11 litigation. Correct?

12 A. Correct.

13 Q. And the navy blue bar does not break it
14 out per hospital on this chart. Correct?

15 A. Correct.

16 Q. And if I look at your footnote underneath
17 this table, you say "Users who visited multiple
18 Plaintiffs Hospitals' Safety Grades are counted
19 multiple times."

20 Do you see that? That's the last sentence
21 underneath.

22 A. I do, yes.

23 Q. Okay. And what is that based on?

24 A. That's just what I did. Users who visited
25 multiple plaintiffs' hospital safety grade pages are

1 counted multiple times.

2 Q. Did you look at specific IP addresses to
3 see how many multiple viewers they were? Or users?

4 A. I don't remember that number offhand.
5 But, again, your side has all the data, and so you're
6 more than welcome to analyze it or cut it any way you
7 like.

8 Q. No, Doctor, I understand we have the data.
9 I'm just asking what data you looked at.

10 So did you -- do you know whether it
11 tracked IP addresses that looked at different -- all
12 five -- you know, which hospitals were looked at?

13 A. Different hospitals have different pages.

14 Q. No, I'm talking about the user IP address.

15 So when you say, "Users who visited
16 multiple Hospital Safety Grades are counted multiple
17 times," my question is, are you tracking that by the
18 user's IP address?

19 A. I'd have to go back to look in the data to
20 refresh my memory. But I'm not creating this data.
21 This is the data provided by Google Analytics and the
22 information contained in that data.

23 Q. Oh, and I'm not suggesting by any means
24 you're creating the data. I'm just suggesting you're
25 interpreting the data and putting it into a table.

1 Correct?

2 A. I'm not interpreting the data. This is
3 what the data is.

4 Q. Okay. So the data is that of these --
5 okay. Let me ask it this way:

6 Of these 3,943 users, do you know how many
7 were duplicative?

8 A. I don't know what you mean by
9 "duplicative."

10 Q. I mean, do you know how many were users
11 who visited multiple plaintiff hospital safety
12 grade pages that were counted multiple times?

13 A. I don't know offhand.

14 Q. Okay. So the way I read this, so the navy
15 blue bar is everybody who clicked on one of these
16 five hospitals' safety grade pages, correct?

17 A. As we've already talked about, it's the
18 number of users who navigated to plaintiff hospital
19 safety grade pages.

20 Q. Okay. Then when we look at the royal blue
21 bar in the middle, 268, these are the number of
22 people that viewed the detailed table view for one of
23 these five hospitals. Correct?

24 A. I believe so. Yes.

25 Q. Okay. And these 268 people are -- were

1 part of the 3,493 users that are in the navy blue
2 bar?

3 A. I believe they're users that took both of
4 these actions. So they both viewed, navigated to
5 plaintiffs' hospital safety grade pages, and went to
6 the detailed table view.

7 Q. Okay. And then when we move to the gray
8 bar, which is in your legend a methodology document,
9 there's 120 users. Correct?

10 A. Correct.

11 Q. And those 120 users are part of the 268
12 users from the royal blue bar in the middle? Is that
13 correct?

14 A. You know, I think it would be helpful --

15 Q. Sure.

16 A. I understand you're totally allowed to ask
17 these questions. It would be helpful if we could
18 bring up the --

19 Q. That's okay.

20 MS. MALONEY: Put it on the screen.

21 MS. BLAIR: I'll share it. Absolutely.

22 MS. MALONEY: That way we're sure what
23 we're referring to is the same thing.

24 MS. BLAIR: Absolutely.

25

1 BY MS. BLAIR:

2 Q. Can you see this? Is it small?

3 A. Sorry. I mean, the -- the TLG's website
4 where -- not my -- I have my -- I have my document in
5 front of me.

6 Q. Okay.

7 A. But I'm saying the website itself. It's
8 hard for me to remember all the details of how things
9 are laid out and how you navigate.

10 Q. Oh, sure, sure, sure. I'm sorry. I
11 didn't understand. Give me one second.

12 MS. MALONEY: I didn't either. For
13 purposes of the record, I don't know if this
14 website has changed in any way since it was
15 reviewed for purposes of the supplemental
16 report. But . . .

17 MS. BLAIR: So noted. I agree. I don't
18 believe it has, but I -- noted for the record.
19 I agree with you, Mary Beth.

20 BY MS. BLAIR:

21 Q. But can you -- can you see my screen here
22 or do you see multiple screens? I don't know what
23 you're seeing.

24 A. I see your screen, yes. Thank you.

25 MS. MALONEY: And also for purposes of the

1 record, can we say that this is
2 hospitalsafetygrade.org that's up on the screen?

3 MS. BLAIR: Yes, absolutely.

4 BY MS. BLAIR:

5 Q. So I'm happy to navigate this, and I
6 should have made Courtney do this. She's better.
7 But -- so, sorry.

8 A. So just picking one of the five hospitals,
9 going to one of their safety grade pages and then
10 going to the detailed table view, I have some of this
11 information in my report, but it's hard to hold it
12 all in memory.

13 Q. Sure, of course.

14 So I'm just going to go to West Boca; for
15 the record, I'll go to West Boca Medical Center.

16 A. Okay.

17 Q. And it's now displaying just the hospital
18 safety grade, hospital matches. And it says "West
19 Boca Medical Center."

20 Do you see that on your screen, Doctor?

21 A. I do, yes.

22 Q. Okay. Where would you like me to go from
23 here?

24 A. Just go to the safety grade page.

25 Q. To the full score?

1 A. This is a fine place to start, yeah.

2 Q. Okay.

3 A. And then we navigate to the detail table
4 view which is in the upper right.

5 Q. And this would represent the royal blue
6 bar in the middle of your Exhibit 1 on your
7 supplemental report. Correct? Navigations to this
8 page. Correct?

9 A. I believe so, yes. I believe so.

10 Q. Okay.

11 A. And then I believe somewhere here is the
12 methodology. Yes, thank you. Yeah.

13 Q. And then --

14 A. Okay. So the action that you just took,
15 clicking on that would be a count of the download of
16 this document.

17 Q. And I wasn't trying to be tricky before.
18 But I'm old, and so it means different things to
19 different people.

20 This -- see this button that I'm
21 highlighting here with the actual arrow down, and it
22 says "download"? So that's why I was asking that
23 question. I wanted to understand whether -- because
24 if I click this, right, it takes me to download it.
25 Right?

1 So when the gray bar that we're looking at
2 in Exhibit 1 of your supplemental report -- it's your
3 understanding that that represents just clicking on
4 this and not actually downloading it. But you tell
5 me. I'm not trying to put words in your mouth.

6 A. I would have to go back to the Google
7 Analytics data to refresh my memory about how things
8 are recorded. But I believe that initial click is
9 enough to treat that document as downloaded.

10 I believe for certain individuals, for
11 example, the way that it just opened up for you is
12 not how it opens up for all individuals. And it --
13 in some ways you are turning what it is into a
14 different type of document by clicking out of the
15 button, but I would need to go to the analytics data
16 to refresh my memory.

17 Q. Okay. So as we sit here today, we're not
18 sure when we use the word "download" whether it means
19 just navigating to the page or actually downloading
20 it like I just demonstrated with the download arrow?
21 We're not 100 percent sure as we sit here today which
22 of those two actions represents the gray bar on
23 Exhibit 1. Correct?

24 A. I said I believe the gray bar is clicking
25 on that link.

1 Q. Oh.

2 A. And having that document open up. That is
3 what I believe. But if you'd like me to be certain
4 of it, I would need to review the Google Analytics
5 file to be sure.

6 Q. I'll move on for now, and I'll ponder that
7 question, Doctor. Thank you for that.

8 Do you want me to keep sharing my screen
9 or --

10 A. I don't know what the next question is
11 going to be, so --

12 Q. I'll leave it up. Why not?

13 A. -- I can't answer whether I still need to
14 see the screen. Thank you.

15 Q. Okay. But you do still have your
16 supplemental report in front of you. Correct?

17 A. I do have my supplemental report in front
18 of me, yes.

19 Q. Okay. And so we talked about this
20 previously, that there's nothing in the Google
21 Analytics report that would provide you with
22 information to determine whether the users who
23 navigated to plaintiffs' hospital safety grades pages
24 were health care consumers or doctors or nurses or
25 press or lawyers. There's nothing for you to look at

1 to make that determination. Correct?

2 A. I think we had this conversation already.

3 Q. We did.

4 A. What I said is that's true for all three
5 colors of bars. So if the notion is that somehow,
6 oh, you know, the numbers of views is higher than it
7 would be because some other type of people were
8 consuming this information, that could also be true
9 of the methodology document indicating that a smaller
10 number of people were downloading the methodology
11 document, let alone making it to page 16 to review
12 the material contained on that page.

13 Q. But it also could be true that of the
14 3,493 users, 268 of them were consumers, the rest
15 were lawyers, journalists, hospitals, nurses,
16 doctors, and 268 of them went to the detailed table
17 view, and 120 of those downloaded the methodology.
18 That could also be true, could it not?

19 A. I've seen no evidence that that's the
20 case. And that is inconsistent with every other type
21 of time that I've engaged with this type of data.

22 Your question about whether all 3,493 I
23 believe are consumers is a fair question. But the
24 situation you just outlined, whether such a small
25 percentage of them are consumers, all of them took

1 the actions that you said is highly unlikely. And
2 I've seen no evidence to suggest that what you're
3 suggesting is the case.

4 Q. Before you got involved in this case, had
5 you ever heard of The Leapfrog Group?

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

7 Q. When we look at this bar chart -- I'm
8 going to stop sharing my screen. But I have it up in
9 case you need it. I just want to see your face.
10 Sorry.

11 If -- when we look at this bar chart, do
12 you know from your Google Analytics review whether it
13 would have been the same visit that the user both or
14 all three clicked on the safety grade, then clicked
15 on the table view, then clicked on the download? Is
16 that all happening in the same visit?

17 A. As I note in the report, I don't believe
18 it has to be the same visit. I think more generally,
19 though, I'm very happy to answer as many questions as
20 you want about this specific point. But this
21 specific point is only one -- this specific --

22 Q. Sure.

23 A. -- point in my supplemental report is only
24 one source of evidence I'm using to support the
25 broader point that consumers would be unlikely to

1 understand exactly how -- the fact that the minimum
2 score is the way that things are being imputed, that
3 TLG assigns a minimum score on the imputed measures.
4 There's a whole part of my initial report that talks
5 about this. And so I'm happy to answer questions
6 about the supplemental report.

7 To me the supplemental report is simply
8 evidence that's additional evidence consistent with
9 the main report that all suggests that it is unlikely
10 that consumers would be aware and understand that TLG
11 assigns a minimum score on the imputed measures.

12 Q. And last I just want to ask on page 9 of
13 your supplemental report, you have this sort of line
14 graph that shows spikes in the views of the hospital
15 safety grades across all hospitals. Correct?

16 A. Correct.

17 Q. And is that consistent with your market
18 research for these types of things that we would see
19 a spike in views in or around the times when rankings
20 are released?

21 A. I'm not sure exactly what you're asking.
22 Consistent with the notion, though, that TLG
23 undertook efforts to publicize these releases, these
24 grades, views of the individual hospital safety pages
25 increased both for the hospitals included in the data

1 overall as well as plaintiffs' hospitals in
2 particular. And so to me that's consistent with the
3 notion and supports the notion that TLG undertook
4 efforts to publicize these releases, and as a result,
5 more people saw the grades.

6 Q. Right.

7 And as we look at this Exhibit 2, for
8 example, again, just like the bar graph, we can't
9 tell who -- what types of users, sorry, are accessing
10 these safety grade data pages, whether it's the
11 hospitals checking out their own scores, hospitals
12 checking out their competitors, nurses, doctors,
13 academics, journalists, lawyers; you can't tell from
14 the data that we're looking at on Exhibit 2 what type
15 of users are exhibited during these spikes. Correct?

16 A. I have not -- I have not analyzed, and I
17 don't know whether it's possible -- I need to think
18 about it more -- whether it's possible to analyze the
19 type of individuals who were looking at this at
20 different points in time.

21 But this evidence still shows that the
22 monthly views, both in general, as well as for
23 plaintiff hospitals in particular increased at the
24 time of TLG releasing the hospital safety grades.

25 Q. Right.

1 And if we turn to Exhibit 3 on page 11 of
2 your supplemental expert report, these would be the
3 total monthly views of the hospital safety grades
4 across all of the plaintiffs, right, during this time
5 frame?

6 A. Across plaintiff hospitals.

7 Q. Right.

8 And so, this is going to out me at how bad
9 I am at mathematics. But if I were to add up all
10 these different clicks that I see in the line
11 graft -- graph, I cannot say that word today, line
12 graph on page 11, would it add up to 3,493 that we
13 see in the navy blue bar in Exhibit 1? Or is it
14 different time period? I'm sorry.

15 A. I'd have to check if it's the same time
16 period.

17 Q. Okay. Yeah, I'll withdraw that question.
18 It was terrible. I prefaced it by saying it will
19 show my terrible math skills so I apologize.

20 A. No problem.

21 Q. Okay. And you, in your expert analysis
22 with respect to this litigation, you did not perform
23 any analysis to determine whether there was a
24 correlation between page views of these five
25 hospitals and admission rates at these five

1 hospitals, have you?

2 A. That was not a specific question. There
3 was not a question that I was asked to opine on that
4 necessitated looking at that data, and so that's not
5 a type of -- I didn't look at that relationship.

6 Q. Okay. And I have to ask because you said
7 "it's not a specific question." Was it a general
8 question that was asked of you to opine on?

9 A. Oh, no, I'm sorry. I was just --

10 Q. Okay.

11 A. Given my assignment, this -- I should be
12 more -- given my assignment, that was not a -- not
13 something I -- I thought would help me answer the
14 questions in my assignment. And so it's not
15 something I considered.

16 Q. Okay. Thank you. And I think -- give me
17 one second to look at my notes.

18 Dr. Berger, I do not believe I have any
19 further questions, and I know that was a long time,
20 but thank you for indulging me.

21 A. No problem. I appreciate your questions.
22 I hope you have a good rest of your day.

23 MS. BLAIR: Thank you.

24 MS. MALONEY: Should we just be in touch
25 with the court reporter separately about -- I

1 don't know what we want in terms of recordings
2 and all that kind of stuff, so -- and I don't
3 know what you want. So can we just be in touch
4 with the court reporter separately on that.

5 MS. BLAIR: Yeah. I will place an order.
6 So -- we ordered the court reporter, right,
7 Courtney? So --

8 MS. MALONEY: I want an order for the
9 rough. But I just don't -- I don't know what
10 the time -- I know there's all this stuff about
11 video and the this and the that, and I never
12 know quite what to ask for.

13 MS. BLAIR: I'm still old school, Mary
14 Beth. I have binders and paper. I don't --

15 MS. MALONEY: Oh, oh, yeah.

16 MS. BLAIR: You asked about real time
17 video -- I was like, I'm not going to read that.
18 I'll just sit and read it like a canary in a
19 birdcage.

20 So, Karen, we will -- can we just be in
21 touch. I mean, I'm certainly going to order a
22 E-Tran, at a minimum. And to Mary Beth's point,
23 I'm not sure if we want the video at this point
24 or not. So I can put on the record I want to
25 order an E-Tran.

1 MS. MALONEY: I don't know what an E-Tran
2 is.

3 MS. BLAIR: It's just an electronic
4 transcript instead of somebody sending you the
5 printed-out one.

6 MS. MALONEY: Okay. That's fine.

7 MS. BLAIR: That's what I want.

8 MS. MALONEY: I never heard of that
9 before. So learn something new. Sure. Is that
10 a rough?

11 Karen, is that a rough?

12 COURT REPORTER: Excuse me. No. Hang on.

13 A rough is a -- it will also come
14 electronically, but it is not a finished
15 transcript. It will have mistakes in it.

16 MS. MALONEY: Right, of course.

17 COURT REPORTER: If you want a rough will
18 come relatively soon. The final will be fixed
19 and it will be electronic.

20 MS. MALONEY: Great.

21 MS. BLAIR: I'll take both the rough and
22 the final.

23 MS. MALONEY: Yeah, that would be great,
24 and I want the final too. But I am just saying
25 I don't need it expedited or anything like that.

1 We're about to head into Labor Day weekend, so.
2 If I can get a rough before the weekend, I'd
3 really appreciate it. But you're going to let
4 us know if we can only get the E-Tran. Okay?

5 MS. BLAIR: Yeah. And, Jason, I will
6 probably at some point in the future want a
7 video, but not today. I got to ask.

8 VIDEOGRAPHER: No problem at all. Magna
9 will reach out to your office anyways just to
10 confirm.

11 MS. BLAIR: Thank you. I appreciate you.

12 VIDEOGRAPHER: All right. Are we ready to
13 go off the record then?

14 MS. BLAIR: We are.

15 VIDEOGRAPHER: Okay. Going off the record
16 at 3:08 p.m.

17 (Time Noted: 3:08 p.m.)
18
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1 STATE OF NORTH CAROLINA
COUNTY OF MECKLENBURG

2
3 I, Karen K. Kidwell, RMR, CRR, Stenographic
4 Court Reporter and Notary Public, the officer before
5 whom the foregoing proceeding was conducted according
6 to the emergency video notarization requirements
7 contained in G.S. 10B-25, do hereby certify that the
8 witness whose testimony appears in the foregoing
9 proceeding was duly sworn by me; that the testimony of
10 said witness was taken by me to the best of my ability
11 and thereafter transcribed by me; and that the
12 foregoing pages, inclusive, constitute a true and
13 accurate transcription of the testimony of the witness;
14 that I was located in Mecklenburg County and the
15 witness stated they were located in Orange County at
16 the time of the deposition.

17 I further certify that I am neither attorney
18 or counsel for, nor related to or employed by, any
19 attorney or counsel employed by the parties hereto or
20 financially interested in the action.

21 This the 8th day of September, 2025.

22
23 Karen K. Kidwell

Karen K. Kidwell, RMR, CRR

24 Notary Public #19971050142

25

1 INSTRUCTIONS TO WITNESS

2 Please read your deposition over
3 carefully and make any necessary corrections.
4 You should state the reason in the
5 appropriate space on the errata sheet for any
6 corrections that are made.

7 After doing so, please sign the
8 errata sheet and date it.

9 You are signing same subject to
10 the changes you have noted on the errata
11 sheet, which will be attached to your
12 deposition.

13 It is imperative that you return
14 the original errata sheet to the deposing
15 attorney within thirty (30) days of receipt
16 of the deposition transcript by you. If you
17 fail to do so, the deposition transcript may
18 be deemed to be accurate and may be used in
19 court.

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1	ERRATA		
2	PAGE	LINE	CHANGE
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4		REASON:	-----
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ACKNOWLEDGMENT OF DEPONENT

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I, JONAH BERGER, Ph.D., do hereby certify
that I have read the foregoing pages and that
the same is a correct transcription of the
answers given by me to the questions therein
propounded, except for the corrections or
changes in form or substance, if any, noted
in the attached Errata Sheet.

JONAH BERGER, Ph.D.

DATE

Subscribed and sworn to before me this
_____ day of _____, 20 _____.
My commission expires: _____

Notary Public

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Exhibit 4

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

-----X

GOOD SAMARITAN MEDICAL CENTER, INC., et al,
PLAINTIFF,

-against-

Case No.:

9:25-cv-80526-DMM

THE LEAPFROG GROUP,

DEFENDANT.

-----X

DATE: September 2, 2025

TIME: 9:45 A.M.

VIDEOTAPED EXPERT DEPOSITION of THOMAS
CHAKURDA, held at Wilson, Elser, Moskowitz,
Edelman & Dicker, 150 East 42nd Street, New
York, New York, before Rivka Trop, a Notary
Public of the State of New York.

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A P P E A R A N C E S:

GIBSON, DUNN & CRUTCHER, LLP
Attorneys for the Plaintiff
GOOD SAMARITAN MEDICAL CENTER, INC., ET
AL
200 Park Avenue
New York, New York 10166
BY: ALLYSON PARKS, ESQ.
MONICA GROVER, ESQ.

WILSON, ELSER, MOSKOWITZ, EDELMAN & DICKER,
LLP
Attorneys for the Defendant
THE LEAPFROG GROUP
150 East 42nd Street
New York, New York 10017
BY: KIMBERLY BLAIR, ESQ.

ALSO PRESENT:

SAMMY VERNI,
Videographer

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F E D E R A L S T I P U L A T I O N S

IT IS HEREBY STIPULATED AND AGREED by and between the counsel for the respective parties hereto, that the filing, sealing, and certification of the within deposition shall be and the same are hereby waived;

IT IS FURTHER STIPULATED AND AGREED that all objections, except as to the form of the question, shall be reserved to the times of the trial.

IT IS FURTHER STIPULATED AND AGREED that the within deposition may be signed before any Notary Public with the same force and effect as if signed and sworn to before this court.

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THE VIDEOGRAPHER: We are now on the record. The time is 9:45 a.m. We are on the record. This begins videotape number 1 in the deposition of Thomas Chakurda in the matter of Good Samaritan Medical Center, Inc., et al. v. Leapfrog Group.

Today is September 2, 2025, and the time is 9:45 a.m. This deposition is being taken at 150 East 42nd Street New York, New York, at the request of Wilson Elser Moskowitz Edelman & Dicker. The videographer is Sammy Verni of Magna Legal Services and the court reporter is Rivka Trop of Magna Legal Services.

Will counsel and all parties present state their appearances and who they represent.

MS. BLAIR: Kim Blair on behalf of the defendants.

MS. PARKS: Allison Parks representing the Plaintiff hospital, and I am joined by my colleague, Monica

1 T. CHAKURDA

2 Grover.

3 THE VIDEOGRAPHER: Will the court
4 reporter please swear in the witness.

5 T H O M A S C H A K U R D A, called as a
6 witness, having been first duly sworn by a
7 Notary Public of the State of New York, was
8 examined and testified as follows:

9 EXAMINATION BY

10 MS. BLAIR:

11 Q. Please state your name for the
12 record.

13 A. Thomas Chakurda.

14 MS. BLAIR: Let the record reflect
15 that this is the deposition of Tom
16 Chakurda taken pursuant to the Federal
17 Rules of Civil Procedure and the local
18 rules for the U.S. District Court for
19 the Southern District of Florida.

20 Q. Mr. Chakurda, could you please
21 state and spell your name for the record?

22 A. Sure. It is Thomas G. Chakurda,
23 C-H-A-K-U-R-D, as in David, -A.

24 Q. And I assume you have had your
25 deposition taken before?

1 T. CHAKURDA

2 A. Yes.

3 Q. So I will just go through just a
4 few brief ground rules. As you know, the
5 court reporter cannot take down both of us
6 speaking at the same time. I am a fast
7 talker, so I will try not to talk over your
8 answers, if you try not to talk over my
9 questions for the courtesy of the court
10 reporter, is that okay?

11 A. Fair enough.

12 Q. It is not an endurance test. So
13 if at any time you or your attorneys need a
14 break, please just let me know. We have a
15 breakout room across the hall for you. I
16 only ask that if there is a question
17 pending, that you answer it before we take a
18 break.

19 Is that okay?

20 A. Certainly.

21 Q. The court reporter can't take down
22 a shrug of the shoulders a uh-huh, ah-ah, so
23 all of your answers must be verbal, is that
24 fine?

25 A. Yes.

1 T. CHAKURDA

2 Q. Can you please tell me what your
3 current job is?

4 A. I am retired as of New Year's Eve
5 of last year.

6 Q. And in your retirement you are
7 still doing expert consulting I assume?

8 A. I am sorry, I didn't hear you.

9 Q. In your retirement you are still
10 doing expert consulting; correct?

11 A. This is my first engagement as an
12 expert witness.

13 Q. Okay. And so when I asked you
14 about your deposition experience previously,
15 that would have been in your capacity as a
16 chief marketing officer and not as an
17 expert?

18 A. Yes.

19 Q. That's a yes?

20 A. Yes.

21 Q. Prior to this engagement, had you
22 ever provided any expert consultation
23 services?

24 A. I did not.

25 Q. So you have never written a

1 T. CHAKURDA

2 report, even if you didn't testify?

3 A. I did not.

4 Q. And can you briefly tell me your
5 educational background?

6 A. I have a BA in rhetoric from the
7 University of Pittsburgh.

8 Q. And how does rhetoric differ from
9 marketing?

10 A. Rhetoric is persuasive speech.
11 The major was rhetoric, but there were
12 subclasses underneath that, marketing,
13 public relations. But the degree was in
14 rhetoric.

15 Q. Got you. And so I guess that sort
16 of answers my next question which is did you
17 take any specific questions -- specific
18 classes in the area of marketing during your
19 education?

20 A. Yes.

21 Q. Do you hold any certifications or
22 licensing in the area of marketing?

23 A. I do not.

24 Q. What year did you graduate from
25 college?

1 T. CHAKURDA

2 A. 1976.

3 Q. Well, I am not going to ask for
4 every job that you have had since 1976, but
5 at some point in time you became involved in
6 the area of marketing for healthcare
7 industry; is that correct?

8 A. That's correct.

9 Q. About what year did you become
10 involved in marketing for healthcare?

11 A. Mid 1980s, if I recall correctly.

12 Q. And was that for a hospital
13 system?

14 A. Yes, it was.

15 Q. And which hospital system was
16 that?

17 A. It was for Presbyterian University
18 Hospital, which is part of the University of
19 Pittsburgh Medical Center as it exists
20 today.

21 Q. And how long were you there?

22 A. I was there almost three years, I
23 believe.

24 Q. And after Presbyterian, did you go
25 to another hospital?

1 T. CHAKURDA

2 A. Yes, I was recruited from
3 Presbyterian to join Allegheny General
4 Hospital.

5 Q. And how long were you at Allegheny
6 General Hospital?

7 A. Ten years.

8 Q. So that brings us somewhere in the
9 '90s, is that fair?

10 A. Yes.

11 Q. And after Allegheny, where did you
12 go?

13 A. I was recruited -- Allegheny
14 General turned into West Penn Allegheny
15 Health System. So I had further years
16 there, I think three or four under the
17 system name West Penn Allegheny Health
18 System. After the West Penn Allegheny
19 Health System I joined what was then Boca
20 Raton Community Hospital which evolved into
21 Boca Raton Regional Hospital. And I was
22 there for ten years.

23 Q. And what year did you leave Boca
24 Raton?

25 A. I joined -- I joined Boca in 2009.

1 T. CHAKURDA

2 So I was there -- I am trying to review my
3 CV here.

4 Q. Oh, again, not a memory test, but
5 roughly ten years would be in 2019?

6 A. Yes, it was ten years there as
7 well.

8 Q. Okay. And what about Excelsa
9 Health System?

10 A. I was recruited from -- while in
11 Boca to come back to Western Pennsylvania,
12 Excelsa Health System is now independence
13 health system. It is a five-hospital system
14 in Western Pennsylvania, the third largest
15 health system in western Pennsylvania.

16 Q. And so Excelsa essentially merged
17 into Independence Healthcare System?

18 A. Yes, it was a five-hospital
19 system.

20 Q. And Excelsa had three hospitals;
21 correct?

22 A. That's correct.

23 Q. Oh, go ahead?

24 A. Excelsa, Butler had -- they were a
25 combination of Butler Health System and

1 T. CHAKURDA

2 Excelsa. Butler had two hospitals, Butler
3 and Clarion and west -- and Excelsa had
4 Westmoreland, Latrobe and Frick.

5 Q. Okay, perfect. And at some
6 point -- and you retired from Independence
7 Healthcare System?

8 A. That's correct.

9 Q. And so if my math is mathing,
10 which it very well may not be mathing, and I
11 know I have your CV. But -- so you were at
12 the Excelsa/Independence Healthcare System
13 from approximately 2019 until your
14 retirement; is that fair?

15 A. That's correct.

16 Q. And so I want to focus then just
17 sort of on that last year, your time at
18 Independence Healthcare System --

19 A. Sure.

20 Q. -- and those five hospitals.

21 What were your duties as -- you
22 were the chief marketing officer; correct?

23 A. That's correct.

24 Q. And what were your duties as a
25 chief marketing officer?

1 T. CHAKURDA

2 A. Essentially have executive
3 leadership over the marketing function of
4 the institution.

5 Q. How many people reported to you?

6 A. Probably 12.

7 Q. Is Independence Healthcare System
8 a publicly traded system?

9 A. It is a private not for profit.

10 Q. Do you know how much approximately
11 the budget was for marketing at Independence
12 Healthcare System?

13 A. It could vary, depending upon the
14 economics. But generally I would say
15 between \$300,000 and a half a million.

16 Q. And I noted that the independent
17 healthcare systems -- the five hospitals,
18 each one of them participated in the
19 Leapfrog survey while you were the chief
20 marketing officer; correct?

21 A. That's my understanding.

22 Q. And as the chief marketing officer
23 at Independence Healthcare System, did you
24 have discussions with executive leadership
25 about participating in the Leapfrog hospital

1 T. CHAKURDA

2 survey?

3 A. I did not have direct
4 conversations with them about that decision.

5 Q. Who made the decision at
6 Independence Healthcare Systems to
7 participate in the Leapfrog survey?

8 A. That would be at the highest level
9 of the executive team including the CEO, the
10 quality officer, operational VPs.

11 Q. And Boca Raton, while you were the
12 chief marketing officer there, they also
13 participated in Leapfrog hospital survey;
14 correct?

15 A. I don't recall.

16 Q. Do you recall putting out press
17 releases for Butler Memorial Hospital about
18 their A safety grade from Leapfrog?

19 A. Yes.

20 Q. And do you know whether or not
21 Butler purchased licensing from Leapfrog to
22 promote that hospital safety grade?

23 A. Yes, they did.

24 Q. And was that part of your
25 marketing budget?

1 T. CHAKURDA

2 A. I believe that expenditure would
3 have come out of marketing.

4 Q. And I don't want you -- that's
5 another one of my rules, I don't want you to
6 guess. So you said I believe, do you know
7 for certain as you sit here today?

8 A. I don't know for certain.

9 Q. You also worked at -- do you know,
10 well, let's talk about West Penn Allegheny
11 Health System?

12 A. Uh-huh.

13 Q. And specifically West Penn
14 Hospital, that's the only -- is that the
15 only hospital in West Penn Allegheny Health
16 System?

17 A. No, there was West Penn Hospital,
18 Allegheny General Hospital and then there
19 were three community hospitals.

20 Q. Do you know, were you the chief
21 marketing officer at West Penn Allegheny
22 Health System?

23 A. I was vice president of
24 communications.

25 Q. Do you know whether or not while

1 T. CHAKURDA

2 you were the vice president of
3 communications at West Penn Allegheny Health
4 System, whether West Penn Hospital completed
5 the Leapfrog survey?

6 A. I don't recall.

7 Q. So if this is your first expert
8 engagement, I suspect that you have not been
9 qualified as an expert in hospital branding
10 in a legal matter before now?

11 A. I would say this is my first
12 engagement as an expert witness.

13 Q. Just getting rid of some questions
14 here, moving this along.

15 And you are being compensated for
16 your time in this matter; correct?

17 A. I am.

18 Q. And what is your rate?

19 A. I believe it is \$900 thereabout.

20 Q. And how many hours have you put
21 into this matter to date?

22 A. I would say approaching 40.

23 Q. And you work with the Cornerstone
24 Group in putting these opinions together?

25 A. I am sorry, the last part?

1 T. CHAKURDA

2 Q. You work with the Cornerstone
3 Group in putting these opinions together?

4 A. I had concert -- I had worked in
5 concert with them, I collaborated with them.

6 Q. And what services does the
7 Cornerstone Group provide to you to help you
8 produce your opinions in this matter?

9 A. I believe they assess my opinions
10 and my observations and synthesize that into
11 a document.

12 Q. So you have calls with the
13 Cornerstone Group to talk about your
14 opinions and then they put it into a
15 document, is that how that works?

16 A. These were done electronically.

17 Q. Were there any opinions that you
18 were asked to give in this matter that you
19 felt that you could not give?

20 A. No.

21 Q. In coming to your opinions in this
22 matter, did you speak with anyone at the
23 five hospitals?

24 A. No.

25 Q. In coming to your conclusions and

1 T. CHAKURDA

2 opinions in this matter, did you review any
3 of the marketing plans for any of the five
4 hospitals?

5 A. No.

6 Q. In coming to your conclusions and
7 opinions in this matter, did you assess the
8 brand of these five hospitals?

9 MS. PARKS: Objection, vague.

10 Q. You still have to answer that, if
11 you can?

12 A. Could you restate the question,
13 please.

14 Q. Yeah, that's another rule I should
15 tell you, if at any time you do not
16 understand one of my questions, it is a good
17 objection, I am happy to rephrase it?

18 A. Thank you.

19 Q. Let me just lay some foundation
20 for that then.

21 Are you aware of whether or not
22 there are any scientific methods that are
23 employed in order to make a determination
24 about a hospital's brand?

25 A. There are surveys, there are

1 T. CHAKURDA
2 ratings that have an impact in my view and
3 my opinion on the brand and the cache of the
4 brand.

5 Q. And I understand those things can
6 have impact on the brand. But I guess my
7 question is a little more general.

8 You understand that these five
9 hospitals complain that due to a change in
10 the Leapfrog grading methodology in November
11 of 2024, they are now being unfairly graded
12 in this, in the Leapfrog hospital safety
13 grades?

14 MS. PARKS: Objection to the
15 extent that misstates the record.

16 A. What I am opining on is the
17 impact, my opinions and my observations are
18 related to the impact of an F or a D grade
19 assigned to a hospital versus an A.

20 Q. Right, but wouldn't you have to
21 know what the brand was before they got the
22 F to determine what the impact was on the
23 brand?

24 A. I was aware of their previous
25 grades.

1 T. CHAKURDA

2 Q. So you are aware that some of
3 these hospitals had D grades previously?

4 A. Yes.

5 Q. Did you do any surveys in
6 connection with coming to your opinions to
7 determine whether or not any of these five
8 hospitals had a good brand or a bad brand
9 prior to November of 2024?

10 A. You have to understand, I spent
11 ten years in that market.

12 Q. Right?

13 A. So I was very aware of their
14 brands and of their presence.

15 Q. And the ten years you spent in
16 that market, I thought you told me you left
17 around 2019; correct?

18 A. Yes.

19 Q. And do you understand that these
20 five hospitals were purchased by Tenet
21 Hospital some time in or around 2019; is
22 that correct?

23 A. I am not aware of that date.

24 Q. Are you aware of -- from your time
25 at Boca Raton, in 2019, what was your view

1 T. CHAKURDA

2 of each of these five hospital's brand?

3 A. They were formidable competitors.

4 Q. Formidable?

5 A. Yes.

6 Q. Do you know when Tenet Healthcare
7 bought these five hospitals?

8 A. I do not.

9 Q. Do you have any opinions about the
10 Tenet Healthcare System's brand?

11 A. Not in particular.

12 Q. What about specifically?

13 A. Again, my -- my experience with
14 them being a competitor that I -- that I
15 perceive them to be a quality and material
16 competitor for the hospital that I worked
17 at.

18 Q. You mean Tenet Healthcare System?

19 A. No, the hospitals in Palm Beach
20 County.

21 Q. So my question is like a little
22 more broad.

23 So you understand that Tenet
24 Healthcare System is a publicly traded
25 healthcare system?

1 T. CHAKURDA

2 A. Yes, they are for profit.

3 Q. For profit. And I looked last
4 night, it looked like their market
5 capitalization was \$16.06 billion, do you
6 have any understanding of how big Tenet
7 Healthcare Systems are?

8 A. I knew and I know that they are a
9 big company.

10 Q. Right. So setting aside these
11 five hospitals --

12 A. Uh-huh.

13 Q. -- which were purchased by Tenet
14 later, right, do you have any view as a
15 chief marketing officer for over -- it looks
16 like 30, 40 years maybe, as a chief
17 marketing officer for healthcare system of
18 the brand of Tenet Healthcare on the
19 system-wide basis?

20 A. I am not, I do not.

21 Q. I know that your opinion -- and I
22 am going to show it to you, don't worry, I
23 know that your opinion refers to a lot of
24 documents that were produced by both
25 Leapfrog and these five hospitals. We will

1 T. CHAKURDA

2 call them Palm Beach Health Net work, I
3 think they are Bates labeled PBHN.

4 Did you specifically ask for
5 certain documents to be provided to you in
6 order for you to formulate your opinions?

7 A. I did not.

8 Q. How did you come to get those
9 particular documents upon which you rely on
10 your opinion?

11 A. The complaint was provided to me.
12 And there were material other documents
13 related to the issue.

14 Q. And who provided those to you?

15 A. Gibson and Dunn.

16 Q. Were there any documents you wish
17 you would have seen to add to your opinions
18 that you did not have in your possession?

19 A. No.

20 Q. Would it have been -- would it
21 have been important to you to see these five
22 hospitals' marketing plans in or around 2023
23 to 2025?

24 A. No. Again, my -- my opinions are
25 based on the impact -- the thrust of my

1 T. CHAKURDA

2 opinions are based on the impact of
3 receiving an F grade or a D grade as opposed
4 to grades higher on the continuum. That has
5 been my sole focus of generating my
6 opinions.

7 Q. Right. And your opinions as I
8 read them are more in the broadest sense
9 that if you get an F grade, that would
10 impact your brand negatively versus an A
11 grade impacting positively; correct?

12 A. Yes, but there is nuance to that
13 as well.

14 Q. Yes, of course and we are going to
15 get into that. And I ask that question
16 because I want to make sure I understand. I
17 didn't read anything in your report where
18 you are talking specifically about metrics
19 as to these five hospitals and a brand
20 impact as it to these five hospitals
21 specifically, is that fair?

22 A. I believe my opinion states that
23 it is -- in my opinion, it is definitive
24 that there is impact to the reputation and
25 brand of the hospital by receiving a D and

1 T. CHAKURDA

2 an F.

3 Q. Okay, but you have not quantified
4 that impact in any way; correct?

5 A. No.

6 Q. And you are not going to offer any
7 opinions today about whether or not the
8 methodology that is employed by Leapfrog is
9 fair; correct?

10 A. I am not opining on the
11 methodology.

12 Q. Did you review the opinion of
13 Dr. Sean Nicholson of coming to your
14 opinions?

15 A. Yes.

16 Q. What about the opinion of
17 Dr. Jonah Berger?

18 A. Yes.

19 Q. You understand that Mr. Berger is
20 also a marketing expert; correct?

21 A. By his credentials, yes.

22 Q. And did you see that -- did you
23 read Dr. Berger's supplemental expert report
24 in this matter?

25 A. I believe I did.

1 T. CHAKURDA

2 Q. That was the one with the Google
3 analytics, do you recall seeing that?

4 A. Yes.

5 Q. Did you do analysis of the
6 Leapfrog Google analytics in coming to your
7 opinions?

8 A. No, I did not.

9 Q. Did you perform any type of
10 patient -- patient surveys in coming to your
11 conclusion?

12 A. No, I did not.

13 Q. Did you have use any
14 methodologies, scientific methodologies in
15 coming to your conclusions?

16 MS. PARKS: Objection, vague.

17 A. Again, my opinions are based on
18 almost 40 years of marketing experience and
19 my impression of the impact that D or F
20 would have on their brand.

21 Q. You cite to a lot of articles and
22 studies in your opinion. Did you read each
23 and every one of those before forming your
24 opinion?

25 A. Yes, I reviewed them.

1 T. CHAKURDA

2 Q. Of all the articles that you cite
3 to in your opinion, are there one or two
4 that you believe are the most important to
5 your opinion?

6 A. Yes, I found the section, and I
7 can't recall the exact letter of that
8 section, but it was the article on
9 negativity bias.

