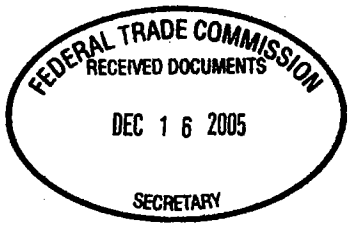
UNITED STATES OF AMERICA
BEFORE THE FEDERAL TRADE COMMISSION



DOCKET NO. 9315

IN THE MATTER OF

EVANSTON NORTHWESTERN HEALTHCARE CORPORATION

MOTION OF THE ADVISORY BOARD COMPANY FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF IN SUPPORT OF EVANSTON NORTHWESTERN HEALTHCARE CORPORATION

[PUBLIC]

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Dated: December 16, 2005

Pursuant to 16 C.F.R. § 3.52(j), The Advisory Board Company ("the Advisory Board") respectfully moves for leave to file a brief *amicus curiae* in this matter. A copy of the Brief *Amicus Curiae* that the Advisory Board proposes to file is attached to this Motion.

The Advisory Board is a for-profit research organization that provides best practices research and analysis to the health care industry, focusing on business strategy, operations and general management issues. The Advisory Board serves 2,500 member hospitals and health systems nationwide, including the vast majority of the most clinically progressive institutions in the country. Evanston Northwestern Healthcare ("ENH") is a member organization, and Mark R. Neaman, ENH's president and chief executive officer, is one of seven directors of the Advisory Board.

Gathering data across and beyond its membership, the Advisory Board publishes daily and weekly news services, 50 major studies and 3,000 customized research briefs each year on progressive management in health care. The Advisory Board's members have a vital concern with the resolution of the legal issues presented in this case, and the Advisory Board believes that its industry-wide perspective on this important issue will be of assistance to the Commission. Indeed, the Administrative Law Judge in this matter reached a significant conclusion on industry-wide trends for which the Advisory Board has special insight.

The Advisory Board's research over the last five years has identified a growing problem facing many American hospitals: too little operating income to fund the capital and skilled staffing investments required to provide the high-quality acute care services vital to the surrounding community.

One of the only viable options open to these organizations—typically smaller, nonprofit, stand-alone community hospitals—is to merge into a larger, better capitalized nonprofit health system. The Advisory Board has recommended this strategy to its hospital and health system clients and believes that this strategy is driving much of the merger activity the U.S. hospital industry has experienced since the 1997 Medicare Balanced Budget Act. This wave of mergers and the resulting capital transfer has provided critical funding to hospitals in communities all across the country that might otherwise face a reduction or even elimination of hospital services.

The Advisory Board is concerned that the decision in this case will threaten the ability of larger health systems to continue to serve this critical role and that the Administrative Law Judge's decision will deter the expenditure of funds by merged entities to improve quality. The Advisory Board explains in its *Amicus Brief* why it believes the Administrative Law Judge mistakenly ignored (in terms of market analysis) the evidentiary import of the more than $100 million spent after the merger of ENH and Highland Park Hospital to improve quality and why the merger is a procompetitive example of this larger, and we believe vital, trend in the hospital industry.

In particular, the proposed *amicus* brief addresses the ALJ's finding that he must ignore the impact of his finding that the merger had resulted in substantial quality of care improvement. This improvement would negate any inference of anticompetitive conduct flowing from the increase in prices post-merger, because the higher prices could have resulted from the improvement in the quality of care. By concluding the "there had been a nationwide trend of improved quality" from 1997 to 2004 (ALJ Initial Decision at 180),

the ALJ ignored the actual improvement in quality of care post-merger, thus brushing aside significant evidence that the merger was procompetitive.

Because of its years of studying the hospital industry, the Advisory Board has particular insight into the ALJ's conclusion that there has been a nationwide trend of improved quality. The Advisory Board's brief explains that there is simply no evidence to support this conclusion, and, in any event, even if it did exist, evidence of a nationwide trend in improved quality is inapposite when applied to Highland Park Hospital.

