UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION

COMMISSIONERS: **Deborah Platt Majoras, Chairman**
Pamela Jones Harbour
Jon Leibowitz
William E. Kovacic
J. Thomas Rosch

In the matter of	)	
	)	**Docket No. 9315**
Evanston Northwestern Healthcare Corporation,	)	
a corporation, and	)	**PUBLIC**
ENH Medical Group, Inc.,	)	
a corporation	)	

RESPONDENTS' RESPONSE TO COMPLAINT COUNSEL'S COMMENTS ON PROPOSED FINAL ORDER

With the exception of three discrete issues, the parties are substantially in agreement as to the content of the Proposed Order.[1] The three issues that remain are whether: (1) outpatient services should be included in separate contracting; (2) the term "payor" should include government entities such as Medicare and Medicaid; and (3) notification should be required of three representatives of each payor.

In an effort to simplify the review of ENH's Proposed Order and Complaint Counsel's Comments, Respondents have attached to this response a Revised Proposed Order which reflects ENH's original Proposed Order together with the edits agreed upon by the parties. *See* Revised Proposed Order, attached as Exhibit A.

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[1] Respondents disagree with Complaint Counsel's commentary to the extent it criticizes the Commission for failing to order divestiture. The Commission's Opinion correctly declined to order the divestiture of Highland Park Hospital and further commentary should not be permitted.

I. Outpatient Services Should Not Be Included In Separate Contracting

Complaint Counsel's attempt to include outpatient services within the scope of the Order contravenes Complaint Counsel's position throughout this litigation because outpatient services were not part of the relevant market in the Complaint, the Initial Decision, or the Commission's Opinion. *See* Comments at 6-7, 14. As the Commission stated, "we conclude that the evidence in the record establishes that the relevant product market is acute *inpatient* hospital services." Opinion at 55-57 (emphasis added); *see also* Respondents' Submission in Support at 2. Because the Commission found that the competitive harm occurred in a market consisting only of inpatient services, and not a market consisting of all hospital services, there is no reason to include outpatient services in the Order.

Complaint Counsel seeks to include outpatient services based on the rationale that separating the two types of services "ignores the reality of competitive negotiations for hospital services." Comments at 6-7. However, Complaint Counsel's current view on the link between inpatient and outpatient services is directly contradictory to its prior statements about the two types of services. *See* Complaint Counsel's Post Trial Reply Brief at 8 ("Prices for inpatient services are not restrained by outpatient prices. ENH and Highland Park set inpatient rates independent of their outpatient rates and without concern that patients would switch to outpatient services."); *see also* Complaint Counsel's Appeal Brief at 37 ("The relevant product market excludes outpatient services, which are provided not only by hospitals, but also by physician offices and outpatient clinics. Outpatient services are not a substitute for inpatient services.").

The proposed inclusion of outpatient services also conflicts with the Commission's Opinion which concluded that "ENH set inpatient rates independently of its outpatient rates." Opinion at 55. Accordingly, Respondents respectfully urge the Commission to issue a Final Order that is consistent with the inpatient product market that served as the basis for the Commission's Opinion. Respondents' Revised Proposed Order attached to this submission therefore does not include Complaint Counsel's proposed substitution of the term "Hospital Services" for the original term "Inpatient Services" included within ENH's Proposed Order.

II. The Definition Of Payor Should Exclude Government Payors

Complaint Counsel's apparent inclusion of government payors such as Medicare and Medicaid within the broad definition of the term "payor" is inconsistent with its theory of the case and the Commission's findings. *See* Comments at 5, 14. As the Commission stated, "[w]e do not discuss the Medicare and Medicaid systems further because Complaint Counsel did not allege that the merger increased prices paid by the Medicare and Medicaid programs." Opinion at 8.

ENH proposed a definition of the term "payor" that included the entities Complaint Counsel alleged were harmed in this case – commercial managed care organizations ("MCOs"). *See* Proposed Order at 2; *see also* Submission in Support at 2 (providing separate contracting for "services contracted through managed care organizations..."); *see also* Complaint at ¶16, 31. In fact, Respondents and Complaint Counsel jointly submitted an Amended Glossary of Terms ("Glossary") that commonly defined frequently used terminology. *See* Glossary, attached as Exhibit B. The Glossary contained a mutually agreed upon definition for the term MCO which did not encompass government payors. *See* Glossary at 8. Complaint Counsel provides no explanation why government payors – who were never alleged to be part of this case – should now be covered by the Final Order.

Although the parties proposed definitions of the term "payor" differed in other ways as well, Respondents accept the definition proposed by Complaint Counsel with the modification that government payors are expressly excluded. Respondents' Revised Proposed Order suggests potential language to effectuate this limitation. *See* Revised Proposed Order at 3, I.M.

III. Payor Notification Should Be Limited To One Representative

Complaint Counsel's proposed payor notification provision is inconsistent with the 2005 ENH Consent Order which required notification to one representative of each Payor (Chief Executive Officer) via first class mail with return receipt requested. *See* 2005 ENH Consent Order.[2] Complaint Counsel's proposed language requires notification to three representatives of each Payor (Chief Executive Officer, General Counsel, and Network Manager) by first class mail and email as well as requiring ENH to request return receipts. *See* Comments at 15.

The proposed notification provision raises concerns about ENH's ability, despite its best efforts, to locate the email addresses for the three required representatives from each Payor as well as its ability to obtain electronic return receipts. ENH believes it has been operating well under the 2005 Consent Order and would agree to utilize the same provision here. Further, ENH's pre-existing contracts contain notification clauses detailing the required notification methods in the event of a change affecting the contract. ENH would consent to language requiring notification pursuant to its current contractual obligations.

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[2] *See* Evanston Northwestern Healthcare Corporation and ENH Medical Group, Inc. Docket No. 9315 at V.A. (issued May 17, 2005), located at http://www.ftc.gov/os/adjpro/d9315/050520do.pdf.

In the event that the Commission adopts Complaint Counsel's proposed notification provision, ENH respectfully requests the inclusion of a "best efforts" clause in order to protect ENH from a finding of technical noncompliance with the Final Order due to acts beyond its control (e.g. the inability to locate unpublished or unavailable addresses, or the inability to obtain a return receipt).[3] Respondents' Revised Proposed Order suggests possible "best efforts" language to be included within the Final Order. *See* Revised Proposed Order at 5, V.A and V.B.

November 8, 2007

Respectfully submitted,

Duane M. Kelley by permission JMD

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[3] For example, ENH intends to request the required mailing and email addresses from payors, but is concerned about a technical violation where a payor is unwilling to provide such information which cannot reasonably be located through other means.

CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing document was served by delivering copies to:

Office of the Secretary
Federal Trade Commission
Room H-159
600 Pennsylvania Avenue, N.W.
Washington, D.C. 20580

Thomas H. Brock
Federal Trade Commission
601 New Jersey Ave., N.W.
Washington, D.C. 20580

Elizabeth A. Piotrowski
Federal Trade Commission
601 New Jersey Ave., N.W.
Washington, D.C. 20580

Dated: November 8, 2007

David E. Dahlquist/
by permission JMP

CHI:1999825.10

Exhibit
A

EXHIBIT A

UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION

COMMISSIONERS: **Deborah Platt Majoras, Chairman**
Pamela Jones Harbour
Jon Leibowitz
William E. Kovacic
J. Thomas Rosch

In the Matter of	)	
	)	
EVANSTON NORTHWESTERN HEALTHCARE CORPORATION,	)	
a corporation, and	)	**Docket No. 9315**
	)	
ENH MEDICAL GROUP, INC.	)	**PUBLIC**
a corporation.	)	
	)	

REVISED PROPOSED FINAL ORDER[1]

This matter having been heard by the Commission upon the respective submissions by the parties and for the reasons stated in the accompanying Opinion, the Commission hereby issues this Final Order. Accordingly,

I.

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

A. "Commission" means Federal Trade Commission.

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

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

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

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[1] Double Underline Edits are additions agreed upon by both Respondents and Complaint Counsel.
~~Line Edits~~ are deletions agreed upon by both Respondents and Complaint Counsel.
Italics Edits are proposed additions by Respondents.

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

F. ~~A.~~ "ENH" means Evanston Northwestern Healthcare Corporation, its officers, directors, employees, agents, representatives, successors, and assigns, subsidiaries, divisions, groups, and affiliates controlled by it, and the representative officers, directors, employees, agent, representatives, successors, and assigns of each.

G. ~~B.~~ "Highland Park Hospital," hereinafter referred to as Highland Park, means the hospital owned by ENH and located at 777 Park Avenue West, Highland Park, Illinois.

H. ~~C.~~ "Evanston Hospital," hereinafter referred to as Evanston, means Evanston Hospital and Glenbrook Hospital, hospitals owned by ENH and located at 2650 Ridge Avenue, Evanston, Illinois, and 2100 Pfingston Road, Glenview, Illinois, respectively.

I. ~~D.~~ "Respondent" means ENH.

J. ~~E.~~ "ENH Negotiating Team" means the team responsible for negotiating a Managed Care Contract for all services at Evanston as well as outpatient services for Highland Park when Payors elect separate negotiations, and for all services at all ENH hospitals when Payors do not elect separate negotiations. The ENH Negotiating Team will be separate and distinct from the Highland Park Negotiating Team. The ENH Negotiating Team shall consist of employees or advisors that report to the ENH Chief Operations Officer ("COO") and will be located at Evanston. The ENH COO is the authorized representative to execute and sign Managed Care Contracts negotiated by the ENH Negotiating Team.

K. ~~F.~~ "Highland Park Negotiating Team" means the distinct team that will be responsible for negotiating Managed Care Contracts for Inpatient Services at Highland Park Hospital and will be based in a different location than the ENH Negotiating Team. The Highland Park Negotiating Team shall consist of employees or advisors that report to the President of Highland Park Hospital. The President of Highland Park Hospital shall be the ENH-authorized representative to execute and sign managed care contracts for Inpatient Services for Highland Park Hospital. The Highland Park Negotiating Team may include a Third-Party Consultant.

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

~~H. "Payor" means a managed care company, its officers, directors, employees, agents, representatives, successors, and assigns, subsidiaries, divisions, groups, and affiliates controlled by it, and the representative officers, directors, employees, agent, representatives, successors, and assigns of each, that provides access to health care services on an insured, partially insured or a self-insured basis, including plans such as health maintenance organizations (HMO), preferred provider organizations (PPO), and point of service plans (POS). A Payor may be a licensed insurer, an administrative services organization, or both. The services may include network access and development, contract negotiation with providers, provider relations, medical and utilization management and claims administration. This definition specifically excludes all Federal, State and Local Government Payors (including Medicare, Medicaid, and Medicare benefits administered by Managed Care Payors, i.e., Medicare Advantage Plans), provider groups including but not limited to Home Health, Hospice Agencies, Independent Physicians Associations (IPA), ENH self-funded employee insurance plan and any employer direct agreement.~~

M. "Payor" means any Person, *except government payors,* that pays, or arranges for payment, for all or any part of any hospital services for itself or for any other Person. Payor includes any Person that develops, leases, or sells access to networks of Hospitals.

N. ~~I.~~ "Third Party Consultant" means an independent third party consultant that may be retained by ENH to assist the Highland Park Negotiating Team. The Third Party Consultant shall not be currently or previously affiliated with ENH, the Federal Trade Commission, or any Payor. The Third Party Consultant shall assist the Highland Park Negotiating Team with data analysis, contracting strategy, contract language, claims modeling, and any other activity reasonably related to the negotiation of Managed Care Contracts.

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

P. ~~K.~~ "~~Current~~Pre-existing Contract" means a Managed Care Contract between a Payor and ENH that is in effect ~~at~~on the ~~time of the entry of~~date this Order becomes final.

Q. ~~L.~~ "Inpatient Services" means general acute care inpatient hospital services which include a broad cluster of medical, surgical, diagnostic, treatment, and other services that are included as part of an admission of a patient to an inpatient bed within Evanston Hospital or Highland Park Hospital.

R. ~~M.~~ "Corporate Managed Care Department" means the department that will be responsible for Contract Administration for both Evanston and Highland Park. The Corporate Managed Care Department will report to the ENH Senior Vice President of Business Services and is currently located in Skokie, Illinois. The Managed Care Contracting Department will be prohibited from sharing Managed Care Contracting

Information with any person or group prohibited from reviewing or receiving such information.

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

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

II.

IT IS FURTHER ORDERED that, Respondent must establish the ENH Negotiating Team and the Highland Park Negotiating Team that will compete with each other and with other hospitals.

III.

IT IS FURTHER ORDERED that, Respondent must allow all Payors to negotiate separate Managed Care Contracts for Inpatient Services at Evanston on the one hand and for Inpatient Services at Highland Park on the other hand;

A. At the request of Payors, the Highland Park Negotiating Team shall negotiate for Inpatient Services at Highland Park.

B. When Payors request separate negotiations for Inpatient Services at Highland Park, the ENH Negotiating Team shall negotiate for all services at Evanston and only outpatient services at Highland Park.