10 Q. You don't remember the author,
11 though? I don't either.

12 A. I don't, I am sorry.

13 MS. BLAIR: We can mark this then
14 as Chakurda Exhibit 1.

15 (Whereupon, the Expert report was
16 marked Chakurda Exhibit 1 for
17 identification as of this date.)

18 Q. Mr. Chakurda, the court reporter
19 is handing you what we have now marked as
20 Chakurda Deposition Exhibit 1, which is a
21 document that contains an 18-page opinion
22 signed by you on page 18 as well as Exhibit
23 A, Exhibit B, I can't remember if there is a
24 C, just through Exhibit B.

25 Do you have that in front of you?

1 T. CHAKURDA

2 A. Yes, I do.

3 Q. And in looking at that, if you
4 look at page 18, is that in fact your
5 signature?

6 A. Let me find page 18. Yes, that
7 is.

8 Q. And just looking through this
9 first 18 pages, is this your opinion in this
10 matter?

11 A. Yes, it is.

12 Q. In your expert opinion, and I am
13 going to ask you some specific questions
14 about this opinion, but I want to know in
15 your expert opinion, how do you define a
16 hospital's brand, what goes into that?

17 A. Hospital brand is essentially its
18 reputation and how that reputation
19 translates into recruitment and retention of
20 staff, how it is perceived in the community
21 by utilization and just by the perception of
22 that community as to the quality of services
23 provided.

24 Q. And in your opinion, what are the
25 key components? So you said a hospital's

1 T. CHAKURDA

2 brand is its reputation and how that
3 translates, right, into recruiting, et
4 cetera.

5 So what are the key components
6 that forms a hospital's reputation in your
7 expert opinion?

8 A. Strength of its clinical staff,
9 technology it employs and the perceived
10 quality of the care that is provided.

11 Q. And when you say perceived quality
12 of care, would that be patient perspective?

13 A. Yes.

14 Q. Do you know whether or not any of
15 these five hospitals have patient
16 satisfaction surveys?

17 A. I do not.

18 Q. Is that something you might have
19 wanted to see in order to form your opinions
20 here today?

21 A. It would not have changed my
22 opinions and my observations.

23 Q. Right, because getting an F
24 impacts a hospital's safety brand; correct?

25 A. Yes. Again, my opinions and my --

1 T. CHAKURDA

2 you know, what I am putting forth here is
3 how a D and an F can impact the brand or the
4 reputation of that institution.

5 Q. What about a 1 star from CMS, can
6 that impact the brand or reputation of a
7 hospital?

8 A. I think all rating platforms have
9 the potential to either enhance or damage a
10 hospital's brand/reputation.

11 Q. What about word of mouth of
12 patients, does that have the potential to
13 increase or decrease?

14 A. Absolutely.

15 Q. What about negative Yelp reviews?

16 A. Yes.

17 Q. What about negative Google
18 reviews?

19 A. Yes.

20 Q. What about comments on social
21 media that are negative about a hospital?

22 A. Yes.

23 Q. Is a hospital's brand more
24 dependent on internal factors, like outcomes
25 and staff or external perception, like

1 T. CHAKURDA

2 advertising and marketing?

3 A. Ground zero is what transpires
4 within the walls of those institutions and
5 the quality of care they provide.

6 Q. What does that mean, what is
7 ground zero?

8 A. I think that's the core issue.

9 Q. That's the core. And who is in
10 the best position to determine the quality
11 of care provided by the hospital?

12 A. Well, certainly the hospital
13 administration itself, starting with the
14 CEO, to the medical staff, to the quality
15 officers. There are myriad staff members
16 and executives that monitor and, you know,
17 review those -- those parameters.

18 Q. What about patients, are they in a
19 good position to determine whether or not
20 they are getting good quality of care?

21 A. Patients clearly have their
22 perspectives, they judge what transpires at
23 the bedside. There are direct survey
24 methods, like H-CAPs that are directed to
25 the patient themselves. So the patients do

1 T. CHAKURDA

2 have voice, if you will, in judging the
3 quality of an institution.

4 Q. And in your role as a chief
5 marketing officer, did you review H-CAPs?

6 A. I would review them at a
7 60,000-foot level with the executive team.

8 Q. And you understand H-CAPs have to
9 do with patient -- patient -- I am using
10 this word, but patient perspective of the
11 quality of care they received?

12 A. Yes, it is a CMS survey --

13 Q. Correct.

14 A. -- of patients themselves.

15 Q. Do you know what the H-CAP scores
16 were for any of these five hospitals.

17 A. I do not.

18 Q. If those H-CAP scores were low,
19 would that in your mind have an impact on
20 their brand?

21 A. Again, my opinion is how a D and
22 an F affects that brand.

23 Q. Right, and I understand that. But
24 would you agree with me in your expert
25 opinion that there are many things that can

1 T. CHAKURDA

2 affect a hospital's brand?

3 A. A brand is built on multiple
4 factors.

5 Q. Okay. Yeah, and I think your
6 report says multifaceted; correct?

7 A. Yes.

8 Q. I am going to ask you some
9 questions about that later, but thank you.

10 What about like -- is a hospital's
11 brand impacted by negative reviews of the
12 doctors that work at that hospital?

13 A. In my experience, if there would
14 be negative reviews of doctors, that would
15 have an impact.

16 Q. Right. And you hesitated, so it
17 might have been a terrible question. So I
18 will ask it again.

19 So there are, you know, like
20 Google ratings or Yelp ratings of a hospital
21 itself; correct, you understand that?

22 A. Uh-huh.

23 Q. You have to say yes?

24 A. Uh-huh, yes, I am sorry.

25 Q. It is all right.

1 T. CHAKURDA

2 And then you understand there are
3 these other services like Zocdoc or like
4 different reviews that are specific reviews
5 of doctors; correct?

6 A. Yes.

7 Q. So my question, I want to make
8 sure you understood it, if a doctor that is
9 associated with let's just say, Good
10 Samaritan is receiving very low, Yelp,
11 Google Zocdoc reviews, can that have a
12 negative impact on a hospital's brand?

13 A. I believe you have to factor in
14 the weight of the rating and how it is
15 presented.

16 Q. Okay.

17 A. If you look at the Leapfrog
18 methodology in portraying their grades, it
19 is extremely ambitious, extremely
20 aggressive, the amount that they put out.

21 So the Leapfrog grade in my
22 opinion is much more prominent in the public
23 eye than some of these other sites that you
24 have surveyed that are less visible and less
25 promoted.

1 T. CHAKURDA

2 Q. But I believe some of these
3 articles that you cited to specifically talk
4 about the fact that these types of Zocdoc, I
5 am not making this up, Zocdoc, Google
6 ratings and Yelp ratings from a specific
7 patient can have an effect on a hospital's
8 brand?

9 A. Yes, they can have an effect, yes.

10 Q. So what I think I just heard you
11 say and I want to make sure, so in your mind
12 do you have a weighting of what is the most
13 impactful to a brand versus the least
14 impactful to a brand in terms of ratings?

15 A. Again, I believe the weight of
16 portraying these ratings has an impact on
17 the impact of that in the public view. And
18 again, Leapfrog in my view is very
19 pronounced in making sure through the media
20 that these grades are extremely well
21 publicized. So in my opinion that eights
22 adds throw weight to these others.

23 Q. What about CMS ratings, do they
24 have a lot of weight?

25 A. In my experience CMS and H-CAPs

1 T. CHAKURDA

2 are more an internal review document. Those
3 opinions are shared with administration and
4 medical staff. They are not vigorously
5 portrayed externally clearly as Leapfrog.

6 Q. But you understand that CMS has a
7 system by which they rate hospitals with --
8 from 1 star to 5 star?

9 A. Yes, they have a website too.

10 Q. And would you agree with me that
11 in South Florida there is a large population
12 of persons over the age of 65?

13 A. Absolutely.

14 Q. And they or may not be recipients
15 of Medicare; correct?

16 A. Could you restate the question.

17 Q. Well, I mean you understand the
18 CMS star ratings are prominently displayed
19 on Medicare websites; correct?

20 A. That's correct.

21 Q. And so do you know in working in
22 Boca Raton for all those years whether or
23 not a large majority of the population in
24 South Florida is in fact on Medicare?

25 A. Medicare did you say?

1 T. CHAKURDA

2 Q. Medicare?

3 A. I believe it is almost 70 percent
4 in that -- in that South Florida area.

5 Q. Okay. And so if 70 percent of the
6 population in the South Florida area is on
7 Medicare, they would be getting access to
8 and seeing CMS star ratings; would they not?

9 A. I would think they would have to
10 do that of their own volition.

11 Q. Well, you have to go to a Leapfrog
12 safety grade of your own volition as well;
13 correct?

14 A. I would disagree with that. You
15 don't have to go to Leapfrog given their
16 aggressive views of portraying their grades
17 in the media. You just have to read the
18 paper, watch TV or listen to the radio.

19 Q. Have you ever gotten an AARP
20 letter that tells you to look at the CMS
21 star ratings for hospitals?

22 A. No.

23 Q. Oh, okay.

24 In terms of social media, which is
25 obviously very prominent, as a chief

1 T. CHAKURDA

2 marketing officer, do you oversee the social
3 media presence of the hospital?

4 A. Yes, the digital component reports
5 to me.

6 Q. And is there somebody in the
7 marketing office that reviews comments to
8 social media posts?

9 A. Yes.

10 Q. And how does -- or at least when
11 you were working at Independence --
12 Independence -- Is it independence?

13 A. Independence Health System,
14 Independence will work.

15 Q. Independence Healthcare Systems,
16 how was that done, the review of negative
17 social media posts?

18 A. We would be the first screen,
19 because we monitor social media. Then those
20 would be triaged, those complaints would be
21 triaged or those comments would be triaged
22 to the relevant administrative or medical
23 staff within the institution.

24 Q. And when you say triaged, are they
25 responded to on the social media platform?

1 T. CHAKURDA

2 A. I am trying to remember. We would
3 not engage on -- on the social media.

4 Q. Do you know whether or not any of
5 these five hospitals have marketing
6 department in place to monitor and/or triage
7 negative social media postings?

8 A. I don't know their protocols.

9 Q. Do you know whether or not the
10 marketing of these five hospitals is done at
11 the Tenet Healthcare parent level or whether
12 it is on done on an individual hospital
13 basis?

14 A. I believe they have a corporate
15 marketing function.

16 Q. And why do you believe that?

17 A. That's just --

18 Q. I don't know the answer.

19 So it is just -- having been a
20 chief medical officer at a healthcare
21 system, you believe that is the most likely
22 that it is done on a --

23 A. Yes, I believe that organization
24 supply marketing materials to their
25 institutions.

1 T. CHAKURDA

2 Q. But you never spoke to anybody at
3 any of these five hospitals or Tenet
4 Healthcare System to confirm that that's how
5 it works?

6 A. No, I did not.

7 Q. What about bad press related to
8 medical malpractice suits, can that have an
9 impact on a hospital's brand?

10 A. Bad press has a negative impact.

11 Q. What about complaints by nurses of
12 understaffing and failure to maintain safe
13 working conditions, which they say
14 compromised patient safety, can that have a
15 negative impact on a hospital safety brand
16 or hospital brand?

17 A. Are you saying that those are
18 portrayed in the press?

19 Q. Uh-huh.

20 A. Again, negative press is negative
21 press regardless of the source.

22 Q. What about if Tenet had press
23 coverage regarding strikes by nurses over
24 concerns about understaffing and unsafe
25 patient conditions, can that have a negative

1 T. CHAKURDA

2 impact on the hospital brand?

3 A. I believe it could. But again, my
4 opinions, again are general --

5 Q. Of course?

6 A. Are targeted towards the impact of
7 Ds and Fs as portrayed by Leapfrog.

8 Q. Understood. But you would agree
9 with me that one of your foundational
10 opinions is about a hospital brand; correct?

11 A. Sure.

12 Q. So I am trying to discover what
13 all goes into that brand and what could
14 impact it?

15 A. Uh-huh.

16 Q. And specifically with respect to
17 these five hospitals, they are part of the
18 Palm Beach Health network which is part of
19 the Tenet Health System?

20 A. Yes.

21 Q. And so as the former chief
22 marketing officer of the health system, I
23 think you told me this before, but I am
24 going to ask it again so I remember, as the
25 chief marketing officer of a health system,

1 T. CHAKURDA

2 can the negative reputation of the health
3 system itself have a negative brand impact
4 on the individual hospitals that operate
5 under that health system's umbrella?

6 A. Absolutely.

7 Q. And so bad press with respect to
8 the health system itself can have a negative
9 impact on an individual hospital within that
10 system?

11 A. I believe it can halo down.

12 Q. So if you turn to your report of
13 paragraph 17, which is in front of you,
14 Exhibit 1?

15 A. And again, the page, what are you
16 referencing?

17 Q. It is your paragraph 17, so it is
18 on page 4?

19 A. Page 4.

20 Okay, I am on page 4.

21 Q. And if you look at paragraph 17,
22 the third sentence that starts, Hospital
23 systems, do you see that?

24 A. Yes.

25 Q. You say, "Hospital systems have

1 T. CHAKURDA

2 dedicated marketing departments responsible
3 for advertising, website and digital
4 communications, competitive intelligence,
5 patient outreach and media relations."

6 Do you see that?

7 A. Yes.

8 Q. And I asked you this probably four
9 times, but you don't know whether these five
10 hospitals have -- well -- strike that.

11 You don't know whether the Tenet
12 Hospital system has a dedicated marketing
13 department responsible for all five of these
14 different areas, do you?

15 A. I believe they have a
16 communications function department that is
17 responsible for those institutions.

18 Q. But you never reviewed any
19 marketing plan or internal papers at Tenet
20 Health?

21 A. No, I did not.

22 Q. And then the next sentence it
23 says, "In addition, many hospitals work with
24 external consultants who provide additional
25 support."

1 T. CHAKURDA

2 Do you see that?

3 A. Yes.

4 Q. Do you know whether or not Tenet
5 Health Systems works with external
6 consultants to provide additional support?

7 A. By that I mean an outside agency
8 that they would work with. I do not know if
9 they had that relationship or they were
10 internal shops.

11 Q. And by talking about external
12 consultants, are you referring to lobbyists?

13 A. No.

14 Q. No. You are referring to like PR
15 firms?

16 A. Marketing, advertising and PR
17 firms.

18 Q. Do you have any sense of what
19 these five marketing firms do in the South
20 Florida region to market their brand?

21 A. I do not.

22 Q. So you don't know what the budget
23 is for Tenet Healthcare for marketing?

24 A. I do not.

25 Q. When you were the chief marketing

1 T. CHAKURDA

2 officer at the health systems that you
3 worked with, was your marketing budget a
4 percentage of the hospital's overall budget?

5 A. It was a portion of the overall
6 operating budget of the institution.

7 Q. And I know it was a portion, it is
8 like based on a percentage? Like this year
9 marketing is getting 4 percent, next year
10 they will get 6 percent?

11 A. It is solely dependent upon the
12 economic situation of the hospital. It is
13 fluid, it can go up, it can go down, it can
14 remain static. We did budgets every year
15 based on those factors.

16 Q. And when you were the chief
17 marketing officer at Independence Health
18 System -- I don't know why I am having such
19 trouble with that today, I apologize -- do
20 you know when those hospitals participated
21 in Leapfrog survey, did they have an
22 overarching collection or -- this is a
23 terrible question, so let me think about it.

24 As I understand it, when
25 healthcare systems participate in the

1 T. CHAKURDA

2 Leapfrog survey, they don't allocate
3 resources at each independent hospital, they
4 have an overarching healthcare system
5 quality officer or director that oversees
6 the collection of data for the Leapfrog
7 survey. Do you know whether or not that's
8 how it was done at Independence?

9 A. I would not know the exact
10 mechanics.

11 Q. In paragraph 20 of your report,
12 you talk about the fact that hospitals --
13 where is this? Let me just make sure I
14 am -- hospitals also must allocate their
15 resources among many marketing channels.

16 And I feel like that might not be
17 the right paragraph. Give me a second.

18 Oh, I am sorry, 21, this is what
19 happens when you are a 50-year-old partner
20 and you do it yourself?

21 A. Okay, I got it.

22 Q. Paragraph 21 you say, "Hospitals
23 must allocate their resources among many
24 marketing channels," do you see that
25 paragraph?

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2 A. Yes, ma'am.

3 Q. And you have five bullet points
4 here; correct?

5 A. Yes.

6 Q. The first is direct to consumer
7 advertising. As you sit here today, you
8 don't know whether or not these five
9 hospitals do direct to consumer advertising,
10 do you?

11 A. I do not know their media mix.

12 Q. Okay. And the same question with
13 respect to Tenet Health Systems, you don't
14 know whether they do direct to consumer
15 advertising?

16 A. I do not know their media mix.

17 Q. Would that be important to you as
18 a brand expert to know what type of media
19 messaging they are putting out into the
20 public?

21 A. Not as it applies to the impact of
22 a D and an F on their brand.

23 Q. Okay. But what if a hospital has
24 no brand before they get a D or an F?

25 A. I am not aware of a hospital that

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2 does not have a brand in terms of whether
3 that brand is good, middle or poor, in 40
4 years.

5 Q. Right. Because even if you don't
6 do advertising, you are going to get a brand
7 based on word of mouth or patient experience
8 at a minimum; correct?

9 A. Yes. There are other ways to
10 evolve a brand.

11 Q. Your third bullet point here is
12 community sponsorships and philanthropy, do
13 you know whether any of these five hospitals
14 engage in community sponsorships and
15 philanthropy in the South Florida area?

16 A. Again, I don't know their mix.

17 Q. The same question with respect to
18 patient outreach through participation in
19 community events, again, you don't know
20 their media mix; correct?

21 A. All I know is that these are very
22 important legs on the stool.

23 Q. I like that, important legs on the
24 stool.

25 And these are important legs on

1 T. CHAKURDA

2 the stool to build your brand; correct?

3 A. Yes.

4 Q. And in your expert opinion, can
5 you build a positive brand without engaging
6 in these five bullet points in paragraph 21?

7 A. You have to realize, there are
8 other elements that go into the development
9 of brand. What transpires at the bedside is
10 probably one of the most important aspects
11 of developing your brand.

12 So it is interactions, there are
13 myriad factors of what transpires within the
14 walls of a hospital that builds their brand.
15 These platforms that you just referenced are
16 in the main external representations of that
17 brand, if that makes sense.

18 Q. That does make sense?

19 A. So there is -- again, there is the
20 internal workings and the patient experience
21 and the family experience versus messaging
22 that marketing constructs, portrays and
23 tries to use in that aspect of developing a
24 brand.

25 Q. Okay, that makes sense. And so

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2 the patient and family experience, that's --
3 that's found in those H-CAPs we talked about
4 previously?

5 A. To an extent.

6 Q. To an extent?

7 A. Sure.

8 Q. In your experience as the chief
9 marketing officer, do hospitals consider
10 participation in the Leapfrog survey as part
11 of their marketing budgets?

12 A. That would be an institutional
13 decision.

14 Q. What about at Independence
15 Healthcare?

16 A. They participate in the surveys.

17 Q. And in fact, we talked about
18 earlier, Butler purchased licensing at one
19 point to advertise its A safety grade;
20 correct?

21 A. That's correct.

22 Q. So my question is, at least
23 specific to Butler, was that part of your
24 marketing budget?

25 A. I actually don't recall when they

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2 did that. I don't know if that was prior to
3 the construction -- Independence Health is a
4 relatively new system, it was the Butler
5 health system and Excela. So I can't recall
6 when Butler made the move to secure the A
7 and what their decision making was. I don't
8 know if that was under my tenure or prior to
9 that.

10 Q. Well, I did see -- I did not make
11 copies of this, but I did see a press
12 release with your name on it about Butler
13 and its A, do you recall putting that out?

14 A. Yes, then that refreshes my
15 memory, thank you.

16 Q. Do you have any understanding of
17 how much a hospital would need in its budget
18 to comply with the Leapfrog survey?

19 A. I would have no idea.

20 Q. Do you know how many FTE hours
21 would be necessary to complete the Leapfrog
22 survey?

23 A. I would have no idea.

24 Q. Do you know what Vizient is?

25 A. I have heard -- I have heard of

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2 Vizient, but I couldn't articulate exactly.

3 Q. Do you understand it to be an
4 internal survey?

5 A. I believe it is some survey
6 instrument of quality.

7 Q. Do you know whether any of these
8 five hospitals engage in Vizient?

9 A. I do not.

10 Q. Have you as a chief marketing
11 officer ever been involved in completing a
12 Vizient survey?

13 A. No.

14 Q. Do you have any position as to
15 whether participation in the Leapfrog survey
16 should be part of a hospital's marketing?

17 A. I do not.

18 Q. Some of the articles that you cite
19 to talk about market share. And I am just
20 going to rephrase some footnotes so you know
21 what I am talking about, because otherwise
22 that's a terrible question that is going to
23 get an objection.

24 So if we look at footnote 8, for
25 example, and footnote 8 is referenced on

1 T. CHAKURDA

2 page 7 of your opinion, and this is the
3 Huppertz article?

4 A. Yes.

5 Q. And you have a parenthetical here
6 that says, "Hospital administrators have
7 continued to spend funds on advertising
8 arguing that they must build and hold market
9 share to survive in an increasingly
10 competitive marketplace."

11 Do you see that?

12 A. Yes.

13 Q. And then you have another
14 footnote, this is on page 9, 18, and this is
15 Hibbard, not to be confused with Huppertz,
16 but Hibbard article. And then you say, "If
17 a hospital's reputation is affected, it may
18 then experience market share declines."

19 Do you see that?

20 A. Yes.

21 Q. Is the best way to determine
22 whether a hospital has a good brand or a bad
23 brand to look at its market share in the
24 geographic regions in which it operates?

25 A. I would consider utilization which

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2 is market share. And a key indicator is are
3 people gravitating towards those
4 institutions or are they staying away.
5 That's one of many barometers.

6 Q. What are the other barometers?

7 A. Recruitment and retention of
8 staff, are you having trouble filling
9 vacancies when recruiting physicians because
10 of possible perceptions relative to the
11 quality and care provided there.

12 Q. Anything else?

13 A. Philanthropy, are people
14 supporting you with their pocketbook because
15 they feel you are providing a quality
16 service and doing good in the community. So
17 that could be another barometer, and that is
18 especially important in the Palm Beach area.

19 Q. Do you know what these five
20 hospitals philanthropy profile is in the
21 Palm Beach area?

22 A. I do not. All I know is that the
23 wealth in Palm Beach County is extreme. And
24 that demographic can vote with their
25 pocketbook or they can vote by getting on a

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2 jet and going back to New York for care.

3 Q. Right, and one of the things you
4 say in your opinion, which I agree with, is
5 about how competitive the Palm Beach area is
6 in terms of medical care; correct?

7 A. Yes.

8 Q. And full disclosure, one of my
9 best friends lives in Palm Beach. And I
10 have noticed when I go to visit her there
11 are all these New York facilities moving
12 into the Palm Beach area; correct?

13 A. In fact the Hospital for Special
14 Surgery out of New York, the number one
15 rated orthopedic hospital, they built a
16 facility there. Langone is down there. So
17 very large, prominent players are
18 establishing footprints in Palm Beach
19 County.

20 Q. And so in terms of your expertise
21 in evaluating not only hospital brands, but
22 also your knowledge and understanding of
23 South Florida, how have those sorts of
24 large, well-known institutions coming into
25 South Florida impacted the hospital brands

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2 of the hospitals that have already been
3 there?

4 A. I don't think they impact their
5 brands, they add another significant
6 competitive element to the market. Hence
7 your brand is going to be important in
8 shielding you against those competing
9 threats.

10 Q. Can your brand as a hospital be
11 minimized if a better, more well renowned
12 hospital moves into your area?

13 A. An interesting question. Again, I
14 don't think the brand automatically gets
15 degraded by Hospital for Special Surgery
16 moving down there, or it is just that the
17 brand -- the important factor is if the
18 brand takes a hit, okay, for some reason,
19 that brand is degraded, it puts them in a
20 much more precarious situation given that
21 new and very formidable competitor.

22 Q. Right. And I am probably thinking
23 about it way too simplistically, but I am
24 thinking if you were the number one
25 hospital, let's just take like rural

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2 Pennsylvania, let's say there are two
3 hospitals, one is a Catholic Charities
4 Hospital and one is a rural safety net
5 hospital, and the Catholic Charities
6 hospital is number one in people's mind and
7 the other is number two, and then Sloan
8 Kettering moves in and opens a hospital,
9 does that not decrease market share? There
10 is only so many people, now you have three
11 hospitals and a much better, well-known
12 hospital, I am just wondering how it works?

13 A. Well, the example you give is an
14 interesting one. Because if Sloan Kettering
15 comes into a rural area where, you know,
16 there are degrees of medicine that are
17 practiced in different pockets such as urban
18 hospitals versus rural hospitals. So if an
19 institution like that planted their flag in
20 a rural market, clearly that would be an
21 extremely competitive threat to those two
22 institutions.

23 Q. Right?

24 A. I don't know if it affects their
25 brand --

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2 Q. That was my question.

3 A. -- or the perception of those
4 logos, jeez, St. James is a really good
5 hospital, but Sloan with cancer, you know.
6 So it is the elements of that brand, the
7 facets of it.

8 I mean, it is just commonsense
9 that if an institution of that gravitas
10 moved in, the existing brands would be
11 threatened, simply because of the strength.
12 Not that they have bad brands, but the
13 strength of the other brand.

14 Q. Right. And so in the work that
15 you do then, do you have to look at a
16 hospital's brand at a certain point in time?
17 In other words, the -- the -- the -- the
18 conversation we were just having about
19 St. James, in -- you know, before Sloan
20 Kettering moving in, it has got this brand
21 or reputation, and then after it may have a
22 different, right, depend on how locals
23 perceive it now in contrast to Sloan? So do
24 you look at a brand at a given point in time
25 or do you look at it over a course of many

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2 years?

3 A. Brands aren't built overnight.

4 And you look at in any commodity, whether it

5 is healthcare, cars, law firms, those brands

6 are built and nurtured since their

7 inception, okay. And there is a sense of

8 fragility to those brands that they can be

9 impacted by factors such as another hospital

10 coming down. So I don't know if I

11 understand your question exactly. But

12 brands are always evolving, to put that down

13 in the most succinct terms.

14 Q. Okay, yeah. Sometimes I ask

15 questions because I am intellectually

16 curious, and that was one of them, thank

17 you.

18 So when we looked at that

19 footnote, I think it was 18?

20 A. Is that the Hibbard?

21 Q. Hibbard, and you say that they --

22 if a hospital's reputation is affected, it

23 may eventually experience a market share

24 decline, you didn't perform any analysis to

25 determine whether any of these five

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2 hospitals suffered a market share decline as
3 a result of their Leapfrog grade?

4 A. I read in the complaint that they
5 had experienced a decline in elective
6 admissions subsequent to the fall grade.
7 They also had anecdotal information about
8 staff, moral and worrying about the impact
9 of a D or an F on their institution and
10 overall institutional pride. So I gleaned
11 those from the plaintiffs.

12 Q. Allegations?

13 A. The document, the complaint.

14 Q. And so my question is a little
15 different, in terms of like, I understand
16 that's their allegation, but did you perform
17 any analysis yourself as an expert with
18 respect to your opinions to make a
19 determination as to whether or not those
20 allegations are true, that market share did
21 decline as a result of --

22 A. I did not perform analysis.

23 Q. And I know that you read those
24 allegations in the complaint, but did you
25 speak with anybody at any of those five

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2 hospitals or anyone at Tenet Healthcare
3 system wide about what their market share
4 was both before and after the November 2024
5 grades?

6 A. I did not.

7 Q. Would a market share -- you know,
8 based on this footnote, it makes sense to
9 me, but would a market share decline be the
10 best indicator as to whether there was, in
11 fact, an impact on a hospital's reputation?

12 A. I think that's one indicator that
13 has credence.

14 Q. Is revenue another indicator?

15 A. Well, revenue is related to
16 utilization, so they go hand and glove.

17 Q. What other indicators?

18 A. Recruitment and retention,
19 referring physician, referrals are another
20 indicator of their confidence in that
21 hospital. So there are a number of
22 barometers that would show. Again, my
23 opinions are based on the impact of a D or
24 an F, that that D or the F is having an
25 affect on consumers and by -- on consumers

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2 by utilization, that's referring physicians,
3 it is also having an affect on recruitment
4 and retention of staff.

5 Q. And the declining referrals, that
6 would have an impact on utilization and
7 revenue as well?

8 A. Yes.

9 Q. And when you -- you reviewed
10 declarations, did you not, from the CEOs of
11 these five hospitals in connection with
12 preparing your opinion?

13 A. From the Tenet, the CEOs?

14 Q. Yes.

15 A. Yes, I read those.

16 Q. And did you notice that they have
17 a document attached to those declarations
18 that appears to talk about market share?

19 A. If they did, I don't recall it.

20 Q. Okay, so if they did, you didn't
21 rely on it?

22 A. I did not.

23 Q. And again, you said, you don't
24 really have any familiarity with Vizient;
25 correct?

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2 A. Outside of those -- of a general,
3 overall understanding of what they do.

4 Q. So you wouldn't know what kind of
5 budget would be set aside to comply with
6 Vizient?

7 A. I would not.

8 Q. What evidence supports your claim
9 that a strong brand directly leads to
10 economic success?

11 A. I would -- quite frankly, I think
12 it is commonsense, you know, a lot of this
13 is commonsense in intuitive thinking. If
14 you have a strong brand, your potential for
15 success or to achieve success, maintain it
16 and expand it, is much more pronounced than
17 if your brand has been dented or impugned.

18 Q. That makes sense to me. But if we
19 talk about that same Jim hypothetical we
20 were talking about, St. Jim could have a
21 really great brand, but once Sloan comes in,
22 people want to go to Sloan despite the good
23 brand of St. Jim; right?

24 A. Well, you have to understand, you
25 picked Sloan --

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2 Q. I can pick any?

3 A. But you picked Sloan, that's
4 cancer, cancer, that's a cancer specialist,
5 it was probably not even available to those
6 at the hospital.

7 Q. So let's talk specific then in
8 South Florida. You talked about Langone
9 coming in, right, that's a competitor of
10 these five hospitals, would it not be?

11 A. It would be.

12 Q. And less just say, for the sake of
13 my hypothetical, that these five hospitals
14 had excellent brand recognition in the South
15 Florida area, could it not still be the case
16 that they suffer economically because
17 competition has now gotten fierce with these
18 New York type hospitals coming in and
19 opening hospitals right next door?

20 A. But again, my core issue -- you
21 know, we are looking at almost two moves
22 down the chess board -- on the chess board.
23 Again, my opinions and my perceptions are
24 solely based in the main, in a macro sense
25 on if a hospital gets a D or an F and shows

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2 a degradation in some cases, will that
3 affect that brand and the reputation of that
4 institution. And unequivocally in my
5 opinion it will.

6 Q. Right. And I guess my question
7 is -- but you say in your opinion that a
8 strong brand directly leads to economic
9 success. And I am just asking, couldn't
10 there be a situation in which you have a
11 strong brand and yet you can't compete
12 because there is a competitor right next
13 door that has a stronger brand?

14 A. I think -- I think you can see
15 that in every facet of -- you know, that's
16 what competition is. But to -- just to
17 qualify that a tad, to -- to maximize your
18 potential to complete, you can't withstand
19 the -- you know, it is going to be hard to
20 withstand the insult of having your
21 institution rated with a scarlet D or a
22 scarlet F.

23 Q. Understood.

24 And we talked about earlier that
25 there is a lot of different things that can

1 T. CHAKURDA

2 scar you, right, bad press for other things
3 or bad patient satisfaction surveys or bad
4 H-CAP scores; correct?

5 A. Yes.

6 Q. Bad CMS scores?

7 A. Yes.

8 Q. Bad reviews of the doctors that
9 work at your hospital; correct?

10 A. Yes.

11 Q. Negative comments on social media;
12 correct?

13 A. Yes.

14 Q. One of the things you say and I
15 think -- I think it is paragraph 20, so give
16 me a sec, and you can refer to your -- it is
17 not a memory test. Yes, paragraph 20?

18 A. What page are we on, I am sorry?

19 Q. Page 5.

20 A. 5.

21 Q. Yes.

22 This is where we were just kind of
23 talking about this, the second sentence you
24 say, "South Florida and the Palm Beach area
25 are a particularly competitive environment

1 T. CHAKURDA

2 for hospitals;" correct?

3 A. You are in paragraph 20 or 19?

4 Q. 20, second sentence.

5 A. Yes, I see it.

6 Q. And then the next sentence is the
7 one I am interested in. You say, "based on
8 my experience work working in this area,
9 patients are highly mobile between nearby
10 cities."

11 What do you mean by that?

12 A. I mean that the proximity of those
13 elements within Palm Beach County, it is not
14 a rigorous journey to move up and down
15 between Palm Beach County.

16 Q. And then you go on, and I think
17 you talked about this a little bit earlier,
18 that say, "Snowbirds that split their team
19 between South Florida and another location
20 have the further capacity and means to seek
21 healthcare from different geographic areas;"
22 correct?

23 A. Absolutely.

24 Q. And by that are you talking about
25 wealthy Palm Beach residents that can fly

1 T. CHAKURDA

2 back to New York?

3 A. Yes, I am.

4 Q. And in your experience at Boca
5 Raton, did that happen?

6 A. Yes.

7 Q. Are there published studies
8 that -- that you know of that -- that
9 demonstrate a direct correlation between
10 brand strength and economic success?

11 A. I could not cite one in
12 particular.

13 Q. When we say economic success, are
14 we referring to profitability?

15 A. In healthcare the ability to
16 generate positive revenue at the end of your
17 fiscal year.

18 Q. Because there is a lot of not for
19 profit hospitals; right, so that question
20 was probably not smart?

21 A. Healthcare is a very difficult
22 entity to generate funds when you are --
23 your reimbursements don't cover your costs.

24 Q. Good point.

25 Are there any scientific or

1 T. CHAKURDA

2 objective measures that exist to determine
3 whether a hospital's brand has been
4 impacted?

5 A. Again, I think if we reference the
6 barometers that we have previously discussed
7 in previous answers, that is one.

8 But I also think you can't dismiss
9 commonsense and intuition. We all know what
10 getting an F in school, the impact that had
11 on your parents versus an A. We all know
12 the impact a D on a restaurant door has when
13 you go up to the front of that door. There
14 is no study that let's me know what that Dis
15 but I know that's a very pejorative rating.
16 So yes, there are tangible barometers, but
17 also there is intuition and commonsense.
18 And again, I want to emphasize, especially
19 when those Ds and Fs are portrayed so
20 vigorously in public platforms.

21 Q. Do you have any opinion about
22 whether or not hospitals should be
23 transparent about patient's safety with
24 their consumers?

25 A. I think hospitals should be

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2 transparent, absolutely.

3 Q. If a hospital really is an F
4 hospital, do you think that should be
5 communicated to consumers of healthcare
6 services?

7 A. Well, the operative phrase is are
8 they really an F.

9 Q. Of course. And you are not here
10 to talk about the methodology?

11 A. I am not.

12 Q. So my question is really a
13 hypothetical. If there is a hospital that
14 is truly an F hospital, that everybody could
15 agree on, which obviously we don't, but if
16 there is a hospital that was truly an F, do
17 you believe that should be communicated to
18 the consuming public of healthcare services?

19 A. If there is legitimate and fair
20 and balanced methodology in determining that
21 F, okay, this is applicable to everyone,
22 that the playing field is legit and level, I
23 as a marketer would have no problem that --
24 to see that those grades portrayed much like
25 I would believe an A should be portrayed.

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2 Q. Like Butler, when we portrayed
3 Butler's A, correct?

4 A. They were a B, I think.

5 Q. They were an A?

6 A. Oh, were they.

7 Q. Can a single event be causally
8 linked to brand harm?

9 MS. PARKS: Objection to form.

10 Q. Sure, do you understand the
11 question?

12 A. Would you repeat it again.

13 Q. Sure, we have been talking a lot
14 about the multifaceted universe of what
15 makes up a brand. And I get that. So if it
16 is so multifaceted, can a single event be --
17 be causally linked to the brand harm? I
18 mean, can you as an expert in marketing say
19 the brand is made up of these 100 different
20 things, patient satisfaction and surveys and
21 philanthropy projects and all the things we
22 have talked about, can you then link a
23 single event to brand harm?

24 A. I think a single event can have a
25 material, negative impact on a brand.

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2 Q. How do you isolate brand damage
3 caused by one event versus market
4 competition or changes in a hospital's
5 leadership or unrelated PR issues?

6 A. I think the barometers are the
7 same.

8 Q. So you would have to look at all
9 those barometers to make the distinction?

10 A. Yes.

11 Q. And while your opinion is that a D
12 or an F can have a negative impact on a
13 brand, you have not analyzed whether that
14 impact alone has a negative impact on these
15 five hospitals compared to other forces;
16 correct?

17 A. If I can address the beginning of
18 your question.

19 Q. Of course, oh, please?

20 A. When you say can have an impact,
21 my opinion is it does have an impact, a D
22 and an F.

23 Q. Okay?

24 A. I don't -- in my opinion there is
25 no dodging that. They are the scarlet D and

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2 the scarlet F. So in my opinion, they do.

3 So if you can give me the back end
4 of the question.

5 Q. Sure. Based on your opinion that
6 Ds and Fs do have a negative impact, can you
7 isolate the damage caused by that D and F
8 versus impacts of market competition,
9 changes in executive leadership at the
10 hospital system, isolated PR issues? Is
11 there a way to isolate this D and F, did
12 this damage to the brand and, you know, the
13 fact that Tenet Healthcare system paid a
14 \$514 million kickback lawsuit to the federal
15 government, didn't, is there a way to put --
16 take those things apart?

17 A. I think timing would be a critical
18 factor. In your litany of all the other
19 audiences and elements, those are like
20 elongated long-term administration --

21 Q. Yeah?

22 A. -- but my understanding is with
23 the issue of the fall survey with the Ds and
24 Fs, that's when they saw a deterioration in
25 elective administrations, anecdotal comments

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2 about affect on moral. So there was a sense
3 of immediacy relatively to that, where
4 others may be much more elongated processes.

5 Q. And do you understand that some of
6 these hospitals had Ds before the
7 methodology change, do you know that?

8 A. That's my understanding.

9 Q. And is it your opinion that a D
10 did not have an impact, but an F would have
11 an impact?

12 A. I think a D and an F are highly
13 negative.

14 Q. So the previous D before the
15 methodology change would have also have a
16 negative impact on their brand?

17 A. It changed after their
18 methodology?

19 Q. They had a D before the
20 methodology and an F after the new
21 methodology?

22 A. And your question again is?

23 Q. Can you make a determination as to
24 what the impact was between the D prior to
25 the change in methodology and the F after

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2 the change in methodology to the hospital
3 brand?

4 A. I don't know if there was any
5 difference between the two.

6 Q. Okay.

7 Are there industry benchmarks for
8 evaluating reputational damage in
9 healthcare?

10 A. Not that I am aware of.

11 MS. BLAIR: Do you need a break at
12 any time?

13 THE WITNESS: I am good.

14 MS. BLAIR: I am going to keep
15 going, but I just want to make sure.

16 MS. PARKS: Yes, I mean, we should
17 probably take a break soon to stretch
18 our legs. But that's up to you.

19 THE WITNESS: Take a little
20 breather?

21 MS. BLAIR: Yes, like five or ten
22 minutes, it doesn't have to be long.

23 THE VIDEOGRAPHER: It is

24 11:02 a.m., we are off the record.