For these reasons, The Advisory Board Company requests leave to file the accompanying *amicus curiae* brief.

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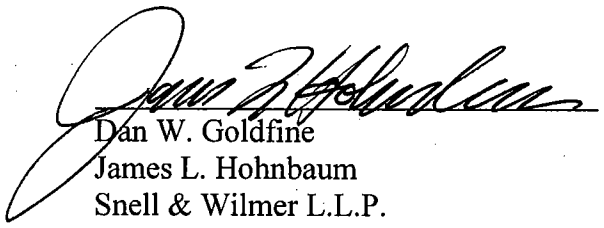
Respectfully Submitted,



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IDENTITY AND INTEREST OF *AMICUS CURIAE*

The Advisory Board Company ("the Advisory Board") is a for-profit research organization that provides best practices research and analysis to the health care industry, focusing on business strategy, operations and general management issues. The Advisory Board serves 2,500 member hospitals and health systems nationwide, including the vast majority of the most clinically progressive institutions in the country. Evanston Northwestern Healthcare ("ENH") is one of the 2,500 member organizations, and Mark R. Neaman, ENH's president and chief executive officer, is one of seven directors of the Advisory Board.

Gathering data across and beyond its membership, the Advisory Board publishes daily and weekly news services, 50 major studies and 3,000 customized research briefs each year on progressive management in health care. The Advisory Board's research over the last five years has identified a growing problem facing many American hospitals: too little operating income to fund the capital and skilled staffing investments required to provide the high-quality acute care services vital to the surrounding community.

One of the only viable options open to these organizations—typically smaller, nonprofit, stand-alone community hospitals—is merger into a better capitalized nonprofit hospital or health system. The Advisory Board has recommended this strategy to its clients and believes that this is driving much of the merger activity the U.S. hospital industry has experienced since the 1997 Medicare Balanced Budget Act. This wave of mergers and the resulting capital transfer has provided critical funding to hospitals in

communities all across the country that might otherwise face a reduction or even elimination of hospital services.

The Advisory Board is concerned that the decision in this case will threaten the ability of health systems to continue to serve this critical role and believes that its years of research into hospital management nationwide can be of assistance to the Commission. In particular, the Advisory Board addresses what it believes to be a key error in the Administrative Law Judge's conclusions: that there was a nationwide trend of quality improvements negating inferences drawn from the fact that the merged entity had expended more than $100 million to increase the quality of care postmerger. The Advisory Board is keenly concerned with improving overall quality of care in the health care industry and fears that this Decision negatively impacts the likelihood that health care firms will make similar large investments in quality improvements in the future.

ARGUMENT

I. ALJ's Conclusion that Quality Improvements Were Not Inconsistent with a Presence of Market Power Is Based on the Erroneous Conclusion that There Was a Nationwide Trend of Quality Improvements

Rejecting Complaint Counsel's expert's opinion (Complaint Counsel Finding of Fact 2045), the Administrative Law Judge ("ALJ") concluded that "Respondent ha[d] provided significant evidence of actual improvements to Highland Park." ALJ Initial Decision at 178;[1] *see* Respondent's Posttrial Brief at 67-107 (summarizing the evidence

[1] We accept this Conclusion on its face as there appears to be substantial evidence in support of it and do not address the difficult issues in quantifying "quality" and applying that quantification to the antitrust analysis. *See* Thomas E. Kauper, *The Role of Quality of Health Care Considerations in Antitrust Analysis*, Law & Contemp. Probs., Spring 1988, at 273, 276-80, 292-319; Jean Tirole, THE THEORY OF INDUSTRIAL ORGANIZATION 95-115 (1988); Kelvin J. Lancaster, *A New Approach to Consumer Theory*, 74 J. Pol. Econ. 132, 133-35 (1966); Michael Spence, *Product Differentiation and Welfare*, 66 Am. Econ. Rev. 407, 413-14 (1976). Moreover, irrespective of the quantification of the quality improvements, the fact that the merged entity made substantial investments in quality improvements is significant to whether market power exists or not.