C. At the request of any specific Payor, the ENH Negotiating Team shall be permitted to negotiate for all services at all ENH Hospitals for that specific Payor for that specific Managed Care Contract.

IV.

IT IS FURTHER ORDERED that, when a Payor requests separate negotiations, Respondent may not make any contract for Inpatient Services for Evanston or Highland Park contingent on entering into a contract for the other, and may not make the availability of any price or term for a contract for Evanston contingent on entering into a contract for Highland Park or vice-versa.

V.

IT IS FURTHER ORDERED that, Respondent shall promptly offer all Payors with which it has a ~~Current~~Pre-existing Contract the option of reopening and renegotiating their contracts with ENH under the terms of this Order;

A. Within thirty (30) days after the date this order becomes final, ENH shall provide all Payors with which it has a ~~Current~~Pre-existing Contract notification of this Order and offer the opportunity to negotiate separately with the Highland Park Negotiating Team for Inpatient Services for Highland Park for each such contract. Respondent shall *use its best efforts to* give such notifications to the Chief Executive Officer, the General Counsel, and to the Network Manager of the Payor by both first class mail and by e-mail with return receipt requested or similar transmission, and keep a file of such receipts for three (3) years after the date on which this Order becomes final. Respondent shall maintain complete records of all such notifications at Respondent's headquarters and shall provide an officer's certification to the Commission stating that such notification program has been implemented and is being complied with.

B. Not later than ten (10) days after being contacted by a Payor to negotiate a Managed Care Contract, ENH shall provide such Payor notification of this Order and offer the opportunity to negotiate separately with the Highland Park Negotiating Team for Inpatient Services for Highland Park. Respondent shall *use its best efforts to* give such notifications to the Chief Executive Officer, the General Counsel, and to the Network Manager of the Payor by both first class mail and by e-mail with return receipt requested or similar transmission, and keep a file of such receipts for three (3) years after the date on which such notification is sent to the Payor. Respondent shall maintain complete records of all such notifications at Respondent's headquarters and shall provide an officer's certification to the Commission stating that such notification program has been implemented and is being complied with.

C. Payors shall have thirty (30) days from the date of notification to respond in writing and to specify the Payor's intent to negotiate separately with the Highland Park Negotiating Team for Inpatient Services for Highland Park. Nothing in this Order will affect the rights and responsibilities under any ~~Current~~Pre-existing Contract with ENH for any Payor who fails to notify ENH in writing within the time allocated.

~~C~~D. When ENH receives notification of a Payor's intent to negotiate separately with the Highland Park Negotiating Team for Inpatient Services at Highland Park, the Payor and the Highland Park Negotiating Team shall be given a reasonable amount of time to complete negotiations.

~~D~~E. During any subsequent renegotiation with a Payor with a ~~Current~~Pre-existing Contract or negotiation with a Payor without a ~~Current~~Pre-existing Contract, ENH

will provide the Payor with the option to negotiate separately for Inpatient Services for Highland Park. Any Payor electing to negotiate separately for Inpatient Services at Highland Park shall notify ENH of its intent in writing.

VI.

IT IS FURTHER ORDERED that, Respondent must establish a firewall-type mechanism that prevents the ENH Negotiating Team from requesting, receiving, sharing or otherwise obtaining any Managed Care Contracting Information with respect to Inpatient Services at Highland Park, and prevents the Highland Park Negotiating Team from requesting, receiving, sharing or otherwise obtaining any Managed Care Contracting Information with respect to Evanston, except as otherwise provided in this Order;

A. ENH shall have one hundred twenty (120) days after the date this order becomes final to establish and implement an appropriate firewall, assemble the Highland Park Negotiating Team and ENH Negotiating Team, including recruiting and training staff, and otherwise prepare to implement the terms of this Order.

B. Nothing in this Order shall prevent the Highland Park Negotiating Team from requesting, receiving, sharing or otherwise obtaining Managed Care Contracting Information with respect to Highland Park.

C. Nothing in this Order shall prevent the Highland Park Negotiating Team from requesting, receiving, sharing or otherwise obtaining non-Managed Care Contracting Information related to any ENH hospital or the entire ENH system, including but not limited to, information related to costs, quality, patient mix, service utilization, experience data, budgets, capital needs, expenses, and overhead.

D. Nothing in this Order shall prevent the ENH Negotiating Team from requesting, receiving, sharing or otherwise obtaining Managed Care Contracting Information with respect to all services at Evanston and outpatient services at Highland Park.

E. Nothing in this Order shall prevent the ENH Negotiating Team from requesting, receiving, sharing or otherwise obtaining non-Managed Care Contracting Information related to any ENH hospital or the entire ENH system, including but not limited to, information related to costs, quality, patient mix, service utilization, experience data, budgets, capital needs, expenses, and overhead at Evanston and Highland Park.

F. Should a Payor not elect to negotiate separately with the Highland Park Negotiating Team and the ENH Negotiating Team, nothing in this Order shall prohibit the ENH Negotiation Team from requesting, receiving or otherwise obtaining Managed Care Contracting Information with respect to all services at both Evanston and Highland Park for that particular Payor.

G. The Corporate Managed Care Department is permitted to use Managed Care Contract Information obtained from both the ENH Negotiating Team and the Highland Park Negotiating Team for the purpose of Contract Administration.

H. The Corporate Managed Care Department is prohibited from providing, sharing, or otherwise making available:

(i) Managed Care Contracting Information from the Highland Park Negotiating Team to the ENH Negotiating Team, except for Managed Care Contracting Information related to a particular Payor who has not elected to contract separately.

(ii) Managed Care Contracting Information from the ENH Negotiating Team to the Highland Park Negotiating Team.

I. ENH shall establish a separate or clearly-partitioned Contract Management System for the Highland Park Negotiating Team and the Evanston Negotiating Team to ensure confidentiality of Managed Care Contracting Information.

VII.

IT IS FURTHER ORDERED that Respondent shall cause each of Respondent's employees having access to Managed Care Contracting Information to sign a statement that the individual will maintain the confidentiality required by the terms and conditions of this Order. Respondent shall maintain complete records of all such statements at Respondent's headquarters and shall provide an officer's certification to the Commission stating that such statements have been signed and are being complied with by all relevant employees.

VIII.