25 (Whereupon, an off-the-record

1 T. CHAKURDA

2 discussion was held.)

3 THE VIDEOGRAPHER: 11:00 a.m.,
4 back on the record.

5 Q. Mr. Chakurda, I want to focus now
6 on part of your report that is, you know,
7 fairly specific to the Leapfrog grades, and
8 I think, at least I think it begins on page
9 10 of your report, paragraph 37.

10 But before we get there, but it is
11 the same page, page 10, footnote 20 you
12 refer to this Hwang article, Finding Order
13 in Chaos, A Review of Hospital Ratings.

14 Do you see that footnote?

15 A. Uh-huh.

16 Q. Did you read this article?

17 A. Yes, I did.

18 Q. And for what purpose did you read
19 the article?

20 A. Again, to look at material that
21 would support my opinion or give me insight
22 as to my opinion about the impact of Ds and
23 Fs.

24 Q. And do you know whether or not any
25 of the other experts relied on this article?

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2 A. I am sorry?

3 Q. Any of the other plaintiffs'
4 experts relied on this article?

5 A. I do not know that.

6 Q. And in reading this article, what
7 I will refer to for the record as the Hwang
8 article, can you just give me a brief
9 understanding of what that article was and
10 how you used to form your opinion?

11 A. We are talking about 20?

12 Q. Yes, Hwang, I don't know if I am
13 saying that right?

14 A. Let me just refresh here.

15 Q. Sure.

16 A. And again, if you could restate
17 the question so I could follow it.

18 Q. Yes. In your own words, what was
19 that article about and how did you use it, I
20 guess that's two different questions, let me
21 -- I am going to get an objection.

22 In your own words, what was that
23 article about?

24 A. There are -- I don't think myriad
25 would be the right word. There are a number

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2 of sources that analyze the rating platforms
3 and the differences between them and the --
4 the exquit -- the information that they
5 portray. That it is -- I think the word was
6 chaotic is in the title of the article.
7 Chaos, that it is -- it is a very diverse
8 set, if you are looking at mechanisms to
9 rate hospitals.

10 Q. And this article was from 2016;
11 correct?

12 A. That appears on the annotation,
13 right.

14 Q. Do you understand that the
15 Leapfrog methodology that was in place in
16 2016 is markedly different than the
17 methodology that was in place in spring of
18 2024 and then again in the fall of 2024?

19 A. That's what they have portrayed.

20 Q. And what do you mean that's what
21 they have portrayed?

22 A. They say their methodology
23 changed.

24 Q. They being Leapfrog?

25 A. They being Leapfrog. I have no

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2 way to verify whether they changed their
3 methodology substantively or -- but they
4 made pronouncement that their methodology
5 has changed.

6 Q. Do you understand that their
7 methodology is fully listed on the website
8 as to how it works, the Leapfrog website.

9 A. Their present methodology; right?

10 Q. Correct.

11 A. Right.

12 Q. And you can go back and look back
13 and older versions?

14 A. They have retro, yes.

15 Q. And do you understand that this
16 Hwang article talks about what the
17 methodology was when they wrote this article
18 in 2016?

19 A. Yes.

20 Q. Did you do a comparison?

21 A. I did not. The takeaway was the
22 methodology changed.

23 Q. As the chief marketing officer or
24 as a former chief marketing officer for
25 several healthcare systems that did

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2 participate in the Leapfrog survey, do you
3 have an opinion about whether or not the
4 Leapfrog methodology is transparent to
5 hospitals?

6 A. I do not.

7 Q. Are you aware of any data or
8 studies that rank the relative importance --
9 rank the relative importance of each type of
10 hospital rating system?

11 A. I think there are varying opinions
12 on the validity of what are numerous rating
13 entities.

14 Q. And asking it a different way, are
15 you aware of any data or studies that rank
16 the different ratings systems in terms of
17 the impact they could have on the reputation
18 of a hospital?

19 A. In terms of their impact?

20 Q. Uh-huh.

21 A. I am not aware of that or I can't
22 recall that.

23 Q. Do you have any data or
24 information regarding the reach of the CMS
25 star ratings to the consumer public?

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2 A. Could you define "reach."

3 Q. Yeah, in this opinion you talk
4 about Leapfrog publicizing its methodology
5 in its rating system; correct?

6 MS. PARKS: I can show it to you.

7 A. Yeah, I understand what you are
8 saying. I just want to draw a distinction
9 between publicizing their -- their D and Fs,
10 or whatever grades they are, very vigorously
11 in public platforms versus being --
12 portraying their methodology, if I
13 understand you correctly, and it is my
14 understanding, on their website.

15 Q. Oh, yes, then my question was
16 terrible, so apologize?

17 A. Do you understand why there was a
18 distinction there?

19 Q. Absolutely, yes.

20 So my question is do you have an
21 opinion about how widespread Leapfrog
22 publicizes its grading, its grading?

23 A. Yes, I do, I have an opinion.

24 Q. And what is that opinion?

25 A. In the main, it is an extremely

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ambitious campaign. They secure the support of CURA, I believe it is C-U-R-A, which assists them in promoting the release of that. The tool kit that they supply in concert with CURA is very deep, the platforms are across all media, print, radio, these are all developed for institutions. The fact that the release is embargoed -- was embargoed in the Southern Florida market, when you embargo a release that allows CURA or the entity to build interest in that, this is coming, okay, here is what you need to do, make sure you contact us. So the fact that they just didn't put the release out, but they embargoed the release, that builds energy in the media. So it is -- it is a very, very deep and very material media campaign to make sure that these scores are portrayed across all media outlets.

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Q. And I understand that, and I don't disagree with you.

And my question then, my follow-up question is do you know of any studies or

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2 data, that either you did or somebody else
3 did, about how many people, consumers that
4 robust marketing effort by Leapfrog reaches?

5 A. I would have to analyze their
6 media reports, how many column inches, how
7 many TV reports were generated. So I would
8 have to -- I -- I would bet -- in fact, I
9 think there is a document that encapsulates
10 the media hits, to use the vernacular.

11 Q. Okay?

12 A. That the article appeared in the
13 Palm Beach Post, that you know, there was a
14 minute and a half story on WPXI. So there
15 is probably analysis. And then you do the
16 queues from that paper, what is their
17 readership, what is the viewership, what is
18 the viewership of their 11:00 news versus
19 the 10. So you can come up with a
20 statistic, I did not, but you can come up
21 with a statistic about how many eyeballs or
22 ears were impacted by those articles.

23 Q. Okay. So can you -- do you know
24 how many eyeballs or ears were impacted by
25 those articles versus how many eyeballs or

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2 ears may have seen, for example, U.S. News
3 and World Report rating?

4 A. I don't have comparison data.

5 Q. And the same question with respect
6 to the CMS star ratings, do you have
7 comparison data?

8 A. I do not have comparison data.

9 Q. So as you sit here today, you
10 don't know if Leapfrog had a bigger impact
11 than U.S. News and World Report on
12 readership or consumers, correct, from a
13 data standpoint?

14 A. I can only say given the scope of
15 their efforts that the impact on viewership
16 or readership given the density of media in
17 the South Florida market would be
18 significant.

19 Q. But you have not analyzed that in
20 comparison to, let's say, CMS ratings?

21 A. I have not.

22 Q. Or U.S. News and World Report
23 ratings?

24 A. I have not.

25 Q. Or Google reviews?

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2 A. I have not.

3 Q. Or social media content?

4 A. No, I have not.

5 Q. You say here on paragraph 38, page
6 10?

7 A. Okay.

8 Q. "Hospitals must pay a TLG
9 licensing fee to promote their grade in
10 marketing efforts."

11 Do you see that?

12 A. Yes, ma'am.

13 Q. That's not exactly true, is it,
14 you can still promote that you got an A
15 without buying the licensure; correct?

16 A. Well, the licensing fee, if I
17 understand it correctly, is the ability to
18 use the badge --

19 Q. Correct.

20 A. -- in your promotional materials.
21 I think there is no charge to do a standard
22 press release, it is kinds of like tops of
23 the waves, okay. But you have to understand
24 too, that there is a cost. The cost
25 associated with securing the badge is only

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2 one tip on the spear. Then you have to put
3 those -- you buy the badge and then you have
4 to put it on outdoor, you have to put it on
5 transit, you have to put the badge on your
6 TV commercials. So there are exponential
7 costs that, you know. If you secure the
8 badge, you better be wanting to use it or
9 you not really secured something.

10 Q. Right, but you don't have to get a
11 badge, you can still people you are an A
12 hospital without getting a badge?

13 A. Yes, in a media release. But if
14 you look -- that's another thing that
15 Leapfrog supply of all the platforms and
16 venues that you can use this in, banners in
17 your hospital, billboard plaques and things.
18 So it is very varied in terms of when you
19 secure it, how you can use it.

20 Q. Right. But again, just so I am
21 clear --

22 A. Sure.

23 Q. -- you can tell people you are an
24 A hospital without buying this badge?

25 A. You mean verbally?

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2 Q. Yes, or in a press release?

3 A. Yes.

4 Q. And can you make a banner without
5 using Leapfrog logos saying we are an A
6 hospital?

7 A. I don't believe so.

8 Q. You don't believe so?

9 A. If you use their --

10 Q. I didn't say logo, if you make a
11 banner that says, we were ranked an A
12 hospital by Leapfrog.org?

13 A. I don't know if that's within
14 their realm of licensing, I have not seen
15 their agreement of what you are allowed to
16 do.

17 Q. And in fact Butler hospital did
18 pay for accolades when they got an A?

19 A. Yes, they used it on their
20 website.

21 Q. On paragraph 43, this is on page
22 12 of your report?

23 A. Okay.

24 Q. You say, first sentence of 43, "In
25 my experience the decision to participate

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2 in, and then subsequently license, TLG
3 grades is a joint decision made at the
4 highest levels of hospital management."

5 Do you see that sentence?

6 A. Yes.

7 Q. Who were at the highest levels of
8 hospital management?

9 A. Starting at the CEO, in reference
10 to these -- this specific, it would be your
11 quality officer, probably your operational
12 vice president, your executive team led by
13 the CEO.

14 Q. What about, when you say the CEO,
15 are you referring in the context of a
16 hospital system to the hospital system CEO
17 or to the individual hospital CEO?

18 A. The system CEO is, you know, top
19 of the pyramid. But that would be done in
20 concert with the individual hospitals. It
21 wouldn't be done in a vacuum.

22 Q. What about the decision not to
23 participate, so you talk about this is the
24 decision to participate in?

25 A. Uh-huh.

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2 Q. Would the decision to not
3 participate in be done at the highest levels
4 of hospital management?

5 A. I think the decision tree would be
6 the same.

7 Q. And have you ever had an
8 experience as a chief marketing officer at
9 any of the hospital systems that you worked
10 in wherein an individual hospital wanted to
11 participate in the Leapfrog survey, but the
12 system refused to allow them?

13 A. I did not have that experience.

14 Q. Is that an experience that
15 surprises you or would not surprise you?

16 A. The factors that go into those
17 decisions are so relative to the specific
18 institutions that there is not a template.
19 It depends on the factors impacting that
20 hospital. It is -- it is a very centric
21 decision, not some global assessment.

22 Q. As a chief marketing officer at
23 Independence Health System, did you believe
24 it had a positive impact on the hospitals in
25 that health system to participate in the

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2 Leapfrog survey? And positive impact, and
3 by positive impact I mean positive impact on
4 brand to participate in the survey?

5 A. If I recall -- well, again, the
6 decision is made by the CEO and it filters
7 down to marketing. So it is not a marketing
8 decision. It is more of an administrative
9 decision.

10 So the skin in the game that I had
11 in that decision-making train, was not a
12 determining factor.

13 Q. Right, and I understand you didn't
14 make the ultimate decision to participate.
15 So I guess I am asking more on like the
16 fundamental marketing level.

17 Did you believe from a marketing
18 standpoint, the hospital's or the system's
19 decision to participate in the Leapfrog
20 survey had a positive or negative impact on
21 these hospital's brand?

22 A. Well, it is a different question
23 if you are asking participate in the
24 Leapfrog survey.

25 Q. I am?

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2 A. As opposed -- I have no bearing on
3 decision to participate in the Leapfrog
4 survey. And -- that would be my answer.

5 Q. Okay. And you understand, because
6 you have read some of these articles that we
7 have talked about briefly, that
8 participating in the survey necessarily
9 translates to certain metrics in the score
10 being calculated based on a hospital's
11 participation in the survey; correct?

12 A. That's my understanding.

13 Q. Okay. And so this whole
14 lawsuit --

15 A. Yes.

16 Q. -- argues that a hospital that
17 does not participate in the survey, I
18 disagree, but necessarily earns a lower
19 grade, you understand that to be the
20 allegation; right?

21 A. Clearly.

22 Q. And so as a chief marketing
23 officer of a healthcare system previously
24 that did participate in the Leapfrog
25 hospital survey, did you find from a

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2 marketing standpoint only that participation
3 in that survey, which led to the ultimate
4 grade, had a positive or negative impact on
5 the hospital's brand?

6 A. Can we go back because --

7 Q. That's a long question?

8 A. It was. And I just want clarity
9 at the top.

10 Q. Sure?

11 A. Because you know, participation --
12 again, my opinions and what I am opining on
13 is the impact of Ds and Fs, not As, not Bs,
14 not Cs. So I kind of got confused with your
15 prefacing remarks. Can you kind of
16 synthesize that down for me a little bit.

17 Q. Well, to be fair, you do talk in
18 your opinion about the fact that Jupiter
19 Hospital got an A and advertises it;
20 correct?

21 A. Uh-huh.

22 Q. And maybe I read your opinion
23 wrong, I thought you were opining just sort
24 of as to grades themselves, the impact they
25 could have on brand management, because you

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2 do talk about Jupiter getting an A, and then
3 they advertise it everywhere?

4 A. Understood, understood.

5 Q. So I didn't mean to say something,
6 I just want to tell you?

7 A. No, no, no.

8 Q. I guess my question then is, as
9 the chief marketing officer at Independence
10 Healthcare System that had five hospitals
11 all of which participated in the survey, and
12 I will tell you the Frick Hospital
13 participated in the survey even though they
14 couldn't get a grade, they are not graded,
15 they don't qualify for a grade, but they
16 participated in the survey nonetheless?

17 A. Okay.

18 Q. From a marketing standpoint, a
19 brand management standpoint only, I
20 understand that you did not make the
21 decision, do you have an opinion about
22 whether participating in the Leapfrog survey
23 has a positive or negative impact on a
24 hospital's brand?

25 A. If participating in the survey

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2 generates an A or a B, okay, that has a
3 positive -- in my view, has a positive
4 affect on the brand of an institution.

5 If that participation or lack
6 thereof, okay, gets you assigned a D or an
7 F, that has a material impact on the brand
8 as well.

9 Concurrently the effect in my
10 opinion of a D or an F is very sticky, okay.
11 That impact lasts a long -- a lot longer
12 than if you get an A. And I think that is
13 substantiated in that article relative to
14 negative bias, that there is a velcro effect
15 that it is hard to shake Ds and Fs. Okay,
16 As, are good, but they are transient you
17 move on, that's what we expect. It is like
18 you remember bad things in your life a lot
19 longer than you remember -- it is
20 commonsense. It is just -- I call it a
21 sticky factor. It sticks with you. It is
22 harder to shake, it is harder to redirect.
23 So yes, the short answer is yes, A, but Ds
24 and Fs have a much more material effect on
25 the brand than an A in my view.

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2 Q. Do you understand that there are
3 hospitals that don't participate in the
4 survey that get As?

5 A. I am not aware of that.

6 Q. Do you have any understanding that
7 there are hospitals that participate in the
8 survey and get Ds?

9 A. I am aware that hospitals
10 participate in the survey and get Ds. I am
11 not aware of ones that don't and get As.

12 Q. Okay. Do you understand that it
13 is 1 percent of hospitals nationwide that
14 earn an F?

15 A. No, I wasn't aware of that
16 percentage.

17 Q. So I guess rounding back to my
18 question, you don't -- your opinion is from
19 a marketing perspective, if you are going to
20 get an A or a B, it makes sense to
21 participate in the survey, otherwise it
22 doesn't make sense from a marketing
23 standpoint?

24 A. From a marketing standpoint?

25 Q. Marketing only?

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2 A. Okay. If you believe methodology
3 is fair and equal, and you believe that your
4 performance, okay, has great potential to
5 generate at least a B or an A, I think from
6 a marketing decision that is sound.
7 However, if you disagree with the
8 methodology, okay, and your refusal -- that
9 the methodology is -- I am trying to find
10 the right words here.

11 That you disagree with the
12 methodology, hence you refuse, would
13 automatically get you an F; right? I just
14 don't see the rationale to participate in a
15 survey, if you believe that you disagree
16 with the methodology, because it won't
17 result in a fair assessment. That was
18 rather long-winded, I apologize.

19 Q. No, I understand what you were
20 saying.

21 But you don't know as you sit here
22 today, whether that's true, that you get an
23 F, if you don't participate; correct?

24 A. I believe in looking at the
25 documents, in fact, stuff -- things

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2 published by Leapfrog, that your hospital
3 did not submit data, ask them why, and I
4 think that came with an automatic F grade,
5 that's my impression.

6 Q. Okay?

7 A. Or, you know, the grade was far
8 from -- I believe there was a grade assigned
9 to you.

10 Q. Okay?

11 A. It was very pejorative.

12 Q. In paragraph 43, right in the
13 middle of that paragraph --

14 A. Okay.

15 Q. -- you start, "In the fall of
16 2024," do you see that sentence that starts,
17 "In the fall"?

18 A. Okay.

19 Q. "TLG made more than 8800 calls to
20 sell licensing resulting in a 174 safety
21 grade licensing."

22 Do you see that?

23 A. Yes.

24 Q. The next sentence is the one I
25 want to focus on, where you say, "Of the

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2 hospitals who declined a license in the fall
3 of 2024, 28 reported declining for financial
4 reasons."

5 Do you see that?

6 A. Yes, due to price, right.

7 Q. Yes, 20 percent due to price,
8 4 percent because, quote, marketing budget
9 already allocated, end quote, and 4 percent
10 because, quote, hospital doesn't have a
11 marketing budget, end quote?

12 A. Okay.

13 Q. And as I see footnote 32, that
14 comes from documents produced by Leapfrog in
15 this litigation; correct, yes?

16 A. I am sorry, go ahead.

17 Q. You have to say yes out loud?

18 A. You are saying yes, did I see
19 that?

20 Q. Yes, do you see that?

21 A. Yes.

22 Q. Awesome. I guess my question is
23 if you look at footnote 32, that information
24 in your report comes from documents that my
25 client produced in this litigation; correct,

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2 because it is marked Leapfrog 510740?

3 A. Yes, Leapfrog, and they are your
4 client.

5 Q. Yes. So as a former chief
6 marketing officer, does it surprise you that
7 hospitals or hospital systems do not have
8 marketing budgets to purchase licensing from
9 Leapfrog?

10 A. Not in the present healthcare
11 economic environment, no, it does not.

12 Q. But then you go in paragraph 44
13 and the sentence starts at the bottom of 44,
14 hospitals would, do you see that?

15 "Hospitals would not make the
16 expenditure to their license to license
17 their TLG grade if they did not think it
18 would have a corresponding positive impact."

19 Do you see that?

20 A. Yes.

21 Q. I am just trying to reconcile your
22 opinion, because in the paragraph above you
23 talk about how there is a decline in -- in
24 purchase -- purchasers of licensures which
25 is true?

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2 A. Okay.

3 Q. And then you say well, it is
4 important, because they are purchasing these
5 licensings -- licenses because they think it
6 is important.

7 And so how do you reconcile those
8 two things or maybe I am not reading it
9 correctly?

10 A. Well, I think -- again, I think it
11 harkens back if you get good grades, there
12 is cachet in that and they will help your
13 brands. Conversely if you get poor grades,
14 the corollary of that is that they will
15 damage your brand. Now, when it comes to
16 making decision in healthcare economics, as
17 one who has been in it for a long time,
18 finance trumps everything, if there are more
19 pressing needs. Marketing is an important
20 facet, but if you need a new CT scanner or
21 you need this or that and you could apply
22 marketing dollars to those, you are going to
23 make the decision for technology and patient
24 care, not for marketing. So it is a
25 balancing act. But from a marketing

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2 perspective, if the budget was there, and
3 you anticipated getting -- or if you got As
4 and Bs, then I think there is value in that
5 decision, as -- again, as opposed to the
6 detriment an F and a D can do.

7 Q. Do you understand that the amount
8 of revenue that Leapfrog has received from
9 licensing has decreased over the years?

10 A. I am not aware of that or I didn't
11 recall it.

12 Q. So that I guess was more my
13 question, and it was asked terribly, which
14 is if hospitals aren't making the
15 expenditure and licensing, doesn't that mean
16 the exact opposite of this last -- you say,
17 "Hospitals would not making the expenditure
18 to license their TLG grades if they did not
19 think it would have a corresponding positive
20 impact."

21 So isn't the reverse true that if
22 hospitals are declining, A and B hospitals
23 are declining to buy licensing from
24 Leapfrog, they do not feel that it has an
25 impact on their brand and patient

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2 utilization?

3 A. I don't -- again, my opinion is,
4 all things being equal, if a hospital
5 believes that submitting data will result in
6 them getting an A, okay, that can be to
7 their advantage. That can be an element in
8 enhancing their brand, okay.

9 Conversely, if that submission
10 generated a D or an F, there is a
11 corresponding detriment to the brand, so.

12 Q. Okay?

13 A. And again, we will go back to
14 another point, I mean, you stated that
15 Leapfrog's revenue is -- is going down,
16 right.

17 Q. Right, from licensing, yes?

18 A. From licensing.

19 But again, as we talked about,
20 there is -- there is two edges to the
21 licensing sword, it is securing the license
22 and then using platforms to portray it. So
23 there is a double -- a double dip. If you
24 get it, you want to use it. So there is --
25 you know, the decision tree on the hospitals

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2 are based on that two factors of finance,
3 secure the license and then use the license
4 in advertising.

5 Q. Okay. And so as I understand your
6 answer then, from a marketing perspective
7 makes little sense to engage in a survey if
8 you anticipate you might get a D or an F,
9 because it doesn't really translate into --
10 it translates into negative brand?

11 A. I don't -- I don't -- I guess my
12 point is I don't -- I am not aware if you
13 can assess what you are going to get.

14 Q. Oh, I didn't know that.

15 Okay, so you don't know that
16 Leapfrog sends a calculator to these
17 hospitals and they can --

18 A. I am sorry.

19 Q. You are not aware, I didn't know
20 that, sorry, you are not aware that Leapfrog
21 sends a calculator to these hospitals where
22 they can calculate their grade far in
23 advance of the embargo period to determine
24 what their likely grade will be?

25 A. I don't recall being aware of a

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2 calculator.

3 Q. You say here, paragraph 45, second
4 sentence, this is on page 13 of your report,
5 it says, "Based on my experience, the
6 detrimental impact of an F grade is
7 magnified as compared to the positive impact
8 of an A."

9 Do you see that?

10 A. Yes.

11 Q. And we have talked a lot about
12 that today; correct?

13 A. Uh-huh.

14 Q. And when I was researching all of
15 the hospitals that you have worked for, I
16 did not see that you ever were the chief
17 marketing officer for a hospital or a
18 hospital system that had an F hospital, is
19 that correct?

20 A. That's correct.

21 Q. So you have never been the chief
22 marketing officer of a hospital system that
23 had a hospital with an F grade from
24 Leapfrog; correct?

25 A. No. But if I can qualify that.

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2 Q. Well, I just -- you can, but I am
3 going to let you answer?

4 A. Fair enough.

5 Q. I just want to make sure I
6 understand the no?

7 A. No, I was never at an institution
8 that had an F.

9 Q. I understand. I thought you were
10 saying no, you are wrong, now you can
11 qualify, thank you?

12 A. But the fact that I never worked
13 at a hospital that received an F doesn't
14 mitigate my opinion or my observations of
15 what an F can do to a brand. I don't think
16 anyone worth their soul in marketing doesn't
17 have to experience getting an F to know what
18 that -- that would do to the brand of
19 whatever they are representing, whether it
20 is an F in healthcare, whether it is a D on
21 restaurants, where it is, whatever. I mean,
22 marketing is not an exact science, okay, it
23 is an art and a science in my opinion.

24 There is a significant aspect of
25 marketing that is intuitive. You just know,

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2 and we all know in our personal lives
3 through schooling or whatever if you got an
4 F, you know that's going to be a big deal at
5 home as opposed to getting a B or a D. And
6 you know mom and dad are going to remember
7 that F a long -- and what you are doing to
8 correct it, a long -- you know, a lot more
9 acutely than we expect another A. So I
10 understand your question, but again,
11 marketing is not a precise science. There
12 is aspects that are intuitive, but basic
13 human intuition knows that an F is much more
14 pejorative and a D is much more pejorative
15 than a B or an A.

16 It is -- I don't think logically
17 anyone can deny that.

18 Q. In paragraph 46 you say, a patient
19 or their caregiver who is researching local
20 hospitals is likely to come across TLG
21 grades, do you see that?

22 A. Yes.

23 Q. What is that based on?

24 A. I just think that is working --
25 knowing patient, what patients do. And let

1 T. CHAKURDA

2 me preface that patients are much more
3 participatory in their healthcare decisions
4 than they were decades ago. Decades ago you
5 went to your PCP, and your PCP said you are
6 going here, this is the surgeon you are
7 going to see and that was that. Now they
8 either discuss that in more depth -- but
9 suffice it to say they are much more
10 participatory in their decision making.

11 Supporting that is all these
12 vehicles where they can glean data, not
13 making stuff up, there is Leapfrog, there is
14 CMS, there is all these resources where they
15 can research that.

16 So -- I think I have forgotten --

17 Q. Let me ask it another way. So I
18 have a daughter who has had 15 facial
19 reconstruction surgeries over her lifetime?

20 A. Oh, my.

21 Q. I until this have never heard of
22 Leapfrog, I have researched hospitals like
23 you wouldn't believe?

24 A. Okay.

25 Q. I am sure I may get fired for

1 T. CHAKURDA

2 saying that, but I don't know what Leapfrog
3 is, I know because of this. So when you say
4 a patient or caregiver who is researching
5 local hospitals is likely to come across TLG
6 grades, I am just curious where does that
7 come from, I didn't --

8 A. While your personal experience is
9 you weren't aware of it --

10 Q. Yes, it is mine?

11 A. -- in my opinion and my
12 experience, I have come to believe that
13 patients, general patients are aware of
14 Leapfrog, as much as they are aware of U.S.
15 News and the others. It is just being in
16 the environment for four decades.

17 Q. Okay. So in your time as a chief
18 marketing officer, did you have meetings and
19 conversations with Leapfrog's safety grades?

20 A. I think there is anecdotal
21 conversations that I have had that weren't
22 business meetings. But I know in my own
23 personal life with friends who knew I was in
24 the industry, you know, I have seen Leapfrog
25 or I just believe, it is my opinion that

1 T. CHAKURDA

2 people are much more aware of these ratings
3 than prior to their existence. It is a
4 major industry now in rating every commodity
5 in our society.

6 Q. Okay. So this is not based on any
7 sort of research you have done, just sort of
8 based on like you said earlier, commonsense
9 that you think patients would come up with?

10 A. Yes, I wouldn't be hesitant to
11 characterize it as that. Plus a dose of
12 personal experience and just working in the
13 industry and how these things evolve in
14 discussions.

15 Q. I want to talk on page 15, this is
16 paragraph 49, it bleeds over onto page 15?

17 A. Okay, page 15.

18 Q. Yes, and you talk about for
19 example, it starts, "For example, TLG grades
20 for Delray and Good Samaritan, Palm Beach
21 Gardens and West Boca Hospitals are featured
22 in videos on TikTok and Instagram."

23 Have you viewed that TikTok?

24 A. I have.

25 Q. Did you look at any of the

1 T. CHAKURDA

2 comments?

3 A. I viewed the actual video where
4 they bring up the hospital and the grades.
5 I did not look at commentary.

6 Q. So you didn't see comments where
7 patients, former patients refer to Delray as
8 Hellray and all the negative comments from
9 patients or patient experience related to
10 those five hospitals, you didn't have a
11 chance to review those?

12 A. I didn't review those.

13 Q. We talked earlier in the
14 deposition about that type of negative
15 comment on social media can carry a lot of
16 weight.

17 Do you have an opinion about
18 whether the video carries the weight or the
19 comments carry the weight?

20 A. The video from a marketing
21 perspective was very striking in terms of
22 their annunciations of the hospitals, the
23 grades, it was to the uninitiated that would
24 be very effective in my view of affixing
25 those scarlet letter -- the scarlet grades

1 T. CHAKURDA

2 to those institutions.

3 Now the second half of your
4 question was, I think there was a second
5 half.

6 Q. The comments. So -- so do you
7 have any opinion about whether the video
8 versus the comments have a more deleterious
9 impact on the brand of these hospitals?

10 A. Well, first, I don't think there
11 is anything that you can research even the
12 most stellar organizations, regardless of
13 what they are, that you can't find negative
14 commentary in this society. People are much
15 more prone to issue negative commentary than
16 they are positives. You could just go on
17 Reddit. I mean, you know the platforms, it
18 is vent city. The great preponderance is
19 negative and I suspect some psychologists
20 can say that is human nature too.

21 In comparison if you are asking
22 the comments, comments are linear, you have
23 to go through all the comments, some may be
24 more striking than others. But if you sit
25 and watch the video, which is a more

1 T. CHAKURDA

2 engaging platform from a marketing
3 standpoint, a tool, I would rather show a
4 video to somebody -- I would rather show a
5 commercial then have somebody read a script,
6 if you follow the analogy.

7 Q. I do follow?

8 A. So the some impact of that I
9 was -- and I mean this in all sincerity, I
10 was struck by the impact of that, it is
11 almost like holy heck. I mean, I don't have
12 any relationship to them, and I was very
13 struck that -- you know, again, like using
14 their names, that it was -- it was an
15 extremely negative piece. So if you are
16 asking me in comparison to the video versus
17 commentary, I would put much more weight on
18 the video than the commentary.

19 Q. Do you have any understanding that
20 that video is AI generated?

21 A. I did not know that.

22 Q. Do you have any understanding of
23 how many of the viewers were bots versus
24 real people?

25 A. I was not aware of that.

1 T. CHAKURDA

2 Q. Would you agree with me that
3 nowhere in that TikTok video did they use
4 the word "Leapfrog"?

5 A. I did not hear. It was a
6 reflection of the hospitals and their
7 grades.

8 Q. And when you listen to the actual
9 words of that video, they talk about H-CAP
10 scores; do they not?

11 A. I don't recall that specifically.

12 Q. Well, we can watch that video.
13 But do you have an understanding that it
14 talks about specific metrics as opposed to
15 overall grades?

16 A. Again, in viewing the video, I was
17 struck by the affixing of the grades to the
18 hospital names. And the supplemental
19 information I couldn't recall it precisely
20 if you asked me.

21 Q. That same paragraph, you say the
22 dissemination of TLG's grade online --

23 A. I am sorry, where we are?

24 Q. Oh, I am sorry, paragraph 49 that
25 bleeds onto page 50, the one sentence, "The

1 T. CHAKURDA

2 dissemination of TLG's grades online and
3 through social media reaches a wide audience
4 of patients and caregivers and makes it
5 difficult for plaintiffs to provide their
6 explanations or clarifications."

7 What is that based on, that
8 plaintiffs have difficult providing their
9 explanations or clarifications?

10 A. Well, when you portray information
11 in nuggets, it is like mixed info, it is
12 very synthesized, condensed information
13 versus my understanding that the ability to
14 condense -- to condense the plaintiff's
15 position would be a much more meatier
16 portrayal of information. So it is not --
17 it is a very quick hits versus the platform
18 that doesn't allow you to be as effusive in
19 their explanation.

20 Q. But at some point in here you talk
21 about crisis management that these hospitals
22 undertook; correct?

23 A. If you can point it out.

24 Q. Oh, yes, there it is, paragraph
25 50?

1 T. CHAKURDA

2 A. 50.

3 Q. Yeah, 50 it is the second
4 sentence, you say, "Plaintiffs engaged in
5 crisis management efforts to counteract the
6 statements"?

7 A. Okay.

8 Q. In your capacity as the chief
9 marketing officer for a -- for several
10 hospital systems, have you ever been engaged
11 in crisis management?

12 A. Absolutely.

13 Q. And generally speaking, what does
14 crisis management consist of in a hospital
15 marketing setting?

16 A. Sure. First of all, is, you know,
17 understanding of the situation, what are the
18 facts of the matter. You know, I don't know
19 what the specific -- but ascertain the
20 situation, identify all the constituencies,
21 both internal and external, where relaying
22 of that situation could have an impact. So
23 what is the problem, who are the
24 constituencies that have skin in the game
25 are going to be impacted internally and

1 T. CHAKURDA

2 externally, what are the vehicles to reach
3 them, craft your message, tell the truth and
4 disseminate that to those constituencies,
5 and that's regardless of the crisis
6 situation. That could be an untoward event,
7 you know, someone is assaulted in your
8 hallway, I mean, you know, it varies. But
9 those would be the four aspects of dealing
10 with crisis management.

11 Q. And in your opinion based on
12 documents that you have seen, these five
13 hospitals engaged in crisis management
14 related to the dissemination of their
15 November 2024 grades?

16 A. Again, the information was very
17 tops of the waves about their response.
18 There were emails, what should we do there,
19 should we have a reactive media statement.
20 But it was just -- they conveyed that they
21 were in a crisis mode, but it did not convey
22 to me the details of their response.

23 Q. Right, because at the end of this
24 sentence you say, for example, drafting
25 multiple press releases, and I saw those --

1 T. CHAKURDA

2 A. Uh-huh.

3 Q. -- in your supporting
4 documentation, but I am not certain whether
5 those were ever put out to the public, do
6 you know whether they were?

7 A. I know they exist, okay. And I
8 would assume that they were used, but I
9 could not verify that for you.

10 Q. Have you ever been involved in a
11 crisis management effort from a marketing
12 standpoint where the ultimate decision was
13 to engage in litigation to counteract the
14 issues presented by the negative PR?

15 A. Quite frankly, no.

16 Q. Do you have any opinions about
17 whether or not the hospital's media campaign
18 in the spring of 2025 about this litigation
19 and about their safety grades in any way
20 highlighted the negative grades to the
21 consuming public?

22 A. I am not familiar with the
23 particulars of that campaign.

24 Q. Okay. So you don't know as you
25 sit here today whether, for example,

1 T. CHAKURDA

2 attorneys associated with Gibson Dunn went
3 on TV to talk about the negative grades?

4 A. No, I am not aware of that.

5 Q. On page 16, and this is the
6 bleed-over of paragraph 51?

7 A. 16.

8 Q. The second full sentence, you say,
9 "The plaintiffs' hospitals in fact received
10 feedback from doctors, other personnel and
11 community members urging plaintiffs to
12 participate in TLG in the future because of
13 reports that patients avoided plaintiffs'
14 hospitals following release of the fall 2024
15 TLG grades."

16 Do you see that?

17 A. Yes, ma'am.

18 Q. Have you reviewed any documents in
19 connection with your opinions that identify
20 the doctors, the personnel or the community
21 members urging plaintiffs' participation in
22 the grades?

23 A. No, this is gleaned from the
24 plaintiffs' complaint. And it was in terms
25 with no specificity relative to names. It

1 T. CHAKURDA

2 didn't say we talked to Susie Smith.

3 Q. Right.

4 And I think you told me earlier,
5 you have not spoken to anybody at these five
6 hospitals in order to get these opinions?

7 A. No, ma'am.

8 Q. Paragraph 55 of your report?

9 A. Okay.

10 Q. You say, and this is just -- so my
11 record is clear, this is in connection with
12 Roman numeral 8, "TLG encourages private
13 pairs to tie fee reimbursement to TLG
14 grades"?

15 A. I am sorry, where are you in the
16 paragraph, can you give me a number?

17 Q. So I just want it for my record,
18 page 16, the heading that we are dealing
19 with now is 8, Roman numeral 8, TLG
20 encourages private payers to tie fee
21 reimbursements to TLG grades, do you see
22 that section?

23 A. Yes.

24 Q. Okay, and if we turn the page to
25 17, if we look at paragraph 55, paragraph 55

1 T. CHAKURDA

2 is part of that section; correct?

3 A. Uh-huh.

4 Q. And 55 says, "As such, in
5 connection with its efforts to secure media
6 placements discussed above, TLG also takes
7 steps to expand the reach of TLG's grades to
8 payers who can exert additional pressure on
9 hospitals to participate in TLG's hospital
10 survey."

11 So paragraph 55 essentially says
12 that Leapfrog takes steps to expand the
13 reach of its grades to payers who can then
14 exert additional pressure on hospitals to
15 participate in the survey, do you see that
16 sentence?

17 A. I do.

18 Q. Do you know as a matter of fact
19 whether any payers have exerted pressure on
20 these five hospitals to participate in the
21 Leapfrog survey?

22 A. I could not.

23 Q. I have a couple of footnotes that
24 I want to ask you about?

25 A. That's okay.

1 T. CHAKURDA

2 Q. Hold on one sec?

3 A. I am not going anywhere.

4 Q. So looking at footnote 17, which
5 is on page 9 of your report?

6 A. On page 9.

7 Q. And 17 is the footnote, and it is
8 in conjunction with paragraph 35?

9 A. Ellis, et al?

10 Q. Ellis, et al.

11 A. Uh-huh.

12 Q. So I read that review, and one of
13 the conclusions of that review is that
14 public quality reports contain information
15 that patients perceive to be a relatively
16 low value which may contribute to low
17 utilization.

18 Do you recall that conclusion from
19 the Ellis report?

20 A. I don't, if you are asking me, I
21 don't recall that one specifically.

22 Q. Okay, but you believe that this
23 Ellis article is something that we should be
24 relying on in order to come to some of the
25 conclusions in or opinions in your report;

1 T. CHAKURDA

2 correct?

3 A. If I can just review it very
4 briefly.

5 Q. Sure?

6 A. I concur with those percentages.
7 They seem to jive with my understanding
8 relative to what is very important, how many
9 times they go online, you know, the
10 70 percent report reputation -- I remember
11 that now that I am refreshed here,
12 70 percent put a high priority on
13 reputation.

14 Q. It was 61.9, but yes?

15 A. Okay.

16 Q. Yes, the same. Am I not reading
17 that right?

18 A. 61.9 percent report the reputation
19 of the hospital is important or very
20 important, that's under 17, Ellis, et al.

21 Q. Yes.

22 So I guess my question is you
23 don't recall that the conclusion of this
24 research paper was that patients perceive
25 public quality reports to be a relatively

1 T. CHAKURDA

2 low value?

3 A. I think what I glean from this
4 article again is that the aspect of
5 reputation -- because again, my opinions are
6 based on the severity of Ds and Fs on
7 reputation. So that's what I gravitated
8 towards.

9 Q. That's what you were using that
10 article for?

11 A. That's my recollection.

12 Q. Okay?

13 A. I mean, it jives with my thinking.

14 Q. That makes sense.

15 In terms of the Huppertz article,
16 which we talked about a little bit earlier
17 in your deposition, and that is the first
18 citation to it is on page 5, footnote 4?

19 A. Okay, got it.

20 H-CAPS, does it pay to advertise,
21 is that the one we are looking at?

22 Q. Yes, yes, H-CAPS does it pay to
23 advertise.

24 And one of the findings from the
25 Huppertz article is that making performance

1 T. CHAKURDA

2 data public results in improvements in the
3 clinical areas reported, that was one of
4 their findings, that making performance data
5 public results in clinical improvement.

