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SPECIALTY HOSPITALS: ASSESSING THEIR ROLE IN THE DELIVERY OF QUALITY HEALTH CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

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SPECIALTY HOSPITALS: ASSESSING THEIR ROLE IN THE DELIVERY OF QUALITY HEALTH CARE

THURSDAY, MAY 12, 2005

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:05 a.m., in room 2123 of the Rayburn House Office Building, Hon. Nathan Deal (chairman) presiding.

Members present: Representatives Deal, Hall, Shimkus, Shadegg, Pitts, Bono, Ferguson, Myrick, Burgess, Barton (ex officio), Brown, Gordon, Eshoo, Green, DeGette, Capps, Allen, and Baldwin.

Staff present: Chuck Clapton, chief health counsel; Melissa Bartlett, majority counsel; Brandon Clark, health policy coordinator; Eugenia Edwards, legislative clerk; Bridgett Taylor, minority professional staff; Amy Hall, minority professional staff; and David Vogel, research assistant.

Mr. DEAL. I am going to ask someone if they could close the doors in the back, please.

Good morning. I am going to call the committee to order, and I will recognize myself for an opening statement.

I am proud to say that this is a hearing that some of you have, perhaps, long awaited, and I think we have two rather distinguished panels that are going to talk to us about all aspects of the issue that is before us and that of specialty hospitals.

This is an issue that, in many respects, is complex and certainly is often contentious. So for those of you who are on our panels, we look forward to your testimony, and we appreciate the fact that you would be willing to appear today.

Our first panel of witnesses, of course, contains some familiar faces to those of us on this subcommittee: Dr. Mark McClellan, the Administrator of the Centers for Medicare and Medicaid Services; and Mr. Glenn Hackbarth, who is the Chairman of the Medicare Payment Advisory Commission, MedPAC. Gentlemen, we are pleased to have you here today, and we will hear from you in just a few minutes.

Our second panel, that I will go ahead and recognize at this time, comes to us from what some would say are "outside the beltway," and offer perspectives from the "real world" that lies outside: Dr. Alan Pierrot from Fresno Surgery Center, representing the American Surgical Hospital Association; Mr. John E. Hornbeak from

Methodist Healthcare Systems of San Antonio representing the Federation of American Hospitals; Mr. John Thomas from Baylor Health Care Systems of Dallas, representing a joint venture; and Dr. Peter Cram from the University of Iowa College of Medicine, who is an independent researcher.

I know, from conversations I have had with many of my colleagues on this subcommittee, that they have held numerous meetings and have had many inputs from constituents from throughout their Congressional Districts. And many of them are like me; they are carefully weighing the consideration of the options that are liable for us.

Again, I want to welcome our witnesses and thank them for being here and participating in this hearing.

And I will now recognize Mr. Brown for 5 minutes for an opening statement.

Mr. BROWN. Thank you, Mr. Chairman. Thanks to our witnesses for joining us this morning.

It is difficult to assess the costs, quality, and access impact, especially hospitals, at least those that have emerged over the last decade or so. As MedPAC pointed out in its March report, the phenomenon is too recent to provide much in the way of trend data. Based on MedPAC's preliminary findings, these hospitals may, in fact, weaken the health care system more than they strengthen it, however some of their impact simply can not be accurately assessed until the market matures.

For example, while it is not clear that competition from specialty hospitals is bringing down cost today, such competition could have a positive effect in the future. Importantly, it should be possible to revise the rules of the game in a way that minimizes the negative effects and maximizes the positive ones. In establishing those rules, if we can't fully rely on the data, then we will have to rely on logic.

Closing the physician referral loophole is the most controversial and probably the most important of these rule changes and, I believe, a logical step. When physicians can directly and tangibly affect their income by referring patients to a particular health care facility, competition has gone awry. As it stands, physicians are permitted to refer patients to whole hospitals because the effect of those referrals is sufficiently diffuse.

But I have to say, it makes no sense to me to define a specialty hospital in this way as a whole hospital. After all, the fact that they are not whole is the very feature that differentiates these hospitals from the rest. If referral for self gain distorts demand and a referral undercuts fair competition, then physicians should not be permitted to refer patients to a specialty hospital in which they have a vested financial interest. One physician's referrals can, in fact, make a tangible difference in a specialty hospital's bottom line. Competitive advantage should be a function of efficiency and quality, not the product of cream-skimming healthier and less-costly patients from community hospitals.

Remember, hospital reimbursements pegged to the cost of an average patient. If specialty hospitals serve a disproportionate share of healthier patients, they are not only placing community hospitals at risk, they are receiving tax dollars that they, in fact, don't deserve. Competitive advantage should not be gained by cream-

skimming insured patients from community hospitals. The consequences of that type of gaming are obvious. Competitive advantage should not be secured by capitalizing on the vagaries of a hospital reimbursement system that has unfortunately produced more profitable and less profitable health conditions, and it should not be deployed in a way that starves community and public hospitals of the patient volume they need to cover their significantly larger fixed costs.

As always, the benefits of competition need to be weighed against the needs of the community. Specialization that benefits some patients at the expense of other patients doesn't move the health care system forward, and specialization that strains the already shaky financial viability of community and public hospitals moves the health system backward.

Ideally, free market competition would work perfectly. There would be no need for rules. Unfortunately, reality, as we know throughout our health care system, is more complicated than that. There are rules against collusion, against price gouging, and in the case of health care, against physician self-referral.

I support an extension of the moratorium on self-referral to specialty hospitals for the same reason that I support the prohibition on self-referral and its other applications, because self-referral so easily corrupts need-based care and value-based competition. In my view, there is definitely a role for specialty hospitals in the Nation's health care system; we just need to make sure it is a productive role.

Thank you, Mr. Chairman.

Mr. DEAL. I thank the gentleman.

We are pleased to have the chairman of the full committee, Mr. Barton from Texas, who I will recognize now for an opening statement for 5 minutes.

Chairman BARTON. Thank you, Mr. Chairman.

And I want to compliment you on holding this hearing. I also want to compliment you on the selection of witnesses. I am sure it is just a coincidence, but half of them are from Texas. So we are definitely going to have a good group of panelists.

This hearing is very important, because it will provide members of the committee a valuable perspective on the issue of specialty hospitals in the role in delivering quality health care.

I want to particularly thank CMS Administrator, Dr. Mark McClellan, for appearing here today. As many of you know, last night CMS released their long-awaited recommendations on specialty hospitals. CMS has recommended a careful review of new special hospital applications.

I support this approach, and I am going to underline that. I support the conclusions of the report that say they are going to change the rules on specialty hospitals. But I also am very pleased about what the report does not say. They did not say that the moratorium on building or expanding specialty hospitals be extended, either by legislation or through other administrative actions.

This decision will be a boom to competition and the quality of care that patients receive. Let me repeat that. The report that CMS released last night does not continue the ban, the moratorium on specialty hospitals. And I think that is very important.

I could not agree more: competition drives down cost and improves the quality of health care. Some say we need less competition and more government regulation, but that will give us these bigger bills and sicker patients. The rise of specialty hospitals will press traditional community hospitals to become leaner, faster, and better. This means more patients will get well quicker.

I have recently met with people on both sides of this issue. I understand the concerns of the community hospitals. They feel the new specialty hospital will cost them patients and revenue. If they decline to react to the competition or sit back and wait for a government bail-out, that is exactly what is going to happen.

At the same time, I have also met with the folks from my District who told me how much they appreciate the quality and service they have received from the existing specialty hospitals. I mean for them to have more, not less.

Taken together, these arguments make the case for why the approach that Dr. McClellan has laid out is a reasonable compromise. The new recommendations will allow CMS to carefully review new specialty hospital applications to assess the need for these institutions. At the same time, the policy will not be an absolute bar that would prohibit the creation of new specialty hospitals and thereby stifle competition. This policy will also allow CMS to begin to consider the concerns raised by some that the specialty hospitals cherry-pick the healthiest and wealthiest patients and deliver only their treatments that are the most lucrative.