of more than $100 million in post-merger quality improvements); Respondent's Posttrial Reply Brief at 69-98 (same). In other words, there were substantial quality of care improvements made post-merger. Such improvements negate inferences of market power that might arise from the presence of higher prices or increased market concentration.[2] *See, e.g., Orson, Inc. v. Miramax Film Corp.*, 79 F.3d 1358, 1367 (3d Cir. 1996); VII Areeda, ANTITRUST LAW: AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION ¶ 1511, at 429 (1986); *see also* Complaint at ¶¶ 24 and 28 (making the corollary allegation that price increases absent quality improvements "reflect[] the market power exercised by the hospitals after the merger"). In fact, Complaint Counsel concedes that "[i]f quality is increasing at one hospital relative to other hospitals, . . . then that could potentially explain a greater price increase at the first hospital." Complaint Counsel's Finding of Fact 597. Likewise, such improvements – in and of themselves – are inconsistent with the exercise of market power; after all, if the merged entity could raise prices regardless of its quality improvements it is implausible that the merged entity would spend more than $100 million to improve quality and therefore voluntarily reduce its monopoly rents. *See, e.g., Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 593-94 (1986).

Nevertheless, the ALJ concluded that he must dismiss the import of his conclusion (in terms of market power) that there had been substantial quality of care improvements made post-merger because he concluded that "there had been a nationwide

[2] The ALJ's Conclusions about the evidence and evidentiary import of higher prices appear muddled. Initially, the ALJ concludes that the Complaint Counsel did not meet its burden in proving that post-merger prices were supracompetitive. ALJ Initial Decision at 155; Complaint Counsel' Finding of Fact 580. Then, the ALJ concluded that post-merger price increases, which were not supracompetitive, nevertheless provided an inference of market power because non-anticompetitive explanations for the price increases had been "ruled out." *Id.* It is this exercise of evidentiary logic that the Advisory Board believes it has important information that will aid the Commission in reaching the proper conclusion based on the interpretation of the facts found by the ALJ.

trend of improved quality" from 1997 to 2004. ALJ Initial Decision at 180. The Advisory Board has particular insight into whether there has been a nationwide trend of improved quality, and, based on that insight and years of study, believes the ALJ's conclusion is simply wrong and not supportable by either evidence in the record or in the public domain, as set forth by federal agencies related to Complaint Counsel. *See Cal. Dental Ass'n v. FTC*, 224 F.3d 942, 953-54 (9th Cir. 2000) (increasing the rigor that courts must apply to the bases of evidentiary presumptions). The reality is that the evidence on which the ALJ relied to reach this conclusion is either simply not there or inapposite to proving a nationwide trend of improved quality from 1997 to 2004.[3] At best, the evidence of changes to quality during this time period on an industry-wide scope is mixed.

a. Complaint Counsel's Evidence of a Purported "Nationwide Trend of Improved Quality" is Inapposite When Applied to Highland Park Hospital

The ALJ found that the Complaint Counsel's expert had opined "that starting in the late 1990s, there has been a nationwide trend of improved quality, with one major study finding an average per state inpatient improvement rate of 12% through 2001" and