6 Do you have any opinion about
7 whether or not that's true?

8 A. I would say that's a logical
9 conclusion that you use those -- those
10 sources to improve yourself or maintain
11 yourself.

12 Q. And then the last one I wanted to
13 ask you about, let me see if I can find it,
14 oh, is footnote 50 on page 15.

15 A. Okay.

16 Footnote 50, 15.

17 Q. Yes, and footnote 50, if I look
18 up, it has to do with that first full
19 sentence on page 15, where you say,
20 "Patients and their caregivers become
21 suspicious or fearful of hospitals with an F
22 grade and the impact can spread via social
23 media, online reviews and word of mouth."

24 And you cite to this medical
25 economics article for that; correct?

1 T. CHAKURDA

2 A. Which is the citation, could you?

3 Q. Oh, footnote 50, sorry, CEG?

4 A. Footnote 50, medical economics.

5 Q. Right?

6 A. Yes, online reviews are becoming
7 more important for patients in choosing
8 their care, yes.

9 Q. Okay. So I read that article and
10 I didn't see anything in that article that
11 talked about patients and caregivers
12 becoming fearful of hospitals with an F
13 grade, do you recall whether or not it says
14 that?

15 A. I don't recall that.

16 Q. And in fact, when I read it, it
17 says that 77 percent of patients look on
18 Google, Zocdoc and health grades for
19 reviews, do you dispute that?

20 A. I would not have a way to dispute
21 or validate that.

22 Q. Okay. So you would agree with me
23 that if this medical economics article
24 doesn't refer to Leapfrog or the Leapfrog
25 grades in any way, then is there any basis

1 T. CHAKURDA

2 for your statement that patients and their
3 caregivers become suspicious or fearful of
4 hospitals with an F grade?

5 A. Again, I would harken back to the
6 intuitive assessment of an F grade --

7 Q. Okay?

8 A. -- that yes, I believe firmly in
9 my experience, and grades are relatively
10 new, but they are now well established, a D
11 and an F are going to have a negative
12 connotation, there is no doubt in my mind.

13 Q. Okay. But if I am right, you
14 don't have to take my word for it, and this
15 medical economics article doesn't say that,
16 then the first half of the sentence is your
17 opinion not based on this article?

18 A. Well, it doesn't explicitly say
19 what I just said, okay.

20 Q. Okay, perfect.

21 Have you ever authored any
22 articles on hospital branding?

23 A. I have not.

24 Q. I couldn't find any, so?

25 A. You didn't look hard enough.

1 T. CHAKURDA

2 Q. Is it possible for a hospital to
3 suffer short-term reputational harm without
4 it being a long-term brand harm?

5 A. State that again.

6 Q. Yes, that might be a terrible
7 question?

8 A. I think I know where you are
9 going, but tell me again.

10 Q. So, yeah, it may be a terrible
11 question, so bear with me, they are not all
12 winners.

13 Is there a possibility that a
14 hospital could suffer short-term harm to its
15 reputation that does not translate into harm
16 to their brand?

17 A. I believe reputation is a very
18 fundamental pillar of brand. So by
19 extension of that logic, if there is an
20 impact to one, it affects the other. I
21 don't think you can separate it.

22 Q. Okay, so hypothetically, if a
23 newspaper article comes out in South Florida
24 that says patient dies at Good Samaritan
25 after sponge is left in abdomen after

1 T. CHAKURDA

2 surgery, and that news cycle, because we
3 know what news cycles looked like in 2025,
4 lasts a week and nobody ever talked about
5 again, does that have a long -- does that
6 type of publicity have a long-term effect on
7 brand or is it a blip on the radar of
8 reputation?

9 A. No, I -- again, if we go back to
10 that article that we have referenced, the
11 negativity.

12 Q. Bias?

13 A. I forget the exact title of it.

14 But it -- it conveys in pretty
15 strong terms that there is an elongated
16 impact of a negative hit that is much more
17 deep and much longer then comparing an A to
18 an F. The impact of that F on brand
19 reputation, whatever you want -- however you
20 want to characterize it, is going to last a
21 lot longer than the positive impact of that
22 A. And I think that is true in this
23 healthcare environment, but I think it is
24 true in everyday life, that a negative event
25 you will remember a lot longer. Or let's

1 T. CHAKURDA
2 say you have a job interview -- a job
3 review, your boss can give you the most
4 glowing review, okay, but there is one line
5 in there that is negative.

6 Q. Right?

7 A. You perseverate that, we do that,
8 it is human nature. We will take that home
9 and say I got a good review, but I got
10 nailed on this, or three weeks later, I
11 can't believe I had that review and I did
12 such a great job, but I had that one -- it
13 sticks in their craw. So -- and I think
14 psychologically there is references in all
15 the literature here, that that's a proven
16 entity, that it is sticky and it lasts. And
17 that negative articles -- and I think there
18 were other citations too, that in any aspect
19 of our life. But when you have a
20 pronouncement that is so overt, F, D, okay,
21 and then there is other pronouncements with
22 little graphs that go this way from green to
23 red, even the use of color and all that
24 extenuates that, that impacts, in my view,
25 in my experience, but I think in anybody's

1 T. CHAKURDA

2 life experiences, they know that's a
3 maximum.

4 Q. What about the opposite? So there
5 are some emails that you reference in your
6 report, internal emails at these five
7 hospitals that talk about if we participate
8 in the survey, we might be able to be a B.

9 So I understand what you are
10 saying about -- I am a lawyer, I understand
11 what you are saying, I remember all the
12 trials I have lost and nobody remembers the
13 ones I have won, so I understand what you
14 are saying.

15 But what about the opposite, if
16 you are an F today and you become an A in
17 the next -- let's say you go from F to A --

18 A. Uh-huh.

19 Q. -- what kind of impact does that
20 have on the brand?

21 A. I think the brand will be -- look,
22 there is -- there is a lot of examples where
23 a brand was damaged to hell and back, excuse
24 my language, okay. But through their
25 actions. The best example that I remember

1 T. CHAKURDA

2 from college was remember the Tylenol
3 poisonings?

4 Q. Oh, yeah?

5 A. People were dying, okay. And I
6 mean it was a fire storm. But Tylenol took
7 that opportunity and developed the first
8 safety package. And people thought that was
9 the greatest thing. It became an industry
10 standard. So out of dire circumstances, you
11 can respond and I think even, you know,
12 really reestablish your brand. So yes, you
13 can recover. But I think there is a
14 period -- and that one -- that one was a
15 really acute example of somebody who really
16 jumped on it.

17 But again, it doesn't dissuade me
18 from things -- people expect hospitals to be
19 As, okay. You don't -- well, I am going to
20 a hospital, they are a C, you expect them to
21 be an A, there is a standard when it comes
22 to human life and medical services. There
23 is no gray areas. You are going into
24 surgery, the surgeon better be A. I don't
25 know if I want a D. I mean, you get no core

1 T. CHAKURDA

2 in healthcare. It is almost like cars, you
3 want that car to be mechanically sound, you
4 don't want the axle to fall off.

5 So again, I know I am trying to
6 oversimplify this. But again, Ds and Fs,
7 especially in healthcare where it is the
8 only commodity where human beings are still
9 taking care of human beings.

10 Q. Right.

11 A. You know, that touch, that the
12 magnitude, the stickiness of it is much more
13 acute than an A. And especially in
14 healthcare, I will summarize it, where you
15 expect to have an A, even if it is just some
16 kind of, you know, thought, well, you know,
17 my hospitals, that should be the standard of
18 performance.

19 Q. Right?

20 A. Because if you don't meet that
21 standard of performance in healthcare, the
22 perception is somebody suffers, okay.

23 Q. And you can, a hospital can
24 improve its grade; right, it is -- an F is
25 avoidable, would you agree?

1 T. CHAKURDA

2 A. Of course, you can -- you can fix.
3 You are not stuck in it, you do things to
4 get out of it.

5 Q. Right.

6 A. But where the sticky is, okay, is
7 the impact of that grade until you can
8 demonstrably and in no uncertain terms prove
9 that you are not a public pronouncement of a
10 D and an F.

11 MS. BLAIR: I think that might be
12 all I have. Can we take a short break
13 so I could look at my notes.

14 THE VIDEOGRAPHER: It is
15 12:15 p.m., we are off the record.

16 (Whereupon, a short recess was
17 taken.)

18 THE VIDEOGRAPHER: It is
19 12:19 p.m., back on the record.

20 MS. BLAIR: Mr. Chakurda, I have
21 no further questions for you today.

22 Q. I do note however that you have
23 reserved your right to supplement your
24 opinions; correct?

25 A. Uh-huh.

1 T. CHAKURDA

2 Q. And you -- do you have any plans
3 as we sit here today to supplement those
4 opinions?

5 A. I am sorry?

6 Q. Do you have any plans today to
7 supplement those opinions?

8 A. No, I do not.

9 (Continued on next page.)

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1 T. CHAKURDA

2 MS. BLAIR: Thank you. I don't
3 know if you have any questions.

4 MS. PARKS: I don't have any
5 questions. Thank you, Mr. Chakurda,
6 for your time.

7 Do you want to take orders on the
8 record?

9 THE COURT REPORTER: Would you
10 like a copy?

11 MS. PARKS: I would like the rough
12 and the final regular.

13 MS. BLAIR: I would like the rough
14 and regular in e-tran.

15 THE COURT REPORTER: Regular
16 delivery?

17 MS. BLAIR: Yes, regular delivery.

18 THE VIDEOGRAPHER: 12:20 p.m., we
19 are off the record.

20 (Whereupon, at 12:20 P.M., the
21 Examination of this witness was
22 concluded.)

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T. CHAKURDA

D E C L A R A T I O N

I hereby certify that having been first
duly sworn to testify to the truth, I gave
the above testimony.

I FURTHER CERTIFY that the foregoing
transcript is a true and correct transcript
of the testimony given by me at the time and
place specified hereinbefore.

THOMAS CHAKURDA

Subscribed and sworn to before me
this _____ day of _____ 20____.

NOTARY PUBLIC

1 T. CHAKURDA

2 I N D E X

3

4 EXAMINATION BY PAGE

5 MS. BLAIR 5

6

7 E X H I B I T S

8

9 CHAKURDA EXHIBITS

10

11 EXHIBIT EXHIBIT

12 LETTER DESCRIPTION PAGE

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14 1 Expert report 27

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1 T. CHAKURDA
2 C E R T I F I C A T E

3
4 STATE OF NEW YORK)
 : SS.:
5 COUNTY OF QUEENS)

6
7 I, RIVKA TROP, a Notary Public for and
8 within the State of New York, do hereby
9 certify:

10 That the witness whose examination is
11 hereinbefore set forth was duly sworn and
12 that such examination is a true record of
13 the testimony given by that witness.

14 I further certify that I am not related
15 to any of the parties to this action by
16 blood or by marriage and that I am in no way
17 interested in the outcome of this matter.

18 IN WITNESS WHEREOF, I have hereunto set
19 my hand this 2nd day of September, 2025.

20
21
22
23
24
25

Rivka Trop

RIVKA TROP



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Exhibit 5

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
WEST PALM BEACH DIVISION

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GOOD SAMARITAN MEDICAL CENTER,
INC., DELRAY MEDICAL CENTER,
INC., PALM BEACH GARDENS
COMMUNITY HOSPITAL, INC. D/B/A
PALM BEACH GARDENS MEDICAL
CENTER, ST. MARY'S MEDICAL
CENTER, INC., AND WEST BOCA
MEDICAL CENTER, INC.,

Plaintiffs,

v. Case No. 9:25-cv-80526

THE LEAPFROG GROUP

Defendants.

** VIDEOTAPED DEPOSITION**

SEAN NICHOLSON, PH.D.

Monday, September 8, 2025

Reported by:

Angela M. Shaw-Crockett, CCR, CRR, RMR, CSR
Job 1395125

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Monday, September 8, 2025

9:58 a.m.

VIDEOTAPED deposition of Sean Nicholson, Ph.D.,
held at Wilson Elser Moskowitz Edelman & Dicker,
LLP, 150 East 42nd Street, New York, New York,
before Angela (Angie) M. Shaw-Crockett, a
Certified Court Reporter, Certified Realtime
Reporter, Registered Merit Reporter and Notary
Public of the States of New York, New Jersey, and
Connecticut.

1 A P P E A R A N C E S:

2 ATTORNEY FOR THE PLAINTIFFS:

3 GIBSON DUNN & CRUTCHER LLP

2001 Ross Avenue

4 Dallas, Texas 75201-2911

5 BY: SCOTT K. HVIDT, ESQ.

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7

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11

BY: KIMBERLY E. BLAIR, ESQ.

12 COURTNEY WOOD, ESQ.

kimberly.blair@wilsonelser.com

13 courtney.wood@wilsonelser.com

14

15 ALSO PRESENT: Sammy Verni, The Videographer

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1 I N D E X

2 Examination of:	Page
3 Sean Nicholson, Ph.D.	

C O N T E N T S

4 MS. BLAIR	6
5 MS. BLAIR	108

6 E X H I B I T S

7 (Retained by the court reporter)

8 DEPOSITION	EXHIBIT	PAGE
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1 THE VIDEOGRAPHER: We're now on the
2 record. This begins videotape number 1 in the
3 deposition of Dr. Sean Nicholson in the matter
4 of Good Samaritan Medical Center, Inc., et al.,
5 v. The Leapfrog Group, in the United States
6 District Court for the Southern District of
7 Florida, West Palm Beach Division.

8 Today is September 8, 2025, and the time
9 is 9:58 a.m. This deposition is being taken at
10 150 East 42nd Street at the request of Wilson
11 Elser Moskowitz Edelman & Dicker, LLP.

12 The videographer is Sammy Verni of Magna
13 Legal Services, and the court reporter is
14 Angie Shaw-Crockett of Magna Legal Services.

15 Will counsel and all parties present state
16 their appearances and whom they represent.

17 MS. BLAIR: Kim Blair on behalf of the
18 Defendant.

19 MR. HVIDT: Scott Hvidt with Gibson Dunn
20 on behalf of the Plaintiffs, with my colleague
21 Kevin Reilly.

22 THE VIDEOGRAPHER: Will the court reporter
23 please swear in the witness.

24 Sean Nicholson, Ph.D., having been first duly sworn by a
25 Notary Public of the State of New York, was examined and

1 testified as follows:

2 MS. BLAIR: Let the record reflect this is
3 the deposition of Dr. Sean Nicholson taken
4 pursuant to the Federal Rules of Civil
5 Procedure and the local rules of the
6 U.S. District Court for the Southern District.

7 EXAMINATION

8 BY MS. BLAIR:

9 Q. Dr. Nicholson, can you state and spell
10 your full name for record, please?

11 A. Sean Nicholson, S-E-A-N,
12 N-I-C-H-O-L-S-O-N.

13 Q. And Dr. Nicholson, I can tell from your CV
14 that you've had many depositions taken before in the
15 past, correct?

16 A. Yes, I have.

17 Q. I'm just going to go over just a few
18 ground rules so we all understand things that you've
19 probably heard before.

20 First and foremost, the court reporter,
21 Angie, can only take down one of us talking at a
22 time. So I will attempt to not talk over you so she
23 can get down all of your answers. And I would just
24 ask that you try not to talk over me so she can get
25 down all of my questions.

1 Does that make sense?

2 A. Yes, it does.

3 Q. And, of course, this is not an endurance
4 test, so if at any time you need to take a break,
5 we'll certainly do that. I only ask, if there's a
6 question pending, that you answer that question
7 before we take the break; is that fair?

8 A. Yes, it is.

9 Q. And as you know, the court reporter cannot
10 take down a "uh-huh," "uh-uh," shrug of the
11 shoulders. So all of your answers must be verbal
12 today; is that fair?

13 A. Yes, it is.

14 Q. I will, from time to time, ask some pretty
15 poorly worded questions. If at any time you don't
16 understand my question, please ask that I rephrase
17 it, and I will do so. If you answer my question,
18 I'm going to assume that you understood the
19 question; is that fair?

20 A. Yes, it is.

21 Q. Can you tell me when you were first
22 retained in this matter?

23 A. In April of 2025.

24 Q. And what was the scope of your engagement
25 in April 2025?

1 A. It was to -- as I indicate in my report,
2 to assess the principles that underlie a proper
3 quality evaluation method, to assess whether
4 Leapfrog's method conforms to those principles, and
5 also to assess the potential effect of the Leapfrog
6 grades on patients' choices in hospitals.

7 Q. And am I right that sometime in
8 April 2025, you put together a declaration in
9 support of a preliminary injunction hearing in this
10 matter, correct?

11 A. Yes. I believe it may have been filed in
12 May, but yes, I was working on it in April.

13 Q. Fair enough.

14 Ultimately, later on, you issue your
15 report in -- I don't remember what the date is.

16 You issue a report time that I'm going to
17 show you at some point today that is dated
18 August 7, 2025, correct?

19 A. Yes, that's correct.

20 Q. So I just want to make sure. There is
21 a -- there's work you did in April that ultimately
22 becomes part of a -- my word, "declaration," in
23 support of a motion for preliminary injunction
24 that's filed in May, and then there's a subsequent
25 report in August of 2025, correct?

1 A. Yes, that's correct.

2 Q. Between your work in May of 2025 and your
3 report on August 7, 2025, did any of your opinions
4 change?

5 A. No. Some of the analyses were added, but
6 no opinions changed.

7 Q. Between the time that you did your work in
8 April/May of 2025, and when you issued a report in
9 August of 2025, did you review any additional
10 materials to come to your conclusions?

11 A. Yes.

12 Q. And what additional materials did you
13 review to come to your conclusions between
14 April/May of 2025 and August of 2025?

15 A. I don't believe I could recall all of
16 them, but certainly, it would include the data from
17 Leapfrog Group that was disclosed from the
18 Spring 2025 report grades. So that would be an
19 example of some additional material.

20 Q. Okay. And when you say data from Leapfrog
21 for the 2025 report grades, did you review any data
22 directly from the Plaintiffs related to their 2025
23 grades?

24 A. Yes, because in those data that Leapfrog
25 disclosed included data for Plaintiff Hospitals. So

1 those data would have been a part of that dataset.

2 Q. As I understand your testimony, you're
3 talking about documents that may have a Leapfrog
4 Bates label on the bottom of them, correct?

5 A. I'm not able to remember which -- the
6 contents of the label.

7 Q. Sure. And I just want to make sure I'm
8 understanding your answer. Maybe I'm not.

9 So you said you reviewed documents that
10 Leapfrog had produced with respect to -- and this is
11 just one of some things. I'm not holding you to it.
12 But you reviewed documents that Leapfrog produced
13 related to its 2025 report grades that would have
14 contained data from the Plaintiff Hospitals,
15 correct?

16 A. Yes. The specific thing I was referring
17 to is the data that underlie the Spring 2025
18 Leapfrog group grade issuance.

19 Q. Between April/May of 2025 and
20 August of 2025, did you get any additional documents
21 from the Plaintiffs related to what their data could
22 have been for the Leapfrog methodology?

23 A. I know a lot of documents were disclosed
24 in that interim, and I have seen some documents, I'm
25 sure, from both Plaintiffs and Defendants.

1 Q. Did you ever see any specific documents
2 from the Plaintiffs about what their hand hygiene
3 metric would have been had they participated in the
4 2025 survey?

5 A. I can't recall specifically the hand
6 hygiene. I do recall seeing some documents related
7 to what their submissions would have been on some of
8 those self-reported scores. I just can't remember
9 the particular measure.

10 Q. Okay. And other than -- well, you told
11 me, specifically between April and May of 2025 and
12 August of 2025, you would have seen some additional
13 materials from Leapfrog related to the Spring 2025
14 safety grade.

15 Do you recall any other documents you
16 would have reviewed between your declaration in
17 April/May of 2025 and your report in August of 2025?

18 A. Are you asking about documents in general
19 or specific to Plaintiff?

20 Q. Do you recall any specific additional
21 documents that you received between April/May of
22 2025 and August of 2025 that you used in formulating
23 your opinions that appear in your August 7, 2025,
24 report?

25 A. I certainly have reviewed some documents

1 that relate to some correspondence, say, Patrick
2 Romano correspondence, some minutes from the safety
3 grade expert panel. So those would be examples of
4 some other documents that I reviewed.

5 Q. Okay. And you did not have those
6 documents when you formed your initial opinions in
7 April/May of 2025, correct?

8 A. That's correct. I believe they were
9 disclosed after that, but I certainly do not recall
10 reviewing them before the May declaration.

11 Q. And what is your hourly rate for this
12 expert service that you're providing to the
13 Plaintiffs?

14 A. It's 1,250 per hour.

15 Q. How many hours do you have into this
16 engagement thus far?

17 A. I'm not sure the exact number of hours.

18 Q. What about estimate? Best estimate?

19 A. I think I submitted invoices for about --
20 about 60 hours through August. I believe that's
21 approximately correct.

22 Q. And you have an affiliation with the
23 Cornerstone group, correct?

24 A. Yes, Cornerstone Research staffs my
25 research, forms my research team for engagements

1 like this.

2 Q. And when you say Cornerstone staffs your
3 research, what do you mean by that?

4 A. I have the ability to get assistance under
5 my direction for conducting analyses. So I have
6 members of Cornerstone Research who perform analyses
7 under my direction and are also able to review
8 documents.

9 Q. And when you say they conduct analyses,
10 there are eight workbooks attached to your expert
11 opinion.

12 Are those the types of analyses you're
13 referring to?

14 A. Yes, they are.

15 Q. Who at Cornerstone group did you work with
16 on your research team for this particular expert
17 engagement?

18 A. Primarily four individuals, Penka
19 Kovacheva -- and I could spell those -- Anand
20 Krishnamurthy, Rezwan Haque, H-A-Q-U-E, and Andy
21 Lehrer.

22 Q. And what are their backgrounds; do you
23 know?

24 A. I believe they have Ph.D.s. I'm not
25 100 percent sure. Certainly, some of them do.

1 Q. Are they economists?

2 A. Yes.

3 Q. Are they healthcare economists?

4 A. I've worked with them before on healthcare
5 cases. I don't believe they work exclusively on
6 healthcare cases, but they do have backgrounds in
7 that discipline.

8 Q. Do you know how much Cornerstone has
9 billed in connection with your expert retention to
10 the Plaintiffs?

11 A. I do not, no.

12 Q. Do you know how many hours Cornerstone has
13 spent assisting you in connection with your expert
14 opinions in this case?

15 A. I don't know.

16 Q. Is your compensation in any way contingent
17 on the outcome of this case?

18 A. No, it is not.

19 Q. Have you ever provided expert services to
20 the Plaintiff -- any of the five Plaintiffs before?

21 A. No, I have not.

22 Q. What about their parent company,
23 Tenet Healthcare?

24 A. No.

25 Q. How many times have you served as an

1 expert for Gibson Dunn?

2 A. I believe this is the first time.

3 Q. In your own words, can you tell me what is
4 a healthcare economist versus an economist? Might
5 be a weird question, but just curious.

6 A. So most healthcare economists like myself
7 receive a Ph.D. in economics, which is the study of
8 how firms and individuals make decisions, and then
9 choose to focus their research, or in my case,
10 research and teaching, on how the healthcare market
11 functions. So the economics of the healthcare
12 market.

13 Q. Do you have -- do you have to have a --
14 well, strike that.

15 Do you have a degree in public health as
16 well? I can't remember.

17 A. No, I do not.

18 Q. Do you take any specific classes in your
19 very lengthy education to focus on healthcare
20 economics?

21 A. I personally did. At
22 University of Wisconsin, there were courses devoted
23 to health economics, which I did take.

24 Q. So is it sort of like you become an
25 economist, and then you just focus on healthcare?

1 A. Yes. And that's typical of economics
2 generally. Generally, economists will choose an
3 area of focus or specialization: Micro, macro,
4 econometrics, health economics.

5 Q. Okay. And in your field of study in
6 health economics, do you have any specific training
7 about what measures are appropriate to include in a
8 methodology regarding patient safety?

9 A. I do, because some of my research has been
10 on that topic. So I've published and I've taught on
11 the topic of quality measurement, which I do discuss
12 in my report, and I'm also on the -- I'm a trustee
13 on a couple of hospital boards where hospital
14 quality is often an issue.

15 Q. Would you agree with me that there's a
16 difference between quality and patient safety?

17 MR. HVIDT: Objection, form.

18 A. I think it depends on the person. I see
19 quality as the broadest term, and then safety as a
20 subset of that.

21 BY MS. BLAIR:

22 Q. Can you just give me a general listing of
23 research you've done on what the proper measures --
24 so not the economics of it, but the proper measures
25 for evaluating healthcare quality should be?

1 A. And you're asking just about research?

2 Q. Research that you've done, yeah.

3 A. So as I discussed in my report, I have
4 conducted a number of research studies that led to
5 publications to measure the quality, either provided
6 by an individual physician or the quality of care
7 provided by a residency program that's training
8 physicians, or the quality of care received by
9 people who are enrolled in a particular health
10 insurance plan. All of those studies would involve
11 making determinations of an appropriate way to
12 measure quality.

13 Q. Do you work alongside medical doctors when
14 you do that research, in determining what measures
15 should be included in looking at hospital quality --
16 or healthcare quality -- excuse me?

17 A. I believe in all of the instances that I
18 just described -- I believe I've had a physician
19 co-author in all of those, either David Asch, on the
20 first several that I mentioned, or Joe Stankaitis,
21 who's a physician, on a study involving health
22 insurance enrollees.

23 Q. What does David Asch do?

24 What is his employment, if you will?

25 A. He is a professor at the

1 University of Pennsylvania. I think he's currently
2 in administration primarily, but is trained as a
3 general internist and practices -- or practiced, at
4 least, as a general internist.

5 Q. What about Joe Stankaitis? What is he a
6 doctor of, or what's his current position?

7 A. I can't remember his specialty. He is a
8 physician. For much of his career, he ran a
9 Medicaid insurance company in New York State. He's
10 currently an executive and resident at Cornell, and
11 he may have some other assignments as well.

12 Q. What is your understanding of what the
13 Leapfrog Hospital Safety Grade is measuring?

14 A. Well, it's measuring -- it's trying to
15 measure, based on structures that are present in
16 hospitals, and processes of care that those
17 hospitals use and patient outcomes, which is trying
18 to assess the quality and safety of hospitals.

19 Q. In coming to your expert opinions in this
20 case, did you review the Leapfrog Safety Grade
21 Expert Panel Guiding Principles?

22 A. Yes, I have seen those.

23 Q. So do you recall that in the Leapfrog
24 Expert Panel, or Safety Grade Expert Panel Guiding
25 Principles, it states that the point is to

1 construct -- or it says "construct." And then it
2 says:

3 "The focus of this composite score is
4 patient safety, which is being defined as freedom
5 from harm. We recognize that patient safety is a
6 different and a narrower construct than hospital
7 quality. The composite score should recognize both
8 the hospital's efforts towards patient safety and
9 the hospital's patient safety outcomes."

10 Do you remember reading that?

11 A. I don't remember those words verbatim, but
12 I'll take your word that that's included there.

13 Q. Do you agree that patient safety is a
14 different and narrower construct than hospital
15 quality?

16 A. I would repeat what I said earlier. In my
17 interpretation, in my practice, I think of safety as
18 a subset of quality. So I do agree it's narrower
19 than quality, but I'm not sure -- maybe you can
20 repeat the language. I'm not sure I think of it as
21 distinct.

22 Q. Sure.

23 It says:

24 "We recognize that patient safety is a
25 different and a narrower construct than hospital

1 quality."

2 And I'm asking if you agree with that
3 statement?

4 A. I would agree that it's narrower. I don't
5 think I would agree that it's different. I think it
6 has many of the similar characteristics.

7 Q. Have you ever authored any articles on
8 specifically patient safety as it -- patient safety?

9 A. I wouldn't say my article set focused
10 solely on that, but in the research that I described
11 previously, when we define what we might refer to as
12 "quality," it does include measures that I believe
13 the Leapfrog Group would consider as patient safety.

14 Q. Right.

15 And I tried to read a lot of the articles
16 that you've written, or at least abstracts of them,
17 et cetera. And I didn't see any that were very
18 specific to patient safety as opposed to patient
19 quality.

20 I'm just asking, if I were to focus on one
21 of your articles that had to do with patient safety
22 as opposed to overall quality, which article should
23 I focus on?

24 A. I think any of the articles that are
25 looking at the quality of care delivered by

1 obstetricians, the primary measures that we use are
2 maternal complications, which I would interpret as
3 patient safety measures. So does a delivering
4 mother experience or not a complication associated
5 with a delivery?

6 Q. Right.

7 So that is -- that article -- again, and
8 you told me that -- that article talks about certain
9 patient safety measures, but it's about quality of
10 care, is it not, that article, in the more general
11 sense?

12 MR. HVIDT: Objection, form, asked and
13 answered.

14 A. I can't recall the specific wording that
15 we used throughout the article. I certainly refer
16 to it that way, because I think of quality as the
17 broadest term.

18 BY MS. BLAIR:

19 Q. Were you asked to opine in this litigation
20 on the accuracy of Leapfrog's grades for each of the
21 five Plaintiff Hospitals?

22 A. I was asked to opine on whether the
23 Leapfrog method conforms to the principles of a
24 proper quality and safety measurement system and
25 whether the grades were reliable. So that is

1 certainly related to that question or assignment.

2 Q. I guess my question is just that -- I want
3 to make sure I understand your opinions. It does
4 not appear to me, but I want to hear it in your
5 words.

6 Were you asked to look at the actual data
7 from each of these five hospitals for the four
8 imputed metrics and make a determination as to
9 whether their grades were accurate?

10 A. I was asked to examine whether the TLG
11 method reported grades in a way that was consistent
12 with what the principles are from the appropriate
13 method. So that would include seeing whether the
14 method affects the grades that were reported and
15 whether the method is applied consistently across
16 all hospitals.

17 Q. Right. And I guess my question is a
18 little different, and I understand that.

19 Did you -- for example, did you go into
20 West Boca's data and say, If they had done the
21 Leapfrog survey on CPOE, for example, they would
22 have scored an X score.

23 Did you do that type of analysis?

24 A. I conducted a counterfactual analysis of
25 what would the reported grades have been had

1 nonrespondents to the Leapfrog survey, in fact,
2 responded in a way that's typical of the
3 respondents.

4 Q. Correct. And I saw that, right?

5 Like, you assign them the mean number for
6 seven measures and recalculated the grades, correct?

7 A. That is part of what I did, correct.

8 Q. And so my question is a little more
9 specific.

10 Did you go to any of these five hospitals
11 and actually say, Let me see your CPOE data -- I'm
12 just being specific to CPOE data now -- let me see
13 your CPOE data and see how far off your CPOE score
14 was? Or did you do it more in just the
15 counter-analysis general sense of it?

16 A. I certainly didn't conduct any site
17 visits. What I did was, see how the Leapfrog Group
18 method would affect the quality and safety that's
19 reported, holding fixed the quality of Plaintiff
20 Hospitals and other hospitals.

21 Q. What do you mean by "holding fixed"? What
22 does that mean?

23 A. What I mean is just using the data that
24 was available for them and then conducting
25 counterfactuals on what would have happened had they

1 responded.

2 Q. I guess that's my question.

3 What was the data that was available for
4 them on those four imputed metrics that you used?

5 A. Well, the data that were available I'm
6 referring to the other measures that were in the TLG
7 dataset.

8 Q. And you understand the CPOE is one of the
9 four imputed -- we're calling them the "imputed
10 metrics."

11 Did you see any data for any of these five
12 hospitals with respect to these five -- four imputed
13 metrics?

14 A. No. I didn't see any, because they -- at
15 least, you know, in the time period of the analysis,
16 they weren't reporting the data to the Leapfrog
17 Group.

18 Q. Right. And as I see, one of your
19 opinions, at least, is you talk about that the
20 Leapfrog methodology as employed starting in -- with
21 respect to the fall 2024 grading period, is unfair,
22 correct?

23 A. Yes. That is one of my opinions. It does
24 not treat hospitals comparably.

25 Q. Can you just, in your own words, tell me

1 what specific opinions you were asked to offer in
2 this matter?

3 And I may have already asked that, so I
4 apologize.

5 MR. HVIDT: Objection, form.

6 A. My assignment consisted of three parts.
7 First, to assess the principles that underlie a
8 proper quality and safety measurement system; second
9 to assess whether the Leapfrog Group's method
10 conforms to those principles; and the third was to
11 assess likely impact of the Leapfrog Group's grades
12 on patient decisions about which hospital to seek
13 care from.

14 BY MS. BLAIR:

15 Q. On that last opinion, did you read the
16 expert reports of Mr. Chakurda and Dr. Berger in
17 this matter?

18 A. Dr. Berger's, yes.

19 Q. He also opines on the likely impact of the
20 Leapfrog safety grades on these five hospitals,
21 correct?

22 A. Yes, he does.

23 Q. And does your opinion in any way differ
24 from Dr. Berger's opinion in this matter?

25 MR. HVIDT: Objection, form.

1 A. I believe our opinions are consistent. He
2 delved more deeply into the topic, I think, or at
3 least some aspects that I didn't delve into.

4 BY MS. BLAIR:

5 Q. As an economist, do you have an opinion as
6 to the best way to measure the impact of the
7 Leapfrog Hospital Safety Grades on the five
8 Plaintiffs?

9 A. In my opinion what I've tried to do with
10 my report is to examine how Leapfrog Group's method
11 affects the grades that are reported, using a method
12 that would be as similar to the principles that
13 underlie an effective system as possible.

14 Q. And I guess I'm asking if I, a
15 layperson -- I'm not an economist -- wanted to
16 figure out what the impact was on any of these five
17 hospitals from the Leapfrog Hospital Safety Grade,
18 as an economist, what would be the best methodology
19 to run to determine whether or not there's a causal
20 link between the Hospital Safety Grades and harm to
21 any of these five Plaintiffs?

22 MR. HVIDT: Objection, form.

23 A. I think you're -- I think you're asking at
24 least a couple of things.

25 MS. BLAIR: Maybe.

1 A. I'll begin with, I believe the
2 counterfactual analysis that I performed is a way to
3 determine how the Leapfrog Group method affects the
4 reported grade because it looks at whether the
5 Leapfrog Group method treats responders differently
6 than nonresponders.

7 My conclusion is that it does, that it
8 inflates responders' grades and deflates
9 nonresponders' grades. And I show the magnitude of
10 that in my counterfactual.

11 BY MS. BLAIR:

12 Q. But if no one ever sees it, right -- if no
13 consumer ever sees that grade, it gets lost in the
14 Dark Web, how do you determine whether or not that
15 grade had an impact on or harmed the hospitals in
16 some way?

17 MR. HVIDT: Objection, form.

18 A. As part of my assignment, I didn't form or
19 conduct a causal analysis of harm. I did refer to
20 literature which consistently shows that reported
21 grades like the Leapfrog Group reports are
22 associated with changes in the number of patients
23 treated at various hospitals or patient choices.

24 BY MS. BLAIR:

25 Q. Were you asked to provide any opinions in

1 this case that you felt uncomfortable providing and,
2 therefore, did not provide?

3 A. No.

4 Q. In preparing for your deposition today,
5 did you review any of the expert reports that were
6 propounded by the Defendants on September 4, 2025?

7 A. Yes.

8 Q. Which ones?

9 A. I reviewed Dr. Harris' report and
10 Mr. Rule's report.

11 Q. Do you know Dr. Harris?

12 A. No. I don't think so.

13 Q. Have you ever heard of Dr. Harris?

14 A. No.

15 Q. What about Mark Rule? Are you familiar
16 with Mark Rule before this case?

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

18 Q. Did you review the deposition transcripts
19 of -- strike that.

20 Did you review any deposition transcripts
21 in this case to prepare for your deposition today?

22 A. No.

23 Q. Did you review the CMS data -- did you
24 review any CMS data for the five Plaintiff Hospitals
25 in preparation for your deposition today?

1 A. Yes. It would have been included in an
2 analysis I did in my report, and I also know that I
3 believe Dr. Harris refers to it.

4 Q. And so for purposes of your deposition
5 here today, you're familiar with all five of these
6 hospitals' CMS ratings -- current CMS ratings?

7 A. I don't have them memorized. I didn't
8 conduct any independent analysis of the whole
9 ratings.

10 Q. But you have a general understanding of
11 what their CMS star ratings are as we sit here
12 today?

13 A. Again, I don't know precisely. I know
14 Dr. Harris -- and I can't remember what time
15 period -- but he presents some information on CMS
16 star ratings.

17 Q. In connection with preparing either your
18 opinion, your August 7, 2025, opinion or for your
19 deposition here today, did you review any of the
20 Leapfrog audit and verification protocols with
21 respect to survey responders?

22 A. So I'm familiar and I do cite to an
23 article in my report regarding how frequently the
24 Leapfrog Group audits, either on-site or
25 electronically, hospital respondents. And I do cite

1 to that. And then I saw some documents related
2 to -- I think a contract with a vendor related to
3 auditing.

4 Q. And that article that you're referring to
5 would be the Smith article, correct?

6 A. No. I'm referring to -- I think the title
7 is "Rate the Raters."

8 Q. Rate --

9 A. "Rate the Raters." I forget who the
10 author is.

11 Q. I think we're talking about the same thing
12 but maybe not. "Rate the Raters."

13 Are you aware there was an amended
14 complaint filed in this matter last week?

15 A. I don't know.

16 Q. So my follow-up question is, have you
17 reviewed the amended complaint in preparation for
18 your deposition here today?

19 A. No, I have not.

20 Q. So you have not made any determination as
21 to whether any of the changes to the complaint
22 affect your opinion -- your opinions in this case,
23 correct?

24 A. I didn't review the complaint. I assumed
25 if it was relevant for my testimony, I would have

1 been informed about it.

2 Q. Part of what's attached to your opinion is
3 declarations of the CEOs of all five hospitals, all
4 five Plaintiff Hospitals.

5 Do you recall reviewing those?

6 MR. HVIDT: Objection, form.

7 A. Yes, I do recall that.

8 BY MS. BLAIR:

9 Q. Were you told that in any way that those
10 declarations have been withdrawn in this litigation?

11 A. No. I'm not aware whether they have or
12 haven't.

13 Q. And so to the extent your opinion, dated
14 August 7, 2025, relies on the declarations of those
15 five CEOs, that still stands, correct?

16 MR. HVIDT: Objection, form.

17 A. Well, my opinions in the August 7 report,
18 my report, do not rely on those declarations. So I
19 don't think it would be relevant.

20 BY MS. BLAIR:

21 Q. Okay. So to the extent your opinion cites
22 to them, they're not relevant to your opinions?

23 A. I should say, certainly they're in my
24 materials considered and I do cite to them, but I
25 don't believe my opinions that I formed are relying

1 on them.

2 Q. Okay. In forming your opinions in this
3 case, did you rely on the Leapfrog methodology
4 document?

5 A. I do cite to it, and I'm aware of it.

6 Q. And obviously a lot of what we're talking
7 about here today is the fact that the methodology
8 was changed between spring of 2024 Hospital Safety
9 Grades and the fall of 2024 Hospital Safety Grades,
10 correct?

11 A. Yes.

12 Q. And is it safe for me to assume, then,
13 that in preparing your opinions, you reviewed both
14 the pre-fall 2024 methodology and the post-fall 2024
15 methodology?

16 A. Yes, maybe not every single one of the
17 pre, but at least some of them, yes.

18 Q. And in forming your opinions here today,
19 did you review the Leapfrog Hospital Survey?

20 A. I certainly didn't look through every of
21 the hundreds of pages of it. I'm aware of the data
22 being elicited from the survey, but I didn't review
23 them in any detail.