That is not going to happen, because we will not allow anybody to game the system that way in neither specialty nor community hospitals. Now I listened with interest to what the Ranking Member, Mr. Brown, said in his opening statement. And most of it I agree with. What I disagree with is that we should ban self-referral in its totality, because if you really mean that and do it across the board, if I go to my family practice doctor in Inez, Texas and he says, "Joe, you have got the flu." And I say, "Okay, doctor. Treat me." He says, "I can't. I have to refer you to somebody else for treatment. I have diagnosed that you have the flu, but I can't treat you." Well, that is silly. So the answer is not to ban self-referral. The answer is that if somebody comes to a particular doctor, and let us say that the doctor is an orthopedic surgeon, and he says, "You need a knee replacement." Well, if that is his diagnosis and he can replace the knee, then he should do that. So he should treat all comers, regardless of ability to pay.

So I agree with what Mr. Brown was saying about making sure that we treat all of the people. I disagree the way to do it, though, is to ban self-referral.

The specialty hospital moratorium will expire in June, and I don't believe that any further action by Congress is necessary. However, should members of the committee want to legislate on the issue, I intend to work with both sides of this debate. I want to pursue a compromise that would allow specialties to continue while ensuring that they carry their fair share of Medicaid patients and other uncompensated care.

So I guess where I am on this particular issue is I am going to be a Senator. This is one where I can do nothing and win, so I am

going to be a Senator on this issue and watch the moratorium expire on specialty hospitals.

And with that, Mr. Chairman, I yield back the balance of my time.

[The prepared statement of Hon. Joe Barton follows:]

PREPARED STATEMENT OF HON. JOE BARTON, CHAIRMAN, COMMITTEE ON ENERGY AND COMMERCE

Thank you, Chairman Deal, for holding today's hearing. This hearing is especially important, because it will provide Members of the Committee with valuable perspectives on the issue of specialty hospitals and their role in delivering quality health care.

I want to particularly thank CMS Administrator Mark McClellan for appearing here today. As many of you know, last night CMS released their long-awaited recommendations on specialty hospitals. CMS has recommended a careful review of new specialty hospital applications. I support this approach.

Better yet was what the CMS recommendations did not say. CMS did not recommend that the moratorium on building or expanding specialty hospitals be extended, either by legislation or through other administrative actions. This decision will be a boon to competition and to the quality of care that patients receive.

I couldn't agree more. Competition drives down cost and improves the quality of health care. Now, some say we need less competition and more government regulation, but all that will give us is bigger bills and sicker patients. The rise of specialty hospitals will press traditional community hospitals to become leaner, faster and better. This means more patients get well quicker.

I have recently met with people on both sides on this issue, and I understand the concerns of the community hospitals. They fear the new specialty hospitals will cost them patients and revenue. If they decline to react to the competition or sit back and wait for a government bailout, that's exactly what will happen to them. At the same time, I have also met with folks from my district who told me how much they appreciated the quality and service they received from their specialty hospitals. I mean for them to have more, not less.

Taken together, these arguments make the case for why the approach Dr. McClellan has laid out is a reasonable compromise. The new recommendations will allow CMS to carefully review new specialty hospital applications, to assess the need for these institutions. At the same time, the policy will not be an absolute bar that would prohibit the creation of new hospitals and thereby stifle competition.

This policy will also allow CMS to begin to consider the concerns raised by some that specialty hospitals cherry-pick healthiest patients and deliver only the treatments that are most lucrative. That's not going to happen because we will not allow anybody to game the system that way—neither specialty nor community hospitals.

Because the specialty hospital moratorium will expire in June, I do not believe any action by Congress is necessary. However, should Members of the Committee want to legislate on this issue, I intend to work with both sides of this debate. I would want to pursue a compromise that could allow specialties to continue, while ensuring that they carry their fair share of Medicaid patients and other uncompensated care.

Thank you again to our witnesses for appearing here today and I look forward to hearing their testimony.

Mr. DEAL. I thank the gentleman.

I recognize Mr. Gordon from Tennessee for an opening statement.

Mr. GORDON. We will not be here at 2 o'clock, so I am going to be very brief.

First of all, let me just thank you for having this important meeting. I am concerned really about the specialty hospitals and the impact they are going to have on my general hospitals in middle Tennessee as well as in the emergency rooms and other critical services that are offered to the community. And I will tell my friend from Texas, Mr. Barton, the good news is that if that doctor that said you needed some knee surgery, he could always take you to

the hospital. You wouldn't have to go to his hospital. You could go to the general hospital. So you could still get that surgery, Joe.

So I think we will have a——

Chairman BARTON. I wish my knees were as good as yours.

Mr. GORDON. So I would have to take a contrary position. I think we do need to have the moratorium extended as we figure this out. And I am glad we are going to have, I guess, competing panel reports this morning. And hopefully that will help us be able to figure out where we need to go, but I think we need a little more time as we figure that out.

So thank you, Mr. Chairman, for having this meeting.

Mr. DEAL. I thank the gentleman.

I now recognize Dr. Burgess for an opening statement.

Mr. BURGESS. Thank you, Mr. Chairman.

I have a statement that I will submit for the record, but I do want to make a few remarks before we start, and it is always good to see you, Dr. McClellan and John Thomas from Baylor down near my District in Dallas. Great to have you here this morning.

And we all look forward to the testimony that we are going to hear today. It is important testimony on an important subject. And we are very fortunate to have such a distinguished panel to give us good information this morning.

I suppose missing from the panel are the patients and the taxpayers, and unfortunately, they are not with us this morning.

It is a complicated issue. On the one hand, the surgery center and the specialty hospital who can do a better, faster, cheaper, and arguably safer, in some instances, things like patient convenience, patient comfort, patient satisfaction, and perhaps even patient safety are all likely to score high on any survey. Patients requiring heart surgery, very specialized procedures, arguably there is a place for these in the specialty hospital.

On the other hand, the full-service community hospital is what most of us recognize as a hospital. These hospitals fund and support services that are not as likely to provide a hefty return on investment. Services such as the pediatric ICU, the emergency room, the medicine wards, the intensive care unit, which because of the community hospital's mission, are likely to have more patients who aren't insured and thus, a lower profit margin, if any profit at all.

And there are likely more examples that we will hear this morning from the panel. I think it is important that this committee recognize that it may be time to recognize that the payment formula is not necessarily going to be the same for both the community hospital and the specialty hospital.

I disagreed with the moratorium when it was passed. I did not think it was right. I do not think it should be extended. But we do now have an opportunity to craft a balanced solution that will benefit the patients and the taxpayers and help us move in the direction that we really should be going in in this Congress. It is time for us to value health. We can't keep up with just paying for disease as it occurs.

It is hard to say that we are going to let market forces work when there has been no free market in the practice of health care in the last 40 years, but all in all, I agree with the chairman. I

think a compromised solution is going to be in everyone's best interest.

But I do look forward to hearing the testimony of the panel this morning, and I will yield back.

Mr. DEAL. I thank the gentleman.

I recognize the gentlelady from California, Ms. Eshoo, for an opening statement.

Ms. ESHOO. Thank you, Mr. Chairman, for holding this important meeting.

And Dr. McClellan, welcome. It is good to see you.

It is important that we have this hearing and hear from the experts, because the 18-month moratorium deadline on self-referrals to physician-owned specialty hospitals is going to expire on June 8.

As I see it, we have two issues here. We have a reimbursement system that pays physicians a higher rate for performing services in specialty hospitals. So that is a double whammy, because, really, the reimbursement system rewards physicians and takes them in a direction that is going to serve them even better. That reimbursement system is a public reimbursement system. It is not a private reimbursement system. So I think it is very important that we find out from Dr. McClellan how he views that reimbursement system. We are going to keep paying a higher rate when we hear from other physicians in the provider community wondering what is going to happen to their formula in Medicare. I am not against physicians earning a good living. God knows we need the best doctors standing on one side of us. And whether my colleagues on the other side of the aisle believe this, an excellent attorney on the other side of us.