IT IS FURTHER ORDERED that Respondent shall, ~~one~~

A. One (1) year from the date this Order becomes final ~~and annually thereafter until the Order terminates or the Commission determines it no longer necessary~~, annually for the next nine (9) years on the anniversary date this Order becomes final, and at such other times as the Commission may require, submit a verified written report to the Commission setting forth in detail the manner and form in which it has complied and is complying with the Order;

B. Within sixty (60) days after the date this Order becomes final, and every sixty (60) days thereafter until Respondent has fully complied with Paragraphs V.A. and X., and has obtained the signed statements of all of Respondents' employees described in Paragraph VII and who are employed by the Respondent as of the date this Order becomes final, submit a verified written report to the Commission

setting forth in detail the manner and form in which it has complied and is complying with the Order;

C. In each such verified written report, include, among other things that are required from time to time, the following:

(i) A full description of the efforts being made to comply with the each Paragraph of the Order; including, all internal memoranda, and all reports and recommendations concerning compliance with the requirements of this Order; and

(ii) The identity of each member of the ENH Negotiating Team, the Highland Park Negotiating Team, any Third Party Consultant(s), and the Corporate Managed Care Department.

IX.

IT IS FURTHER ORDERED that, for the purpose of determining or securing compliance with this Order, ~~Respondent shall~~and subject to any legally recognized privileged and upon written request and upon five (5) days notice to the Respondent made to its headquarters address, Respondent shall, without restraint or inference, permit any duly authorized representative of the Commission:

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

B. ~~Upon five (5) days' notice to Respondent, and in the presence of counsel, to~~To interview officers, directors, or employees of Respondent who may have counsel present, regarding such matters.

X.

IT IS FURTHER ORDERED ~~that, any and all disputes between ENH and Payors with respect to Respondent's compliance with this Order shall be solely and exclusively resolved in accordance with this section. ENH and the Payor shall first try in good faith to settle the dispute by mediation under the Commercial Mediation Rules of the American Arbitration Association ("AAA"). If the dispute cannot be settled by mediation, then by arbitration administered by the AAA under its Commercial Arbitration Rules before a single arbitrator mutually agreed upon by ENH and the Payor. Any mediation or arbitration proceeding shall be conducted in Chicago, Illinois.~~

~~XI.IT IS FURTHER ORDERED~~ that ENH shall, within sixty (60) days after the date this Order becomes final, send by first-class mail, return receipt requested, a copy of this Order to each officer and director of ENH.

~~XII.~~
XI.

IT IS FURTHER ORDERED that, this Order ~~will remain in effect for ten (10) years after the date of its issuance. ENH may petition the Commission at any time for removal or expiration the Order~~shall terminate ten (10) years from the date on which this Order becomes final.

PRIOR NOTIFICATION PROVISION

IT IS FURTHER ORDERED that, for a period of commencing on the date this Order becomes final and continuing for ten (10) years, Respondent shall not, directly or indirectly, through subsidiaries or otherwise, without providing advance written notification to the Commission:

A. acquire any Ownership Interest in:

(i) a Hospital that is located within the Chicago Metropolitan Statistical Area; or

(ii) any Person that Operates a Hospital that is located within the Chicago Metropolitan Statistical Area; or

B. enter into any agreement or other arrangement to Operate or otherwise obtain direct or indirect ownership, management, or control of a Hospital that is located within the Chicago Metropolitan Statistical Area, or any part thereof, including but not limited to a lease of or management contract for any such Hospital.

Said notification shall be given on the Notification and Report Form set forth in the Appendix to Part 803 of Title 16 of the code of Federal Regulations as amended (hereinafter referred to as "the Notification"), and shall be prepared and transmitted in accordance with the requirements of that part, except that no filing fee will be required for any such Notification, Notification shall be filed with the Secretary of the Commission, Notification need not be made to the United States Department of Justice, and Notification is required only of the Respondents and not of any other party to the transaction. Respondents shall provide two (2) complete copies (with all attachments and exhibits) of the Notification to the Commission at least thirty (3) days prior to consummating any such transaction (hereinafter referred to as the "first waiting period"). If, within the first waiting period, representations of the Commission make a written require for additional information or documentary material (within the meaning of 16 C.F.R. § 803.20),

Respondents shall not consummate the transaction until thirty (30) days after substantially complying with such request. Early termination of the waiting periods in this Paragraph may be required and, where appropriate, granted by letter from the Bureau of Competition; *provided, however*, that prior notification shall not be required by this Paragraph for a transaction for which notification is required to be made, and has been made, pursuant to Section 7A of the Clayton Act, 15 U.S.C. § 18a.

Exhibit
B

UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION
OFFICE OF ADMINISTRATIVE LAW JUDGES

In the matter of	)	
	)	
Evanston Northwestern Healthcare Corporation, a corporation	)	Docket No. 9315
	)	

AMENDED GLOSSARY OF TERMS

At the Court's request, the parties are submitting an Amended Glossary of Terms, which amends the Glossary of Terms filed on February 10, 2005. This amendment includes all of the terms previously submitted in the original Glossary of Terms, as well as additional relevant terms. This glossary is being provided as a reference only and does not constitute an admission by either party.

- **ACUTE CARE HOSPITAL SERVICES** - Services furnished to patients with acute needs for health care services, as distinguished from services furnished for chronic physical conditions through the provision of long-term inpatient care. Some acute care hospitals also provide some long term care services such as skilled nursing or rehabilitation.
- **ACUTE MYOCARDIAL INFARCTIONS (AMI)** - AMI, or heart attack, occurs when the supply of oxygen to a portion of the heart muscle is insufficient, due to reduced supply or increased demand or both, leading to the death of muscle (myocardial) cells in that area. Most commonly, an acute MI is due to atherosclerosis partially or completely blocking the heart arteries, thereby reducing the blood and oxygen flow to the heart muscle.
- **ADJUDICATION** - The activity associated with the processing of claims according to the contract between a provider and an insurer.
- **ADMINISTRATIVE DATA** - Data submitted by hospitals to various payors for billing or to public agencies as part of their routine operations. Administrative data contain various information about patients, including demographic information, specific diagnoses, and procedures