24 Q. I think you told me you did review the
25 expert panel's guiding principles on the development

1 of the composite Leapfrog Hospital Safety Grade for
2 U.S. hospitals?

3 A. Yes. I have seen those principles.

4 Q. I think you testified earlier that you
5 also reviewed transcripts from the Hospital Safety
6 Grades Expert Panel discussions?

7 MR. HVIDT: Objection -- sorry.

8 MS. BLAIR: Go ahead.

9 MR. HVIDT: Objection to form.

10 A. I recall seeing at least minutes from a
11 2020 meeting, also maybe from a 2024 meeting.

12 BY MS. BLAIR:

13 Q. Do you recall what those minutes -- what
14 the substance of those minutes were?

15 A. The 2020 was, among other things, I think,
16 discussing the method being proposed by Mathematica
17 regarding imputing values. There may have been
18 other topics, but that's what I recall seeing. And
19 in 2024, I think, slides of the meeting, and then
20 maybe some email correspondence following that
21 meeting. I'm not sure if I saw the minutes to that
22 meeting. I might have.

23 Q. And the 2024 meeting -- strike that.

24 Again, did you see at some point
25 correspondence from Patrick Romano related to the

1 Leapfrog methodology and, in particular, the
2 imputation method?

3 A. I have seen some. I'm not sure I've seen
4 all of them or the ones you're referring to.

5 Q. Do you know who Patrick Romano is?

6 A. Yes. He's an employee at
7 University of California Davis and also a member of
8 the safety grade expert panel, the TLG Safety Grade
9 Expert Panel.

10 Q. Before becoming involved in this
11 litigation, had you ever heard of Patrick Romano?

12 A. No. I don't believe so, no.

13 Q. In forming your opinions in this matter,
14 did you review the qualifications of the members of
15 the Leapfrog Hospital Safety Grade Expert Panel?

16 A. I don't believe so. I looked at the names
17 at some point. I don't believe I looked at the bios
18 or the credentials.

19 Q. Are there any names on the Leapfrog
20 Hospital Safety Grade Expert Panel that you know
21 prior to this litigation?

22 A. I don't think know personally. I know of
23 them from -- some of them, or at least one of them,
24 from research work.

25 Q. Which one do you know from research work?

1 A. I've never met him personally, but I do
2 know of Peter Provonost and maybe -- is Bates on
3 that?

4 Q. Yes. David Bates.

5 A. I know, I believe, some of his work, but I
6 don't believe I know him personally.

7 Q. And, in fact, would you agree with me that
8 Peter Provonost, I think, was on the cover of Time
9 Magazine for winning the genius grant.

10 Were you aware of that?

11 A. I was not aware of that.

12 Q. And in what context do you know David
13 Bates?

14 A. I believe I read some of his work on -- I
15 think this is the correct person -- electronic
16 medical records, when I was teaching a course on
17 information technology and quality improvement.

18 Q. Do you know Matthew McHugh from
19 University of Pennsylvania?

20 A. I don't believe so.

21 Q. Have you ever heard of Arnie Milstein from
22 Stanford University?

23 A. His name is familiar. I'm not sure I
24 could describe his research. His name is familiar.

25 Q. What about Arjun Srinivasan, who is with

1 the CDC in the U.S. Public Health Service? Were you
2 familiar with him before this litigation?

3 A. His name is familiar, but I also would not
4 be able to describe what research he focuses on.

5 Q. Do you have any reason to dispute the
6 qualifications of the Leapfrog Safety Grade Expert
7 Panel to advise on patient safety methodology?

8 A. It was not part of my assignment to assess
9 their credentials, but I don't, sitting here, have
10 any reason to dispute them.

11 Q. Prior to this litigation, did you have any
12 interactions with the Armstrong Institute of
13 Johns Hopkins?

14 A. No. I don't believe so.

15 Q. Prior to this litigation, have you had any
16 interactions with Matt Austin from Johns Hopkins?

17 A. No.

18 Q. After reviewing the documents in this case
19 and offering your opinions, are you familiar with
20 who Matt Austin is?

21 A. Yes, I am.

22 Q. And what is your understanding of how Matt
23 Austin fits into the Leapfrog fixture?

24 A. I believe he chairs the safety grade
25 expert committee, but I could be wrong about that.

1 But certainly, he was one of the authors on the
2 Leapfrog Group white paper and I've seen him
3 corresponding with people like Patrick Romano. So I
4 know he's been involved in working with the Leapfrog
5 Group on the method.

6 Q. Other than that, you have no understanding
7 of who he is or what he does for a living?

8 A. I was not aware of him prior to this case.
9 (Attorney Wood arrives.)

10 BY MS. BLAIR:

11 Q. In researching and formulating your
12 opinions in this matter, did you review the other
13 expert panels that Leapfrog has?

14 A. I don't believe so. I'm not aware of what
15 those panels are.

16 Q. Well, what about the Barcode Medication
17 Administration Expert Panel? Did you review that in
18 connection with your opinions here today?

19 A. I did not, no.

20 Q. And what about the Computerized Physicians
21 Order Entry Expert Panel? Did you review anything
22 related to that expert panel in formulating your
23 opinions in this litigation?

24 A. No, I did not.

25 Q. What about the Hand Hygiene Expert Panel?

1 Did you review anything regarding the Hand Hygiene
2 Expert Panel in formulating your opinions?

3 A. No. I didn't believe those were necessary
4 for me to complete my assignment.

5 Q. Why didn't you feel like those were
6 necessary in completing your assignment?

7 MR. HVIDT: Objection, form.

8 A. I guess my assessment was understanding
9 the Leapfrog Group methodology as articulated in
10 some of their methodology guides. And having access
11 to the data were sufficient to conduct the analyses
12 that I wanted to conduct.

13 BY MS. BLAIR:

14 Q. In making the determination that the
15 Leapfrog Hospital Safety Grades methodology was
16 unfair, do you believe it would be helpful to know
17 what the expert panels on the four imputed measures
18 are saying about the methodology for those imputed
19 measures?

20 MR. HVIDT: Objection, form.

21 A. I'm aware of the general data that the
22 Leapfrog Group is requesting of hospitals that
23 respond and how they use them -- the variables that
24 are submitted by respondents for those variables.
25 In my opinion, that was sufficient for me to

1 complete my assignment.

2 BY MS. BLAIR:

3 Q. Okay. But you have some statements in
4 your expert report about, for example, the
5 unreliability of the measures for hand hygiene, and
6 that participating hospitals are just
7 self-reporting, correct?

8 MR. HVIDT: Objection, form.

9 A. What I do state in my report is that a
10 majority of hospitals self-report the maximum value
11 for those four measures, and more than just those
12 four, the seven self-reported protocol and structure
13 measures, and that TLG's method inappropriately
14 inflates those scores for the hospitals that report
15 and inappropriately deflates the score for hospitals
16 that don't report those variables.

17 BY MS. BLAIR:

18 Q. But in coming to those conclusions, you
19 didn't review in any way what the expert panels on
20 those four imputed measures looked at or reviewed in
21 coming to their conclusions as to how those four
22 structural measures should be used in connection
23 with the Leapfrog Hospital Safety Grade, correct?

24 MR. HVIDT: Objection, form, asked and
25 answered.

1 A. I didn't review those specific things. As
2 I mentioned, I've seen some minutes from the Safety
3 Grade Expert Panel that relates to imputation.

4 BY MS. BLAIR:

5 Q. Did you speak to any personnel at any of
6 the five Plaintiff Hospitals about their performance
7 on Hospital Safety Grades in forming your opinions?

8 A. No, I did not.

9 Q. Did you review any internal documents from
10 any of the five Plaintiff Hospitals related to their
11 own internal quality audits?

12 A. I don't believe so. I don't recall seeing
13 those documents.

14 Q. Did you review any patient satisfaction
15 surveys for any of the five Plaintiff Hospitals in
16 coming to your opinions in this matter?

17 A. Are you asking about the actual survey
18 documents?

19 Q. No. I'm asking, did you do any sort of
20 internal review of patient surveys of any of these
21 five hospitals in formulating your opinions?

22 Not the HCAHPS scores, but did you go to
23 these five hospitals and look at their patient
24 satisfaction surveys and results?

25 A. I did not. That wouldn't have been

1 necessary for me to complete my assignment.

2 Q. Why wouldn't that have been necessary?

3 A. I was not asked to conduct an analysis of
4 Plaintiff Hospitals' quality or the programs or
5 measures that they're using to manage their quality.

6 Q. And each one of these five hospitals has
7 HCAHPS scores, correct? You saw those?

8 A. Yes.

9 Q. And so my question is, did you do anything
10 in formulating your opinions to confirm that the
11 five Plaintiff Hospitals -- any of the five
12 Plaintiff Hospitals' HCAHPS scores were accurate as
13 reported?

14 A. I didn't conduct any independent analysis.
15 In my experience, the questions are pretty standard,
16 I think, for HCAHPS. And CMS reserves the right to
17 audit those.

18 Q. So you have confidence that CMS and HCAHPS
19 responses by hospitals are accurate?

20 MR. HVIDT: Objection, form.

21 A. I didn't conduct an independent analysis
22 to conclude that. I'm just commenting that in my
23 experience, the questions that are asked of patients
24 for HCAHPS, I think, are pretty straightforward.

25

1 BY MS. BLAIR:

2 Q. Did you perform any assessment to
3 determine whether the Plaintiff Hospitals were
4 accurately reporting their data to CMS?

5 A. I did not conduct that analysis. I do, in
6 my report, talk about the ability of CMS to audit.
7 But I didn't perform any analyses of that.

8 Q. And you understand that for nonreporting
9 hospitals, about 76 percent of the Hospital Safety
10 Grade comes from CMS data, correct?

11 MR. HVIDT: Objection, form.

12 A. I'm sorry. Could you just say that one
13 more time.

14 MS. BLAIR: Sure. Let me ask it more
15 open-ended.

16 BY MS. BLAIR:

17 Q. Do you know for a nonreporting hospital --
18 and by "nonreporting," I mean a hospital that did
19 not participate in the Leapfrog Hospital Survey --
20 do you know which percentage of that hospital score
21 comes from CMS data?

22 A. I would have to work it out. But of
23 the -- so of the 12 variables that would be
24 submitted in survey, seven of them would not be
25 submitted by the nonrespondents, and then the five

1 outcome measures would be pulled from CMS data as
2 opposed to the NHSN dataset.

3 Q. And the remaining measures all come from
4 CMS as well, correct?

5 A. I believe that's correct. And that's part
6 of the inconsistency that I discuss in the report.

7 Q. We'll get to that, but circling back to my
8 original question, you did not perform any
9 assessment to determine whether the five Plaintiff
10 Hospitals were accurately reporting their data to
11 CMS, correct?

12 A. Correct. I didn't conduct that analysis
13 independently.

14 Q. Have you ever been excluded as an expert
15 by a court?

16 A. I had one part of an opinion that was
17 excluded based on a judge's factual determination
18 but not an opinion entirely -- or one part of my
19 testimony, I should say.

20 Q. And what part of your testimony was
21 precluded?

22 A. I was a damages expert. And as part of my
23 analysis, I conducted scenarios related to damages.
24 And those scenarios differed on the date when a
25 company would have been aware of an exclusive supply

1 agreement. So I was not opining on what the correct
2 date was, but I was providing analysis associated
3 with, I think, three dates. And once the judge
4 decided what the correct date was, I was told not to
5 talking about the other dates.

6 Q. Fair enough.

7 And was that a healthcare economist expert
8 opinion?

9 A. I was opining as an economist, and it was
10 a -- a case that was in the healthcare industry,
11 yes.

12 Q. Have you ever offered any expert opinions
13 previously about the use of imputed data in a
14 methodology?

15 A. I don't believe so. I'm not 100 percent
16 sure, but I don't believe so.

17 Q. And, again, I didn't read every word of
18 every article you've ever written. I apologize for
19 this open-ended question.

20 But has any of your research over the
21 years been related to the use of imputed data?

22 A. I can't recall. I think in most instances
23 in my research -- but I'm not sure that it's
24 100 percent -- when data -- when important data are
25 not available, those -- we don't use those

1 observations.

2 But I'm just not 100 percent sure. There
3 could have been an instance where we did some
4 imputations. I can't recall any.

5 Q. When you say data -- "When important data
6 are not available, we don't use those observations,"
7 what do you mean by that?

8 I got a little lost there, so I apologize.

9 A. Oh. Well, for example, if we're measuring
10 the quality and safety of care provided by
11 obstetricians in, say, the State of New York, if we
12 don't have data on a particular obstetrician, we do
13 not include that person in the sample.

14 Q. So you don't have any -- you don't believe
15 you've ever done any research or authored any
16 articles relating to the propriety of using imputed
17 data for an analysis?

18 A. That topic has never been the sole focus
19 of an article, and I can't recall an instance
20 where -- really, its context-specific. But in my
21 cases for the questions we were asking, imputation
22 wasn't necessary.

23 Q. In your world as an economist, is there
24 ever a scenario in which imputation makes sense?

25 MR. HVIDT: Objection, form.

1 A. Yes. I think there certainly can be
2 instances, and there are methods in the literature
3 for ways that are deemed to be appropriate to do
4 imputation.

5 BY MS. BLAIR:

6 Q. Have you ever provided any expert opinions
7 in the past related to ratings of hospitals?

8 A. No.

9 Q. Have you ever performed any analysis about
10 the accuracy or reliability of hospital rankings
11 other than Leapfrog?

12 A. I wouldn't say accuracy or reliability.
13 In at least one article, we do compare how residency
14 programs are ranked based on an outcomes-based
15 method that we use versus U.S. News & World Report.
16 But that wasn't for purposes of determining which
17 was more accurate.

18 Q. What was -- it was for purposes of
19 determining what?

20 A. It was really to see whether the method we
21 had developed, because I believe we were the first
22 ones to develop it, was providing information that
23 would have been complementary to, in addition to
24 other rankings that exist.

25 Q. In doing that research did you form any

1 opinions about the reliability or accuracy of
2 U.S. News & World Report hospital rankings?

3 A. No. That wasn't the objective.

4 What we did say, I believe -- this has
5 been a while -- is that using our method, there were
6 hospitals -- there were residency programs that
7 performed very well that may not have performed
8 necessarily very well in U.S. News & World Report,
9 and our conclusion, really, was that this new method
10 was adding value to what already existed.

11 Q. Is it the case that academics like
12 yourself are constantly looking for ways to improve
13 methodologies regardless of what they are?

14 A. Certainly, that can be an objective for
15 some academics. I don't think all academics are
16 trying to do that, but certainly some.

17 Q. Do you think there's any perfect
18 methodology for evaluating a hospital's patient
19 safety?

20 A. I guess, what do you mean by "perfect"?

21 Q. Well, as I see it, there's, as they say --
22 I'm from the country, right? A lot of different
23 ways to skin the cat, right?

24 So I'm just asking, Leapfrog has one
25 methodology, U.S. News & World Report has a

1 different methodology. Healthgrades has a different
2 methodology. So I'm asking you in your position as
3 a healthcare economist, do you believe there is one
4 right methodology for analyzing patient safety in a
5 hospital?

6 A. I believe there are principles of a method
7 that are right, and that method should strive to
8 adhere to those principles. And I do talk in more
9 detail in the report about what those principles
10 are.

11 Q. Right. And those principles come from
12 that -- I think the original article was in 1966,
13 from the University of Michigan, right?

14 That's sort of the baseline principles
15 that we're talking about?

16 A. Yes, I think Professor Donabedian sort of
17 initiated the research.

18 Q. Thank you. I didn't know how to pronounce
19 that, so I didn't want to murder it.

20 So it's Donabedian (pronunciation)?

21 A. That's how I pronounce it.

22 Q. Okay. And as I read that article, it
23 looked like it's been updated -- is 2005 the most
24 recent?

25 A. I can't recall. I know his original

1 article was 1966, but I think -- you know, he
2 published throughout his career. So I'm sure he
3 updated his thinking.

4 Q. Okay. And in just researching it myself,
5 that was the last one I found. So I just wanted to
6 know if there was a newer one that you knew of, but
7 we can all figure that out.

8 MS. BLAIR: We've been going for about an
9 hour. Are we okay to keep going?

10 THE COURT REPORTER: I could use a break.

11 MS. BLAIR: We'll take five minutes, then.
12 Thank you.

13 THE VIDEOGRAPHER: 10:59 a.m., off the
14 record.

15 (Recess.)

16 THE VIDEOGRAPHER: 11:11 a.m., back on the
17 record.

18 MS. BLAIR: Dr. Nicholson, right before
19 the break we started talking about the guiding
20 principles that you discuss in your report.

21 And so I think it might be a good time to
22 mark this as Nicholson Exhibit 1.

23 (Nicholson Exhibit 1 was received and
24 marked for identification, as of this date.)

25

1 BY MS. BLAIR:

2 Q. Dr. Nicholson, I've now handed you what
3 we've marked as Nicholson Exhibit 1. And if we turn
4 to page 43, what's marked on the bottom, page 43.

5 A. (Witness complies.)

6 Yes.

7 Q. Is that your signature?

8 A. Yes, it is.

9 Q. And this says that this was executed on
10 the 7th day of August 2025, correct?

11 A. Yes, that's correct.

12 Q. And flipping through this document, can
13 you confirm for the record that this is, in fact,
14 your August 7, 2025, report that you have offered in
15 this matter?

16 A. Yes, it is.

17 Q. I want to turn to your summary of your
18 opinions on page 9.

19 A. Yes.

20 Q. You say in paragraph 17:

21 "Hospital ratings are only valuable to
22 patients if the ratings are based on measures
23 predictive of actual health outcomes for patients."

24 Do you see that?

25 And now I'm thinking I might be not on the

1 right paragraph. So give me a sec.

2 A. Yes, I do.

3 Q. Oh, you do see that?

4 A. At least something close to that.

5 Q. Yes, correct.

6 And in looking at that, what do you mean
7 by that statement?

8 Are you taking the position in this case
9 that outcome measures are the only measures that are
10 important to patients in the area of patient safety?

11 A. I am, consistent with Donabedian and other
12 people in this field, of the opinion that what
13 patients, including hospital patients, care about
14 primarily is the health outcome that they receive.

15 Q. Would you agree with me that patients also
16 care about how they are treated while being cared
17 for?

18 A. They certainly can. I think health is a
19 primary concern.

20 Q. And in fact, the HCAHPS scores have to do
21 with patient satisfaction; don't they?

22 A. Yes. Subjective measures of patient
23 satisfaction and whether patients would recommend
24 the hospital.

25 Q. And those are not outcome measures; are

1 they?

2 A. I don't think of them as outcome measures,
3 no.

4 Q. But they are -- would you agree with me
5 that they -- at least CMS must think they're
6 important to hospital quality and safety, in that
7 they include them in measures that they look at with
8 respect to hospitals, correct?

9 MR. HVIDT: Objection, form.

10 A. Yes. And I agree that to the extent that
11 structure measures and process measures are
12 predictive of outcomes, there's an argument to
13 include them. But my point and, I think, other
14 people's point is patients engage with healthcare
15 providers because they have a health issue, health
16 problem. And so the outcome is of primary concern.

17 BY MS. BLAIR:

18 Q. And would you agree with me that hand
19 hygiene is a structural measure?

20 A. I would think of -- if there are protocols
21 in place related to that, I'd call it "structure."
22 If there's measures of whether providers are
23 adhering to those protocols, I suppose I'd call that
24 "process measures."

25 Q. And in an area like hand hygiene, is that

1 not related at least in some way to patient
2 outcomes?

3 A. It can be predictive of patient outcomes.
4 And as I opine, structure and process measures that
5 are predictive of patient outcomes have a reason to
6 be included.

7 Q. So you have no issue with the fact that
8 hand hygiene is included as a measure in the
9 Leapfrog methodology, correct?

10 A. Not per se. I have issues with how it's
11 measured, whether it's measured consistently. And I
12 do look at whether it and other components predict
13 outcomes.

14 Q. We've talked about Donabedian's article --
15 now that I know how to say that.

16 Would you agree with me that that article
17 which is entitled "Evaluating the Quality of Medical
18 Care," was focused on the evaluation and measurement
19 of quality and not specifically patient safety?

20 A. My recollection is that he is thinking
21 about quality broadly.

22 Q. And in reviewing the Leapfrog methodology,
23 do you understand it contains 32 measures?

24 A. I think the most recent version is 22.

25 Q. It depends on how you count PSI 90, right,

1 because that's ten measures in and of itself,
2 correct?

3 A. Okay. Correct.

4 Q. Have you looked at the Leapfrog Hospital
5 Safety Grade website in coming to your opinions here
6 today?

7 A. I have over time, yes.

8 Q. And do you remember on that website it
9 has, like, gas gauges for each of the measures?

10 A. Yes, I do recall seeing that.

11 Q. And do you have any recollection that
12 there's 32 of those gas gauges, which is why I refer
13 to 32?

14 Do you recall seeing that?

15 A. I do know PSI 90 is a composite. I can't
16 remember how many components there are.

17 Q. I'm only asking because I want to make
18 sure my record is clear. I want you to know I'm
19 using 32 because, one, PSI 90 has ten measures, and
20 two, when we look at the Hospital Safety Grades as
21 displayed by Leapfrog on its website, it has gas
22 gauges for 32 measures.

23 Are you good if I refer to it as "32
24 measures" in that way?

25 A. Yes, I am.

1 Q. So when we look at the 32 measures -- and
2 I'm just using 32, as we just discussed -- are there
3 any of those 32 measures that you believe should not
4 be included in a methodology that is assessing
5 patient safety of a hospital?

6 A. As part of my assignment, I did not do an
7 independent analysis of what belongs in versus what
8 doesn't belong in. I was taking the methodology as
9 constructed. So I didn't conduct that analysis.

10 Q. Okay. And when we look at Donabedian's
11 article, she talks -- or, he sorry. When I hear
12 "Dona," I think it's a woman.

13 He talks about three areas of measures:
14 Outcomes, structural, and process measures, correct?

15 A. Yes. That's his paradigm.

16 Q. And when you look at the 32 measures in
17 the Leapfrog Hospital Safety Grade, would you agree
18 with me that there are outcome, structural, and
19 process measures included in that methodology?

20 A. Yes, I would.

21 Q. And so is it fair to say, as I read your
22 opinion, that you're not opining on the measures
23 themselves but, rather, how the scoring of those
24 measures is occurring?

25 Is that a fair assessment?

1 A. I am opining on whether the scoring is
2 performed in a consistent fashion and in a fashion
3 consistent with the principles of a proper method,
4 but also, whether the grades are predictive of
5 specific health outcomes.

6 Q. And I understand that, but I just want to
7 make sure you're not taking the position that ICU
8 staffing, for example, is a measure that should not
9 be included in patient safety methodology?

10 A. That's correct. As part of my assignment,
11 I was not assessing what should or should not be
12 included.

13 Q. Can you describe for me in your own words
14 how you understand the pre-fall 2024 methodology for
15 the Leapfrog Hospital Safety Grade to have worked
16 with respect to the survey measures that migrate
17 into the Hospital Safety Grades?

18 A. Yes. So -- prior to fall of 2024?

19 Q. Yes.

20 A. So for a responding hospital, Leapfrog
21 would use the 12 variables that a respondent would
22 report on the survey, supplement that with ten other
23 variables, or maybe more, based on the PSI 90 --
24 we're counting that -- and apply the weights that
25 have been determined across those variables.

1 For the nonrespondents particularly, for
2 the 12 variables for which the Leapfrog Group
3 doesn't have information, they will pull from CMS
4 data for five of those measures and reassign the
5 weights for three of those subjective measures. And
6 they would have assigned the mean value for the four
7 other variables to nonresponder calculations.

8 Q. Do you have an opinion about whether or
9 not the pre-fall 2024 methodology was reliable and
10 transparent?

11 A. I believe it was transparent. But maybe
12 you could tell me what you mean by "reliable."

13 Q. Yeah. So you had on page 1 of your
14 report, which I've marked as Nicholson Exhibit 1,
15 and this is paragraph 3, you say:

16 "Based on my review of TLG's hospital
17 rating methodology, I find that TLG's methodology
18 departs from guiding principles for how hospital
19 quality or safety should be measured." And then you
20 say "resulting in hospital grades that are
21 misleading and unreliable predictors of actual
22 patient outcomes."

23 Do you see that?

24 A. That's paragraph 3 on page 1.

25 MR. HVIDT: The page just flipped over.

1 MS. BLAIR: Sorry.

2 BY MS. BLAIR:

3 Q. Paragraph 3, do you see that?

4 A. Yes.

5 Q. And so that paragraph appears to be
6 talking about the post-fall 2024 methodology,
7 correct?

8 A. Yes. I think there are some -- the -- in
9 my opinion, the pre-fall 2024 was a better method
10 than the subsequent method in terms of consistency.
11 But it still did not treat hospitals comparably.

12 And an example would be the Leapfrog Group
13 would be, for those five variables -- other than the
14 seven subjective process and structure measures, the
15 Leapfrog Group, for example, would be pulling data
16 from two different sources and two different time
17 periods across the reporting and nonreporting
18 hospitals.

19 So that is a way of having grades that
20 could be unreliable, given that inconsistency in the
21 application and the method across hospitals.

22 Q. When you did your recalculation of these
23 grades, as I see it, it appears that you used this
24 old method in coming to your conclusions about what
25 the five Hospital Safety Grades would have been had

1 the methodology not changed, correct?

2 MR. HVIDT: Objection, form.

3 A. One of the things I do in my report is I
4 conduct a counterfactual for what grades would
5 nonresponding hospitals have received had they
6 responded and responded in a way typical of the
7 respondents.

8 MS. BLAIR: Right.

9 BY MS. BLAIR:

10 Q. So do you understand that prior to fall of
11 2024 nonresponding hospitals for the four imputed
12 metrics would have been assigned a cohort median for
13 those grades, correct?

14 A. Yes, that's correct.

15 Q. And what is your understanding of what the
16 cohort median was based on pre-fall 2024?

17 A. Yes. I forget the very particulars of it,
18 but it would be the mean of hospitals with similar
19 characteristics as a nonresponding hospital, and I
20 just can't recall those specific characteristics.

21 Q. And when you did you your recalculation,
22 you assigned, as I read it -- and you tell me -- you
23 assigned a mean to these five hospitals for those
24 four measures, just like it would have been done in
25 the pre-fall 2024 methodology, correct?

1 MR. HVIDT: Objection, form.

2 A. I assigned in my counterfactual analysis,
3 which I believe is conservative -- I assigned to the
4 nonresponders in the actual world what they would
5 have responded in the but-for world, the overall
6 mean, meaning across all hospitals that responded of
7 all different characteristics for those seven
8 variables.

9 BY MS. BLAIR:

10 Q. And when you say "what they would have
11 responded," how do you know that's how they would
12 have responded to the survey if you've not seen
13 their actual data for those measures?

14 A. Well, I'm analyzing a counterfactual to
15 come up with a defensible scenario for the
16 nonresponders responding in a way that's typical of
17 the responders. So not assigning the maximum value,
18 which a majority of responders do, but the average,
19 which is a well-established approach statistically
20 and is consistent generally with how the
21 Leapfrog Group had been conducting things.

22 Q. Wouldn't the best way to do the
23 counterfactual analysis for this litigation be to
24 figure out what these hospitals actually would have
25 scored on those four imputed metrics to show that

1 the methodology doesn't properly capture the scores
2 of nonparticipating hospitals?

3 MR. HVIDT: Objection, form.

4 A. That information is not available. That's
5 the -- that's the challenge that confronts the
6 Leapfrog Group. And they had a way of addressing
7 that prior to the fall of 2024, and they changed it
8 in the way that I show, introduced more bias, less
9 consistency than it had prior.

10 BY MS. BLAIR:

11 Q. But you have no way of knowing, as we sit
12 here today, whether these five hospitals would have
13 scored consistent with the mean had they responded
14 to the survey, correct?

15 A. Those data don't exist for me or for the
16 Leapfrog Group; therefore, the statistical question
17 of how would a principle method approach that
18 situation? And my counterfactual, in my opinion, is
19 consistent with the nonresponders responding in a
20 way that's typical of those who actually do respond.

21 Q. Is there any scientific method where a
22 nonresponding hospital should be given the same
23 score as a responsive A hospital?

24 A. You mean an A-grade hospital?

25 Q. Well, yeah. I guess I'm trying to

1 understand what you're saying to me.

2 So if you're taking the mean of all
3 responding hospitals, and then you're assigning that
4 mean to nonresponding hospitals, is there a
5 scientific method -- well, let me ask some
6 foundational questions.

7 Do you agree that in that mean that you're
8 using to calculate would include A hospitals that
9 responded to the survey, correct?

10 A. You mean like the letter "A"?

11 Q. The letter "A."

12 A. It would include all hospitals who
13 responded to the survey.

14 Q. Right.

15 A. Of all grades.

16 Q. And it would include hospitals that are
17 five-star CMS hospitals; would it not?

18 A. If five-star CMS hospitals responded to
19 the Leapfrog Group, that would represent one data
20 point towards the mean.

21 Q. Is there any reason to believe that a
22 one-star CMS hospital would have responded on the
23 survey consistently with a five-star CMS hospital
24 that responded on the survey?

25 A. I certainly cite to literature that shows

1 that in many cases, the respondents and the
2 nonrespondents don't differ on various measures:
3 The Smith study, Gonzalez study. So there's data
4 consistent with nonresponders having the same
5 performance as responders, and I haven't seen
6 evidence from the Leapfrog Group counter to that.

7 Q. And is that based at least partly on your
8 assumption that hospitals that participate in the
9 survey assign themselves grades for survey
10 responses?

11 A. Well, what I do show is, both from
12 literature and from the data from the spring of
13 2025, that a majority of hospitals that are
14 responding are assigning themselves scores that are
15 the maximum value for those seven variables.

16 Q. And you keep saying -- your report says
17 often about assigning themselves scores.

18 And I'm just curious where that comes
19 from.

20 A. It depends on the variable. It could be
21 that they're -- the responding hospitals are
22 answering specific questions about, say, the
23 protocols or processes that then lead to the
24 provision of a maximum score.

25 Q. Okay. So when you say "assign themselves

1 scores," you're not just -- I just want to make sure
2 I understand.

3 You're not saying that they just say
4 100 percent and they don't do the work and the
5 300-page survey that they need to do to come to that
6 number, correct?

7 A. Correct. They're responding to the
8 specific questions that the Leapfrog Group asks,
9 such that the Leapfrog Group can enter a numeric
10 value into that field.

11 Q. And do you have any understanding of what
12 the survey requires for hand hygiene?

13 A. Sitting here, I can't recall precisely.
14 But as I said, in general, it's a series of
15 questions related to protocols and other measures
16 that hospitals have in place. I just don't know the
17 exact wording.

18 Q. So you don't have any understanding, as
19 you sit here today, about the type of observations
20 that must be made throughout the course over the
21 year to properly report on hand hygiene for the
22 Leapfrog Hospital Survey?

23 MR. HVIDT: Objection, form.

24 A. I don't. Sitting here, I don't have the
25 subquestions verbatim.

1 BY MS. BLAIR:

2 Q. Do you know whether or not you have an
3 opinion about -- do you have an opinion about
4 whether the Leapfrog Hospital Survey's requirements
5 for hand hygiene are onerous?

6 A. I can't recall seeing anything specific to
7 that question. Certainly, they're -- there is a
8 study I report to, and there's sort of commentary
9 about the burden of the entire process. I don't
10 recall seeing it specific to hand hygiene.

11 Q. Would you agree with me as a healthcare
12 economist familiar with hospital quality and patient
13 safety that hand hygiene is an important part of
14 hospital quality and hand hygiene -- or hospital
15 quality and patient safety?

16 A. I do believe that clinicians and hospitals
17 strive to make sure that clinicians have -- are
18 following the right processes, because it can
19 matter.

20 Q. Do you know whether or not there are any
21 studies showing a causal link between poor hand
22 hygiene and hospital-acquired infection?

23 A. There could be. I can't recall sitting
24 here.

25 Q. Would it surprise you if there were a

1 causal connection between poor hand hygiene and
2 hospital-acquired infections?

3 A. No, because I think that's a reason to
4 include a variable, if it has been shown to be
5 predictive of health outcomes.

6 Q. When you said earlier that the pre-fall
7 2024 methodology was a better methodology, is it
8 your opinion that Leapfrog's methodology would be
9 fair and reasonable in fall 2024 if it was conducted
10 in the same way it was pre-fall 2024?

11 A. So as I said, on -- in my opinion, the
12 method that was used prior to fall of 2024 was more
13 consistent with the principles. It was more
14 consistent with the safety expert principles of
15 treating nonresponders equitably than the subsequent
16 method. But it still -- "it" being the method prior
17 to fall of 2024 -- still had elements of treating
18 hospitals inconsistently and creating potentially
19 unreliable grades for the reasons of pulling from
20 different data sources and different time periods.

21 But it was closer to -- the pre-method was
22 closer to the guiding principles that Leapfrog Group
23 articulates.

24 Q. So it's your position that the fall 2024
25 methodology diverted further from the guiding

1 principles that we see in Donabedian?

2 A. Yes. And also for the Leapfrog Group's
3 own principles as stated in documents I've seen.

4 Q. And which principles are those?

5 A. I believe Dr. Harris quotes the principles
6 in a section on imputing scores that says something
7 to the effect of when a secondary data source is
8 being used, efforts should be made to treat
9 hospitals equitably, as if the data from the primary
10 source were available.

11 And in my opinion, the method prior to
12 fall of 2024 adhered more closely to that than after
13 fall of 2024.

14 Q. Do you have any issue with the way
15 Leapfrog grades hospitals that do respond to the
16 hospital survey?

17 A. I do have some criticisms, yes, including
18 things like the principles of a proper quality
19 measurement -- quality and safety measurement system
20 would be having, to the extent possible, objective
21 measures that are applied consistently across
22 hospitals, and if there are subjective measures,
23 having rubrics that would help hospitals understand
24 those subjective measures.

25 And pulling data from two different

1 sources, a different one for the respondents and the
2 nonrespondents, also doesn't adhere to those
3 principles.

4 Q. Do you have any understanding of whether
5 or not the 300-page hospital survey has rubrics for
6 the subjective measures for hospitals to follow?

7 A. It doesn't have them consistently, so
8 that -- in my opinion, so that hospitals understand
9 how to interpret the language associated with, say,
10 achieving a standard versus limited achievement or
11 some achievement.

12 Q. So it's your opinion that Leapfrog does
13 not adequately communicate to hospitals how they can
14 achieve certain scores for those subjective
15 measures?

16 A. Yes. I mean, for example, something like,
17 you know, culture of safety. That, in my opinion,
18 is a set of questions that doesn't sort of make the
19 responses objective -- as objective as it could be.

20 Q. Okay. And you've read those questions on
21 the survey?

22 A. I have. I can't recall them verbatim
23 here.

24 Q. Would you agree with me, though, to the
25 extent a rubric exists, it would be in that 300-page

1 survey?

2 MR. HVIDT: Objection, form.

3 A. I believe that's where it would belong.

4 That wouldn't surprise me.

5 BY MS. BLAIR:

6 Q. Have you seen the methodology document
7 that Leapfrog puts on its website?

8 A. Yes, I have.

9 Q. And would you agree with me that that
10 document lays out for hospitals how they can achieve
11 different scores based on the 32 measures that make
12 up the Hospital Safety Grade and the survey
13 submissions?

14 A. I'm not sure what you mean by how they can
15 achieve it. You mean mathematically?

16 Q. I thought what you said to me was one of
17 issues -- and I can look it up -- but one of your
18 criticisms was: "It doesn't have them consistently
19 so that in my opinion -- so that hospitals
20 understand how to interpret the language associated
21 with, say, achieving a standard versus limited
22 achievement or some achievement."

23 That was your answer.

24 And so my question is, would you agree
25 with me that that methodology document, 26-page

1 methodology document does set forth how hospitals
2 can achieve a standard versus limited achievement or
3 some achievement?

4 MR. HVIDT: Just objection to form, in
5 case there's a misstatement there.

6 A. If we're referring to the same document,
7 the 23-page methodology document would report the
8 math that's involved, but it doesn't tell a
9 hospital, what does it mean to have a perfect
10 culture of safety, or how does one implement
11 protocols that would lead to -- achieve the standard
12 CPOE score.

13 BY MS. BLAIR:

14 Q. Do you understand that Leapfrog doesn't
15 offer consulting services to help hospitals do
16 better on the survey, correct?

17 MR. HVIDT: Objection to form.

18 A. I didn't examine that as part of my
19 assignment. So I don't know if they do or don't.

20 BY MS. BLAIR:

21 Q. Would you have a problem if Leapfrog were
22 offering paid-for services to consult with hospitals
23 to help them get a better grade?

24 A. I haven't looked at that specifically, so
25 I haven't formed an opinion on that. It could be

1 perceived as some sort of a conflict, but I didn't
2 study that.

3 Q. Are you familiar with organizations like
4 Vizient, where hospitals do pay for those types of
5 consulting companies to come in and measure their
6 performance?

7 A. Yes. I don't know all the particulars of
8 their offerings, but I'm familiar with some of what
9 Vizient does.

10 Q. Same with Premier? Are you familiar with
11 Premier; they offer the same sort of service?

12 A. I know they're a group purchasing
13 organization. I'm less familiar with what they do
14 in this realm.

15 Q. Do you know whether or not any of these
16 five hospitals engage with Vizient?

17 A. I don't know. I didn't study that as part
18 of my assignment.

19 Q. Have you personally ever been involved in
20 a hospital that does engage with Vizient?

21 A. Yes. I know Robert Packer, where I'm on
22 the board of trustees, we have used Vizient, for
23 example, to do, say, a mock site visit for JCAHO,
24 J-C-A-H-O, and then they report the results of that
25 mock survey.

1 Q. And in your role on Robert Packer as a
2 trustee, right, do you have any opinion about
3 whether the utilization of a company like Vizient is
4 helpful to a hospital in achieving high quality and
5 patient safety for their hospital?

6 A. I think it can be. I think, in general,
7 it depends on whether a hospital feels like it has
8 the internal capabilities of doing that function
9 itself or it feels like an external management
10 consulting firm might be able to provide superior
11 advice. But I think one way or the other, hospitals
12 will examine their quality.

13 Q. Do you know how these five hospitals
14 examine their quality?

15 A. That wasn't part of my assignment. I
16 didn't examine the quality independently.

17 Q. Okay. So you don't know whether they have
18 an outside quality consultant, correct?

19 A. I don't. I didn't study that.

20 Q. All right. And I guess I'm just asking,
21 like, generally.

22 Because you are very involved in the
23 healthcare industry, do you know whether
24 Tenet Healthcare employs an outside quality
25 consultant to consult on the quality of its

1 hospitals?

2 A. I don't know. I haven't looked at that.

3 Q. If we look at your report, and this is
4 Roman numeral 7, starts with paragraph 22 on page 11
5 of your report.

6 And I want to talk again -- you say in
7 paragraph 22 -- and we talked about this a little
8 bit earlier. Right in the middle of that paragraph,
9 you say:

10 "Health outcomes are what ultimately
11 matter to patients and people covered by health
12 insurance. By contrast, people do not derive any
13 utility directly from structures and processes;
14 rather, only from the outcomes that those structures
15 and processes produce."

16 Do you see that?

17 A. Yes.

18 Q. Why is it that you think that people do
19 not derive any utility directly from structures and
20 processes?

21 A. Because -- and I think here, I'm agreeing
22 with Professor Donabedian -- that when people have a
23 health problem, they're either trying to get their
24 problem addressed, or they're trying to improve
25 their health. That's their objective. Restore

1 their health if it's been worsened or improve their
2 health if it's already good.