But the system, as I see it, is tilted. It is tilted. It is tilted because there is more money from the system that we have, the public system, and in addition to that, you have a stake in that specialty hospital. You own that place. You have ownership in it. Then obviously you are bringing in more money as a result of it. I mean, that is the way it stands. And I think that those are the two things that we need to take a look at.

Now if the rest of the system was really doing well, if everyone else in the system was doing well, you say, "Well, this is a part of an overall healthy system where there are many dollars for it that support it." Well, maybe in that context, this would not really raise its head as an all-important issue. But it is, because there are strains on the system throughout.

So I think that that is what we need to examine, and Dr. McClellan, I hope that you will address that. I think that you touch on this in your printed testimony of shedding more light on whether refining the reimbursement system would reduce the need for physician self-referrals.

So thank you, Mr. Chairman, again for having the hearing. I am glad to see the witnesses. You are more than welcome here always, and I look forward to the testimony.

Thank you.

Mr. DEAL. Thank you.

I will recognize the other gentlelady from California, Ms. Bono.

Ms. BONO. Thank you, Mr. Chairman.

I would like to welcome our witnesses. It is an extremely important hearing, and a lot of great questions and comments have been brought up by my colleagues, and I look forward to hearing the answers.

I just want to respectfully disagree with my colleague from California, for whom I have the highest respect, but I think the biggest problem in health care is that lawyer being on the other side of the patient.

So again, welcome. I look forward to hearing you and your answers. And I yield back.

Mr. DEAL. Thank you.

I recognize Mr. Allen.

Mr. ALLEN. Mr. Chairman, thank you for convening this hearing.

I want to thank all of the witnesses for being here.

The growth of physician-owned specialty hospitals has coincided with rising concerns about possible conflicts of interests inherent in these for-profit entities. Community hospitals carry on a proud tradition in Maine providing quality health care 24 hours a day, 7 days a week, 365 days a year to all patients, regardless of their ability to pay. Maine has a certificate of need requirement, and therefore does not have any private specialty hospitals. The State of Maine has 39 non-profit community hospitals.

In two recent studies conducted by CMS and published in the Journal of the American Medical Association, Maine hospitals rated third-best in the Nation on 22 indicators of the quality of care given to Medicare patients. These indicators measured delivery of services that are effective in treating breast cancer, diabetes, heart attack, heart disease, pneumonia, and stroke. Maine's hospitals strive to improve the affordability of health care, increase access, and make investments in quality health care a top priority. Balancing the cost of quality care to all, regardless of their insurance, is daunting in the context of a fragmented health care system.

I believe that it is critical that initiatives to control costs and improve services do not jeopardize access to high-quality health care. I am particularly concerned about the negative financial effects that these physician-owned specialty hospitals could have on community hospitals.

I look forward to hearing our panelists' views on three critical issues involving specialty hospitals.

First, are physicians with a financial stake in a hospital "cherry picking" less-sick, better-insured patients, essentially skimming the cream from the broader patient pool?

Second, specialty hospitals are half as likely to have emergency departments. What impact could this have on life-saving emergency and trauma care?

Third, what is the prevalence of physicians over-prescribing care when referring patients for services to specialty hospitals in which they have a financial interest?

With 45 million uninsured Americans and exploding health care premiums for businesses and individuals, we already know that we have a deeply flawed health care system. Community hospitals are an essential component of our Nation's health care safety net, providing millions of dollars in charity care each year. But in order to

provide quality care to all patients, community hospitals need to be financially healthy. It is important and appropriate for this committee to examine the impact of physician-owned specialty hospitals on the entire health care system.

And with that, I want to thank all of the witnesses and yield back.

Mr. DEAL. Thank you.

I recognize Mr. Ferguson for an opening statement.

Mr. FERGUSON. Thank you, Mr. Chairman, and thank you for holding this important hearing.

And I certainly want to thank all of our witnesses for being here today.

Dr. McClellan, great to see you again. Thank you for all of your great work. And Mr. Hackbarth, thank you, too, for being here. We appreciate you both being here, and certainly we look forward to hearing your thoughts on this.

This issue is really important, as a number of other folks have said already, about the referral system through which our Nation's hospitals and doctors provide care for our Nation.

At the heart of the issue is the desire for physicians to have more control over hospital operations. This is a noble goal, but it is important that it is not done in conjunction with practices, such as referring more profitable patients to hospitals where doctors have an ownership stake. As a result of that behavior, there are fewer Medicaid and Medicare patients admitted to the physician-owned hospitals at the heart of it, that is why we include it in the moratorium and the MMA almost a year and a half ago.

I am looking forward to hearing the testimony of our panels today. I am particularly interested in hearing the findings by CMS and MedPAC and their recommendations for future action.

In the meantime, we can also look at proposals like gain sharing that are already being innovated today in my home State of New Jersey and other opportunities for physicians to participate with the hospital, working in tandem to drive down costs and to reach incentives for increased pay. Specifically, the New Jersey project is a pay-for-performance efficiency project that attempts to align physicians and hospital incentives to control Medicare costs and improve the efficiency of care. It is a win-win for the doctors and the hospitals to work on a level playing field.

I urge our committee to review this project and to allow CMS to approve this pay-for-performance project on a demonstration basis.

Thank you, again, Mr. Chairman, for holding this important hearing. I again look forward to hearing the testimony today, and I yield back.

Mr. DEAL. I thank the gentleman.

I recognize Ms. Baldwin for an opening statement.

Ms. BALDWIN. Thank you, Mr. Chairman.

And I thank the witnesses who are here today.

Health care is the issue that prompted me to enter public service in the first place, and the challenges in our health care system continue to be the issue that keeps me here. I am always interested in hearing about innovations in health care that seek to improve access and delivery of health care. I know that the proponents of specialty hospitals see them as a step toward more efficient health

care while opponents see them as draining scarce health care dollars from community hospitals.

These two totally different perspectives then raise a number of questions that I look forward to having addressed today. Specifically, I am interested in learning more about the impact of specialty hospitals on community hospitals. And I am interested in hearing from the specialty hospital proponents about their treatment of Medicaid patients and the uninsured and what role they can play in moving our country toward one where all Americans have access to quality, affordable, comprehensive health care.

I would like to commend the chairman for calling this important hearing. The issue of physician-owned specialty hospitals raises some serious questions, and I look forward to this opportunity to have some of those questions examined more closely by the experts.

Thank you.

Mr. DEAL. Thank you.

Mr. Shimkus.

Mr. SHIMKUS. Thank you, Mr. Chairman.

I wasn't going to speak, but I wanted to take this time, obviously, when you get the bully pulpit for a few minutes to raise an issue you and I talked about the last 2 weeks. And I just got an article in a local paper. We have lost our second doctor in 2 weeks, now probably about 175 practitioners in a 2-county area. And this is from the Alton telegraph of yesterday. Dr. Charles Sam has carried on his father's medical service to a local community, but the malpractice insurance crisis is sending him to Wisconsin. Sam is a Bethalto native. He has practiced here for 20 years. He has announced that July 15 will be his last day practicing locally. They are moving to Wisconsin, Tammy, so maybe he can help in the medical field here.

His quote says: "You find yourself waking up every day wondering if this is the day that you are going to lose it all." Sam has said Tuesday, "It is like doctors here have a target on their backs." And then he also is quoted as saying, "It is with great sadness that I wish to announce my departure from the Bethalto medical practice. I truly thought that I would practice here until I retired, but the malpractice climate has forced me to do otherwise." He also quotes, and this is what I hope Dr. McClellan will take back to the Administration, of course President Bush visited Madison County early this year. Great hopes that we would have some reforms. We are starting to move in the committee, under the direction of the chairman, in discussions, and I hope that you all would continue to intervene so that we can get legislation to the President's desk.

With that, Mr. Chairman, I yield back my time.

Mr. DEAL. Thank you.

Mr. Green, do you wish to make an opening statement?

Mr. GREEN. Mr. Chairman, I would just look forward to the questioning. I will have a statement for the record. Welcome, Dr. McClellan.

Mr. DEAL. Well, thank you. I believe that concludes the opening statements of all members who are present.