[3] Similarly, Complaint Counsel's assumption of a nationwide trend of quality improvement is flawed for the same reasons. *See* Complaint Counsel's Proposed Finding of Fact 2384. For example, Complaint Counsel is dismissive of Highland Park Hospital's quality improvements. Like the ALJ, we believe, however, that ENH's made real and substantial investments in improved quality and that much of the investment made by ENH at Highland Park Hospital went to address issues related to patient safety and adverse events and closing the gap between patient care and medical and technological advances. *See* Respondent's Posttrial Brief at 67-107 (summarizing the evidence of more than $100 million in post-merger quality improvements); Respondent's Posttrial Reply Brief at 69-98 (same). This investment included the following: A better system was put in place to identify and prevent adverse events. The improvements in the nursing staff also served to help prevent adverse events and ensure patient safety. And finally, above all, ENH successfully introduced an electronic computerized physician order entry (CPOE) system, which aids in helping physicians make better clinical decisions and has been shown to reduce medical errors, particularly in the area of medication administration. According to the Leapfrog group, it is estimated that only a small percentage of hospitals have installed this technology despite its ability to reduce medical errors and adverse events. *See, e.g.,* Respondent's Response to Complaint Counsel's Finding of Fact 2394.

"[o]ther studies also show that hospitals were improving their quality during the time from 1997 through 2004." ALJ Initial Decision, Finding of Fact 859, at 107 (citing Romano Tr. at 2999-3001 and Noether Tr. at 6011). Initially, the ALJ's citation to Noether simply does not support either finding of fact because Noether was discussing the fact that there has been "increased *focus* on quality nationwide" and not the fact that there had been studies showing "increased quality nationwide." Noether Tr. at 6011 (emphasis added).[4] Likewise, the ALJ's citation to the "the other studies" showing improvement in quality is also not supported by the evidence cited; any fair reading of the studies cited by the ALJ simply does not support that hospitals were, in fact, "improving their quality during the time from 1997 through 2004." Romano Tr. at 2999-3001 and Noether Tr. at 601.

All the ALJ has to support his conclusion that there was a nationwide trend of improving quality is a single inapposite study, the Jencks study,[5] which concluded that there were quality improvements from the 1998-99 time period to the 2000-01 time period. Such evidence is hardly sufficient to conclude that there were nationwide quality improvements from 1997 to 2004 thereby negating the evidentiary import of the ALJ's conclusion that "Respondent ha[d] provided significant evidence of actual improvements to Highland Park." ALJ Initial Decision at 178.

[4] By "focus," Noether clearly references increased attention by policymakers and not actual increases in quality.

[5] The Jencks study made some significant conclusions about care in Illinois, placing the improvements at Highland Park Hospital in a unique context. The Jencks study put Illinois in the lowest quartile for quality improvement, signifying that quality of care in Illinois did not significantly improve during the very limited study period.

b. No Nationwide Trend of Improved Quality

As discussed above, the Jencks study simply does not support his conclusion that there was a nationwide trend from 1997 to 2004. Moreover, the Jencks study has been misapplied by the ALJ and is inconsistent with other more thorough studies of the period in question looking at trends in quality of care.

First and foremost, the indicators examined in the Jencks study measure compliance with appropriate or "evidence-based" care across four conditions, a small subset of the care provided within the hospital.[6] This is an extremely limited segment of the care provided within the hospital, and the variance in improvement across the metrics (some showing improvement, some holding flat or deteriorating) of these four conditions is certainly not sufficient to draw the ALJ's conclusion that there had been a nationwide trend of quality.

Second, the Jencks study omits key areas associated with the provision of quality health care, most notably patient safety and adverse events, limiting any of the study's conclusions about nationwide trends.[7] In fact, the particular improvements implemented at Highland Park Hospital were focused on these key areas. Recent studies by the Institute of Medicine and the Agency for Healthcare Research and Quality, obliquely referenced by the ALJ at ALJ Initial Decision, Finding of Fact 859, at 107 (citing Romano Tr. at 2999-3001 and Noether Tr. at 6011), identify the need for a broader universe of patient safety metrics to measure quality and acknowledge the lack of a

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[6] One study found the four conditions to represent less than 15 percent of all Medicare admissions. Jha, Zhonghe, Orav and Epstein, *Care in U.S. Hospitals – The Hospital Quality Alliance Program*, N. Engl. J. Med. 353:3 at 273 (July 21, 2005).