3 Structure and processes matter to them if
4 it increases the chance that they're going to get an
5 improvement in health, but people don't inherently
6 get utility from seeing that a hospital has a
7 computerized version of entry system. It's what
8 that CPOE can produce in terms of their health
9 improvement.

10 Q. What about nurse staffing? Would that not
11 have -- would people not derive utility from having
12 their -- the nurse staffing be adequate, even though
13 it might not necessarily directly link to their
14 outcome?

15 A. Not to me for their primary interest,
16 which is restore health or improve health. So nurse
17 staffing can increase the chances that somebody's
18 health will be improved. And that's why it would
19 matter to somebody, not just nurse staffing per se.

20 Q. Well, let's say there's complaints by
21 patients and nurses that there's a lack of staffing
22 that results in patients not being toileted on a
23 regular basis, causing discomfort to the patients.

24 They don't get sicker from that, but it's
25 certainly uncomfortable; wouldn't you agree with me?

1 A. Yes. And I think -- and maybe this is,
2 you know, a matter of semantics, but I and, I think,
3 other economists would think about, you have an
4 overall health outcome, but there's also component
5 parts. So it might be like -- proper bathroom
6 function might be a health outcome.

7 And so that would be something they would
8 care about, because the ability to have normal
9 bathroom function would be something that's part of
10 their health and well-being.

11 Q. What about, like, nurse staffing affecting
12 whether pain medications are provided to patients
13 after a surgery on time?

14 It might not affect the ultimate outcome
15 of your heart surgery, but it certainly would be of
16 a utility to a patient sitting in a bed, suffering
17 from pain; would it not?

18 A. Yes. And I think in a similar way,
19 economist -- health economists think of health
20 outcomes as being multifaceted. So I arrive in a
21 hospital, one part of my outcome is, am I pain free?
22 So that would be something that I would derive
23 utility from. And another would be, was the surgery
24 successful in restoring my function?

25 So there can be more than one health

1 outcome.

2 Q. Okay. So as I understand your sentence
3 here in this opinion, it's that everything a
4 hospital does ultimately affects in some way
5 outcomes to patients?

6 MR. HVIDT: Objection, form.

7 A. No. My opinion is that the principles of
8 an appropriate quality and safety measurement system
9 would be that the ultimate goal that patients care
10 about when they're selecting a provider is -- the
11 primary ultimate goal is to achieve excellent health
12 outcomes.

13 And so that should always be the focus of
14 a measurement system, is what are the health
15 outcomes, maybe risk-adjusted? What are the health
16 outcomes of a facility or provider. And what are
17 processes and structures that are predictive of
18 those?

19 So hand hygiene can predict the kinds of
20 things that are primary health outcomes, and
21 therefore, there can be an argument to include them.
22 But a patient doesn't inherently get value from
23 seeing somebody wash their hands.

24 MS. BLAIR: I see.

25

1 BY MS. BLAIR:

2 Q. So I guess I misunderstood the phrase
3 "health outcome," as you've used it.

4 Because let's just say there's a patient
5 who has terminal cancer but needs to go to the
6 hospital for some sort of surgery. The health
7 outcome you're speaking of might not be they walk
8 out of the hospital cancer free, but bit may be
9 their health outcome is they have pain management
10 until their ultimate demise, right?

11 A. Yes.

12 Q. Okay. I misunderstood. Thank you. I
13 appreciate that.

14 Are you aware of how each of these five
15 hospitals performed on the CMS outcome measures that
16 are a part of the Leapfrog Hospital Safety Grade?

17 A. Did you say five? You said five
18 hospitals?

19 Q. These five hospitals.

20 Are you aware of how these five hospitals
21 performed -- or perform on the CMS outcome measures
22 that are a part of the Leapfrog Hospital Safety
23 Grade?

24 A. I certainly can't -- I don't have them
25 memorized. I have seen them at some point.

1 Q. Are you aware that each of these five
2 hospitals are a one- or two-star CMS hospital?

3 A. I'm aware that Dr. Harris has an exhibit
4 to that effect. I can't remember what the time
5 period is, but I'm aware at some time period that
6 was correct.

7 Q. Have you looked at the CMS data for each
8 of these five hospitals in coming to your
9 determinations or your opinions in this case?

10 A. My assignment wasn't to independently
11 evaluate the quality of the five Plaintiff
12 Hospitals, but rather, to focus on whether the
13 Leapfrog Group's method was producing reliable
14 grades that were predictive of outcomes.

15 Q. In your view as a healthcare economist, is
16 it reliable to give a hospital that has poor CMS
17 outcome scores -- to assign them the mean or average
18 score for the four imputed measures?

19 A. I think that assignment is in closer
20 keeping -- it's closer to the principles of a proper
21 system. It's closer to the principles of the
22 Leapfrog Group. And it's consistent with data that
23 I've seen that responders and nonresponders on many
24 measures are very similar.

25 Q. Well, I just read that in your report,

1 that people do not derive any utility directly from
2 structures and processes, rather, only from the
3 outcomes that those structures and processes
4 produce.

5 And this is paragraph 22. We just
6 discussed that, right, and that's your opinion,
7 correct?

8 A. Yes, as a general matter for designing an
9 evaluation system.

10 Q. And the four imputed metrics we're dealing
11 with in this litigation are structural measures,
12 correct?

13 A. I think there's more than four.
14 Certainly, at least seven are not available from any
15 source for the nonrespondents.

16 Q. But for only four of those does Leapfrog
17 impute a score, correct?

18 A. In the most recent methodology, that's
19 correct.

20 Q. And those are hand hygiene, CPOE, BCMA,
21 and ICU staffing, correct?

22 A. Yes, correct.

23 Q. And as I read your paragraph 22, you say
24 that people do not derive any utility directly from
25 structures, rather, only from the outcomes that

1 those structures produce, correct?

2 A. Yes.

3 Q. And so if the outcomes for these five
4 hospitals as reported by CMS are of poor quality --
5 one-star CMS rating -- why, in your view as an
6 economic healthcare expert, would it be fair to
7 assign them the mean score for structural measures
8 when the outcomes themselves are poor?

9 MR. HVIDT: Objection, form, asked and
10 answered.

11 A. So first, the outcome measures that the
12 Leapfrog uses from CMS is just a subset of health
13 outcomes; it's not all-encompassing health outcomes.
14 But the problem is the Leapfrog Group is -- by
15 imputing and assigning the lowest value, is treating
16 hospitals inconsistently, without any support for
17 why it's doing that.

18 And it produces grades that are unreliable
19 that might be directing patients to hospitals that,
20 in fact, have lower outcomes, worse outcomes, in
21 spite of a relatively high grade.

22 So that's the problem, is the
23 inconsistency, and therefore, the lack of meaning
24 that the grade has to the consumers that it's
25 supposed to be helping -- the system is supposed to

1 be helping.

2 BY MS. BLAIR:

3 Q. Isn't it inconsistent and misleading to
4 consumers to tell consumers that poor-performing
5 hospitals on outcome measures would have received a
6 mean score, an average score, on structural
7 measures?

8 MR. HVIDT: Objection, form, asked and
9 answered.

10 A. Yeah. I think it's consistent with the
11 literature that I cite, and I haven't seen any
12 information from the Leapfrog Group that this
13 nonresponse bias, as Dr. Harris refers to, is
14 substantiated.

15 BY MS. BLAIR:

16 Q. And you've looked at the meeting minutes
17 from the expert -- the Hospital Safety Grade Expert
18 Panel from 2024, correct?

19 A. Yeah. I believe so. And also, I think,
20 2020, I've seen.

21 Q. And are you familiar with the concept of
22 nonresponse bias?

23 A. Yes, in general.

24 Q. Are you familiar with the concept of
25 nonresponse bias in the area of public health

1 specifically?

2 A. Maybe. I'm not sure what you're referring
3 to.

4 Q. Well, you referred to Dr. Harris' report,
5 correct?

6 A. Yes.

7 Q. And he talks about that they, in fact,
8 teach nonresponse bias in medical school, correct?

9 A. I can't recall if he said that.

10 Q. He refers to two epidemiology textbooks
11 where it is taught in medical school, the concept of
12 nonresponse bias.

13 Do you recall reading that on Dr. Harris'
14 report?

15 A. I don't, but I trust that it's there. He
16 doesn't provide any evidence for the context at
17 issue here, whether there's reason to believe that
18 the nonrespondents would have different values on
19 those seven variables than respondents.

20 Q. Isn't that the entire concept of
21 nonresponse bias?

22 A. But he just asserts it. It's a
23 theoretical general concept. He doesn't apply any
24 particular data to it.

25 Q. And you don't apply any particular data to

1 assigning the mean score to these five hospitals for
2 the four imputed measures; you rely on Donabedian's
3 article in large part, correct?

4 MR. HVIDT: Objection, form.

5 A. Well, I'm relying on, in part, literature
6 from Smith, from Gonzalez, that shows, on many
7 measures, nonrespondents have similar performance to
8 respondents. And a method that the Leapfrog Group
9 developed based on Mathematica, a consulting firm,
10 and used for years and one that the meeting minutes
11 indicate would minimize bias, the method of
12 assigning mean values.

13 And I'm being conservative because a
14 majority of hospitals are getting the maximum value
15 on those seven variables.

16 BY MS. BLAIR:

17 Q. Do you understand that one of the
18 considerations that the Leapfrog Safety Grade Expert
19 Panel took into consideration when it revamped the
20 methodology for fall of 2024 was that the mean score
21 that was being applied to nonparticipating hospitals
22 was getting very close to the top score?

23 Are you aware that that was a concern that
24 they had?

25 A. I think that speaks in part to the

1 inflation that the responders had in terms of
2 submitting data that translated into the maximum
3 score for a majority of hospitals. But I still
4 haven't seen any data showing that there's a
5 nonresponse bias, where the nonrespondents are
6 performing worse on those variables that are being
7 imputed.

8 Q. How do you know that the inverse isn't
9 true, that reporting hospitals are doing better
10 because they're showing a commitment to patient
11 safety and that's why their scores are increasing?

12 A. My opinion that it would be appropriate
13 for a quality measurement -- safety measurement
14 system to not just assert something or posit a
15 theory, but to actually have data that supports that
16 decision about how to treat hospitals consistently.

17 Q. Right.

18 And would you not agree with me that the
19 expert panel for the safety grade made the
20 determination that they were not treating hospitals
21 consistently by allowing nonparticipating hospitals
22 to get grades that were overinflated based on the
23 fact that participating hospitals were increasing
24 their patient safety and nonparticipating hospitals
25 were getting the benefit of that?

1 MR. HVIDT: Objection, form.

2 A. There may have been language to that
3 effect. I don't think it was unanimous. I think
4 Patrick Romano believed that the order method was
5 less biased than the imputation method. So a member

6 of the panel doesn't seem to agree. And when
7 Mathematica developed the mean imputation method in
8 2020, the minutes indicated this was a way to
9 minimize bias.

10 So I haven't seen data that's empirical
11 that shows that the nonresponders were
12 underperforming on these variables.

13 BY MS. BLAIR:

14 Q. And you have not seen data that's
15 empirical that nonresponding hospitals would have,
16 in fact, earned the mean score on these four imputed
17 measures; have you?

18 A. Some of the literature I cite is
19 consistent with that, that the nonresponders, when
20 somebody had access to the same variables for the
21 nonresponders and the responders, were finding that
22 those performance levels were similar. But it would
23 behoove the creator of the method to provide data
24 that supports their decisions on how to apply the
25 method.

1 Q. When you say the "literature," you're
2 referring to the Smith article, correct -- and
3 Gonzalez, correct?

4 A. Smith and Gonzalez -- well, Smith and
5 Hwang definitely. Gonzalez is more on the
6 predictive ability of the grades.

7 Q. And you would agree with me that both the
8 Smith and Hwang articles were assessing the Leapfrog
9 methodology that was neither the post-fall-2024
10 methodology or the pre-fall 2024 methodology but a
11 methodology that was almost eight years old at the
12 time they did their analysis, correct?

13 A. True, which doesn't mean they're not
14 informative about responders versus nonresponders at
15 a certain point in time.

16 Q. Well, there were different measures on the
17 Leapfrog Hospital Safety Grade back in that day;
18 were there not?

19 A. Yes, but at least it provides some
20 empirical evidence about whether there is a
21 difference between responders and nonresponders,
22 which seems to be -- you know, it's empirical
23 evidence; it's not just conjecture.

24 Q. Right. But it's empirical evidence based
25 on different measures than we're measuring today,

1 correct?

2 MR. HVIDT: Asked and answered.

3 A. I'd have to go back. Hwang is looking at
4 a number of measures in 2013. There could be some
5 in common. And Smith looks at, at least four
6 variables. I have to recall whether those are still
7 included. Still speaks to what was the behavior and
8 the data at that point in time.

9 BY MS. BLAIR:

10 Q. In one of the articles you cite to you
11 talk about the fact that you believe the
12 verification process from Leapfrog for the reporting
13 hospitals is not robust.

14 Is that a fair assessment of how you
15 categorize the verification process at Leapfrog?

16 A. I can't -- maybe we can look. I can't
17 recall the exact language. I certainly do reference
18 an article that indicates that in a year, the
19 Leapfrog Group, I think, audited five hospitals
20 on-site, and maybe 25 electronically, something like
21 that.

22 Q. And you don't know whether that
23 verification process has expanded since that time;
24 do you?

25 A. I have seen some documents -- I don't know

1 if they're all the documents that exist -- that the
2 Leapfrog Group has a contract for a firm to audit
3 five or six hospitals a year. I think it's five in
4 2024 and maybe six in 2025.

5 Q. And they're random audits, correct?

6 A. That's my understanding. I can't recall.

7 Q. And you understand that the Safety Grade
8 Expert Panel periodically reviews the methodology
9 and makes change to the methodology over time,
10 correct?

11 A. Yes. That's my understanding.

12 Q. And, in fact, if I read from the guiding
13 principles of the Safety Grade Expert Panel, they
14 say:

15 "The composite grade will evolve as the
16 science of performance measurement improves. On a
17 regular basis, the methods used to calculate the
18 composite grade will be revisited. Possible
19 methodology modifications will be generated from
20 analyses, expert panel input, and stakeholder
21 comments."

22 Do you recall reading that in the guiding
23 principles, or something to that effect?

24 A. Yes.

25 Q. As a healthcare --

1 MR. HVIDT: Objection, form to the last --
2 reading a document not presently in the record.

3 MS. BLAIR: Sure.

4 BY MS. BLAIR:

5 Q. Would you agree with me, as a healthcare
6 economist, that it is a sound scientific principle
7 to continue to review the methodology and improve
8 upon it when necessary?

9 A. Yes, as a general matter, as long as those
10 improvements are consistent with the principles and
11 bringing the method closer to adhering to the
12 principles.

13 Q. Would you agree with me that it is in the
14 best interests of patient safety for academics to
15 continually rework the methodology to improve upon
16 it so we're getting as close to the guiding
17 principles as we can?

18 A. Yes, as a general matter. I don't know
19 the pace of that, but I think that's a noble
20 aspiration.

21 Q. And I think I asked you this before: You
22 have no reason to doubt the qualifications of the
23 Leapfrog Safety Grade Expert Panel in being capable
24 of reviewing the methodology, correct?

25 A. I didn't, as part of my assignment, review

1 their credentials, but sitting here, I don't have
2 any reason to be critical of them.

3 Q. Did you review as part of your opinions,
4 the public comment that Leapfrog received related
5 to -- well, strike that.

6 I'm going to the lay some foundation.

7 Are you aware that Leapfrog put out for
8 public comment the changes it was going to make for
9 the fall 2024 grade?

10 A. Yes.

11 Q. As part of your review of materials in
12 coming to your opinions here today, did you review
13 the public comments that Leapfrog received in
14 connection with the methodology change in the
15 fall of 2024?

16 A. I've seen some of the comments. I don't
17 know that I've seen all of them. I've seen some of
18 them.

19 Q. What comments do you recall seeing?

20 A. Again, I can't remember how many there
21 are. I certainly recall seeing some that I believe
22 are supportive because they believed that this would
23 be a better method, in their opinion, and there were
24 some that would talk about the burden and how that
25 was underlying some of the nonresponse.

1 So I'm sure there's more categories of
2 comments than those, but I think those are the ones
3 I can recall.

4 Q. Would you agree with me that the more
5 hospitals that publish their hospital safety data,
6 the safer patients would be?

7 A. No. Not if the grades are unreliable.

8 Q. That's fair.

9 I'm not talking about the grades. I'm
10 just saying, in general, if the world or healthcare
11 economists are trying to improve patient safety,
12 should it be the goal to have hospitals be
13 transparent about their patient safety?

14 Forget about the grade, just hospitals
15 being transparent about their patient safety?

16 A. As a general matter, I think that's true.
17 I think one has to be cognizant of what -- you know,
18 whether what's being reported, publicly and
19 transparently, is important and whether the consumer
20 is able to absorb that and recognize it. And also,
21 one should be careful about whether there are
22 meaningful differences between different values in
23 distribution.

24 So it could be that two numbers are
25 different, but statistically, you can't reject that

1 they're the same. So I think, in general,
2 transparency is a good idea, but I think one still
3 has to be careful about helping decision-makers.

4 Q. Are you familiar, in your work as a
5 healthcare economist, with how CMS collects its
6 data?

7 A. I'm certainly familiar to some extent. I
8 wouldn't say I'm an expert on exactly how the data
9 are collected.

10 Q. I certainly am not.

11 Do you have any opinion about whether or
12 not the CMS data that's reported by hospitals to CMS
13 is accurate and reliable?

14 A. Well, as I talk in the report, CMS has an
15 ability to audit and find. And, in some cases, CMS
16 will conduct initial calculations with the data that
17 they have on their own and then allow hospitals an
18 opportunity to respond to those data.

19 So sometimes CMS gets access to the data
20 from sources other than from the hospitals
21 themselves; but they do have an ability to fine
22 hospitals, if they're not reporting or not reporting
23 appropriately, and to audit them.

24 Q. So in your opinion as a healthcare
25 economic expert, is it fair to rely on CMS data

1 because it is audited in all the things you just
2 described?

3 A. I'm sorry. Did you say, is it fair?

4 Q. Yeah. Is it fair to rely on CMS data?

5 A. I mean, depends on what the purpose is.
6 CMS does report something like 45 different measures
7 of hospital quality and safety and process and
8 structural measures on their website. So that's
9 already happening.

10 And I think CMS is trying to be -- my
11 understanding is they're trying to be, you know,
12 careful with those data and accurate with those
13 data. But like I said, it really depends on what
14 the purpose is.

15 Q. Right.

16 And, I guess, let's just say the purpose
17 is you're a consumer. Let's just say I'm a
18 consumer.

19 Would it be -- in your expert opinion is
20 the CMS data that I have access to as a consumer
21 something that, as a consumer, I can and should rely
22 on?

23 A. I have not conducted that analysis. I
24 would need to do an independent analysis of that
25 before I'd come to conclusion, for example, for the

1 reasons that I mentioned, which is, you know: Are
2 there statistical differences between hospitals that
3 are receiving different numeric scores? And are
4 these measures ones that consumers are able to
5 process and understand?

6 But I haven't conducted that analysis.

7 Q. Okay. And I'm not trying to be tricky.

8 If you could turn to paragraph 47 of your
9 exhibit which we've marked as Exhibit 1.

10 A. (Witness complies.)

11 Yes.

12 Q. You talk at length about how CMS collects
13 its data very similar to what you just told me,
14 right? The second sentence is:

15 "CMS collects and maintains data through
16 the HQI, a CMS program that collects and distributes
17 data on hospital performance and other metrics, and
18 these data are fundamentally different from TLG's
19 hospital survey data."

20 Do you see that sentence?

21 A. Yes, I do.

22 Q. Okay. And then you go on to talk about
23 CMS has mandatory reporting standards, correct?

24 A. Yes.

25 Q. And I think second -- you say "Second, CMS

1 hospital data are audited."

2 Do you see that? Starts with "second."

3 "Second, CMS hospital data" --

4 A. Yes, I see that.

5 Q. -- "are audited"?

6 And then you go on to say:

7 "In some cases, CMS may conduct additional
8 'quality oversight activities,' including inspection
9 of survey administration procedures," and the
10 sentence goes on.

11 Do you see that?

12 A. Yes, I do.

13 Q. And so I'm just asking you, in light of
14 the fact that this is in your report, is it your
15 position that the CMS data, because it is -- there's
16 mandatory reporting standards and its audited, and
17 there are quality oversight activities -- is it
18 reliable CMS data, in your opinion?

19 A. I guess my opinion is CMS is adhering to
20 many of the principles of a proper quality
21 measurement and reporting system by trying to be
22 consistent across hospitals, defining the variables,
23 defining how the variables should be reported, which
24 improves consistency between the hospitals,
25 encouraging the hospitals to report accurately

1 because there's penalties associated with not.

2 I'm just stopping short of saying that I
3 think, you know, providing all of the raw data to
4 consumers is necessarily the right thing to do.

5 Q. And I'm asking this question because you
6 understand -- and I want to set the 12 measures
7 aside, the 12 measures that migrate from the
8 survey -- there are 20 measures that are outcome and
9 process measures, mostly outcome, that come from CMS
10 data?

11 You understand that, right, on the
12 Leapfrog Hospital Safety Grade, correct?

13 MR. HVIDT: Objection, form.

14 A. Yes, I do.

15 BY MS. BLAIR:

16 Q. And do you have an issue -- setting aside
17 the 12, do you have any issue with Leapfrog using
18 CMS data for those 20 measures?

19 A. I don't have an issue, per se. I didn't
20 do an analysis to conclude that those are the best
21 22 to include in the system, but I don't have any
22 reason, per se, to think that those are
23 inappropriate inputs.

24 Q. Okay. And I think you said it more
25 eloquently than I did.

1 So to the extent that Leapfrog is relying
2 on CMS data for the 20 outcome and process measures
3 that don't migrate from the survey, your opinions
4 aren't based on those -- that data being inaccurate
5 in some way.

6 Is that a fair statement about your
7 opinion?

8 A. Yeah. I didn't conduct an independent
9 analysis to verify the accuracy, but I don't have
10 any reason to believe that, given the way that CMS
11 approaches the data collection, that they would be
12 inaccurate.

13 I do -- I know you've asked me to this set
14 it aside, but on the five outcome measure from the
15 survey, there's the inconsistency in the source and
16 the timing.

17 Q. Right.

18 Because if you don't participate in the
19 survey, Leapfrog has to take -- the only secondary
20 source of information available for nonparticipating
21 hospital for those five measures is from CMS,
22 correct?

23 A. I don't know if it's the only source, but
24 it certainly is a source that can be used.

25 Q. And if you participate in the survey, for

1 those five measures, you can report your current
2 data from the NHNS [sic], correct?

3 Am I -- maybe the acronym is wrong?

4 A. Maybe it's NHSN. But I think I know what
5 you're referring to.

6 Q. Right.

7 And that's the problem you have, at least
8 with those five measures; is it not, as I read your
9 opinion?

10 A. Yes, for responding hospitals, there's an
11 ability for the hospital to edit the data, and the
12 data are being pulled from a more recent time period
13 for the responding hospitals. And those data are
14 not audited, the ones that allow for edits; whereas
15 the nonrespondents are of a different time period,
16 and it's the audited CMS data.

17 Q. Do you agree with me that Leapfrog --
18 neither Leapfrog nor any other hospital rating
19 system has access to the NHSN data of a hospital
20 unless they voluntarily provide it to them?

21 MR. HVIDT: Objection, form.

22 A. I'm not sure. People do have access to
23 the 100 percent Medicare claims data. So it's
24 possible that if one knew the method, one could
25 replicate the data from that claims dataset. But I

1 don't know for sure.

2 BY MS. BLAIR:

3 Q. So you don't know, as you sit here today,
4 whether that is why there's a difference in those
5 two types of data, because for a nonreporting
6 hospital, Leapfrog doesn't have access to the NHSN
7 data for a nonreporting hospital for those five
8 measures?

9 You don't know that?

10 A. Well, I do know that -- I believe I know
11 that the responding hospitals essentially link their
12 NHSN data such that Leapfrog could pull it. And I
13 know that if you don't respond, there's no linkage.

14 What I was getting at is it's possible
15 with the underlying claims data, meaning how is each
16 patient treated at each hospital, someone could
17 replicate what CMS is doing to the nonresponders
18 with the same time period. I just -- I don't know
19 whether they could or couldn't.

20 Q. Okay. So you don't know whether they
21 could or couldn't?

22 A. Correct.

23 Q. You go on to say in this paragraph 47,
24 by -- after we talk about CMS, you say:

25 "By contrast, TLG's hospital survey data

1 are self-reported with hundreds of hospitals
2 declining to participate, and the available TLG data
3 documentation do not mention any auditing of the
4 survey responses."

5 Do you see that?

6 A. Yes.

7 Q. Do you have an understanding now that, in
8 fact, Leapfrog does verify the data from responding
9 hospitals?

10 MR. HVIDT: Objection, form.

11 A. Well, I do cite in one of the subsequent
12 sentences to an article that indicates that, at
13 least in one year, TLG audited five hospitals, which
14 is .1, .2 percent of hospitals.

15 And then I've seen some documents more
16 recently that I think TLG is contracted with a firm
17 to conduct five or six audits per year, so, again, a
18 pretty small percentage.

19 BY MS. BLAIR:

20 Q. Well, you go on to say, though -- you say:
21 "TLG audits very few hospitals."

22 And, again, you're referring to the
23 "Rating the Raters" article. And you say:

24 "TLG leadership stated that they had only
25 done a formal audit for approximately five hospitals

1 of about 2,600 in the past year, and only 72
2 hospitals underwent an electronic audit."

3 Do you see that?

4 A. Yes.

5 Q. So it's not just five hospitals from that
6 article. It's an additional 72 that underwent an
7 electronic audit, correct?

8 MR. HVIDT: Objection, form.

9 A. That's correct. I don't know exactly what
10 that entails, but that's correct.

11 BY MS. BLAIR:

12 Q. Do you have any understanding as you sit
13 here today that Leapfrog, in fact, does document
14 requests to participating hospitals to verify their
15 information?

16 A. I don't know the particulars of their
17 method.

18 Q. Are you aware that, for example, on the
19 CPOE measure, reporting hospitals are required to
20 enter actual cases into their system and document
21 the results that the electronic hospital record
22 generates?

23 A. I can't recall. What I do say is that
24 it's still the case that a majority of hospitals are
25 obtaining the highest -- the maximum score on those

1 seven variables.

2 Q. Your report assumes that they're
3 self-reporting those high scores and not, in fact,
4 earning them, correct?

5 A. They end up with a maximum score based on
6 the responses that they're asked to give.

7 Q. But as you sit here today, your only
8 basis -- the only basis for your opinion that
9 hospitals that participate in the survey aren't
10 audited is this "Rating the Raters" article from
11 2019, correct?

12 MR. HVIDT: Objection, form, misstates.

13 A. It's that as well as, as I said higher up,
14 available to me at the time TLG data documentation
15 do not mention any auditing of this survey
16 responses.

17 BY MS. BLAIR:

18 Q. Do you understand that to not be the case,
19 now that you have additional documentation?

20 MR. HVIDT: Objection, form.

21 A. I think it still may be the case that the
22 documentation don't mention it. I don't know what
23 matches behind the scenes.

24 BY MS. BLAIR:

25 Q. But you've seen at least some indication

1 either through expert reports in this matter or
2 documents that you've seen, that Leapfrog does have
3 a verification process for participating hospitals,
4 correct?

5 MR. HVIDT: Objection, form.

6 A. I haven't studied it. The on-site audits,
7 to me, would seem to be a very small percentage. I
8 don't know what the electronic audits consist of.

9 BY MS. BLAIR:

10 Q. I know that you have a criticism of the
11 fact that Leapfrog uses self-reported HIA data for
12 more recent time periods.

13 We just talked about that, correct? That
14 would be the NHSN data?

15 A. Yes.

16 Q. And you understand that Leapfrog would
17 prefer to have up-to-date data from every hospital
18 in order to evaluate a hospital's patient safety,
19 correct?

20 MR. HVIDT: Objection, form.

21 A. Yes. I understand that's Leapfrog's
22 preference, yes.

23 BY MS. BLAIR:

24 Q. And as a healthcare economist, would you
25 agree that the best way to measure patient safety

1 across all hospitals would be to have full and
2 fulsome information from each and every hospital?

3 A. Yes. I think there could be a debate over
4 what "full" means, but there's also a question about
5 at what cost of obtaining that.

6 Q. Sure.

7 Do you know what the cost is of complying
8 with the Leapfrog Hospital Survey?

9 A. I know a little bit, at least for one
10 hospital, the time cost or personnel cost, number of
11 personnel. I don't know the out-of-pocket cost.

12 Q. Do you have any understanding of whether
13 or not -- strike that.

14 Do you understand that these five
15 hospitals operate under the umbrella of Palm Beach
16 Health Network?

17 A. I'm not sure if they do or don't.

18 Q. Do you have an understanding that these
19 five hospitals are also part of the Tenet Healthcare
20 system?

21 A. Yes, they are.

22 Q. Do you have any understanding of how the
23 Tenet Healthcare system oversees hospital quality
24 for its hospitals across the health system?

25 A. I have not studied the particulars of that

1 as part of my assignment.

2 Q. Do you know whether or not Tenet Health
3 System has FTEs who have the responsibility of, for
4 example, complying with requests from the Joint
5 Commission?

6 MR. HVIDT: Objection, form.

7 A. I certainly believe they do. I don't know
8 the particulars.

9 BY MS. BLAIR:

10 Q. Do you know whether or not Tenet Health
11 System has a chief quality officer?

12 A. I would think they have something similar
13 to that. I just don't know the particular title.

14 Q. Do you know how large Tenet Health
15 Systems' quality office is, how many people are
16 employed by the quality office?

17 MR. HVIDT: Objection, form.

18 A. I don't know.

19 BY MS. BLAIR:

20 Q. And you sit on the board of Atlantic
21 Healthcare [sic], correct?

22 A. Yes. Atlantic Health System.

23 Q. Atlantic Health System.

24 I assume they have a chief quality
25 officer, correct?

1 A. I forget the title, but yes, there is
2 someone in that role.

3 Q. And how many hospitals are in Atlantic
4 Healthcare?

5 A. Six.

6 Q. And do you have any understanding how
7 large the staff is that reports up to the quality
8 officer?

9 A. I don't know.

10 Q. Do you know whether or not the hospitals
11 in Atlantic Health System participate in the
12 Leapfrog Hospital Survey?

13 A. I think so, but I'm not 100 percent sure.

14 THE WITNESS: Can we do a break soon?

15 MS. BLAIR: Yeah. Yeah, of course.

16 THE WITNESS: If this -- unless --

17 MS. BLAIR: It might be -- I don't know
18 what time it is because my computer is still on
19 Central Time.

20 MR. HVIDT: It's 12:30.

21 MS. BLAIR: Unlike Gibson Dunn, we don't
22 have lunch delivered here. My apologies.

23 Do you want to take a quick lunch break?

24 MR. HVIDT: We can go off.

25 THE VIDEOGRAPHER: 12:30 p.m. We're off

1 the record.

2 (At 12:30 p.m. a luncheon recess was
3 taken.)

4 (At 1:30 p.m. the deposition resumes.)
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1 THE VIDEOGRAPHER: 1:30 p.m. Back on the
2 record.

3 CONTINUED EXAMINATION

4 BY MS. BLAIR:

5 Q. Dr. Nicholson, I want to turn to your
6 report and go over like some of the details of this.
7 And I want to start with Section 10, which is
8 entitled, "TLG's rating methodology is fundamentally
9 flawed." And that is on page 27 of your report.

10 A. Okay.

11 Q. And I want to make sure that we're all on
12 the same page before we start getting into the
13 minutia here. But you understand that the
14 significant change in the Leapfrog grading
15 methodology from spring of 2024 to fall of 2024, was
16 how the four imputed measures were going to be
17 handled, correct?

18 A. Yes, that was the primary change.

19 Q. And as we understand it for the record, in
20 spring of 2024, those four measures, which are CPOE,
21 BCMA, ICU staffing, and hand hygiene, were going to
22 go from giving nonparticipating hospitals the cohort
23 median score, to giving nonparticipating hospitals a
24 lowest achievement score for those four measures,
25 correct?

1 A. Yes.

2 Q. And you understand that if you
3 participated in the survey, you wouldn't be given,
4 necessarily, the lowest achievement score as an
5 automatic value, correct?

6 A. Correct.

7 Q. So to put it another way, a
8 nonparticipating hospital could avoid having those
9 four measures be scored at lowest achievement if
10 they participated in the survey, correct?

11 A. Correct. That would be the only way that
12 they could avoid that automatic measure.

13 Q. And other than that change, the four
14 imputed measures -- I'm calling them the four
15 imputed measures, CPOE, BCMA, IC staffing, and hand
16 hygiene. Other than the change in how those four
17 measures were going to be scored, do you have any
18 other opinion -- issues with the Leapfrog grading
19 methodology that you're offering an opinion about in
20 this litigation?

21 A. Yes. I mentioned that for five of the
22 measures for the nonrespondents, the Leapfrog Group
23 would pull the data from CMS, but for respondents it
24 would take the data from the NHSN, National Health
25 Safety Network. But also, the respondents got the

1 benefit of receiving what turns out to be, on
2 average, a maximum score for the majority, for those
3 three subjective measures that are self-reported but
4 not imputed. So that's another criticism that I
5 have. It's another way that the Leapfrog Group
6 method wasn't being applied consistently across the
7 responders and nonresponders.

8 Q. Okay. And so for the five measures where
9 nonresponders are being pulled -- I'm sorry -- for
10 nonresponders Leapfrog's pulling CMS data and for
11 the same five measures, participating hospitals are
12 reporting NHSN data, correct?

13 A. Yes, that's one criticism.

14 Q. And was that not the case pre-fall 2024
15 for those five measures?

16 A. Yes, I thought you were asking me whether
17 I had some criticisms of the Leapfrog Group's method
18 prior to the fall 2024, other than those four.

19 Q. That's fair.

20 Are you offering an opinion in this
21 litigation about how those five measures should be
22 handled differently?

23 A. In the counterfactual analysis that I
24 conducted, I didn't change the way that those
25 variables would be recorded.

1 Q. Right.

2 A. I did in estimating how a nonresponding
3 hospital that responded would be scored. I did
4 include mean values for the seven variables,
5 including the three that were not imputed.

6 Q. Right. But not the five?

7 A. Correct.

8 Q. So when you did your counterfactual
9 analysis for the five, you kept it the same,
10 correct?

11 A. That's correct.

12 In the counterfactual there was no -- I
13 didn't change the scores for those five variables.

14 Q. So while you may have a criticism about
15 the fact that it's not the same data for a reporting
16 hospital and a nonreporting hospital for those five
17 measures, your counterfactual analysis did not
18 change that part of the methodology, correct?

19 A. That's correct. It did not.

20 Q. And I think I probably asked this before,
21 but to your knowledge, there is no way for Leapfrog
22 to obtain the NHSN data for a nonreporting hospital
23 to your knowledge?

24 A. That is my understanding, that a hospital
25 would have to link their responses -- the data in

1 NHSN to give Leapfrog access, and they do that as
2 part of the responding process.

3 Q. And so if a hospital participated in the
4 survey, they could avoid having the CMS data used
5 for that -- those five measures because they could
6 use their NHSN data?

7 A. If they chose to participate, and if they
8 were willing to give access to the data.

9 Q. Do you know whether there are any
10 participating -- any hospitals that participate in
11 the Leapfrog survey that do not provide their NHSN
12 data for those five measures?

13 A. I didn't study that so I'm not sure.

14 Q. So when you say one of the criticisms is
15 that reporting hospitals use NHSN data that they can
16 change and it's more up-to-date versus CMS data, you
17 don't know if that's true for all participating
18 hospitals, correct?

19 A. I don't. I do know that -- and this has
20 been recommended for at least one of the articles
21 that I cited -- the Leapfrog Group could use CMS
22 data consistently across participating and
23 nonparticipating hospitals for those five measures.
24 Because those data are available, those CMS data are
25 available for the participating hospitals too. That

1 would at least make it more consistent between the
2 responders and nonresponders.

3 Q. And as a healthcare economist, would you
4 agree that more up-to-date information would be more
5 beneficial to actually calculating a patient safety
6 for a hospital?

7 A. It depends on the available, but generally
8 that would be true, that the more recent would give
9 you more predictive power about what to expect.

10 Q. And do you understand that CMS data that's
11 available to the public, like Leapfrog, lags in
12 time?

13 A. Yes.

14 Q. So by that I mean -- and I want to make
15 sure we're saying the same thing. As I understand
16 it, and I'm not a healthcare economist, the CMS data
17 that's available to Leapfrog when calculating
18 measures that rely on CMS data, could be a year or
19 two behind the current time period, correct?

20 A. I can't recall the exact difference in
21 time, but certainly know for example for those five
22 variables that we've been talking about there's a
23 six-month difference between the responders and the
24 nonresponders. I just can't remember how long the
25 lag is between today and when the data were

1 collected.

2 Q. And do you understand that there's, at
3 least in the complaint, there's some allegations
4 about a hospital in North Carolina that was under
5 investigation by, I believe, CMS and yet Leapfrog
6 had rated it an A hospital.

7 Do you remember seeing those allegations?

8 A. I did read the complaint, but I can't
9 remember -- sitting here, I can't remember them.

10 Q. And so as you sit here you don't have any
11 understanding as to whether that could have been
12 because the CMS data for which the hospital grades
13 rely is out dated versus what is happening in real
14 time today?

15 A. I don't recall the circumstances of that
16 incident.

17 Q. But you haven't seen any peer-reviewed
18 publications or validation studies of the Leapfrog
19 methodology in 2024 or 2025, correct?

20 A. I have not. Generally, there's a
21 publication lag in academia, but I have not seen
22 any.

23 Q. Because a lot of the articles we've talked
24 about here today are from 2019 or older that have --
25 are critical of the Leapfrog methodology, correct?

1 A. I certainly do cite to some articles from
2 2017, 2019, 2014, but yes, it generally takes a
3 little bit of time between when an article is
4 submitted and when it's accepted for publication.

5 Q. Do you have any opinions about whether or
6 not Leapfrog is transparent with respect to its
7 methodology for Fall 2024 and subsequent?

8 A. Since the method is described on one of
9 the documents that's linked to the internet, I
10 think, in my opinion, someone who understands
11 healthcare measurement and is expert would
12 understand the method, it would be transparent. I
13 can't speak to the general consumer, whether the
14 consumer might understand it.

15 Q. Understood. And I'm just asking, you
16 agree with me that Leapfrog makes its methodology
17 available to the public if they want to read it.
18 Anyone on their website could look at the
19 methodology, correct?

20 A. Yes, they can see the variables that are
21 measured, the sources, the secondary sources, the
22 weights, and understand how those calculations are
23 made.

24 Q. Do you know whether or not CMS makes its
25 methodology available to anybody on the internet who

1 wants to review it to determine how CMS comes up
2 with its star rating?

3 A. I haven't studied that. I certainly know
4 that they will disclose the variables, the domains,
5 the weights for the domains, but I don't know
6 whether it's fully transparent or not.

7 Q. What about U.S. News and World Report, to
8 the extent they rank hospitals, do you know whether
9 or not they publish on their website how their
10 methodology works?

11 A. I don't know. I haven't studied that. I
12 do know that they do ask subjective questions and
13 they probably -- well, I shouldn't even say.