[Additional statement submitted for the record follows:]

PREPARED STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. Chairman, thank you for holding this hearing. And thank you to our witnesses for being here to testify on this critical issue.

Physician-owned specialty hospitals have been growing rapidly in recent years. According to the Government Accountability Office, the number of specialty hospitals tripled between 1990 and 2003.

There are two complex sides to this issue. Some view specialty hospitals as innovative, focused facilities for high-quality, specialized care, adding competition to the health care marketplace. Others say specialty hospitals flourish because they exploit a Medicare loophole allowing physician-owners to select patients who are less sick and, therefore, more profitable. This leaves the less-profitable patients for community full-service hospitals, likely undermining their financial viability.

There are also concerns about physician ownership of speciality facilities. The physician self-referral laws were enacted because of evidence that doctors prescribe more tests and services when they have a financial ownership in facilities providing those tests and services. But a loophole in physician self-referral laws allows physicians to self-refer to specialty hospitals in which they have a financial interest. This loophole may well need closing.

Because of concerns over specialty hospitals, the Medicare Modernization Act put a moratorium on reimbursement of new specialty hospitals. Regardless of whether the moratorium on specialty hospitals is continued, the recommendations that MedPAC has made on better aligning physician-hospital incentives and improving payment accuracy merit consideration. These recommendations could mitigate specialty hospitals' incentives to choose healthy patients over sick ones and could also improve physician satisfaction with hospital management practices.

I am pleased this hearing will provide some perspectives on this complex issue, and again thank the witnesses for their testimony today.

Mr. DEAL. So we will proceed to our first panel, and Dr. McClellan, welcome. We look forward to your testimony. And I am sure you will shed some light on the report that was released last night.

STATEMENTS OF MARK B. McCLELLAN, ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES; AND GLENN M. HACKBARTH, CHAIRMAN, MEDICARE PAYMENT ADVISORY COMMISSION

Mr. MCCLELLAN. That is right.

Well, Mr. Chairman, Representative Brown, Chairman Barton, and all of the distinguished members of the committee, it is a pleasure to be back with you today. You know, we have been dealing with many important health care issues for the Nation in this committee. This is another one, the issue of physician-owned specialty hospitals.

At the Centers for Medicare & Medicaid Services, we remain deeply committed to improving the quality of patient care and avoiding unnecessary Medicare spending.

How Medicare pays for services and how we work with other stakeholders in our health care system can significantly impact quality and medical costs for our beneficiaries and for the overall health care system. By carefully examining features of our payments and the realities of medical practice, we can find ways to make sure that the financial incentives created by Medicare can be improved to help ensure not only that Medicare pays accurately, but that our rules promote quality care for Medicare beneficiaries and other hospital patients. And to this goal, Section 507 of the Medicare Prescription Drug, Improvement, and Modernization Act, the MMA, requires us to study this set of important quality and cost issues related to specialty hospitals and to report to Congress on our findings.

Now this is the first presentation of our results and our recommendations. You all are very knowledgeable, I can tell from the opening statements, about this important issue, so I am going to just briefly summarize the report and then turn to our recommendations and how we intend to proceed.

As you know, during this 18-month moratorium imposed by the MMA, we were required to study a number of factors, including referral patterns of specialty hospital physician owners, quality of care, patient satisfaction, differences in uncompensated care and tax payments between specialty hospitals and community hospitals. We contracted with an independent research organization to conduct this technical analysis. The researchers used available national data for many aspects of this report. In addition, they also drew on a collection of a considerable amount of new data related to a detailed investigation of ownership and performance and impact of specialty hospitals, supplemental data from certain communities. They made site visits to specialty hospitals in six market areas around the country.

The hospitals there comprised about one-sixth of the 67 cardiac surgery and orthopedic specialty hospitals that were in operation and approved by Medicare in 2003. The researchers selected the market areas, because they represented a range of circumstances in which specialty hospitals operate as well as geographic diversity. They used Medicare claims data from the entire national population, the whole country, in terms of physician-owned specialty hospitals to assess quality of care. To do this, they used inpatient hospital quality indicators developed by the Agency for Health Care Research and Quality to assess quality of care at specialty hospitals visited and at the local competitor community hospitals. To estimate the total tax payments on uncompensated care for these hospitals, they used data obtained from the Internal Revenue Service as well as from the hospitals themselves.

The empirical evidence from this report clearly shows that cardiac hospitals differ significantly from surgery and orthopedic hospitals. Compared to surgery and orthopedic hospitals, cardiac hospitals tend to have a higher average daily count of inpatients in the hospital. They tend to have an emergency department. They have other features, like community outreach programs, whereas surgery and orthopedic hospitals more closely resemble ambulatory surgical centers where they focus primarily on outpatient services. All of the cardiac hospitals reportedly were built exclusively for cardiac care, to specialize in it. The average daily census of the 16 cardiac hospitals that were open for more than a year in 2003, was 40 patients. For surgery and orthopedic hospitals, the average daily census was only about 5 patients. Cardiac hospitals in 2003 treated 38,000 Medicare cases and Medicare patients accounted for most, about two-thirds, of the inpatient days of these hospitals nationwide. In surgery and orthopedic hospitals, Medicare patients accounted for about 36 percent of the inpatient days, a much smaller percentage.

The small number of inpatient cases at surgery and orthopedic hospitals prevented a development of meaningful findings for this group on some of the dimensions of performance in the report. For

all of these reasons, the report focuses on cardiac hospitals and orthopedic surgical hospitals separately.

Now in the report, CMS found that physician owners referred or admitted the majority of Medicare patients in most cardiac hospitals, as I said, but these physicians do not refer their patients exclusively to the specialty hospitals that they own. Patients treated at cardiac specialty hospitals are less severely ill than community hospitals. We confirmed other results with similar findings. However, both the owners and the non-owners refer patients of high and low severity in a very similar way. Both send a greater proportion of the more severe patients to the community hospital. In addition, in terms of quality of care, quality of care is as good as better, and patient satisfaction is very high at the cardiac hospitals. Although the small number of patients treated in surgery and orthopedic hospitals prevented careful measurement of quality in many dimensions, the patients at those hospitals also expressed very high satisfaction with their care. Moreover, the total proportion of net revenue that specialty hospitals devote to both uncompensated care and taxes significantly exceeds the proportion of net revenues that community hospitals devote to uncompensated care. And real estate, property, and a portion of these sales taxes remain in the local community.

These results, and the results of other studies, indicate that the activities and impacts of specialty hospitals may reflect some important impacts on quality, but also may reflect some imperfections in current hospital payment systems and differences in the patients served, not just efficiency and quality differences. Our current payment systems may not be providing appropriate incentives for maximizing quality and minimizing costs for all of our beneficiaries.

As a result of our findings, we expect to proceed with some significant administrative reforms to our payment systems. These are similar to the recommendations from MedPAC, and we also will proceed carefully and deliberately with further evaluation of enrollment and health and safety issues before additional specialty hospitals receive Medicare payment.

In particular, we have developed four key recommendations, which we can implement with our existing authority.

First, to help reduce the possibility that specialty hospitals could take advantage of imprecise payment rates and the inpatient hospital payment system, we are analyzing the MedPAC recommendations to improve the accuracy of the payment rates for inpatient hospital services, and we expect to adopt significant revisions in our payment system in fiscal year 2007. We will fully examine and simulate the changes between now and then, and we are going to proceed with those that lead to significant improvements in payment accuracy.

Second, physicians may be participating in the ownership of some of these hospitals, particularly the small orthopedic and surgical hospitals, rather than ambulatory surgical centers in part to take advantage of payment differences between hospital outpatient department and ambulatory surgery centers. We are currently planning to reform our ambulatory surgery center fee schedule to diminish these differences in payment levels that can create artifi-

cial incentives to create small orthopedic and surgical hospitals. And we plan to implement these ASC payment reforms no later than January 1, 2008.

Third, to address the concern that existing entities, such as those that we have been talking about today, these kinds of hospitals may be concentrating primarily on outpatient care rather than inpatient care, we are going to scrutinize whether specialty hospitals truly meet the definition of a hospital. If we determine that a specialty hospital operating under an existing provider agreement is not or is no longer primarily engaged in treating inpatients, the hospital may have its provider agreement terminated.