- **ADMINISTRATIVE SERVICES ORGANIZATION (ASO)** - A company that administers a managed care plan on behalf of an entity, usually an employer or union, that is self-insured, *i.e.*, that directly bears the risk for the costs of the health care services required by the company's employees. Typically, an ASO will provide back office services (claims administration, enrollment verification, etc.), and medical management and network development services (network access, contract negotiation and provider relations) for self-insured employers. In particular, an ASO will typically negotiate contracts with hospitals, doctors, and other providers and then, through its contract with the self-insured employer, provide the employer and its employees access to those providers under the negotiated contracts. Many managed care companies will market their product both as an "ASO," in which the employer or union retains the liability for all services that are furnished to enrollees, and as an insurer, in which the managed care company assumes some or all of the liability for all services furnished to enrollees of the health care plan.
- **AGENCY FOR HEALTH CARE POLICY AND RESEARCH (AHRQ)** - A government agency within the U.S. Department of Health and Human Services that sponsors and conducts research on health care quality, outcomes, cost, and patient safety. Its web address is www.ahrq.gov.
- **AHRQ INPATIENT QUALITY INDICATORS (IQIS)** - A set of inpatient quality indicators developed by the Agency for Healthcare Research and Quality (AHRQ). IQIs use administrative data to calculate risk-adjusted rates of inpatient mortality for certain procedures and medical conditions; the level of utilization of procedures for which there are questions of overuse, underuse, and misuse; and the total volume of procedures for which there is evidence that higher volume is associated with lower mortality.
- **AHRQ PATIENT SAFETY INDICATORS (PSIS)** - A set of inpatient quality indicators developed by the Agency for Healthcare Research and Quality (AHRQ). PSIs use administrative data to calculate risk-adjusted rates of in-hospital complications and adverse events following surgeries, procedures, and childbirth.
- **AHRQ PREVENTION QUALITY INDICATORS (PQIS)** - A set of measures developed by the Agency for Healthcare Research and Quality (AHRQ) that focus on identifying potentially avoidable hospitalizations (also known as ambulatory care sensitive admissions), based on the premise that timely access to high-quality outpatient care could prevent many of these hospitalizations. The PQIs differ from the other quality indicators developed by the Agency for Healthcare Research and Quality (IQIs and PSIs) in that the PQIs are intended to assess quality of care at the general population level, not the hospital level.
- **AMBULATORY FEE SCHEDULE** - A table of fixed rates for outpatient services.
- **AMBULATORY SURGERY GROUPERS (ASG)** - A categorization system for outpatient surgery procedures that groups those services into a limited number of payment categories. In most cases, commercial ASGs follow the Medicare guidelines for categorization and most commercial payors reimburse providers on a percent of Medicare reimbursement schedule basis.

- **AMERICAN COLLEGE OF CARDIOLOGY (ACC) /AMERICAN HEART ASSOCIATION (AHA) CLINICAL PRACTICE GUIDELINES** – Clinical practice guidelines are developed through a rigorous methodological approach that mandates the review and consideration of the available medical literature. Practice guidelines define the role of specific diagnostic tests and therapeutic interventions, including non-invasive and invasive procedures, in the diagnosis and treatment of patients with cardiovascular (heart) diseases. These evidence-based guidelines are intended to assist physicians in clinical decision making by describing a range of generally acceptable approaches for the diagnosis, management, or prevention of specific diseases or conditions. They attempt to define practices that meet the needs of most patients in most circumstances by categorizing the recommendations into a classification system. The development of clinical practice guidelines for cardiology is the domain of the ACC/AHA Task Force on Practice Guidelines. Its web address is: http://www.acc.org/clinical/definitions/definitions.htm
- **AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS (ACOG)** – The leading national association of health care professionals specializing in obstetric and gynecological medicine. ACOG defines and promotes best practice standards and administers the specialty board examination and renewal process for physician specialists in this field. Its web address is: www.acog.org.
- **ANCILLARY SERVICES** – Support services provided in conjunction with medical or hospital care; they can include laboratory, radiology, pharmacy, physical rehabilitation, social work, and dietetics.
- **BENCHMARKING** – A method of measuring performance against established standards of best practice.
- **BIRTH TRAUMA** – Refers to physical injury to the newborn infant sustained during the birth process.
- **BOARD CERTIFICATION** – Board certification is an examination physicians undergo designed to assess the knowledge, skills, and experience physicians have acquired in a particular specialty. Different medical boards have different requirements. Requirements often include a specified number of years of residency (and fellowship training for certain subspecialties), passing oral and written exams that demonstrate knowledge and skill for a particular specialty. In addition, many medical boards require recertification every five to ten years. They are administered by a Board which governs that specialty. The mission of the Board is to maintain and improve the quality of medical care by developing and implementing educational and professional standards to evaluate and certify physician specialists.
- **CAPITATION OR CAPITATION RATE** – A fixed amount that a managed care plan periodically pays to a provider for all covered services that its enrollees might require, regardless of the actual services that the enrollees ultimately consumes. Typically, the amount paid is expressed as a payment "per covered life" or as an amount "per member per month."
- **CARDIOTHORACIC SURGERY** – The practice of medicine directed toward the surgical management of diseases of the blood supply to the heart, heart valves and the

arteries and veins in the chest. This surgical field also focuses on surgical treatments for lung and esophageal problems, such as lung or esophageal cancer, emphysema, esophageal swallowing problems, and gastroesophageal reflux.

- **CARVE OUT OR EXCLUSION CLAUSES** – A clause in a contract between a managed care plan and a hospital that specifies that particular procedures or services (either inpatient or outpatient) are not included under the standard reimbursement formula of the contract. For example, an agreement between a managed care plan and a hospital might specify that the managed care plan will pay for services received by enrollees on a per diem basis. Nevertheless, the contract might specifically "carve out" particular procedures from this general formula and specify, instead, that the managed care plan will pay for those services using a different payment formula. Alternatively, under an exclusion clause, a contract might provide that the managed care plan will compensate a hospital for all inpatient services furnished to an enrollee, subject to an "exclusion clause" that specifies that the managed care plan will not compensate a hospital for specific procedures under any circumstances.
- **CASE MIX INDEX** – An estimate of the average complexity of the medical and surgical treatments provided by a hospital to its inpatients. In its most simple form, the case mix index identifies and groups patients based on the various types of medical conditions on a very broad basis (such as medical, surgical, and obstetric patients). On a more detailed basis, case mix index can be measured by categorizing patients into Diagnostic Related Groups ("DRGs"), as defined below.
- **CASE RATE REIMBURSEMENT** – A financial method of payment where reimbursement is a pre-determined amount for a particular type of patient, such as an obstetrics patient or an open heart surgery patient, without regard to the hospital services that the patient actually receives.
- **CHARGES** - The published or list prices for services provided by a hospital. These rates are found in the hospital's "chargemaster," which reflects tens of thousands of predetermined itemized amounts to be billed for each good or service the hospital provides. Each hospital maintains its own chargemaster.
- **CHICAGO HOSPITAL RISK POOLING PROGRAM (CHRPP)** – A self-insurance retention trust which provides insurance coverage for participating hospitals against malpractice claims by pooling hospital resources. It also implements risk management programs by encouraging its members' compliance with clinical requirements and recommendations. It is managed by the Metropolitan Chicago Healthcare Council, www.mchc.org.
- **CLINICAL** – Anything relating to the observation and treatment of patients.
- **CLINICAL DATA** – Clinical data include data elements that describe a patient's condition throughout a medical encounter. Such data includes patients' symptoms and complaints, physical exam findings, laboratory and radiology results, and medical staff assessments. Clinical data is collected by medical chart review.