14 Q. Don't guess.

15 A. I don't know. I don't think they report
16 the specific values of the surveys, but I haven't
17 studied it.

18 Q. What about health grades, do you know
19 whether they report specifics regarding their
20 methodology?

21 A. I can't recall.

22 Q. Turning to paragraph 54 of your report,
23 which you have in front of you and we previously
24 marked as Exhibit 1, and this is on page 27.

25 A. (Witness complies.)

1 Q. You state -- are you there?

2 A. Yes.

3 Q. You state the unreliability of TLG's
4 hospital grades is further underscored by the fact
5 that the major contributor of these hospital grades,
6 56.6 percent of the overall grade, is the collective
7 12 measures.

8 Do you see that?

9 A. Yes.

10 Q. How did you get to 56.6 percent?

11 A. Twelve divided by 22.

12 Q. Okay. But we discussed earlier in your
13 deposition that there are in fact 32 measures that
14 go into the hospital safety grade, with the PSI
15 being ten full measures.

16 Do you understand that?

17 A. The methodology document that I'm familiar
18 with talks about 22. I mean, at the end of the day
19 a single value is entered for the PSI 90 into the
20 algorithm or into the calculation.

21 Q. Do you understand that the calculation is
22 divided into two parts, outcome measures and process
23 structural measures?

24 A. Yes.

25 Q. And the outcome measures make up

1 50 percent of the grade, correct?

2 A. By weight, for a responding hospital.

3 Q. By weight, yes.

4 And the same is true for structural
5 process measures. By weight, they make up
6 50 percent, correct?

7 A. Yes.

8 Q. And the four imputed measures that we keep
9 talking about, CPOE, BCMA, hand hygiene, and ICU
10 staffing, those are all structural measures,
11 correct?

12 A. Yes, correct.

13 Q. And there are three measures for which a
14 nonreporting hospital simply gets a "declined to
15 respond" and does not get a score for those
16 measures, correct?

17 A. That's correct, and those weights get
18 reassigned.

19 Q. You answered my next question.

20 So those weights get reassigned within
21 that structural process 50 percent, correct?

22 A. Yes, and that introduces some
23 inconsistency between the responding and
24 nonresponding hospitals. There's different weights
25 and different variables that go into the grade.

1 Q. And then there's the other remainder of
2 the 12 measures, correct, for which we've discussed
3 at nauseam that CMS data, rather NHSN data, is used
4 for nonresponding hospitals, correct?

5 A. Correct.

6 Q. Do you have any issue with the fact that
7 Leapfrog, both in the pre-fall 2024 methodology and
8 the post-fall 2024 methodology, does not provide any
9 score for the three measures that we just discussed,
10 the decline to respond measures?

11 A. Yes. It's a deviation from the principle
12 of applying a method in a consistent fashion across
13 all organizations -- on this case, all hospitals --
14 where the weights are different, and between the
15 responding and nonresponding hospitals on the
16 remaining variables and the set of variables is
17 different. So it introduces some incomparability
18 between the grades of the responding and the
19 nonresponding hospitals.

20 Q. And you understand that was the case for
21 the Leapfrog methodology pre-fall 2024 as well,
22 correct?

23 A. Yes.

24 Q. In looking at those three measures, for
25 which Leapfrog gives a decline to respond measure

1 for nonreporting hospitals, did you look into
2 whether or not assigning the mean for those three
3 measures would be appropriate for nonresponding
4 hospitals?

5 A. I do think it's appropriate for my
6 counterfactual where I'm estimating analyzing
7 whether TLG's method treats responding and
8 nonresponding hospitals differently by assigning
9 nonresponding hospitals the mean, which is a typical
10 response for the responding hospitals. So for that
11 purposes, it's appropriate for my counterfactual.

12 Q. And you keep saying counterfactual. I
13 want to make sure for the record we all understand
14 what that means. Can you tell me exactly what that
15 means in your mind?

16 A. Sure.

17 So in the actual world there's some
18 hospitals that responded to the TLG survey and some
19 that didn't. And I'm analyzing a world that we
20 didn't observe where all of the hospitals responded
21 under certain conditions. And the conditions is
22 that the nonresponders responded in a way that was
23 typical of the responders.

24 Q. Would it be a better method, though --
25 would it be the best method, though, if we could

1 know the actual data for the nonresponding hospitals
2 to see if assigning them a mean score was in fact
3 appropriate?

4 A. Well, there's no getting around that in
5 the actual world, some hospitals responded and some
6 hospitals didn't respond. And it's a common
7 statistical challenge or exercise. So it's
8 realistic because it describes what happens in the
9 actual world.

10 Q. Do you have any understanding whether or
11 not these five hospitals would have had to
12 accumulate data for these seven measures, I'm
13 talking about the four imputed and the three
14 declined to respond, in order to comply with joint
15 commission requests or CMS data requests?

16 A. To the best of my knowledge, CMS does not
17 request those data, the data for the seven
18 variables. I'm not aware of CMS having measures for
19 any of those seven structural variables. For joint
20 commission, I don't know if they do or don't.

21 Q. So you don't know as you sit here today
22 whether these five hospitals actually have a
23 repository of the data from fall of 2024 that would
24 have answered with specificity these -- the question
25 about what their data actually was for these seven

1 measures, correct?

2 A. I don't know for sure. I also don't know
3 if it would be at this same point in time that
4 they're being asked potentially to provide that data
5 to Leapfrog Group.

6 Q. Do you know whether or not hospitals keep
7 data -- forget about Leapfrog -- whether hospitals
8 keep data on for example computerized physician
9 order entry?

10 MR. HVIDT: Objection, form.

11 A. I'm not sure what you mean by "keep data."

12 BY MS. BLAIR:

13 Q. Sure. I thought what you just said to me
14 is, well, we don't know whether or not these five
15 hospitals would have had data for the right given
16 time to look at to see what their scores would have
17 been. And I guess my follow-up question then is,
18 using as example CPOE, and you have a lot of board
19 experience on healthcare systems, do you know
20 whether that's something that hospitals track, for
21 example, whether or not there are adverse issues
22 with respect to computerized physician order entries
23 or whether there's protocols about computerized
24 physician order entries? Does that data usually
25 exist in a healthcare system?

1 MR. HVIDT: Objection, form.

2 A. I can't recall in my capacity as a board
3 member having a dashboard where that information was
4 presented to us. It could be the case that somebody
5 would have to conduct an analysis. Say with the
6 computerized physician order entry system or with an
7 electronic medical records system, to see the extent
8 to which it's being used, and they'd have to
9 customize it to the questions being asked, say by
10 TLG. I'm not familiar with that being presented in
11 my two board assignments.

12 BY MS. BLAIR:

13 Q. And I think your report does refer to the
14 fact that when you sit on these boards, you do have
15 some access to some dashboard materials. And again,
16 I don't want to know about your specific hospitals,
17 but that that is information that a dashboard does
18 exist that you have access to in your capacity as a
19 board member, correct?

20 MR. HVIDT: Objection, form.

21 A. Yes, generally before each board meeting
22 there are reports that provide the performance of a
23 hospital or hospitals relative to say a target and
24 trend data for some measures, not every single
25 measure that could possibly be measured.

1 BY MS. BLAIR:

2 Q. Do you know whether or not Tenet
3 Healthcare System has such a dashboard?

4 A. I don't know. I haven't analyzed whether
5 they do or don't.

6 Q. Based on your experience as a board member
7 at various healthcare systems in the past, would you
8 expect that a large organization like Tenet
9 Healthcare would have some sort of dashboard
10 available?

11 A. I don't know for sure. I think it's
12 likely that they do. What the contents of that are,
13 like how disaggregated it is, or granular, I don't
14 know.

15 Q. Moving to paragraph 57 of your report, and
16 again this is talking about the 12 measures that
17 we've just discussed. As I understand this
18 paragraph -- well, why don't you tell me, what are
19 you trying to get at in this paragraph of your
20 opinion?

21 A. My point is that there are certainly
22 differences in the way the Leapfrog Group method is
23 applied for the participating versus the
24 nonparticipating hospitals. But even among or
25 across the participating hospitals, the measures

1 aren't necessarily comparable because some of the
2 questions are subjective and there's not a rubric
3 necessarily or structure to guide a respondent's
4 answer. So rating yourself on a culture of safety,
5 you might be getting difference responses from one
6 responding hospital on that scale versus another
7 because they're interpreting those scales in a
8 different fashion.

9 Q. Would you agree with me that some of the
10 metrics that CMS reviews are subjective as well?

11 A. I mean, the HCAHPS measures are. Those
12 are coming from patients. The questions are -- CMS
13 is using the responses, but for the outcomes and
14 process measures I think -- and I think I give an
15 example. There's often guidance on what should and
16 shouldn't be included. For example, readmissions.
17 CMS will define what a readmission is and which
18 patients get counted as being readmitted and which
19 ones don't.

20 Q. And you understand that unlike CMS,
21 Leapfrog, which isn't -- again, we talked about this
22 earlier -- isn't looking at quality, it's looking --
23 that's specific of patient safety, does not look at
24 readmission rates or mortality rates, correct?

25 MR. HVIDT: Objection, form.

1 A. Correct. That's something that CMS
2 measures that the Leapfrog Group has chosen not to
3 include in their grades.

4 BY MS. BLAIR:

5 Q. In your expert opinion as a healthcare
6 economist, is there a prohibition against using
7 subjective metrics in a methodology?

8 A. What do you mean by "prohibition"?

9 Q. Well, I'm trying to understand what you
10 mean. Maybe that's my difficulty.

11 You said some of these metrics that
12 Leapfrog uses are subjective in nature, correct?

13 A. Yes.

14 Q. And as I read paragraph 57, you say:

15 "This is because the 12 measures that are
16 derived from hospital responses to TLG survey, are
17 self-reported and hospitals are provided no uniform
18 rubric to generate these responses."

19 Do you see that sentence?

20 A. Yes.

21 Q. And you've looked at the 300-page survey
22 that's a part of this, that at least those 12
23 measures come from the survey, correct?

24 A. Yes.

25 Q. And in looking at that 300-page hospital

1 survey, wouldn't you agree with me that it provided
2 a lot of background information so that hospitals
3 know exactly what's being looked for, for these
4 measures.

5 Would you agree with that?

6 MR. HVIDT: Objection, form.

7 A. No, I do not. I mean, the example that I
8 give in that paragraph that begins with -- the
9 sentence begins with "for example." In my opinion,
10 you know, quote, measuring a hospital's progress
11 towards implementing endorsed processes and
12 protocols to reduce and prevent adverse events, it's
13 not, in my opinion, self-explanatory to a respondent
14 how they should score themselves. That's not -- I
15 wouldn't call that a rubric.

16 BY MS. BLAIR:

17 Q. Would you agree with me the best place for
18 us to look about whether or not there's a rubric,
19 specifically for BCMA let's say because that's
20 what's in your paragraph here, would be in that
21 300-page survey?

22 A. Certainly that would be a place to look.
23 But to me in my reading of it, it leaves too much
24 ambiguity, too much discretion. And the principles
25 of quality measurement system, by Donabedian and

1 others, do emphasize the importance of objectivity,
2 and when there is subjectivity, some structure
3 around the subjectivity.

4 Q. And if I were to look at that 300-page
5 survey, specifically about how BCMA progress should
6 be measured, it's your opinion that it provides no
7 specific rubric for measuring BCMA progress, for
8 example?

9 MR. HVIDT: Objection, form.

10 A. Not sufficient structure. Not sufficient
11 objectivity in my opinion, yes.

12 BY MS. BLAIR:

13 Q. Okay. What would need to be included in
14 the -- and we will stick with BCMA -- the BCMA
15 rubric for it to be sufficient, in your opinion?

16 A. Yeah, I don't -- I don't have sitting here
17 like a construction of the perfect rubric. But I do
18 believe in my report I talk about -- and I'm not
19 sure if it's in this paragraph or elsewhere, I could
20 check. I think what's a better structure, maybe not
21 perfect, is some of the language around the
22 meaningful use of electronic medical records where
23 an entity will provide some context around what is
24 extensive and meaningful use, versus what is sort of
25 very initial preliminary use.

1 So I do talk about that. I'm not sure I
2 would go so far to say that's perfect, but there's
3 more structure bringing it more towards an objective
4 measure.

5 Q. And I think we talked about this earlier,
6 but there probably is no perfect methodology for
7 evaluating patient safety in the hospital, is there,
8 at least not in 2025?

9 MR. HVIDT: Objection, form.

10 A. I think there are principles that are well
11 established that an organization should strive for
12 in trying to achieve that objective.

13 BY MS. BLAIR:

14 Q. Well, you used the word "perfect," so I'm
15 just making sure we understand each other.

16 Do you believe there's a perfect
17 methodology for measuring a hospital's patient
18 safety in 2025?

19 A. Well, I think you'd have to define
20 "perfect." I don't know what the right definition
21 is of "perfect" for a measurement system.

22 Q. You used the word. I just was asking the
23 question.

24 A. Well, I was -- you asked a question about
25 it.

1 Q. Okay.

2 MR. HVIDT: Objection, form.

3 BY MS. BLAIR:

4 Q. So as you sit here today, you can't --
5 well, strike that.

6 You told me everything you thought a BCMA
7 rubric should include in order to be more objective,
8 correct?

9 A. Well, I do think -- when a variable is
10 subjective, I think the literature on quality and
11 safety measurement would stress the importance of
12 providing as much objectivity as possible, as much
13 structure as possible. I was using the meaningful
14 use of electronic medical records as an example of
15 something that I think does provide some concrete
16 information about what a top score is versus what a
17 lower score is.

18 Q. So in looking at the next section, B, you
19 say:

20 "TLG's rating system results in
21 inappropriately inflated grades for hospitals that
22 choose to participate in its survey, and
23 inappropriately deflates grades for hospitals that
24 choose not to participate."

25 Do you see that heading right before

1 paragraph 58 of your report on page 30?

2 A. Yes. Yes, I do.

3 Q. And I don't understand, and we'll talk
4 some more about the fact that you believe
5 nonparticipants grades are deflated. But can you
6 tell me my how you believe that participating
7 hospitals have overinflated grades?

8 A. Sure.

9 I do show in both Exhibit 1 and Exhibit 2
10 and 3 -- well, let's say 1 and 2, that both in, I
11 think's 2013 from the Smith article and in 2025,
12 that a majority of hospitals are given the top, the
13 maximum score for those seven, at least for the
14 subjective variables that were used at the time of
15 the study, which is a very odd distribution for a
16 majority of respondents to any question, to be given
17 the absolute maximum score. So that's in large part
18 how I conclude that the respondents are able to
19 inflate their grades.

20 Q. And I just wanted to make sure, you used
21 the phrase throughout, that they "assign
22 themselves," or "give themselves" the highest
23 possible score. You say that repeatedly in this
24 opinion. And can you tell me what you mean by that
25 because I am confused by that?

1 A. Right. They are -- the respondents are
2 completing the survey and then TLG is assembling the
3 data in a way that those respondents obtain, through
4 the TLG method, the maximum score.

5 Q. Okay. So you would agree with me that the
6 participating hospitals don't pick their score and
7 just write it down, right? They're just answering
8 survey questions, and that information is being
9 evaluated and turned into a score, correct?

10 A. Yes. And if they're answering those
11 individual component questions with the best
12 possible answer, it ends up leading to values such
13 that a majority of them get the -- are assigned the
14 maximum value.

15 Q. Okay. So like at the top of page 31 when
16 you say, "Participating hospitals still tend to give
17 themselves the highest possible score," we can agree
18 they don't give themselves a score, correct, they
19 just answer survey questions, correct?

20 A. Right. So I think a better wording would
21 be they submit data such that they end up with the
22 maximum possible score.

23 Q. And so is it your position that these
24 participating hospitals are trying to game the
25 system by their responses?

1 A. I'm not -- I mean, I don't have -- I
2 didn't do a formal analysis of their motivation.
3 But from an economic perspective, they do have
4 incentives to end up with a good grade. And if the
5 auditing mechanism isn't rigorous enough, then it
6 could lead to them gaming the system. But I didn't
7 do a formal analysis of the intentions and the
8 motivations of the respondent.

9 Q. Well, if the survey isn't rigorous then
10 why don't all hospitals participate and just give
11 themselves the best possible answers they can from
12 an economic standpoint?

13 MR. HVIDT: Objection to form,
14 mischaracterizes.

15 A. I think I referred to the rigorous nature
16 of the auditing.

17 BY MS. BLAIR:

18 Q. So you would agree there's a rigorous
19 nature to answering the survey questions, correct?

20 A. Well, I do talk about it's a long survey.
21 It's 350 pages and there certainly is some evidence
22 that it takes substantial time for people to fill it
23 out, and there are comments about the burden being
24 the potential barrier to responding. So all of
25 those are consistent with what I'm saying.

1 Q. But taking hand washing for instance, the
2 rubric is not about whether or not doctors or nurses
3 are washing their hands whenever they claim they
4 did, it's about observations of doctors and nurses
5 washing their hands, correct?

6 MR. HVIDT: Objection, form, lacks
7 foundation.

8 A. I can't recall all of the particular
9 questions. Sitting here, I can't recall all of the
10 particular questions go into that variable.

11 BY MS. BLAIR:

12 Q. Can it not be true that participating
13 hospitals truly earned their grades and they're not
14 overinflated, and you can still have the opinion
15 that nonparticipating hospitals have over-deflated
16 grades?

17 A. Again, it's a very -- you know, I'm an
18 economist. I'm an empirical economist, I work with
19 numbers. It's a very odd -- it's very odd to see a
20 distribution of data where a majority have -- they
21 end up with the maximum value. It's not something
22 that's commonly observed in statistics.

23 Q. Isn't it common sense, though, that if
24 your scores are really good, you're going to report
25 them because economically it helps you?

1 MR. HVIDT: Objection, form.

2 A. Well, I think there's a number of factors,
3 and certainly the amount of time that it takes to
4 complete it versus what one could do with that time
5 alternatively, is also, from an economic
6 perspective, going to affect somebody's willingness
7 to participate.

8 BY MS. BLAIR:

9 Q. Do you have an opinion about whether or
10 not hospitals are more willing to participate in the
11 Leapfrog survey if their commitment to patient
12 safety is higher than other hospitals?

13 A. I haven't seen any evidence to that
14 effect. I know I've seen correspondence from Romano
15 where he also thinks the time burden is a big factor
16 in why hospitals do or don't respond to the survey,
17 and he's on the expert panel.

18 Q. Would you agree with me that one of the
19 assumptions that you're making in your opinions is
20 that all hospitals that are being graded by Leapfrog
21 have the same commitment to patient safety if you're
22 applying to the same mean to all of them?

23 A. No, I'm not -- I don't know how commitment
24 to patient safety and patient quality translates
25 into the delivery of patient safety and patient

1 quality. I don't equate those two. I'm not
2 familiar with any study that's been able to do that.

3 Q. Do you think there's any validity to the
4 argument that a hospital who has committed
5 significant time and resources to patient safety
6 would be more likely to participate in the Leapfrog
7 survey than a hospital who had not committed time
8 and resources to patient safety?

9 MR. HVIDT: Objection, form.

10 A. I haven't seen any evidence to that
11 effect. And in my opinion, if someone is
12 constructing a safety and quality measurement
13 method, they should make decisions based on
14 evidence. And I haven't seen evidence to that
15 effect.

16 BY MS. BLAIR:

17 Q. Well, but that would be the nonresponse
18 bias that Dr. Harris discusses in his opinion,
19 correct?

20 MR. HVIDT: Objection, form, confusing.

21 A. He posits that, but again with no
22 evidence. I didn't see him provide any evidence to
23 that effect. And I cite literature that does show
24 in my instances the nonrespondents have very similar
25 patient safety, patient quality measures as the

1 respondents.

2 BY MS. BLAIR:

3 Q. What which studies are those again?

4 A. Smith study, Hwang study, those are the
5 two examples.

6 Q. And it's your position that those two
7 studies went and found that nonparticipating
8 hospitals' actual data would have resulted in a
9 grade substantially similar to participating
10 hospitals?

11 A. I didn't say anything about a grade. What
12 I did say is if you look at when they looked -- when
13 Smith looks at measures of patient safety and
14 quality where they, Smith, et al., have access to
15 both responding to the TLG survey and nonresponding.
16 On those four measures that they show on the
17 exhibits, the nonrespondents and the respondents are
18 very similar.

19 And Hwang chooses a different approach by
20 basically starting with top U.S. News hospitals,
21 which presumably are high quality, and shows that
22 the nonrespondents would score much higher if they
23 reported in a way consistent with respondents.

24 Q. And wasn't Hwang looking at outcome
25 measures, not structural measures?

1 A. Well, Hwang scores using the TLG method
2 calculates a similar sort of counterfactual to what
3 I do using the TLG method at the time.

4 Q. Right.

5 And what he does is exactly what you did.
6 He goes back and puts in a mean grade for
7 nonreporting hospitals, correct, and comes out with
8 a different grade once he does that, correct?

9 A. Yes. For 18 hospitals that didn't respond
10 and 17 hospitals that did, where all 35 of those
11 were top U.S. News hospitals.

12 Q. Right.

13 And again, would you agree with me that
14 U.S. News and World Report is scoring something
15 different than what Leapfrog is scoring?

16 A. Yes. That is what the authors chose to
17 use as sort of creating a sample of purportedly high
18 quality hospitals.

19 Q. Is it your position that all participating
20 hospitals have overinflated grades as a result of
21 the Leapfrog methodology?

22 A. No. I'm not -- I'm not able to perform an
23 analysis at the level of each respondent, but that
24 collectively, if you look at the entire distribution
25 of responses, it's consistent with overinflation

1 when the majority of hospitals are getting the
2 maximum score.

3 Q. And do you understand that Mark Rule's
4 audit of the findings takes issue with your
5 statement that the majority of -- the significant
6 majority of participating hospitals are getting full
7 score for those measures? Did you look at that?

8 MR. HVIDT: Objection, form, document
9 referenced not in evidence.

10 A. I've read his report. I can't remember
11 that particular conclusion or assertion.

12 BY MS. BLAIR:

13 Q. What criticisms do you have of Mr. Rule's
14 report?

15 MR. HVIDT: Objection, form.

16 A. Well, one of them is -- I don't find his
17 analysis of reassigning the weights for the
18 nonparticipate- -- nonresponding hospitals, across
19 all seven of those measures, I don't find that to be
20 a particularly instructive analytic exercise or
21 counterfactual. It's clearly not estimating -- how
22 does the method -- does the method treat responding
23 and nonresponding hospitals differently, because his
24 analysis, it clearly creates great inconsistency
25 where responding hospitals get scored on 22 measures

1 and nonresponding on 15 measures and the weights are
2 different. So it doesn't create a comparable
3 situation between responding and nonresponding
4 hospitals.

5 BY MS. BLAIR:

6 Q. I'm not sure I fully understood that so I
7 apologize.

8 So is your criticism that he didn't run it
9 across all hospitals that were scored on the
10 weighted -- with the same weights?

11 MR. HVIDT: Objection, form.

12 A. Basically, I think his, I'll call it
13 "counterfactual," I don't know if he refers to it
14 that way, is moving away from the principles, moving
15 further away from the principles of a proper quality
16 measurement, safety measurement system. He's got
17 great inconsistencies between how the responding
18 hospitals are graded versus how the nonresponding
19 hospitals are graded. Because the nonresponding
20 hospitals, he doesn't use scores for any of those
21 seven subjective variables.

22 BY MS. BLAIR:

23 Q. For the nonparticipating hospitals?

24 A. Yes.

25 Q. And you believe that is inaccurate because

1 they should be graded on all seven?

2 MR. HVIDT: Objection, form.

3 A. Well, I believe that to adhere to a
4 principled quality and safety measuring system, you
5 want to have a method that's applied consistently
6 across all hospitals and he doesn't have that. He
7 has great inconsistency in how the method is being
8 applied between the responding and nonresponding
9 hospitals.

10 BY MS. BLAIR:

11 Q. But by your own admission, yours is also
12 inconsistent because you're still applying NHSN data
13 no nonparticipating hospitals versus CMS -- I'm
14 sorry -- CMS data for nonparticipating hospitals and
15 NHSN data for participating hospitals for five of
16 those 12 measures, correct?

17 A. True, because I'm addressing what I think
18 is a major shortcoming, which is the difference in
19 how those seven objective measures are scored.
20 Plus, if anything, that would just make my approach
21 more conservative because the responding hospitals
22 are able to edit -- likely, trying to correct low
23 quality events, whereas the nonresponding are not.
24 So I don't see that as particularly problematic.

25 Q. But if the CMS data, it was correct when

1 it was put in by the nonresponding hospitals, why
2 would they need to correct it?

3 A. Well, my understanding is there can --
4 because CMS establishes sort of rubrics or sort of
5 rules with very specific patient events, there is
6 sometimes information the hospital has that CMS
7 doesn't have, like the circumstances of why a
8 patient might be readmitted. Like it was a prior
9 scheduled event as opposed to a complication from
10 the previous admission.

11 Q. And we've agreed on this before, but you
12 understand Leapfrog does not look at readmissions or
13 mortality rates in its patient safety measure,
14 correct?

15 (Reporter clarification request.)

16 BY MS. BLAIR:

17 Q. You understand that Leapfrog does not look
18 at readmissions or mortality rates in its patient
19 safety measure, correct?

20 A. Yes. I was using that as an example.
21 With the safety measures, the same thing occurs.
22 And this comes up on the Robert Packer quality
23 committee that I'm on. When the patient safety
24 incidents are often -- for a subset of patients who
25 are, say, on a -- have a central line, or on a

1 ventilator, sometimes the hospital has information
2 that CMS doesn't yet have on whether a patient is --
3 should be included in that calculation or not.

4 Q. Tell me a little bit more on what you do
5 on the Robert Packer quality committee. Is that the
6 right term for it?

7 A. Yes. It's the quality subcommittee to the
8 board. There are two or three other board members
9 who are also on the quality subcommittee. And we
10 meet once a month and we review the dashboard, so
11 the latest quality and safety data relative to prior
12 months and to the benchmark, the goal, and discuss
13 programs that the hospital is putting in place to
14 try to improve quality.

15 Q. And you said on this dashboard there's
16 quality and safety data, are they two different
17 things?

18 A. I can't remember. Certainly, things like
19 HCAHPS are separate. I can't remember if the
20 quality and safety -- the -- if the nonsafety
21 quality is presented differently from the safety
22 quality. Again, I think of patient safety as being
23 a subset of quality.

24 Q. That's why I asked.

25 And in your work on the Robert Packer

1 quality subcommittee, do you ever have occasion to
2 discuss the Leapfrog grading methodology?

3 A. I don't recall ever discussing it, no.

4 Q. Robert Packer is a hospital?

5 A. Yes.

6 Q. I thought it was -- not a health system,
7 it's an individual hospital, correct?

8 A. Correct. The health system is Guthrie,
9 and Robert Packer is one of five or six hospitals in
10 that system. But I'm on the hospital board, not the
11 system board.

12 Q. Right.

13 A. With Atlantic health system I'm on the
14 system board.

15 Q. Right. I looked that up.

16 So for Robert Packer, do you know if they
17 participate in Leapfrog?

18 A. I think so.

19 Q. But that's not something the subcommittee,
20 the quality subcommittee looks at, their
21 participation in the Leapfrog survey?

22 A. We haven't, as I recall, since I've been
23 on it.

24 Q. Would you agree with me that the scores
25 that are assigned to nonparticipating hospitals for

1 CPOE, BCMA, ICU staffing, and hand hygiene, are just
2 that, assigned scores?

3 A. Yes. They're given the numeric value
4 equivalent with limited achievement.

5 Q. Limited achievement. I think I was saying
6 lowest achievement earlier. Thank you for that.

7 And so -- and would you agree with me that
8 the Leapfrog documents describing its methodology
9 make clear that it's just an assigned grade of
10 limited achievement?

11 MR. HVIDT: Objection, form.

12 A. I can't remember what -- you know, what
13 verb is used. But I do agree that the scoring
14 methodology document makes it clear what value
15 nonresponding hospitals will be given. I don't know
16 what the word is, assigned, or -- I don't know what
17 word is used.

18 BY MS. BLAIR:

19 Q. And I ask that because we talk about --
20 we've talked about transparency here today and I
21 want to make sure that you don't have an opinion
22 that Leapfrog is somehow deceptive in communicating
23 that the score is anything other than an assigned
24 score, correct?

25 MR. HVIDT: Objection, form, calls for a

1 legal conclusion.

2 A. Well, I do -- I do talk about that, you
3 know, on different parts of the website the data
4 appear differently. So sometimes a hospital's grade
5 would appear. Sometimes it will be like, "did not
6 respond" or something. So I think -- I highlight
7 that there's a difference in the way some
8 information is communicated. But I wasn't asked to
9 analyze -- I forget, maybe you should ask the
10 question again.

11 BY MS. BLAIR:

12 Q. So I just want to make sure, we've used
13 this phrase, "imputed measures," right, in this
14 litigation because we're not healthcare economists.
15 And do you have an understanding, as an expert
16 economist, that there's a difference between an
17 imputed score and just an assigned score?

18 MR. HVIDT: Objection, form.

19 A. Well, I don't know how everyone would see
20 those. I certainly see those as different. My
21 recollection is that there's at least some places in
22 the scoring methodology, I think, that uses the term
23 "imputed." Certainly, the safety grade expert panel
24 guiding principles have a section on imputed scores.
25 And I know there was an email exchange regarding

1 whether the language would be used as estimated, I
2 think, or assigned. I just can't -- I don't know
3 how everyone would see those. Whether people would
4 always see those as being different or not.

5 BY MS. BLAIR:

6 Q. But do you have any reason to dispute that
7 the documents -- the methodology documents that
8 Leapfrog has do not suggest that the fall 2024
9 scoring methodology for these four metrics, is
10 anything other than an assigned grade of limited
11 achievement?

12 MR. HVIDT: Objection, form. The
13 documents aren't records in generic form.

14 A. I can't speak to how a layperson would
15 interpret it. I certainly see the methodology as
16 making it clear that the limited achievement value
17 will be assigned. I can't speak for how a potential
18 consumer on a website is going to respond to the
19 information.

20 BY MS. BLAIR:

21 Q. Yeah. No one would accuse you of being an
22 everyday layman consumer. I understand that.

23 And again, in your opinion that we've
24 marked as Exhibit 1, you don't rely or discuss any
25 articles that talk about nonresponse bias in surveys

1 being a well-recognized principle, correct?

2 A. I don't think so. I cite at least one
3 document that discusses different methods of
4 imputation. But sitting here, I can't recall
5 whether in that document they also talk about
6 nonresponse bias.

7 Q. And let me ask it another way.

8 When you put together your August 7, 2025,
9 opinion, you did not focus on the potential impact
10 of nonresponse bias in the survey, correct?

11 A. I didn't. And in part because I didn't
12 see any evidence that it existed.

13 Q. But you didn't consider it when you put
14 this opinion together, correct?

15 A. Well, if the data in the documents
16 indicate that it was relevant, I very well may have
17 addressed it.

18 Q. What data in the documents would you have
19 liked to have seen in order to make a determination
20 as to whether or not nonresponse bias in the survey
21 should have been considered?

22 A. Well, I really think it would have
23 depended on whether the Leapfrog Group, in designing
24 their method, was designing their method based on
25 some observations or conclusions that they were

1 addressing nonresponse bias.

2 Q. Did you see in the meeting minutes from
3 the expert panel -- safety grade expert panel
4 meetings, discussions about nonresponse bias?

5 A. I can't recall. I can't recall certainly
6 seeing anything quantitative. Maybe it was a
7 discussion of it theoretically being the case. I
8 don't even recall seeing that.

9 Q. Do you have any criticisms -- if -- if
10 Leapfrog discussed nonresponse bias on a theoretical
11 basis, would you have an objection to that
12 consideration as a healthcare economist?

13 MR. HVIDT: Objection, form.

14 A. I'm not sure. Consideration of what?

15 BY MS. BLAIR:

16 Q. Sure.

17 If -- and again, you don't believe you've
18 seen this, but if there was a discussion among the
19 safety grade expert panel about whether or not
20 nonresponse bias should be considered with respect
21 to these four metrics, do you have an opinion about
22 whether that would be -- be appropriate to consider
23 or not?

24 A. Well, I would have to see the particular
25 circumstances and the data presented and the context

1 in which that data were presented. I can't just
2 make a statement in general.

3 Q. Okay.

4 When you did your counter-analysis, did
5 you consider the impact of Leapfrog's audit process
6 on the distribution of the self-reported scores in
7 any way?

8 A. Certainly, I talk about my understanding
9 of TLG's, The Leapfrog Group's, auditing process.
10 So I'm not making a causal connection between the
11 process and the responses of the respondents, the
12 participants on the survey. But it's consistent
13 with the situation where if there isn't a rigorous
14 auditing mechanism, it is easier with subjective
15 questions to have the maximum -- majority of people
16 responding to the maximum value relative to a
17 situation where there are severe penalties of not
18 replying as asked.

19 Q. And in coming to that conclusion, did you
20 rely on anything other than the 2019 article,
21 "Rating the Raters," I forget who the author was,
22 for your proposition that Leapfrog does very little
23 in terms of verifying survey responses?

24 A. Well, that, the "Rating the Raters"
25 article. And then, I think I also talk about how,

1 at least in some of the documentation, there isn't a
2 mention or a description of the auditing mechanism.
3 I believe that's the situation.

4 Q. Okay. And when you say "in the
5 documents," which documents -- when you say, "I was
6 talking about how at least in some of the
7 documentation there isn't a mention or a
8 distribution of the auditing mechanism," what
9 documentation are you referring to?

10 A. If I might check here.

11 I'm not -- I'm looking at paragraph 47.
12 I'm not specific enough here for me to recall
13 exactly what documentation I'm referring to. So I
14 think it's the methodology document on the -- I
15 believe it's the methodology document on the website
16 that I'm referring to.

17 Q. Okay. And when you started your
18 engagement as an expert for this litigation, what
19 documents did you ask the Plaintiffs for in order to
20 put your opinions together?

21 A. Well, I had -- I had access to -- my team
22 had access to all of the documents that were
23 disclosed for both the Plaintiffs and the
24 Defendants. So I had access to all of the
25 documents.

1 Q. Was there ever a time where you reached
2 out to the Plaintiffs and said, I'd like to see this
3 type of document or that type of document that
4 wasn't within the range of documents that you had to
5 review to come to your opinions?

6 A. No.

7 Q. And on August 7, 2025, the date of your
8 report, what documents did you understand the
9 Plaintiffs had produced to us in this litigation?

10 A. I had and my team had access to all of
11 those that were disclosed. But my understanding
12 is -- I'll just say July, but I don't know
13 exactly -- that there were a lot of documents being
14 disclosed from both Plaintiffs and Defendants. And
15 so I think there was an accumulating portfolio. But
16 I don't know which ones were on the Plaintiffs' side
17 and which ones were on the Defendant's side. And
18 frankly, I don't think we've been able to process
19 all of them yet.

20 Q. Do you understand that there was a point
21 in time, prior to Tenet purchasing these five
22 hospitals, where all five of these hospitals did
23 participate in the Leapfrog survey?

24 MR. HVIDT: Objection, form.

25 A. I'm not aware of the historical

1 participation.

2 BY MS. BLAIR:

3 Q. So follow-up question then.

4 You're not aware of what these hospitals
5 reported on their Leapfrog hospital surveys during
6 the time in which they did participate in the
7 Leapfrog hospital survey, correct?

8 A. Correct. I'm not aware. I have not seen
9 those data.

10 Q. Are you aware -- do you have any
11 understanding of what these five hospitals' CMS
12 ratings were prior to being purchased by Tenet
13 Healthcare versus today?

14 A. No, I have not studied that.

15 Q. In your work as a healthcare economist, do
16 you believe that the CMS star ratings are an
17 accurate indicator of hospital quality?

18 A. Well, I haven't undertaken that as an
19 assignment so I would hesitate to form an opinion on
20 it.

21 Q. But you do have, in paragraph, I believe
22 it's 47 of your complaint, a pretty robust
23 discussion of CMS, correct?

24 MR. HVIDT: Objection, you said the word
25 "complaint," I just want to make sure --

1 MS. BLAIR: Oh, I'm sorry, report. Thank
2 you.

3 BY MS. BLAIR:

4 Q. On paragraph 47 of your report, you do
5 have a pretty robust discussion of the quality of
6 CMS data, correct?

7 A. I do believe that CMS, because of the
8 mandatory reporting and the stiff penalties
9 associated with not reporting and the large
10 potential penalties associated with not scoring
11 well, and the fairly robust auditing mechanism, does
12 have some benefits to it. I'm also aware that the
13 "Rate the Raters" article that I do cite, had some
14 critiques of the CMS system. So I don't think
15 people think it's above any potential improvement.

16 Q. Well, of course. And I think -- I don't
17 know, you tell me, do you think there's any hospital
18 rating methodology currently on the market that is
19 not above improvement?

20 A. I haven't conducted that analysis. I do
21 think, as I've said, there are principles that I
22 think all organizations that are measuring quality
23 should be aware of and should be striving for, but
24 yes, I acknowledge it could be an iterative effort.

25 Q. And you don't have any criticisms of the

1 fact that the Leapfrog hospital safety grade expert
2 panel meets on a regular basis to attempt to improve
3 their methodology for measuring patient safety,
4 correct?

5 MR. HVIDT: Objection to form.

6 A. No, I think meeting and discussing would
7 be a sensible thing for that organization, that
8 panel, to do.

9 BY MS. BLAIR:

10 Q. Is that similar to what you do on the
11 subcommittee for quality for Robert Packer?

12 A. Well, we meet regularly. I think our
13 objective is different. We're focused on one
14 organization and not thinking about establishing
15 methods that might affect the measurement of other
16 organizations' quality. But the regular meeting
17 part I think is similar.

18 Q. Right.

19 And you are constantly kind of
20 recalibrating to improve hospital quality and
21 patient safety for Robert Packer; is that a fair
22 assessment?

23 A. Well, I think it's a fair assessment of
24 what Robert Packer's management is doing. They're
25 trying to measure, identify opportunities, improve.

1 We as the board are really observing the data,
2 asking questions, providing advice, but they're full
3 time thinking about how they can make quality
4 better.

5 Q. And is that because quality and patient
6 safety are important to hospitals?

7 A. Of course. It's important to hospitals
8 because it's important to patients.

9 Q. I think you told me this, but can you
10 explain to me again, why in your counter-analysis,
11 you assign the median -- or I'm sorry -- the mean
12 score for seven measures instead of just the four?

13 A. Sure. Because I'm analyzing a
14 counterfactual, a situation where hospitals that in
15 the actual world did not respond to the survey do
16 choose in fact to respond. And if they respond to
17 the survey, they're going to respond to all of the
18 questions on the survey, not just the four imputed
19 variables, but all seven of those variables. So as
20 responders, they'll be then given a score for all
21 seven of those.

22 Q. Would you have an issue with the Leapfrog
23 methodology if it had remained the same as it was in
24 spring of 2024?

25 MR. HVIDT: Objection to form, asked and

1 answered.

2 A. So as I mentioned, I think it's -- Prior
3 to fall of 2024, there was still the problematic
4 inconsistency that the responders were scored on all
5 22 variables and the nonresponders on 19 of the 22.
6 So that's an inconsistency between how hospitals are
7 being treated that I found problematic. And then,
8 another possible -- another issue is this question
9 about the NHSN versus the CMS, and then I think I've
10 also talked about the subjectivity of some of those
11 responses with the lack of structure on how
12 respondents should be responding to each question.

13 BY MS. BLAIR:

14 Q. So to ask it another way, is it -- do you
15 have an opinion about whether or not the spring 2024
16 methodology departed from what you called "the
17 guiding principles" for this type of methodology?