Fourth, we are going to carefully review our criteria for approving and starting to pay new specialty hospitals. We want to make sure that, given their limited focus, specialty hospitals meet such core requirements as are necessary for the health and safety of our beneficiaries. That includes a review of our EMTALA, our Emergency Medical Treatment and Labor Act policies are applied to specialty hospitals. It includes addressing these issues related to whether the hospitals are assuring that the safety of our beneficiaries, given their limited scope of activities. So we will be conducting that review over the coming months.

All of these issues raise some important policy concerns, so during an upcoming 6-month review period, we plan to review our procedures for examining whether specialty hospitals meet the applicable standards for enrolling in Medicare. We are going to instruct our fiscal intermediaries to refrain from processing further participation applications from specialty hospitals until this review is completed and any indicated revisions are implemented. In the course of this review, we want to make sure we get all of the input to build on the reports to date. We are going to confer with State survey and certification organizations, with the Joint Commission on the Accreditation of Health Care Organizations, the American Osteopathic Association, and we will be having meetings to make sure we are getting appropriate public input as well as relying on our EMTALA Technical Advisory Group.

During this same period, we are also going to assess whether the standards are appropriate, and I mentioned the connection with EMTALA already. We are currently operating this Technical Advisory Group so that interested parties can provide testimony on issues related to emergency care. Depending on the results of this review, we will draft appropriate instructions to implement revised EMTALA procedures, and we will consider whether to proceed with changes in the regulations governing the EMTALA standards. Again, we expect to complete revisions to these procedures by January 2006.

So, Mr. Chairman, I want to thank you for this opportunity to discuss our report and recommendations on physician-owned specialty hospitals. We have been studying this important and complex topic carefully with a lot of data collection as part of our ongoing efforts to provide the best possible evidence-based foundation for implementing effective policies to get patients the highest quality care at the lowest cost. We look forward to continuing to work with you, with all of you, on these important issues.

Thank you.

[The prepared statement of Mark B. McClellan follows:]

PREPARED STATEMENT OF MARK B. MCCLELLAN, ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Chairman Deal, Representative Brown, distinguished committee members, thank you for inviting me to testify today about physician-owned specialty hospitals. At the Centers for Medicare & Medicaid Services (CMS), we remain deeply committed to improving the quality of patient care and to increasing the efficiency of Medicare spending. As you know, how Medicare pays for medical services can significantly impact quality and medical costs for our beneficiaries and our overall health care system. By carefully examining interactions between physicians and hospitals, we can consider how the financial incentives created by the Medicare program might be improved, to help ensure not only that Medicare pays accurately but that Medicare's payment rules promote quality of care for Medicare beneficiaries and other hospital patients. To that end, Section 507(b)(2) and (b)(3) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires HHS to study a set of important quality and cost issues related to specialty hospitals, and to report to Congress on our findings. I am here today to present the results and recommendations from the CMS report and the actions we will take.

In the CMS report on specialty hospitals we found some notable results. For example, we found specialty hospitals provide high patient satisfaction, high quality of care and patient outcomes in some important dimensions, greater predictability in scheduling and services, and significant tax contributions to the community. However, our results and those of others indicate that the activities and impacts of these hospitals may also reflect imperfections in current Medicare payment systems and differences in patients served, not simply efficiency and quality differences. Our current payment systems may not provide appropriate incentives for maximizing quality and costs for our overall beneficiary population. Therefore, we expect to proceed with significant administrative reforms to our payment systems, similar to those recommended by Medicare Payment Advisory Commission (MedPAC) in its specialty hospital report to Congress. In addition, we plan to comprehensively review the procedures used to qualify specialty hospitals.

Specifically, CMS has developed four key recommendations for physician-owned specialty hospitals. First, to help reduce the possibility that specialty hospitals may take advantage of imprecise payment rates in the inpatient hospital prospective payment system (IPPS), CMS is analyzing MedPAC's recommendations to improve the accuracy of the payment rates for inpatient hospital services and expects to adopt significant revisions in FY07. CMS will fully examine and simulate the changes and proceed with those that actually lead to significant improvements in the accuracy of our payment system. Second, we will reform payment rates for ambulatory surgical centers (ASCs). In particular, our report showed that some physicians may have an ownership interest in entities that describe themselves as small orthopedic or surgical "hospitals" to which they refer patients. We speculate that these entities may describe themselves as hospitals rather than ASCs in part to take advantage of the more favorable payment rates that apply under the hospital outpatient prospective payment system (OPPS) as opposed to the ASC payment system. This is problematic from CMS' perspective, however, since the Medicare program defines a "hospital" as an entity that provides care "primarily" to inpatients. To the extent that such an entity is not, in fact, primarily providing care to inpatients, it is inappropriately categorized as a hospital and should not be treated as one under the Medicare program. CMS is currently planning to reform the ASC fee schedule to diminish the divergences in payment levels that create artificial incentives for the creation of small orthopedic or surgical hospitals. CMS plans to implement these ASC payment reforms in conjunction with other revisions to the ASC fee schedule required by the MMA by January 1, 2008. Third, to address the concern that entities such as those described above may be concentrating primarily on outpatient care, CMS will scrutinize whether specialty hospitals meet the definition of a hospital. Specifically, we will analyze existing data to assess whether specialty hospitals meet the requirement that to be defined as a hospital it must provide primarily inpatient care. Fourth, we will carefully review our criteria for approving and starting to pay new specialty hospitals. CMS wants to be assured that, given their limited focus, specialty hospitals meet core requirements that we determine are necessary for the health and safety of our beneficiaries. In addition, we wish to consider how EMTALA applies to specialty hospitals, with particular reference to potential transfer cases arising in the emergency departments of other hospitals. All four of these issues raise important policy concerns. CMS plans to review our procedures for examining such hospitals, and we will instruct our state survey and certification

agencies to refrain from processing further participation applications from specialty hospitals until this review is completed and any indicated revisions are implemented. We expect to complete this process by January 2006.

CMS' STUDY OF PHYSICIAN-OWNED SPECIALTY HOSPITALS

Section 507(a) of the MMA placed a moratorium on physician-investor referrals of Medicare or Medicaid patients to new specialty hospitals (thus effectively halting the development of new specialty hospitals) for an 18-month period and required HHS to study referral patterns of specialty hospital physician-owners, to assess quality of care and patient satisfaction, and to examine the differences in uncompensated care and tax payments between specialty hospitals and community hospitals. CMS contracted with RTI International, an independent research organization, to conduct the technical analysis.

In addition, Section 507(a) of the MMA added a new paragraph (7)(A) to section 1877(h) of the Social Security Act. That paragraph defined a specialty hospital for the purposes of the moratorium as a hospital in one of the 50 States or the District of Columbia that is primarily or exclusively engaged in the care and treatment of one of the following:

- patients with a cardiac condition;
- patients with an orthopedic condition;
- patients receiving a surgical procedure; or
- patients receiving any other specialized category of services designated by the Secretary (none have been designated thus far.)

The MMA also required a complementary MedPAC study of certain issues related to the payments, costs, and patient severity at specialty hospitals. For purposes of identifying appropriate specialty hospitals for the MMA study, MedPAC used the following criteria.[1] Specialty hospitals must:

- be physician-owned;
- specialize in certain services—at least 45 percent of their Medicare cases must be in cardiac, orthopedic, or surgical services or at least 66 percent must be in two major diagnostic categories, with the primary one being cardiac, orthopedic, or surgical cases;
- have a minimum volume of at least 25 total Medicare cases during 2002; and
- have submitted Medicare cost reports and claims for 2002.

CMS generally followed the MedPAC report criteria, but with an additional requirement that cardiac and orthopedic hospitals perform at least five major procedures. To be considered a cardiac specialty hospital, 45 percent or more of a hospital's Medicare cases must have been in the Major Diagnostic Category (MDC) 5, Diseases and Disorders of the Circulatory System. Orthopedic hospitals must have had 45 percent of their cases in MDC 8, Diseases and Disorders of the Musculoskeletal System and Connective Tissue. For surgery hospitals, 45 percent or more of their discharges must have involved a surgical procedure.