- **CLINICAL DECISION SUPPORT SYSTEMS (CDSS)** – An electronic system that can make clinical suggestions to a physician by applying information on patient care, from a variety of sources, to patient-specific clinical variables
- **COMORBIDITY** – The presence of co-existing or additional diseases with reference to a patient's initial diagnosis or condition. A comorbidity is an additional disease or condition that developed prior to the treatment of the patient's initial diagnosis. For example, a patient with diabetes may come to the emergency department with a heart attack. Diabetes is considered a comorbid illness because the patient had the disease prior to the current episode of care. Comorbidity may affect the ability of affected individuals to function and also their survival; it may be used as a prognostic indicator for length of hospital stay, cost factors, and outcome or survival.
- **COMPLICATIONS** – A complication is a disease or injury that develops during the treatment of a pre-existing disorder. The complication frequently alters the original prognosis of the patient based on the pre-existing disorder. A complication is a condition that was not present at the time the episode of care commenced and develops following a procedure, treatment, or illness. It may represent a development in response to a treatment or intervention.
- **COMPUTERIZED PHYSICIAN ORDER ENTRY (CPOE)** – Electronic systems in which physicians can enter and transmit medication and prescription orders as well as orders for radiology, laboratory work, and other ancillary services, eliminating the need for handwritten orders. It is used for both inpatient and outpatient services.
- **CONTRACT YEAR** - A period of twelve consecutive months under which an agreement between a managed care organization and a provider is in effect. This period may constitute a calendar year beginning on January 1 and ending on December 31 of that year, or it may be based on the fiscal year of either the provider or the managed care company, as agreed to by the parties.
- **CORE MEASURES** – A set of quality measures that the Joint Commission for the Accreditation of Health Care Organizations (JCAHO) has established for Acute Myocardial Infarction (Heart Attack), Heart Failure, Pregnancy and Related Conditions, and Community Acquired Pneumonia.
- **CORONARY ARTERY BYPASS GRAFT SURGERY (CABG)** – CABG surgery is a procedure in which a vein or artery from another part of the body is used to create an alternate path for blood to flow to the heart, bypassing the arterial blockage. Typically, a section of one of the large (saphenous) veins in the leg, the radial artery in the arm or the mammary artery in the chest is used to construct the bypass. One or more bypasses may be performed during a single operation, since providing several routes for the blood supply to travel is believed to improve long-term success for the procedure.
- **COVERED LIVES** – Another way of referring to the enrollees, members, or participants, in a health plan, generally referring to an employee group and their families.
- **CURRENT PROCEDURAL TERMINOLOGY (CPT)** - A standardized list of numeric codes that includes a five digit code for each medical service and procedure to allow for standardization of claims processing throughout the health care industry. CPT

codes are most commonly used by physicians for billing purposes; sometimes they are also used for outpatient services provided by facilities. Rarely they are used to categorize inpatient services.

- **DIAGNOSIS RELATED GROUP (DRG)** - A grouping of inpatients into hundreds of separate categories based on their diagnoses and the procedures they undergo while hospitalized. Each DRG is assigned a case weight based on the average resources among many hospitals required to treat patients in that DRG.
- **DIAGNOSIS RELATED GROUP (DRG) REIMBURSEMENT** - A method of payment in which the reimbursement for inpatient hospital services is set based on the DRG into which a patient is classified. As a general rule, the amount of payment will not vary if the hospital renders significantly greater or less services in treating the patient than is the estimated average, or if the hospital incurs costs that are greater or less than the typical cost incurred by hospitals.
- **DISCOUNT FROM CHARGES OR DISCOUNT OFF CHARGES REIMBURSEMENT** - A method of payment where reimbursement for inpatient services, outpatient services or both is based upon a discount from the hospital's published charges, as set forth in its chargemaster.
- **ELECTRONIC MEDICAL RECORD (EMR)** – Patient clinical information that is electronically recorded and stored.
- **EPIC CLINICAL INFORMATION SYSTEM (EPIC)** – An electronic clinical information system that includes an electronic medical record, a computer order entry system, and a clinical decision support system. The corporation's web site is www.epicsys.com
- **EXPECTED MORTALITY RATE** – The sum of the predicted number of deaths for all patients in a defined group (for example, the projected number of deaths of patients undergoing a specific procedure or with a specific diagnosis) divided by the total number of patients (that is, all patients undergoing that same procedure or hospitalized with that same diagnosis).
- **FEE SCHEDULE** - A listing established by a managed care plan of accepted fees or established allowances for specified services. Under a managed care contract it represents the maximum amounts that the insurer will pay for specific services (usually identified by ICD-9 (see below) or CPT codes).
- **FEE-FOR-SERVICE REIMBURSEMENT** - A method of payment for health services where payment is made based upon a provider's fee schedule as set forth in its chargemaster or another specified fee schedule.
- **FOURTH DEGREE PERINEAL LACERATION** – This is a perineal laceration that extends further than a 3rd degree laceration and disrupts the anal lining. It may predispose patients to subsequent problems with defecation.
- **HEALTH CARE FINANCING ADMINISTRATION BILLING FORM 1500 (HCFA-1500)** - The Health Care Financing Administration standard form for submitting

provider outpatient services claims to third party companies or insurance carriers. HCFA is now known as the Centers for Medicare and Medicaid Services (CMS).