[7] This is not to suggest that the Jencks study did not contain many other significant observations and conclusions.

baseline (at least until 2003) for measuring any meaningful trends in quality. *See* Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (2001); Reports found at Institute of Medicine Website at http://www.iom.edu; 2003 and 2004 National Heathcare Quality Reports found at the Agency for Heath Care Research and Quality, United States Department of Health and Human Services, at http://www.ahrq.gov/qual/measurix.htm. "Until recently, however, we have lacked any national database that could provide analogous data on [nationwide trends of] the quality of care provided by hospitals." Jha, Zhonghe, Orav and Epstein, *Care in U.S. Hospitals – The Hospital Quality Alliance Program*, N. Engl. J. Med. 353:3 at 265 (July 21, 2005).

In fact, Complaint Counsel's own expert believes that the Jencks study's approach is not an appropriate measure of overall quality and that, to reach any meaningful conclusions with respect to nationwide trends of quality of care, a more holistic approach is necessary. Complaint Counsel's Findings of Fact 2122-27. Indeed, only an approach to measuring quality that establishes a quality baseline and accounts for the "chasm" between the rapid technological and medical advances and the actual care provided to patients across a broad set of metrics would be meaningful to overall quality assessments. *See* Exhibit 1 at 1-2; Reports located at the Institute of Medicine Website at http://www.iom.edu/focuson.asp?id=8089.

Expanding the definition of quality beyond the Jencks study's too narrow "four conditions" and including adverse events within hospitals creates a mixed viewpoint, at best, as to whether quality in health care nationally has actually improved during the relevant time period and, for the ALJ's purposes, leaves no admissible evidence from

which the ALJ could make any inference about Highland Park Hospital's investments in quality ***relative to national trends.***

Third, the data underlying the Jencks study does not support the conclusion reached by the ALJ. MedPac, the independent body charged with advising Congress on Medicare issues, evaluated the data employed by the Jencks study as well as other data and reached a different conclusion as to where quality trends are heading:

> [D]ata on mortality, the appropriateness of care and adverse events provide ***a mixed picture*** of the clinical effectiveness, timeliness and safety of care in hospitals. Based on our data, measures of effectiveness of care such as mortality and the provision of clinically appropriate services in a timely manner show improvement, while the safety of patients, as measured by the rate of adverse events, does not.

MedPac 2004 Report to Congress at 36 (emphasis added), which can be found at http://www.medpac.gov/publications/congressional_reports/Mar04_Entire_reportv3.pdf

The MedPac report provides data on 13 patient safety indicators developed by the Agency for Healthcare Research and Quality. *Id.* at 38. Among their major findings – from 1995 to 2002, 9 out of 13 rates of adverse events experienced by Medicare beneficiaries increased; in other words, 9 out of 13 rates suggested a decline in quality. *Id.* at 39. The data also shows that not only are many Medicare beneficiaries experiencing adverse events, but that they are doing so at increasing rates. *Id.*

c. Conclusion: ALJ's Inference of Anticompetitive Conduct from the Fact of Higher Prices is Erroneous

Stripped to its core, there are two facts, (1) higher prices, and (2) large expenditures on meaningful quality improvements, which provide conflicting inferences of whether the merged entity had market power. The ALJ held that the first fact by itself

was not sufficient to conclude that the merged entity had market power. When confronted by the Respondent with the fact that the merged entity made large expenditures on meaningful quality improvements, the ALJ agreed that that was true but dismissed that fact because he concluded that the large expenditures were merely part of an industry-wide trend from 1997 to 2004 of quality improvements. He then concluded that because quality improvements (and other explanations) could not explain the increased prices, the higher prices must have been the result of market power. *See* ALJ Initial Decision, Summary of Conclusion No. 18, at 209. However, the underlying premise of an industry-wide trend of quality improvement is simply mistaken. In light of that mistake, the ALJ is left with two conflicting facts, one that does not establish market power, and one that is contrary to presence of market power.