Although the researchers used national data for as many aspects as possible of this analysis, some key questions related to quality, cost, and community impact required the detailed analysis of richer data than have been available previously. Consequently, the analysis involved the collection of a considerable amount of new data related to the ownership, performance, and impact of specialty hospitals. The analysis included information about the environment in which specialty hospitals and community hospitals in the same geographic areas operate, and sensitive and proprietary non-public data on such issues as ownership. Because only a small number of specialty hospitals met the criteria for inclusion in this CMS report, and a subset of 11 was analyzed in some cases, caution should be used in making generalization based on the data.

These data were collected in six diverse market areas around the country. In particular, to conduct this detailed analysis, RTI International made site visits to 11 specialty hospitals in six market areas around the country including Dayton, OH; Fresno, CA; Rapid City, SD; Hot Springs, AR; Oklahoma City, OK; and Tucson, AZ. These 11 hospitals comprise about one-sixth of the 67 cardiac, surgery, and orthopedic specialty hospitals that were in operation as approved Medicare providers by the end of 2003. The researchers selected these market areas because they were thought to represent a range of the circumstances in which specialty hospitals operate. Within each market area, the researchers interviewed specialty hospital managers, physician owners, and staff in order to gather information that was needed to answer the questions posed by Congress. In addition, they interviewed executives at several local community hospitals to evaluate their views and concerns with re-

[1] Report to the Congress: Physician-Owned Specialty Hospitals," MedPAC, March 2005

spect to the specialty hospitals. To assess patient satisfaction with specialty hospitals, the study used patient focus groups composed of beneficiaries treated in cardiac, surgery, orthopedic and competitor hospitals

In addition to these detailed analyses within six market areas, researchers used Medicare claims data from the entire national population of physician-owned specialty hospitals to assess the quality of care. They specifically used inpatient hospital quality indicators developed by the Agency for Health Research and Quality (AHRQ) to assess quality of care at all the specialty hospitals and local competitor community hospitals. To estimate total tax payments and uncompensated care for these hospitals they used data obtained from Internal Revenue Service (IRS) submissions and financial reports, as well as from the hospitals themselves.

CMS' RESEARCH FINDINGS REGARDING PHYSICIAN-OWNED SPECIALTY HOSPITALS

Based on this research, we reached a number of conclusions that are described below.

Cardiac Hospitals Differ from Surgery and Orthopedic Hospitals

The empirical evidence clearly shows that cardiac hospitals differ substantially from surgery and orthopedic hospitals as shown in Chart 1.

Chart 1

	Cardiac	Orthopedic and Surgical
Average Daily Census	40	5
Percent Medicare Inpatient Days	67	36
Aggregate Percent of Physician Ownership in sample of hospitals visited	34	80
Individual Ownership Shares per Physician in sample of hospitals visited	Range: 0.1 to 9.8 Median: 0.6 Mean: 0.9	Range: 0.1 to 22.5 Median: 0.9 Mean: 2.2

Compared to surgery and orthopedic hospitals, cardiac hospitals tend to have a higher average daily census, an emergency department, and other features, such as community outreach programs while surgery and orthopedic hospitals more closely resemble ambulatory surgical centers, focusing primarily on outpatient services. All cardiac hospitals reportedly were built exclusively for cardiac care. The average daily census of the 16 cardiac hospitals that were open for more than one year in 2003 was 40 patients. For surgery and orthopedic hospitals, the aggregate average daily census of inpatients is about 5 patients. Cardiac hospitals treated 38,000 Medicare cases in 2003, and Medicare beneficiaries account for a very high proportion (about two-thirds) of inpatient days in those hospitals nationwide. In surgery and orthopedic hospitals, Medicare patients account for about 36 percent of the inpatient days in these facilities. The small number of inpatient cases at surgery and orthopedic hospitals precluded the development of meaningful findings for this group on several of the dimensions of performance that we examined. For all of these reasons, our report examines cardiac hospitals and orthopedic/surgical hospitals separately.

The degree of physician ownership also differed between cardiac hospitals and surgery and orthopedic hospitals. In the study hospitals, the aggregate physician ownership averaged approximately 34 percent for the cardiac hospitals in the study. Physicians generally own a large share of the interest, averaging 80 percent in aggregate, for the surgery and orthopedic hospitals in the study. The balance is typically owned by a non-profit hospital or national corporation. The average ownership share per physician in cardiac hospitals visited is 0.9 percent, with individual ownership share per physician ranging from 0.1 percent to 9.8 percent, and a median of 0.6 percent. In surgery and orthopedic hospitals visited, the average ownership share per physician is 2.2 percent, with individual ownership shares per physician ranging from 0.1 percent to 22.5 percent, with a median of 0.9 percent.

Referral Patterns

CMS' findings on physician-owner referral patterns indicate that physician owners refer or admit the majority of Medicare patients in most specialty hospitals. However, these physicians do not refer their patients exclusively to the specialty hospitals that they own. They also refer patients to the local community hospital competitors.

CMS found that physicians in general are constrained by where they refer patients because of several factors, including patient preferences, managed care networks, specialty hospital location, and taking emergency department "call" from

local competitor hospitals. Using ownership data provided by the 11 specialty hospitals, we found Medicare referrals to physician-owned hospitals came primarily from physician-owners. The proportion of all Medicare cardiac cases in three cardiac specialty hospitals visited, referred by physician-owners, ranged from 61% to 82%. In five orthopedic hospitals visited, physician-owners referred between 48% and 98% of the orthopedic cases, and in one surgery hospital, physician-owners referred 90% of the cases.

CMS also examined the extent to which physician-owners refer Medicare patients to other facilities, and how these patients differ from the patients referred to the specialty facility, given the financial incentive to refer patients to their own facility. In two cardiac hospitals visited, owners had a clear preference for referring cases to their own hospital, with 65% and 75% of all their cases admitted to their hospital. In the third specialty cardiac hospital visited, owners referred almost the same percentage of cases to their facilities as to competitor hospitals in the area. Physician-owners in all orthopedic and surgery specialty hospitals visited, except for one, referred most of their orthopedic or surgery inpatient cases to their competitor hospitals. This is not surprising, given the very small inpatient census at these specialty hospitals. Consequently, CMS did not see clear, consistent patterns of preference for referring to specialty hospitals among physician owners relative to their peers.

Overall, the Medicare cardiac patients treated in community hospitals are more severely ill than those treated in cardiac specialty hospitals in most of the study sites. This generally is true for patients admitted both by physicians with ownership in specialty hospitals and by other physicians without such ownership. That is, our analysis found no difference in referral patterns to community hospitals between physician owners and non-owners in this aspect of referrals. However, though it does not appear to result from selective referral by physician owners compared to non-owners, there is some variation in patients treated, with cardiac hospitals in some areas having higher average severity than in the community hospitals. Although the number of cases was too small to draw definitive conclusions for the orthopedic and surgery specialty hospitals, the severity level of cases involving the same or similar procedures appears to be much lower in these specialty hospitals than in the competitor hospitals.

The analysis of patients transferred out of cardiac hospitals also does not suggest any particular pattern. The proportion of patients transferred from cardiac hospitals to community hospitals is about the same, around one percent, as the proportion of patients transferred between community hospitals. The proportion of severely ill patients transferred from cardiac hospitals to community hospitals is similar (slightly higher but without statistical significance) to patients in the same diagnosis related group (DRG) who are transferred between community hospitals. The number of cases transferred from surgery and orthopedic hospitals is too small to derive meaningful results on this type of analysis.