- **HEALTH MAINTENANCE ORGANIZATION (HMO)** – Traditionally, a managed care plan that contracts with a limited number of hospitals, doctors, and other providers, and which specifies that an enrollee of the HMO will bear a significant portion of (and, possibly, all) fees for services that he or she receives from a provider with which the HMO does not contract. In recent years the lines between HMOs and other forms of managed care organization, such as Preferred Provider Organizations (PPOs) have blurred as consumer demand for increased choice of providers has dominated the market place.
- **HEALTHGRADES** – A health care quality ratings and services company that uses administrative data (such as Medicare claims data and state abstract data) to rate the performance of many hospitals in the United States engaged in cardiac surgery, cardiology, orthopedic surgery, pulmonary care, vascular surgery, critical care, and obstetrics. Using risk-adjustment models to take into account variations in the severity of illness of patients cared for by different hospitals, HealthGrades applies a five-star rating system and posts these ratings on its web site, www.healthgrades.com.
- **ICU (Intensive Care Unit)** – The ward in a hospital where critically ill patients are continuously monitored. An ICU contains highly technical and sophisticated monitoring devices and equipment. Typically, the patient-staff ratio in an ICU is low.
- **INPATIENT HOSPITAL SERVICES** – Hospital services that are furnished to a patient who, to obtain the services, must stay overnight at the hospital.
- **INPATIENT MORTALITY RATE** – Deaths that occur during a hospital admission for patients with a specific diagnosis (or procedure) divided by the total number of patients admitted with the same diagnosis (or procedure) for a specified time period. For example, CABG inpatient mortality rate for 1999 at any given hospital would equal the number of deaths that occurred in patients who underwent a CABG and died during the same hospital admission (in 1999) divided by the total number of patients who underwent a CABG (in 1999).
- **INTENSIVIST** – A physician who specializes in the care and treatment of patients in an intensive care unit (ICU). These physicians focus primarily on the care of the critically ill or injured patients admitted to a hospital to either a surgical, medical or pediatric ICU.
- **INTERNATIONAL CLASSIFICATION OF DISEASES, NINTH REVISION (ICD-9)** - A universal coding method used to document the incidence of disease, injury, mortality and illness. This system is used to assist hospitals and physicians in the preparation of billings and claims. Classification is achieved through the development of a six-digit identifier for each diagnosis.
- **INTERVENTIONAL RADIOLOGY** – A specialty within the field of radiology which uses various radiological techniques (e.g., x-ray, computed tomography (CT) scans, magnetic resonance imaging (MRI) scans, and ultrasounds) to place wires, tubes, or other instruments inside a patient to diagnose or treat an array of conditions.

- **MANAGED CARE ORGANIZATION** - A company that provides access to health care services on an insured, partially insured or a self-insured basis, including plans such as health maintenance organizations, preferred provider organizations, and point of service plans. A managed care company may be a licensed insurer or an administrative services organization, or both. The services may include network access and development, contract negotiation with providers, provider relations, medical and utilization management and claims administration.
- **MANAGED CARE PLAN** – Health insurance plans offered by Managed Care Organizations. These plans include "health maintenance organizations," "point of service plans," and "preferred provider organizations," which are defined below. Nevertheless, the different types of managed care plans are difficult to distinguish because, over time, the managed care organizations have modified each type of plan to incorporate different elements of the other plans that consumers demand.
- **MAXIMUM ALLOWABLE PAYMENT** - The maximum amount that a payor would pay a hospital for a particular service or procedure as stipulated in the contract between the payor and the hospital, even if the hospital's costs exceed this amount.
- **MEDICAL CONSUMER PRICE INDEX ("M-CPI")** – An index published by the Bureau of Labor Statistics which measures the monthly average change in price for hospital and related services (inpatient, outpatient and nursing home services), professional medical services (physicians' services, dental services, eye care and services by other medical professionals) and medical care commodities (prescription drugs, nonprescription drugs and medical equipment and supplies). This price index (which is also reported by the Bureau of Labor Statistics for geographic areas smaller than the entire United States) is a measure of the inflation rate for medical costs. In addition the Bureau of Labor Statistics publishes a price index for the hospital component of the M-CPI.
- **MEDICARE COST REPORT** - An annual report required of all hospitals participating in the Medicare program. The Medicare cost report records each institution's total costs and charges associated with providing services to all patients, the portion of those costs and charges allocated to Medicare patients and Medicare payments received.
- **MORBIDITY** – The rate of illness, injury, or disability in a population.
- **MORTALITY** – The rate of death in a population.
- **NATIONAL PERINATAL INFORMATION CENTER (NPIC)** – A non-profit organization which, among other activities, gathers perinatal data from member hospitals – based upon hospital administrative data – from which it provides quarterly comparative data reports. Its web address is www.npic.org.
- **NEONATAL MORTALITY** – Death rate for infants in the first 28 days of life. It includes infant deaths that occurred in the first 28 days of life divided by all live infant births.
- **NETWORK** – The group of hospitals, doctors and ancillary health service providers (laboratories, home health agencies, diagnostic radiology facilities, etc.) that have signed

contracts to provide services to enrollees of a health benefit plan (HMO, PPO, POS, etc.) for the contractually-determined prices.

- **OBSERVED MORTALITY (OMR)** – Is the observed number of deaths (for patients who underwent a specific procedure or had a specific diagnosis) divided by the total number of patients (who underwent the same procedure or had the same diagnosis).
- **OBSTETRIC TRAUMA** – Refers to injuries suffered by women during delivery. In the setting of a vaginal delivery, it usually refers to perineal lacerations.
- **OUTLIER** - A condition where the services that must be rendered to a patient with a particular diagnosis are significantly greater than the services that typically must be rendered to a patient with that diagnosis. Depending on the system, this measurement can be made on the basis of the number of days of inpatient care that are required or the charges or costs of the services that actually must be furnished to that particular patient. Under Medicare's DRG payment system, for example, a hospital that treats an "outlier" patient, defined either by a long length of stay or unusually high charges, receives an incremental payment for the services it must render to the patient, in addition to the fixed payment that it receives for patients in the same diagnosis related group.
- **OUTLIER THRESHOLD** - The point at which a hospital would receive additional reimbursement for an outlier patient.
- **OUTPATIENT SERVICES** – Services that are furnished to patients who do not require an overnight stay at the facility.
- **PER DIEM REIMBURSEMENT** - A formula for payment in which reimbursement for inpatient services is based upon a fixed all-inclusive amount for each day that the patient is in the hospital, regardless of the amount of services or the costs or charges for the services that actually must be rendered to that patient.
- **PERCUTANEOUS CORONARY INTERVENTIONS (PCI)** – A family of procedures performed by interventional cardiologists whose purpose is to restore normal blood flow to the heart muscle by removing or compressing plaque within blocked coronary arteries. This was originally done using a balloon-tipped catheter to dilate blocked arteries and squeeze plaques within them (i.e., percutaneous coronary transluminal angioplasty or PTCA), but newer techniques involve drilling through blockages and inserting stents to reduce the risk of later recurrence.
- **PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY (PTCA)** – PTCA is used to dilate (widen) narrowed arteries. A doctor inserts and advances a catheter with a deflated balloon at its tip into the narrowed part of an artery. Then the balloon is inflated, compressing the plaque and enlarging the inner diameter of the blood vessel so blood can flow more easily. Then the balloon is deflated and the catheter removed.
- **PERINATAL** – Pertaining to or occurring in the period shortly before or after childbirth.
- **PERINEAL LACERATIONS** – These are lacerations that occur in the perineum (the area between the vagina and the anus). They are classified into four categories depending

on severity (1st degree, 2nd degree, 3rd degree, and 4th degree). These tears are associated with vaginal deliveries, particularly operative vaginal deliveries.