II. Absent an Infusion of Capital, Highland Park Hospital was Not in the Position to Implement the Quality Improvements that ENH, in Fact, Implemented

As we have noted in the **IDENTITY AND INTEREST OF *AMICUS CURIAE*** Section of this Brief, Advisory Board has gained special expertise over the last five years and identified a growing problem facing many American hospitals: too little operating income to fund the capital and skilled staffing investments required to provide the high-quality acute care services vital to the surrounding community. No doubt that this was the case with respect to Highland Park Hospital. The public record reveals that Highland Park Hospital was a "weakened firm" "fac[ing] high costs, ha[d] low reserves, had at best uncertain prospects for loans or new reserves, [and was] in a weakened financial condition[.]" *See FTC v. Arch Coal, Inc.*, 329 F.Supp.2d 109, 157-58 (D.D.C. 2004) (holding that the weakened financial condition of the acquired firm impacts the

competitive significance of the acquisition).[8] In sum, Highland Park Hospital was not prepared financially to make the quality improvements that actually took place, and that fact appears to be overlooked by the ALJ, who assumes that most of the improvements would have taken place regardless of how irrational it would have been for Highland Park Hospital's Board and management to make such investments as opposed to investing surplus funds elsewhere.

Much of the "but for the merger" analysis is missing from the record. Perhaps, this is the case because Complaint Counsel has that burden but relied on other theories instead. The key to the analysis is that it is, in the first place, dynamic: what quality improvements would have taken place, and, importantly, *how fast*? Instead of carrying out this analysis and determining whether such investments would have been made and when, the ALJ appears to simply assume that competition would have caused the same or similar investments in improvements that took place. ALJ's Initial Decision at 182.[9]

The situation faced by Highland Park Hospital in 1999 was similar to the issues faced by the majority of the Advisory Board's 2,500 member hospitals. There is a long list of capital projects – including investments to shore up deteriorating physical plant as well as innovative clinical and information systems – that, due to insufficient operating margins and poor investment performance, that hospitals have been unable to fund despite their initial intentions to do so. In our research, hospitals assumed four courses of action:

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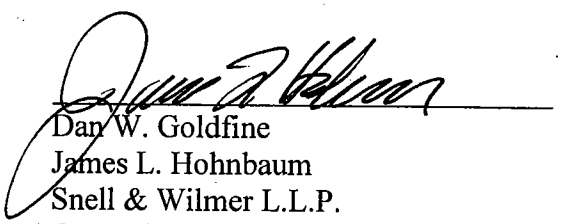
[8] It does not appear to the Advisory Board that the record reflects evidence that other suitors were prepared to make the degree of investments that ENH made in Highland Park Hospital post merger.

[9] The ALJ concludes that he does such an analysis, but a close review of his conclusions is that, in this respect, they are just that: conclusory. *See* ALJ Initial Decision at 182 citing Section III.C.2.e., which is also conclusory.

- elevating operating margin performance to increase available capital, which often led to extending the time horizon on planned capital investments
- trimming the capital spending ambition, prioritizing "mission" critical physical plant reinvestment often at the expense of clinical or information technology investments
- accepting a lower bond rating , which was a limited option given that many hospitals were already highly leveraged and many hospital board members were uncomfortable with a lower rating
- selling the hospital asset to a better capitalized health system in order to fund the majority of initiatives

Given the financial situation at Highland Park Hospital prior to the merger, it is unlikely that operating margin improvement alone would be sufficient to fund the outlined projects. In this light, the ALJ's unsupported conclusions about the fact of and the speed of quality improvements appears not to be realistic.

Respectfully Submitted,



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Dated: December 16, 2005.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on December 16, 2005, I caused true and correct copies of the foregoing Motion for Leave to File Amicus Curiae Brief and accompanying Brief Amicus Curiae of The Advisors Board Company to be served as described below.

Service by overnight delivery of paper copies, including an original, signed version, 12 photocopies, and an electronic version was provided to:

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Service of one copy was provided, by First Class mail, postage prepaid, to:

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