Quality of Care and Patient Satisfaction

Based on claims analysis using the AHRQ quality indicators and methodology, measures of quality at cardiac hospitals are generally at least as good and in some cases better than the local community hospitals. Complication and mortality rates are lower at cardiac specialty hospitals even when adjusted for severity. Because of the small number of discharges, a statistically valid assessment could not be made for surgery and orthopedic hospitals. Specialty hospitals generally provide a more uniform set of services and have fewer competing pressures than community hospitals, and thus are able to provide more predictable scheduling and patient care. Patient satisfaction is very high in both cardiac hospitals and surgery and orthopedic hospitals. Medicare beneficiaries mentioned large private rooms, quiet surroundings, adjacent sleeping rooms for family members if needed, easy parking, and good food. Patients also have very favorable perceptions of the clinical quality of care they receive at the specialty hospitals.

Uncompensated Care and Tax Benefits

To calculate their taxes paid and the uncompensated care they provided as a proportion of net revenues, the specialty hospitals visited provided proprietary financial information. The specialty hospitals pay real estate and property taxes, as well as income and sales taxes, whereas non-profit community hospitals do not pay any of these taxes. Overall, the proportion of net revenue that specialty hospitals devote to both uncompensated care and taxes significantly exceeds the proportion of net revenues that community hospitals devote to uncompensated care. Real estate and property tax payments stay in the local community, as does a share of sales tax payments in most areas. It should be noted that the physician-owned specialty hospitals

visited reported very little Medicaid utilization, which, on average, ranged from zero to six percent.

To summarize, we found that physician owners refer or admit the majority of Medicare patients in most cardiac hospitals, but these physicians do not refer their patients exclusively to the specialty hospitals that they own. Patients treated at cardiac specialty hospitals are less severely ill than at community hospitals; however both the owners and non-owners refer patients of high and low severity in the same way. Both send a greater proportion of the more severe patients to the community hospital. In addition, quality of care is as good or better and patient satisfaction is very high in cardiac hospitals. Although the small number of patients in surgery and orthopedic hospitals prevented valid measurement of quality, patients expressed very high satisfaction. Furthermore, the total proportion of net revenue that specialty hospitals devote to both uncompensated care and taxes significantly exceeds the proportion of net revenues that community hospitals devote to uncompensated care. In addition, real estate, property, and a portion of sales tax payments stay in the local community.

RECOMMENDATIONS REGARDING PHYSICIAN-OWNED SPECIALTY HOSPITALS

After consideration of the results of our study and that of (MedPAC)[2], we offer the following four recommendations. These recommendations require administrative steps, which CMS will take under its current authority.

- Reform payment rates for inpatient hospital services through Diagnosis Related Group (DRG) refinements
- Reform payment rates for ambulatory surgical centers (ASCs)
- More closely scrutinize whether entities meet the definition of a hospital
- Review procedures for approval for participation in Medicare

Recommendation 1: Reform Payment Rates for Inpatient Hospital Services through Diagnosis Related Group (DRG) Refinements

To help reduce the possibility that specialty hospitals may take advantage of imprecise payment rates in the inpatient hospital prospective payment system (IPPS), MedPAC has recommended several changes to improve the accuracy of payment rates in the IPPS.

In general, CMS agrees with MedPAC that the accuracy of IPPS payment rates should be improved, and the emergence of specialty hospitals clearly illustrates the need for such change. We have initiated analysis of MedPAC's recommendations and intend to simulate the changes so we can explore the impacts on hospitals. Consequently, CMS addressed this issue briefly in the preamble to the notice of proposed rulemaking for the FY 2006 update to the IPPS. After completing further analysis, we will consider making recommendations for change in the notice of proposed rulemaking for the FY 2007 update, if such revisions lead to a significant increase in accuracy of payments. We may expect to adopt significant revisions in our payment system to address these issues in FY07. The exact details of how these payment revisions can best lead to significant improvements in payment accuracy and thus to better incentives for hospital quality and efficiency will reflect further work in our upcoming regulations. CMS plans to publish this notice in April 2006 and make any resulting changes, after considering public comment, effective starting in October 2006.

A. *Refine DRGs to more fully capture differences in severity of illness*

MedPAC recommends that CMS refine the current DRGs to fully capture differences in severity of illness among patients. In making this recommendation, the Commission recognizes several implementation issues regarding potential low-volume DRGs and changes in hospital coding and reporting behavior. In particular, MedPAC recommends that the Secretary project the likely effect of reporting improvements on total payments and make an offsetting adjustment to the standardized amounts.

CMS will propose changes to the DRGs to better reflect severity of illness. There is a standard list of diagnoses that are considered complications or co-morbidities (CC). These conditions, when present as a secondary diagnosis, may result in payment using a higher weighted DRG. Currently, 3,285 diagnosis codes appear on this list, and 121 paired DRGs are differentiated based on the presence or absence of a CC. Our analysis indicates that the majority of cases assigned to these DRGs fall into the "with CC" DRGs. CMS believes that it is possible that the CC distinction has lost much of its ability to differentiate the resource needs of patients, given the

[2] Report to the Congress: Physician-Owned Specialty Hospitals," MedPAC, March 2005

long time since the original CC list was developed and the incremental nature of subsequent changes in an environment of major changes in the way inpatient care is delivered.

CMS is planning a comprehensive and systematic review of the CC list for the IPPS rule for FY 2007. As part of this process, we will consider revising the standard for determining when a condition is a CC. For instance, we expect to use an alternative to the current method of classifying a condition as a CC based on how it affects the length of stay of a case. Similar to other aspects of the DRG system, CMS will consider the effect of a specific secondary diagnosis on the charges or costs of a case to evaluate whether to include the condition on the CC list.

CMS also is considering a selective review of the specific DRGs, such as cardiac, orthopedic, and surgical DRGs, that are alleged to be overpaid and that may create incentives for physicians to form specialty hospitals. We will selectively review particular DRGs based on statistical criteria such as the range or standard deviation among charges for cases included within the DRG. It is possible specific DRGs have high variation in resource costs and that a better recognition of severity would reduce incentives for hospitals to select the least costly and most profitable patients within these DRGs. Any analysis CMS does would balance the goal of making payment based on accurate coding that recognizes severity of illness with the premise that the IPPS is a system of payment based on averages. We agree with MedPAC that, in refining the DRGs, we must continue to be mindful of issues such as the instability of small volume DRGs and the potential impact of changes in hospital coding and reporting behavior. As the Commission noted, previous refinements to DRG definitions have led to unanticipated increases in payment because of more complete reporting of patients' diagnoses and procedures. Therefore, CMS is concerned with our ability to account for the effect of changes in coding behavior on payment. We must consider how to mitigate the risk that the program could pay significantly more without commensurate benefit to Medicare patients.

CMS also will evaluate the use of alternative DRG systems, such as the all-patient refined diagnosis-related groups (APR-DRGs), in place of Medicare's current DRG system. APR-DRGs have a greater number of DRGs that could relate payment rates more closely to patient resource needs, and thus reduce the advantage of selecting healthier patients. This could have a substantial effect on all hospitals, however, and CMS believes we must thoroughly analyze these options and their impacts before advancing a proposal.

B. *Base DRG weights on estimated cost of providing care*

MedPAC recommends that CMS base the DRG relative weights on the estimated cost of providing care rather than on charges.

CMS does not have access to any information that would provide a direct measure of the costs of individual discharges. However, claims filed by hospitals do provide information on the *charges* for individual cases. At present, we use this information to set the relative weights for the DRGs. CMS obtains information on costs from the hospital cost reports, but this information is at best at the department level: it does not include information about the costs of individual cases. Consequently, the most straightforward way to estimate costs of an individual case is to calculate a cost-to-charge ratio for some body of claims (e.g., for a hospital's radiology department), and then apply this ratio to the charges for that department.

This procedure is not without disadvantages. Assignment of costs to departments is not uniform from hospital to hospital, given the variability of hospital accounting systems, and cost information is not available until a year or more after claims information. In addition, the application of a cost-to-charge ratio that is uniform across any body of claims may result in biased estimates of individual costs if hospital charging behavior is not uniform. CMS uses estimated costs, based on hospital-specific, department-level cost-to-charge ratios, in the outpatient prospective payment system. The accuracy of this procedure has generated some concern, and without further analysis, the extent to which inpatient payment rates would be improved by adopting this method is not clear.