- **PICTURE ARCHIVING AND COMMUNICATION SYSTEM (PACS)** – Picture Archiving and Communication System collects radiographic images digitally and allows them to be distributed electronically and interpreted at computer workstations.
- **PLAN CODE** - The identifying symbol used by a hospital in its computer system billing software to determine which contract and which contract rate will be used for billing for a specific admission or set of medical services provided.
- **POINT OF SERVICE PLAN (POS)** - A managed care plan that, typically, contracts with a limited number of hospitals, doctors, and other providers and extends terms of coverage to enrollees based on terms that will vary depending on the provider from which the enrollee seeks care.
- **PREFERRED PROVIDER ORGANIZATION (PPO)** – A managed care plan that contracts with a group of hospitals, doctors and other health care providers that usually is somewhat larger than the groups with which an HMO may contract. In many PPOs, the enrollees in the plan are offered a financial incentive, such as a lower deductible or co-payment obligation, to obtain care from the "preferred providers," but the enrollees may use providers outside the panel at an additional cost. As noted above, the distinctions between HMOs and PPOs have blurred in the last several years.
- **PRESS GANEY** – A survey research firm focusing on patient satisfaction with health care. Approximately 800 US hospitals contract with Press Ganey to obtain systematic feedback about processes of care, typically focusing on those that are perceptible to patients. Its web address is www.pressganey.com.
- **PYXIS** – An automated drug dispensing system available from Cardinal Health, which can be used in hospitals and pharmacies. Pyxis machines are locked cabinets, containing prepackaged medications, which are connected to a computer system. More information on the Pyxis line of products can be found on the web site, www.pyxis.com.
- **QUALITY ASSURANCE** – Hospital operated set of activities that identify and address specific quality failings. Quality assurance (QA) deals with complaints, patient injuries caused by errors, regulatory agency investigations, and lawsuits. It is also charged with protecting patients from incompetent or impaired doctors, nurses, and other practitioners. QA programs investigate cases in which patients suffer injuries in order to determine whether and how serious errors or faulty systems contributed to causing the adverse event. QA is typically reactive and disciplinary.
- **QUALITY IMPROVEMENT** – Hospital operated set of activities primarily focused on multidisciplinary efforts to improve specific aspects of patient care. Targets for improvement activities are identified by various sources. These activities aim for measurable improvements as documented by data on valid quality measures.
- **RISK ADJUSTED MORTALITY RATE (RAMR)** – Is the best estimate, based on the statistical model, of what the provider's mortality rate would have been if the provider had a mix of patients identical to the statewide mix. It is obtained by first dividing the observed mortality rate by the expected mortality rate, and then multiplying by the

relevant statewide mortality rate (for example 2.25% for isolated CABG patients in 1999-2001 or 7.13% for Valve or Valve/CABG patients in 1999-2001).

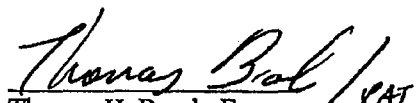
- **RISK-ADJUSTMENT** – A statistical technique that is used to account for differences in patient characteristics when comparing hospital performance. Different hospitals tend to treat different types of patients. For example, some hospitals treat sicker and older patients than other hospitals. Risk-adjustment is a technique to account for these differences in patient characteristics at different hospitals. Risk-adjustment models try to account for a number of risk factors that might influence the outcome of medical care for patients.
- **SEVERITY OF ILLNESS** – A measure of how sick a particular patient is. Severity of illness is not identical to the concept of case mix. Severity of illness can be one factor used in determining the "case mix" of a hospital. Depending on the illness, the severity of the illness may affect the "diagnosis related group" to which that patient is assigned.
- **SOCIETY OF THORACIC SURGEONS (STS) NATIONAL ADULT CARDIAC SURGERY DATABASE** – A voluntary national database and benchmarking program sponsored by the Society of Thoracic Surgeons, which includes detailed hospital-reported clinical data about the use of preferred techniques during CABG surgery. Its web address is www.sts.org.
- **STOP LOSS** - A provision in a contract between a managed care plan and a hospital under which the hospital receives additional reimbursement for cases in which the hospital incurs specified costs of furnishing services to an enrollee of the managed care plan. There are two primary forms of stop loss payments.

  Under "first dollar" coverage, a managed care plan will compensate the hospital at the contractually specified rate. Once the payment amount exceeds a specified threshold, however, the managed care plan payment formula will be changed so that the managed care plan compensates the hospital an additional amount for all services furnished to that patient, including those that were furnished before the threshold was met.

  Under "second dollar" coverage, a managed care plan will compensate the hospital pursuant to the contractual formula until the dollar threshold is met. Under this approach the managed care plan will pay the hospital under a different formula, but only for the services that are in excess of the threshold amount
- **THE LEAPFROG GROUP** – An employer-led effort to establish standards for improving patient safety in hospitals, and to reward hospitals that meet those standards. Its web address is www.leapfroggroup.org.
- **THIRD DEGREE PERINEAL LACERATION** – This is a perineal laceration that extends through the skin, mucous membrane, perineal body, and the muscles but leaves the anal lining intact.
- **THORACIC SURGERY** – A branch of medicine dealing with the use of surgery to treat diseases of the chest and lungs.
- **UNIFORM BILLING CODE OF 1992 (UB-92)** - Bill form used to submit inpatient hospital claims for payments to third parties.

- **VAGINAL BIRTH AFTER CESAREAN (VBAC)** – A vaginal delivery after a previous caesarean delivery. One of the most common reasons for cesarean sections is the presence of a uterine scar from a previous cesarean section. A previous uterine scar can tear or open up during a labor with a subsequent pregnancy. Some physicians attempt a VBAC in their patients in order to avoid repeat cesarean sections (because of the increased morbidity associated with cesarean sections).
- **VOLUNTARY REVIEW OF QUALITY OF CARE (VRQC) PROGRAM** – An ACOG program that assists hospitals and physicians in assessing the quality of care provided in their departments of obstetrics and gynecology. Through this program, ACOG can supply, upon request, a team of qualified obstetrician/gynecologists to evaluate the clinical performance in the area of obstetrics and gynecology.

Respectfully Submitted,



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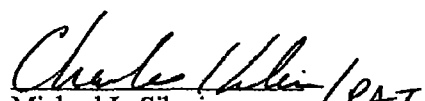

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CERTIFICATE OF SERVICE

I hereby certify that on April 22, 2005, a copy of the foregoing ***Amended Glossary of Terms*** was served by hand, email and first class mail, postage prepaid, on:

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