18 A. I do think there instances where it did
19 depart. It created inconsistencies between
20 hospitals, and it wasn't conforming to those
21 principles as closely as it could have.

22 Q. And your counterfactual, while it includes
23 seven of the -- adding a mean score for seven of the
24 measures, it still does not account for the use of
25 NHSN data for participating hospitals and CMS data

1 for nonparticipating hospitals on the remainder of
2 the five measures, correct?

3 MR. HVIDT: Objection to form, asked and
4 answered.

5 A. That's correct. I'm simulating a
6 counterfactual where the values for the seven
7 variables change. But I'm holding everything else
8 fixed, including those five variables where there's
9 a different source and a different time period.

10 BY MS. BLAIR:

11 Q. Mr. Rule's counterfactual, if he calls it
12 that, I don't know -- held everything the same,
13 including nonscoring the seven measures, and just
14 took out the four measures, correct?

15 A. Well, he begins from a situation where
16 three of the subjective measures aren't being scored
17 for the nonrespondents. And then he, instead of
18 imputing -- maybe he has it two ways. But at least
19 one way, he just reassigns the weights from those
20 seven variables to the remaining 15 variables. So
21 he was not assigning a value at all for the four,
22 and never was for the other three.

23 Q. So he -- his counterfactual -- in his
24 counterfactual, two things remained the same, which
25 is the use of CMS data for the five measures and no

1 scoring for three of the measures. And in your
2 counterfactual, only one thing stays the same, that
3 being the use of CMS data for nonparticipating
4 hospitals versus the use of NHSN data for
5 participating hospitals, correct?

6 MR. HVIDT: Objection to form.

7 A. That's certainly not a reason to prefer
8 his method to my method.

9 BY MS. BLAIR:

10 Q. No, no, I'm not saying it is. I'm just
11 asking, is that a fair assessment of what's
12 happening?

13 A. Maybe you could say it one more time or we
14 could read it back.

15 Q. And not all of the questions are winners,
16 Doctor, I apologize. I'm trying -- I'm not an
17 economist.

18 So as I understand, you kept the NHSN
19 versus CMS data the same for five of the measures,
20 correct?

21 A. Yes, as does he.

22 Q. As does he.

23 You -- for three of the measures that were
24 declined to respond previously, you filled those in,
25 you changed that, correct?

1 A. Consistent with simulating response by the
2 nonrespondents.

3 Q. Correct.

4 And Mark Rule, he leaves that the same,
5 correct?

6 A. Correct.

7 Q. So he leaves two things the same. You
8 only leave one thing the same; is that a fair
9 assessment?

10 A. Yes. I still think my counterfactual is
11 more informative.

12 Q. You wouldn't be here if you didn't.

13 MR. HVIDT: If you're changing topics
14 would now be a good time to take a break?

15 MS. BLAIR: I think so. Let's take five,
16 ten minutes. That's fine.

17 THE VIDEOGRAPHER: 2:46 p.m. Off the
18 record.

19 (Recess.)

20 THE VIDEOGRAPHER: 3:03 p.m. Back on the
21 record.

22 BY MS. BLAIR:

23 Q. Dr. Nicholson, so we -- right before the
24 break, we talked a little bit about your opinions
25 that participating hospitals unnecessarily

1 receive -- or that's a terrible word.

2 Right before the break, we were talking
3 about the opinions that you believe that hospitals
4 that do participate in the survey get inflated
5 grades under the Leapfrog methodology, correct?

6 MR. HVIDT: Objection, form.

7 A. Yes.

8 BY MS. BLAIR:

9 Q. And you have an opinion as well. and I
10 think it starts at paragraph 61 of your report, just
11 to kind of orient you to where we are, that the
12 opposite is true for nonparticipating hospitals.
13 That the -- and you say here on the second line:

14 "TLG's methodology does in fact
15 automatically penalize hospitals that do not respond
16 to the survey by inappropriately deflating those
17 hospitals' grades."

18 Do you see that?

19 A. Yes.

20 Q. And you go on to say:

21 "This occurs primarily through TLG's
22 imputation model adopted in the fall of 2024, as
23 discussed in Section IX," correct?

24 A. Yes.

25 Q. It goes on.

1 Are you aware that there are in fact
2 hospitals that don't participate in the survey that
3 receive an A?

4 A. I do think that there are a handful of
5 those, yes.

6 Q. And so if not participating in the survey
7 automatically lowers your grade, how could they
8 still receive an A?

9 A. Well, because there are more variables
10 than just those four.

11 Q. Okay. So while your score may be impacted
12 by imputed measures, the grade itself is not
13 necessarily impacted by the imputed measures; is
14 that a fair statement?

15 A. Sure. It depends on -- but directionally,
16 it always pushes a hospital's score down. But yes,
17 it depends on the other -- the values of the other
18 variables that remain in the model.

19 Q. So for example, if you have high scores on
20 the CMS data that is part of the Leapfrog hospital
21 safety grade, that could counteract any of the
22 limited achievement scores that a nonparticipating
23 hospital may earn for the four, what we call,
24 "imputed metrics," correct?

25 A. Yes, it's possible. It makes it very

1 difficult given that there's 24 percent of the
2 weight is on those four variables. And as I show
3 it -- it doesn't occur in Florida, at least in
4 spring of 2025, but I am aware that nationally this
5 can happen.

6 Q. And are you aware that in Florida for
7 spring of 2025, there were only ten hospitals in
8 South Florida that didn't participate in the survey?

9 A. Sitting here I can't recall the number.

10 Q. Did you see that in Dr. Harris' report?

11 A. I don't recall seeing it. I know he has a
12 figure where he -- well, I guess I just don't recall
13 seeing it.

14 Q. Okay. But you understand of -- if I'm
15 right -- I don't want to put words in your mouth --
16 that there are ten hospitals in South Florida that
17 didn't respond to the Leapfrog survey, you
18 understand that these would be five of those
19 hospitals, correct?

20 A. Yes, if the ten is correct. And you're
21 saying for South Florida, not all of Florida versus
22 South Florida.

23 Q. I'm saying all of Florida. It's all of
24 Florida, I apologize. I'll restate any question.

25 Do you understand that for the entire

1 state of Florida, there are only ten hospitals that
2 did not participate in the Leapfrog hospital survey?

3 A. Yes. I cannot recall the number.

4 Q. And so you didn't do any analysis about
5 how these five nonreporting hospitals compared to
6 the other five nonreporting hospitals in terms of
7 their safety grade?

8 MR. HVIDT: Objection to form.

9 A. I did not. That was not necessary for me
10 to conduct.

11 BY MS. BLAIR:

12 Q. Did you do any analysis to determine
13 whether or not -- well, strike that.

14 I want to bring your attention to
15 paragraph 62 of your opinion.

16 You say:

17 "The spring 2025 TLG grades for Florida
18 hospitals demonstrate the marked difference in
19 grades between participating and nonparticipating
20 hospitals."

21 Do you see that?

22 A. Yes.

23 Q. But you did not do any analysis between
24 the nonparticipating hospitals and how they fared as
25 compared to each other in Florida, correct?

1 A. Do you mean among those that did not
2 participate? A comparison of the quality of those
3 who did not participate?

4 Q. Correct.

5 A. No, that was not necessary for my analysis
6 for my assignment.

7 Q. And you say here, and this is the same
8 paragraph:

9 "Moreover, the majority of these Florida
10 hospitals that received a grade of A or B from TLG
11 received CMS overall hospital's quality star ratings
12 below the national average of 3.1 stars out of 5."

13 Do you see that?

14 A. Yes.

15 Q. Do you have an understanding that these
16 five hospitals have a 1 or 2 star CMS rating for
17 spring of 2025?

18 A. Yes. That is my understanding. I'm
19 sorry, you mean the Plaintiff?

20 Q. Yes. The five Plaintiff Hospitals. I
21 apologize. You understand that their CMS scores are
22 1 for most of them and a 2 for one of them?

23 A. Yes. That's my understanding.

24 Q. I think I asked you this before, so I'm
25 sure I'll get an objection and I apologize.

1 You did no review of the actual CMS data
2 for the outcome measures for these five Plaintiff
3 Hospitals; did you?

4 MR. HVIDT: Just because you said so,
5 objection, form, asked and answered.

6 A. I guess I'm not sure what you mean by
7 "analysis." Are you talking about the inputs?

8 BY MS. BLAIR:

9 Q. Yes.

10 A. No. I can observe -- I can observe what
11 Plaintiff Hospitals either submitted or have been
12 scored by CMS. But I didn't analyze the inputs.

13 Q. And you say at paragraph 63:

14 "Even prior to adopting this imputation
15 model in the fall of 2024, TLG's methodology
16 penalized nonparticipating hospitals."

17 Do you see that?

18 A. Yes.

19 Q. And I know it goes on to tell me how, but
20 can you tell me how in your own words?

21 MR. HVIDT: Objection, form, asked and
22 answered.

23 A. Sure. So at one point for one of the TLG
24 variables, responding hospitals had a scale, I think
25 it was zero to 100. So maximum value would be 100,

1 minimum would be zero. And then, for the
2 respondents, the secondary data source had a lower
3 maximum value. So there was no way for a
4 nonresponding hospital to be given an imputed value
5 that was as high as the...

6 BY MS. BLAIR:

7 Q. As I read your paragraph 63, you're
8 referring to two methodologies prior to fall of 2024
9 because you're referring here to the methodology in
10 which Leapfrog at that point in time in history, had
11 access to AHA surveys, correct?

12 A. Yes, that's right. And I'm clear about
13 the timing here in the report.

14 Q. Okay. And so when you say, at the
15 beginning of paragraph 63, that even prior to
16 adopting this imputation model in the fall of 2024,
17 you're referring to two methodologies ago where
18 Leapfrog was using the AHA data and not the spring
19 2024 methodology where Leapfrog was imputing the
20 cohort median for nonparticipating hospitals on
21 those four measures, correct?

22 MR. HVIDT: Objection, form.

23 A. That's right. I don't know if it's
24 exactly two, but it's at least two.

25

1 BY MS. BLAIR:

2 Q. At least two.

3 A. Yes.

4 Q. And then on paragraph 64 again, you refer
5 to the Hwang article, correct, from 2014?

6 A. Yes.

7 Q. And again, in two thousand -- do you know
8 in 2014 whether the imputation model in effect was
9 the imputation model that used the AHA data?

10 A. I don't recall. I mean, the article was
11 published in 2014. The data that they're analyzing
12 could have been a year prior to that. So I can't
13 recall.

14 Q. Okay. So we don't know as we sit here, at
15 least today on September 8, 2025, whether the Hwang
16 article was using Leapfrog methodology that
17 discussed the AHA imputation model or a different
18 methodology, correct?

19 A. That's right. My main conclusion from
20 this is an observation on whether there's a
21 difference between the hospitals that are responding
22 to the TLG survey versus those that are not, which
23 does not depend on the use of the AHA data.

24 Q. It depends on what?

25 A. It depends on the characteristics of the

1 hospitals that choose to respond versus those that
2 choose not to respond.

3 Q. Do you know what the characteristic
4 differences are between hospitals that choose to
5 respond and hospitals that don't respond?

6 A. Well, I mentioned a couple of ways of
7 looking at that. The Hwang construct is, and this
8 is really their premise, but if they start with 35
9 hospitals that are all U.S. News top hospitals, then
10 they're all presumed to be high quality. And yet,
11 what they're finding is that half of them did
12 respond and half of them didn't respond.

13 And then, the Smith article is more
14 explicit. It has -- for nonrespondents and
15 respondents it has access to some of the same
16 quality measures, and so it's able to compare the
17 quality levels for some measures for the respondents
18 to the TLG survey and the nonrespondents, and
19 concludes that there's no statistical difference.

20 Q. Would agree with me that U.S. News and
21 World Report is analyzing something different than
22 what Leapfrog is analyzing when it puts out its
23 ratings?

24 A. Sure. It has a different method.

25 Q. And it's -- as I understand it, it's not

1 specific to patient safety, the U.S. News and World
2 Report rankings; is that true?

3 A. That is my understanding. I don't have a
4 perfect recollection of the method but certainly
5 they rely on surveying people and asking their
6 perceptions of other hospitals.

7 Q. And so to just round out your
8 counter-analysis, it is based on the assumption that
9 nonparticipating hospitals would respond similarly
10 to the seven survey questions as those hospitals
11 that did respond, correct?

12 A. Yes.

13 Q. Can you talk to me just briefly about how
14 you recalculated -- well, did you recalculate the
15 measure weights in your analysis?

16 A. No. In the -- well, so in the
17 counterfactual analysis, the hospitals that did not
18 respond in the actual world respond, and so there's
19 a value for all 22 variables. And I used the
20 weights for each of those 22 as specified by the
21 Leapfrog Group.

22 Q. And did you -- in doing that
23 counterfactual analysis, did you just use the
24 Leapfrog calculator and put in those scores and it
25 recalculates?

1 MR. HVIDT: Objection to form.

2 A. It should produce the same. But no, we
3 did it in Excel or R, the calculations.

4 BY MS. BLAIR:

5 Q. And so do you understand that all of the
6 hospitals are provided -- whether you participate or
7 not in the survey, are provided a calculator by
8 Leapfrog that they can put in their scores and sort
9 of estimate what their ultimate rate is going to be
10 before the grades come out.

11 Do you understand that's something that
12 Leapfrog does for hospitals?

13 A. Yes. I guess I can't recall if the
14 cutoffs have already been established for the grades
15 or maybe the prior cutoffs are used. But yes, I
16 understand that's a feature.

17 Q. And did you have access to the calculator,
18 I'm going to call it, that any one of these five
19 hospitals would have received for let's just say,
20 the spring 2025, grading period?

21 A. I mean, I did the analysis in either Excel
22 or R, but implementing the method as it's supposed
23 to be implemented. So I didn't use that calculator.
24 I'm aware that it exists.

25 Q. And I'm only asking because I

1 understand -- whether I know what I'm talking about
2 is a whole different story. But I understand that
3 the SAS code that is embedded in that calculator is
4 not otherwise available. But you were able to
5 reverse engineer that?

6 A. You can -- one can, from the description
7 of the TLG methodology, write computer code with --
8 that takes the raw data from discovery and
9 calculates the overall Z-score and then you just
10 know the grade cutoffs and you can determine the
11 grades.

12 Q. Oh, okay. And is that how you did it
13 then?

14 A. That's right.

15 Q. Okay. I didn't understand that. Thank
16 you.

17 So you didn't use the calculator that the
18 hospitals would have had. You just recreated the
19 math based on the methodology itself?

20 A. That's right.

21 Q. And so because you used all 22 measures in
22 your calculation, there was no need to redistribute
23 the weights?

24 A. That's correct.

25 MR. HVIDT: Objection to form of the prior

1 question, just thinking back through that.

2 MS. BLAIR: Okay.

3 BY MS. BLAIR:

4 Q. When you reran that calculation in your R
5 file, did you have any issues with the weights or
6 the Z-scores in your calculation?

7 A. What do you mean by "issues"?

8 Q. I don't know.

9 A. No. There's -- there's a two-step
10 imputation process. So if step 1 was applied to a
11 hospital, then in the counterfactual I didn't change
12 it. I didn't override it with the mean of the
13 respondents.

14 Q. Okay.

15 A. So I wouldn't call that an issue but that
16 was just something that I had to be cognizant of.

17 Q. And if step 1 of the imputation model was
18 utilized, that data would necessarily be older than
19 CMS data being used by participating hospitals,
20 correct?

21 MR. HVIDT: Objection to the form.

22 A. Well, these are not CMS variables. These
23 would be the seven.

24 BY MS. BLAIR:

25 Q. Oh, I'm sorry, yes.

1 A. The seven software program variable.

2 Q. You're absolutely right. Let me ask it
3 again.

4 So you understand that step 1 of the
5 imputation model, used -- will use reported data
6 from that hospital from one or two cycles in the
7 past if they are currently not reporting, correct?

8 A. Yes, correct.

9 Q. And if a hospital is currently reporting,
10 the data that's being used is current data that was
11 freshly reported by that participating hospital,
12 correct?

13 A. Yes, correct.

14 Q. So it could be the case, by using the
15 step 1 imputation, that data would be older for a
16 nonparticipating hospital than the data that's
17 utilized for a participating hospital on that
18 measure, correct?

19 A. That's right. In the note to Exhibit 5 I
20 indicate the number of hospitals for whom that's
21 relevant. It's a relatively small number at the
22 very bottom of that note, on page 38.

23 Q. I see it, yes.

24 And do you understand -- do you have any
25 understanding that -- well, strike that.

1 In anything that you reviewed in preparing
2 your opinion, did you see a reason why these five
3 hospitals chose not to report on the Leapfrog
4 hospital survey?

5 A. I just can't recall if there were
6 documents where they discussed the burden. I just
7 can't recall.

8 Q. Do you have any recollection of seeing any
9 documents where these hospitals were told by Tenet
10 Healthcare, on a system-wide basis, that the
11 hospitals were not to participate in the survey
12 unless it was directly linked to payment or
13 contracts?

14 A. I don't recall seeing anything to that
15 effect.

16 Q. But you did have access to all of the
17 documents that were produced in the litigation, at
18 least as of August 7, 2025, correct?

19 A. That's correct. I think there were still
20 some documents that we had not fully processed.

21 Q. I want to go back up in your report and
22 talk about your opinions related to the impact the
23 Leapfrog hospital safety grades has on these five
24 hospitals. You have an opinion about that, correct,
25 Dr. Nicholson?

1 A. Yes, the likely impact.

2 Q. Yes. And I think that's on page -- you
3 tell me -- but I think that starts on page 15 of
4 your report at Roman numeral 8, right before
5 paragraph 31.

6 A. Yes, that's correct.

7 Q. And can you just, in your own words, tell
8 me, again probably, what your opinion is about the
9 likely impact that the Leapfrog hospital safety
10 grade has on these five hospitals?

11 A. Sure. So based on my review of the
12 literature, there is -- there's evidence that when
13 hospital -- I'll use it broadly -- quality measures
14 are reported, and the studies look at different
15 types of reports, U.S. News and World Reports, CMS
16 measures, report cards, that the empirical evidence
17 is that the hospitals that do well tend to gain
18 patients. The hospitals that to poorly on those
19 reported measures tend to lose patients.

20 So it's consistent with patients, or
21 people making decisions on behalf of patients, are
22 responding to the reported quality measures.

23 Q. Is that the only factor that goes into
24 whether or not patients go to a specific hospital?

25 A. No, I certainly wouldn't believe that to

1 be the case. And I think the studies that I'm
2 referring to are looking at the impact of reported
3 quality holding other things fixed, including other
4 things that influence patient decisions. So the
5 studies are trying to isolate just the incremental
6 impact of the reporting, beyond the other factors
7 that matter.

8 Q. Have you authored any articles on the
9 impact of hospital ratings on consumer behavior?

10 A. I don't think so. I discussed earlier
11 today, and I discussed in the report, some of the
12 work that I've done on quality measurement. I don't
13 believe any of those articles are looking at the way
14 that those measures might be impacting decisions.

15 Q. Have you reviewed any articles drafted by
16 Patrick Romano, on the impact of hospital ratings on
17 consumer behavior?

18 A. I don't believe so.

19 Q. Would you agree that it's possible to
20 measure statistically significant events in terms of
21 the impact of hospital safety grades on consumer
22 behavior, but generally speaking those effects tend
23 to be short-lived. Have you seen any research in
24 that regard?

25 A. I can't recall -- I can't recall -- the

1 studies that I cite, sitting here I just can't
2 recall the time period over which they analyzed the
3 impact and whether the impacts diminished or went to
4 zero.

5 Q. And even if there's an impact, do you know
6 of any research that's concluded that the impact of
7 a hospital safety grade is statistically
8 significant -- has a statistically significant
9 effect on consumer behavior?

10 A. Well, I think at least three of the
11 articles that I cited, the effects that they find
12 are statistically significant.

13 Q. And which three articles?

14 A. So I'm thinking of the -- I'm looking on
15 page 16.

16 Q. Okay.

17 A. So among others, but the three that I'm
18 thinking of are the Cutler article in footnote 35,
19 the Pope article in footnote 37, and the Chandra, et
20 al., article in footnote 39.

21 Q. Okay. And if we look at the Cutler
22 article, that is an analysis of publicly reported
23 outcomes in cardiac surgery, correct?

24 A. Yes, correct.

25 Q. Was that a hospital ratings -- an article

1 that was evaluating hospital ratings?

2 A. I believe it was a cardiovascular surgeon
3 ratings, I'd have to refresh my memory. But that's
4 my recollection. It's Pennsylvania -- I'm sorry --
5 New York measuring at the level of the surgeon,
6 surgeon quality.

7 Q. Okay. And so that wasn't -- I agree with
8 you. And that was not, though, with respect to the
9 hospital rating, an effect on a consumer going to a
10 hospital, correct?

11 A. I believe so. I would have to go back and
12 look at whether the quantity or the volume effect
13 was measured at the level of the surgeon or was it
14 aggregated to the hospital in which the surgeon
15 practiced. I just can't recall.

16 Q. Okay. And what about the Pope article,
17 which is entitled, "Reacting to Rankings: Evidence
18 from 'America's Best Hospitals.'"

19 What do you recall that article being
20 about?

21 A. So that is at the level of the hospital.
22 So it's looking at the impact of patient volume
23 subsequent to hospitals. And I think it even looks
24 at it by service line after hospitals either score
25 well or not so well on the U.S. News and World

1 Report study.

2 Q. And we talked a lot about today already
3 that U.S. News and World Report measures something
4 different than the patient safety measure that
5 Leapfrog is measuring, correct?

6 A. That's right. They have their own
7 customized, individualized method.

8 Q. Is it your position that -- well, you
9 don't opine that it is the Leapfrog hospital safety
10 grade that's causing better outcomes, are you? In
11 other words, it's not -- the inverse isn't true,
12 that if a hospital gets an A it's going to provide
13 better outcomes just because it has an A, correct?
14 Isn't it really that because it has better outcomes
15 it has an A?

16 MR. HVIDT: Objection, form.

17 MS. BLAIR: That's a great objection.
18 It's a very confusing question.

19 MR. HVIDT: I decided not to go into all
20 of the forms.

21 A. I mean, the latter is what one would hope
22 comes from a well constructed safety and quality
23 measurement system is that the data determines what
24 the appropriate grade is. But then the grade
25 predicts better outcomes, so the outcomes of A grade

1 hospitals are better than B, better than C, and so
2 forth.

3 BY MS. BLAIR:

4 Q. And when you talk about the impact of
5 hospital ratings on consumer choice, is that also
6 true with respect to the impact of a CMS star rating
7 that that would also have an impact on consumer
8 behavior?

9 A. It certainly would, consistent with the
10 literature, it would be expected to. And the
11 Chandra, et al., it's not -- it's not looking at the
12 CMS star rating in the sense of an aggregate of 45
13 different measures. But it's looking at, I believe,
14 a risk-adjusted mortality, CMS measure, and
15 readmission rates as an indicator of quality. And
16 then, it's performing the analysis for several
17 different service lines, you know, cardiovascular
18 surgery, cardiology, pneumonia.

19 Q. Right. And that's your footnote 39, the
20 Chandra article which is titled, "Health Care
21 Exceptionalism, question mark, Performance and
22 Allocation in the U.S. Health Care Sector."

23 A. Yes. That's right. So it's not -- it's
24 not the CMS star rating but it's components of it.

25 Q. Okay. And so while your heading for --

1 your heading for Roman Numeral 8, "Hospital Ratings
2 Influence Patient Decisions," that is not limited to
3 the Leapfrog ratings as I understand it. It would
4 be any hospital rating could have influence -- or
5 could influence patient decisions about medical
6 care?

7 A. That's right. I think the fact that
8 economists have found an impact across different
9 measures, at least to me, would strengthen that
10 patient decisions can be affected by them because
11 it's not specific to one particular measurement
12 system.

13 Q. And that would go both ways. So if you
14 have a better grade you're seeing an increase in
15 patient volume. And if you have lower grade you're
16 seeing a decrease in patient volume?

17 A. That's right.

18 Q. And as an economist, would that translate
19 into increased revenues or increased patient volume?

20 MR. HVIDT: Objection, form.

21 A. Certainly under most methods of
22 reimbursement, hospitals that see more patients
23 generate more revenue. And there can be situations
24 where that's not true. But at least for fee for
25 service, which would have been in place at the time

1 of these studies, yes, would be higher revenues.

2 BY MS. BLAIR:

3 Q. Okay. So looking at the change in
4 revenue, whether it's up or down, would be an
5 indicator, at least one indicator, of whether or not
6 there was in fact an impact on a hospital from a
7 safety grade?

8 A. Yes. But you would have to at least, that
9 is, try -- try to isolate the impact of the quality
10 reporting from other things that could be affecting,
11 say, hospital revenues.

12 Q. Like patient satisfaction could impact
13 patient volume in a hospital, correct?

14 A. Sure, or just demographic trends or
15 hospital closures, things like that.

16 Q. Or we say hospital closures or if more
17 hospitals enter a market, that could have an impact
18 on patient volume as well, if there's more choices
19 for patients to choose from, correct?

20 A. Sure. That's why, if a study is well
21 done, it finds a method to hone in on the impact of
22 the rating grade disclosure relative to other things
23 it might affect, patient volume or hospital revenue.

24 Q. Are you aware of any studies that hone in
25 on whether or not a Leapfrog safety grade impacts

1 patient volume for a hospital?

2 A. I'm not aware of anything in the published
3 literature. Again, nothing that I've seen.

4 Q. Are you aware -- did you tell me you read
5 Mr. Chakurda's report, expert report?

6 A. I did not.

7 Q. Oh, okay.

8 Do you have any understanding of how
9 competitive South Florida is in terms of the
10 healthcare market?

11 A. I haven't studied it. I haven't measured
12 it.

13 Q. In paragraph 35, you talk about the travel
14 that patients might have to undergo because of these
15 Leapfrog safety grades, correct?

16 A. Yes.

17 Q. Do you have any understanding of the fact
18 that hospitals must go to the closest hospital --
19 ambulances must go to the closest hospital when
20 picking up a patient?

21 MR. HVIDT: Objection, form.

22 A. Yes, I believe I discuss that in this
23 section.

24 BY MS. BLAIR:

25 Q. And so when you're talking about traveling

1 you're talking about elective procedures; is that
2 what you're referring to?

3 A. That's right.

4 Q. Do you have any understanding of whether
5 or not the South Florida demographic is a mobile
6 demographic? And by that I mean going between
7 Florida and perhaps New York or being snowbirds in
8 that area? Do you have any understanding of the
9 demographics?

10 A. Well, I haven't quantified it or studied
11 it, but certainly I'm aware that there are people
12 who spend a good chunk of the year in Florida and
13 then the rest of the year in a northern state, but I
14 don't know what percentage of people.

15 Q. And do you have any understanding of
16 whether or not that sort of snowbird mentality
17 affects where they might have elective surgeries,
18 Florida versus New York, let's say? Have you looked
19 into that?

20 A. No, I have not.

21 Q. In Paragraph 38, you talk about Leapfrog's
22 poor ratings have caused a drop in outpatient visits
23 and surgeries, as well as recruitment challenges.

24 Do you see that?

25 And I'm referring to the bottom of that

1 paragraph on page 20.

2 A. Yes, I cite to a Hibbard study.

3 (Reporter clarification request.)

4 BY MS. BLAIR:

5 Q. And that's your footnote 61 through 64?

6 A. Yes, that's correct.

7 Q. I'm referring, though, to that last
8 sentence that starts:

9 "Indeed, I understand that chief executive
10 officers of Plaintiff Hospitals have noted that
11 their hospitals have suffered substantial
12 reputational harm as a result of the poor grades
13 they were signed by TLG, and that reputational harm
14 has been accompanied by a decline in total
15 outpatient visits, referred outpatient visits, and
16 outpatient surgeries as well as recruitment
17 challenges and worsened relationships with
18 physicians."

19 Do you see that?

20 A. Yes, I do.

21 Q. What documents did you review to -- other
22 than the declarations of the five CEOs, did you
23 review any documents to substantiate that in fact
24 there has been substantial reputational harm from
25 the TLG grades?

1 A. Are you asking specifically about the five
2 Plaintiff Hospitals?

3 Q. Yes. I understand that footnote 65 refers
4 to the declarations -- interrogatory answers in the
5 declarations of these five CEOs. And so my question
6 is, when you wrote this sentence in your opinion
7 about these five Plaintiff Hospitals suffering
8 substantial reputational harm as a result of the
9 poor grades assigned by TLG, did you see any
10 specific documentation other than interrogatory
11 answers or declarations to substantiate that fact?

12 MR. HVIDT: Objection, form,
13 mischaracterizes footnote.

14 A. I didn't conduct any independent analysis.
15 The information from those declarations is
16 consistent with the studies that I cited earlier in
17 that section that we discussed, but I didn't conduct
18 any independent analyses.

19 BY MS. BLAIR:

20 Q. And in all of the documents that you had
21 access to as of August 7, 2025, did you see any
22 documents in there that substantiated a decline in
23 total outpatient visits?

24 A. I can't recall something specifically on
25 total outpatient visits. I know there's at least

1 some email correspondence where somebody was
2 mentioning decline in volume. I don't know whether
3 it was outpatient or inpatient.

4 Q. Did you see any specific documents that
5 referenced a decline in referred outpatient visits
6 at any of the five hospitals?

7 A. I don't recall seeing anything beyond the
8 declarations that I cited here.

9 Q. Okay. And same question with respect to
10 outpatient surgeries. Any documents that you
11 reviewed other than the declarations you cite there?

12 A. No, I didn't do any other independent
13 analysis.

14 Q. And then last, recruitment challenges.
15 Have you seen any documentation that suggests that
16 any of these five hospitals are having difficulty
17 recruiting nurses or other staff based on the
18 Leapfrog safety grades?

19 A. No. It was not part of my assignment. I
20 did not look at that independently.

21 Q. In your work as a healthcare economist,
22 and a board member on several different health
23 system boards, what is your opinion of the
24 prevalence of consumers knowing about Leapfrog?

25 A. Well, I certainly haven't -- I haven't

1 studied it. I haven't quantified it. I would think
2 it would be better known amongst board members than
3 the layperson. And certainly people who've followed
4 the healthcare industry are aware that -- of what
5 Leapfrog does. Professors would know. The lay
6 public I just don't know.

7 Q. So going back to that sentence that
8 started "indeed," on 38, page -- Paragraph 38
9 page 20.

10 A. (Witness comply.)

11 Q. It starts off by saying:

12 "I understand that chief executive
13 officers of the Plaintiff Hospitals have noted that
14 their hospitals have suffered reputational harm as a
15 result of the poor grades they were assigned by
16 TLG."

17 And then, you go on to say -- and I'm just
18 curious whether you chose these words carefully or
19 not. You go on to say:

20 "And that reputational harm has been
21 accompanied by a decline."

22 Do you see that word "been accompanied
23 by"?

24 A. Yes.

25 Q. Did you use that wording in order to stay

1 away from any causal link between the grades
2 themselves and the alleged reputational harm?

3 A. Well, I certainly am not asserting a
4 causal conclusion because I didn't perform the
5 causal analysis. So I think I was using my words
6 intentionally.

7 Q. And just to round this out, you're not
8 offering any opinions today about the quantification
9 of reputational harm to the Plaintiffs, correct?

10 A. I am not, correct.

11 Q. How long have you served on the board of
12 Atlantic Health System?

13 A. Since 2018.

14 Q. And how many hospitals make up Atlantic
15 Health System?

16 A. Currently six. I think when I joined it
17 was five.

18 Q. Do you serve on any committees for
19 Atlantic Health System?

20 A. I serve on the medical staff and
21 leadership committee, and the governance committee.

22 Q. Is there a quality oversight committee?

23 A. I think it's just called the quality
24 committee. There is a quality focus committee.

25 Q. And you don't sit on that committee?

1 A. I do not.

2 Q. Have you ever?

3 A. No.

4 Q. Is there six hospitals or seven?

5 A. In my -- it's either six or seven.

6 There's one more now than there used to be.

7 CentraState is the newest addition.

8 Q. Okay. CentraState?

9 A. Centra.

10 Q. Oh, CentraState. Okay.

11 And one of those hospitals is a

12 children's hospital, correct?

13 A. I don't think so. For Atlantic Health
14 System, I don't think so.

15 Q. Oh, no. I'm sorry. I made that up.
16 Sorry.

17 I went back and looked up -- well, let me
18 ask you this. Here are the hospitals I believe make
19 up Atlantic Health System, and you tell me if I'm
20 right. Morristown Medical Center, is that one of
21 your hospitals?

22 A. Yes.

23 Q. Overlook Medical Center?

24 A. Yes.

25 Q. CentraState Medical Center?

1 A. Yes.

2 Q. Hackettstown Medical Center?

3 A. Yes.

4 Q. Newton Medical Center?

5 A. Yes.

6 Q. Chilton Medical Center?

7 A. Yes.

8 Q. And Atlantic General Hospitals or
9 Hospital?

10 A. I think Atlantic General Hospital might be
11 like a subsidiary.

12 Q. Well, it does the Leapfrog hospital survey
13 so I'm curious. You don't know?

14 A. I don't believe it's -- it's a distinct
15 hospital.

16 Q. Okay.

17 A. Yeah, it's possible it's some aggregation
18 of something.

19 Q. I did go, in preparation for your
20 deposition today, and looked up each one of these
21 hospitals, and every one, including Atlantic General
22 Hospital, participated in the Leapfrog survey for
23 many years. And my question is, in your capacity as
24 a board member for Atlantic Health System, do you
25 recall having any discussions at the system level

1 about the value of engaging in the Leapfrog hospital
2 survey?

3 A. No. I don't recall that ever rising to
4 the level of being on the board's agenda.

5 Q. Does anybody ever talk about, at these
6 board meetings for Atlantic healthcare, the grades
7 that these hospitals are getting?

8 A. It's not -- it's possible. It's not on
9 the dashboard, I think I'm pretty sure about that.
10 It could be part of say the CEO's report
11 occasionally. But I don't believe it's on the
12 dashboard, and I don't recall it coming up in a
13 substantial way at a meeting.

14 Q. Okay.

15 Do you have an opinion, as a board member
16 for Atlantic Health System, about participating in
17 the Leapfrog hospital survey?

18 A. That's, I think, something I personally as
19 a board member am content to let management make a
20 decision on. I don't think it's risen to the level
21 of the board either questioning whether we should or
22 shouldn't or questioning management's decision. I
23 just don't recall it coming up.

24 Q. Have there been any discussions at the
25 board level that you know about, about the onerous

1 nature of complying with the Leapfrog survey?

2 A. No. But as I said, I can't remember any
3 board time devoted to that issue at all so.

4 Q. Would it surprise you to know that four of
5 the hospitals at Atlantic Healthcare [sic] are
6 straight-A hospitals? Have received A's for a
7 significant period of time from Leapfrog?

8 A. No. It wouldn't surprise me. I know that
9 Morristown and Overlook consistently ranked in the
10 top 100 -- well, Morristown consistently in the top
11 100 U.S. News hospitals. And both Overlook and
12 Morristown consistently in the top New York City
13 area hospitals. So no, it wouldn't surprise me.
14 And I know on some of the dashboard measures, the
15 hospitals scored very well.

16 Q. And other of the hospitals in your system
17 score -- have scored a B for quite some time.
18 Again, does that surprise you in any way?

19 A. No, I think I'm fortunate to be a board
20 member at hospitals that, you know, are doing well
21 on that convention.

22 Q. Do you have any reason to believe that
23 these hospitals are assigning themselves the high
24 score for the seven measures that we've discussed
25 today?

1 A. Well, I think we've talked about the word
2 "assigning." But no, I don't know the particulars
3 about the way in which the hospitals are replying,
4 responding.

5 Q. Would you believe that these hospitals are
6 doing the survey and are transmitting accurate data
7 to Leapfrog in connection with this survey?

8 A. I would hope all hospitals are doing that.
9 I just worry when I see the distribution that
10 results, which is a very unusual statistical
11 distribution.

12 Q. Do you believe that the grades that are
13 received by the hospitals that are part of the
14 Atlantic Health System are overinflated?

15 A. I haven't studied it for those hospitals.

16 Q. Do you plan on expressing your concern
17 at -- to the Atlantic Health board that the grades
18 that your hospitals are receiving are overinflated
19 on the Leapfrog hospital safety grades?

20 MR. HVIDT: Objection to form.

21 A. No, I don't think that is an appropriate
22 thing for me to bring up. But if the conversation
23 comes up, I will weigh in as appropriate.

24 BY MS. BLAIR:

25 Q. Would it surprise you to know that

1 Atlantic Health has put out a press release
2 recently, May 1, 2025, entitled, "Three Atlantic
3 Health System Hospitals Earned 'A' Grades From
4 Leapfrog." And in part of that press release, they
5 say:

6 "The Leapfrog hospital safety grade stands
7 as the only hospital rating program focused solely
8 on preventable medical errors, infections, and
9 injuries, that kill more than 500 patients a day in
10 the United States. This program is peer-reviewed,
11 fully transparent, and free to the public. Grades
12 are updated twice annually, in the fall and the
13 spring."

14 Does that surprise you that a press
15 release was put out by Atlantic Healthcare in that
16 regard?

17 MR. HVIDT: Objection to form.

18 A. No. I think that can be a rational
19 response to receiving a high grade.

20 MS. BLAIR: I have no further questions.

21 MR. HVIDT: We'll reserve for trial.

22 MS. BLAIR: Excellent.

23 And on the record, I will order a rough.

24 MR. HVIDT: And may I also have a rough,
25 regular delivery for final.

1 MS. BLAIR: And I will also regular
2 delivery and Etran.

3 THE VIDEOGRAPHER: 3:55 p.m., off the
4 record.

5

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9 (Time noted: 3:55 p.m.)

10

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13

SEAN NICHOLSON, Ph.D.

14

15 Subscribed and sworn to

16 before me this day

17 of 2025.

18

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1 CERTIFICATE

2

3 STATE OF NEW YORK)

4 : ss

5 I, Angela M. Shaw-Crockett, a Certified Court
6 Reporter, Registered Merit Reporter and Notary Public within
7 and for the States of New York, New Jersey and Connecticut,
8 do hereby certify:

9 That SEAN NICHOLSON, Ph.D., the witness whose
10 deposition is herein before set forth, was duly sworn by me
11 and that such deposition is a true record of the testimony
12 given by such witness.

13 I further certify that I am not related to any of
14 the parties to this action by blood or marriage and that I
15 am in no way interested in the outcome of this matter.

16 In witness whereof, I have hereunto set my hand
17 this 18th day of September, 2025.

18

19 -----

ANGELA M. SHAW-CROCKETT, CCR, CRR, RMR, CSR

20 LICENSE NO. XI00218400

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1 NAME OF CASE: Good Samaritan Medical Center, Inc., et al.
v. The Leapfrog Group

2 DATE OF DEPOSITION: September 8, 2025

3 NAME OF WITNESS: Sean Nicholson, Ph.D.

4 Reason Codes:

5 1. To clarify the record.

2. To conform to the facts.

6 3. To correct transcription errors.

7 Page _____ Line _____ Reason _____

From _____ to _____

8

9 Page _____ Line _____ Reason _____

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10

11 Page _____ Line _____ Reason _____

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12

13 Page _____ Line _____ Reason _____

From _____ to _____

14

15 Page _____ Line _____ Reason _____

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17 Page _____ Line _____ Reason _____

From _____ to _____

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19 Page _____ Line _____ Reason _____

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21 Page _____ Line _____ Reason _____

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23

SEAN NICHOLSON, Ph.D.

24

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