CMS will closely examine the impact of changing the current charge-based DRG weights to cost-based DRG weights, but we recognize that such a change is complex and requires further study. CMS will consider the following issues in performing this analysis:

- The effect of using cost-to-charge ratio data, which is frequently older than the claims data currently used to set the charge-based weights,
- The impact of changes in hospitals' charging behavior that may have resulted from the recent modifications to the outlier payment methodology.

- Whether using this method has different effects on DRGs that have experienced substantial technological change compared to DRGs with more stable procedures for care.
- The effect of using a routine cost-to-charge ratio and department-level ancillary cost-to-charge data as compared to either (1) an overall hospital cost-to-charge ratio or (2) a routine cost-to-charge ratio and an overall ancillary cost-to-charge ratio, particularly considering earlier studies performed for the Prospective Payment Assessment Commission indicating that an overall ancillary cost-to-charge ratio led to more accurate estimates of case level costs.[3]
- Whether developing relative weights by estimating costs from charges multiplied by cost-to-charge ratios compared to using only charges improves payment accuracy.
- How payments to hospitals would be affected by MedPAC's suggestion to recalibrate weights based on costs every few years and to calculate an adjustment to charge-based weights for the intervening periods.

C. *Base DRG weights on national average of hospitals' relative values in each DRG*

MedPAC recommended that CMS base DRG weights on the national average of hospitals' relative values in each DRG. At present we set the relative weights using standardized charges (adjusted to remove the effects of differences in area wage costs, indirect medical education, and disproportionate share payments). In contrast, MedPAC proposes that Medicare set the DRG relative weights using non-standardized hospital-specific charges. Each hospital's non-standardized charges would become the basis for determining the relative weights for the DRGs for that hospital. These relative weights would be adjusted by the hospital's case-mix index when combining each hospital's relative weights to determine a national relative weight for all hospitals. This adjustment is designed to reduce the influence that a single hospital's charge structure could have on determining the relative weight when it provides a high proportion of the total nationwide number of discharges in a particular DRG.

We will analyze the possibility of moving to hospital-specific relative values while conducting the analysis outlined above in response to the recommendations regarding improved severity adjustment and using charges adjusted to estimated cost using cost-to-charge ratios to set the relative weights. CMS would like to note that we currently use this method to set weights for the long-term care hospital prospective payment system. This method is utilized for long-term care hospitals because of the small volume of providers and the possibility that only a few providers provide care for certain DRGs. Thus, the charges of one or a few hospitals could materially affect the relative weights for these DRGs. In this event, looking at relative weights within hospitals first can offset the hospital-specific effects on DRG weights. Significantly, a 1993 RAND Report on hospital-specific relative values noted the possibility of DRG compression (or the undervaluing of high-cost cases and overvaluing of low-cost cases) if we were to shift to a hospital-specific relative value method from the current method for determining DRG weights. CMS will need to consider whether the resulting level of compression is appropriate.

D. *Adjust DRG weights to account for differences in prevalence of high-cost outlier cases*

One of MedPAC's recommendations is to adjust DRG weights to account for prevalence of high-cost outlier cases. Although MedPAC's language suggests that the law would need to be amended for CMS to adopt this suggestion, we believe the statute may give the Secretary broad discretion to consider all factors that change the relative use of hospital resources in calculating the DRG relative weights. Under current Medicare policy, CMS includes all the charges associated with high-cost outlier cases to determine the DRG relative weight. We believe that MedPAC's recommendation developed from a concern that including high-charge outlier cases in the relative-weight calculation results in overvaluing DRGs that have a high prevalence of outlier cases. However, CMS believes, that excluding outlier cases completely in calculating the relative weights would be inappropriate. Doing so would undervalue the relative weight for a DRG with a high percentage of outliers by not including that portion of hospital charges that is above the median but below the outlier threshold. We believe it would be preferable to adjust the charges used for

[3] Cost Accounting for Health Care Organizations, Technical Report Series, I-93-01, ProPAC, March 1993, page 6. Using a cost report package, the contractor simulated single and multiple ancillary cost-to-charge ratios and found that inpatient ancillary costs were 2.5 percent understated relative to what hospitals thought their costs were with the single cost-to-charge ratio, and 4.9 percent understated with the multiple cost-to-charge ratios.

calculating the relative weights to exclude the portion of charges above the outlier threshold but to include the charges up to the outlier threshold. At this time, CMS will further analyze these ideas as we consider the other changes recommended by MedPAC.

CMS believes the recommendations made by MedPAC have significant promise in improving the accuracy of rates in the inpatient hospital prospective payment system. We agree with MedPAC that they should be analyzed even in the absence of concerns about the proliferation of specialty hospitals for reasons related to payment advantages rather than reasons related to quality and efficiency of care. However, improving payment accuracy should reduce inappropriate incentives for specialty hospital proliferation, to the extent that Medicare payments currently provide significantly higher margins for certain identifiable and predictable categories of patients. CMS plans to aggressively identify payment reforms to address these concerns.

E. *Provide a transition for these changes*

MedPAC explicitly recommended that a transition period be included for adopting any changes. Before proposing changes to the DRGs, CMS would need to model the impact of any specific proposal and verify our authority under the statute, to determine whether any changes should be implemented immediately or over a period of time. We do note that when replacing the existing DRG system with a revised DRG system that fully captures differences in severity, there likely would be unique complexities in creating a transition from one DRG system to another. CMS' payment would be a blend of two different relative weights that would be determined by using two different systems of DRGs. The systems and legal implications of such a transition or any other major change to the DRGs could be significant.

Recommendation 2: Reform Payment Rates for Ambulatory Surgical Centers (ASCs)

The results presented elsewhere in this testimony indicate that as a group surgical and orthopedic hospitals are different from cardiac hospitals. The cardiac hospitals tend to have more inpatient beds and to more closely resemble community hospitals (for instance, by participating in community emergency medical service protocols). Physicians may be participating in the ownership of small orthopedic or surgical hospitals rather than in ASCs in part to take advantage of payment differences between hospital outpatient departments and ASCs. An important goal of Medicare's planned reform of the ASC fee schedule is to reduce such divergences of payment levels between these settings when resource costs consumed in producing the same service in the two settings are similar.

Section 626 of the MMA requires and sets parameters for a revision to the ASC fee schedule. The existing fee schedule is comparatively crude, especially relative to recent changes in outpatient medical practice, with only nine payment rates used for approximately 2500 different services. Consequently, each payment cell spans a broad set of clinically heterogeneous services. In addition, the basic structure of rates has not been updated since 1990. This has resulted in a situation in which payment rates for particular services in ASCs differ significantly from those in hospital outpatient departments, where Medicare pays using the more differentiated and current outpatient prospective payment system. In many instances, the payments for particular services are significantly higher in hospital outpatient departments. Insofar as these divergences do not reflect differences in the needs of patients treated in the two settings or the resources used in treating them, they create incentives for development of specialty hospitals, where the outpatient services are paid under the outpatient prospective payment system. Reforming the ASC fee schedule to 1) use the same payment categories in the two settings so payments an be compared and 2) to adjust payment rates where the resource costs consumed in providing the same services are similar can materially reduce these divergences and mitigate incentives that now favor proliferation of specialty hospitals.

The MMA requires that the new ASC payment system be implemented after December 2005 and not later than 2008. Making these reforms is a substantial undertaking. The MMA requires CMS to take into account recommendations by the Government Accountability Office, based in turn on its survey of the relative costs of services performed in ASCs, which is currently underway. Following the completion of the GAO survey and report, CMS will design the new payment rates and complete notice-and-comment rulemaking.

As a foundation for these payment reforms, the MMA also requires a comparison of the relative costs of services delivered in ASCs versus hospital outpatient departments. Therefore we are exploring relating the ASC fee schedule directly to the outpatient prospective payment system, using the same or very similar ambulatory payment classifications (APCs). Because this course of action is already ongoing, we

do not recommend any further changes, however, we will continue to look at the ASC payment system.

Recommendation 3: Closer Scrutiny of Whether Entities Meet the Definition of a Hospital

Section 1861(e) of the Social Security Act provides that in order to be a hospital, an institution must be engaged, among other things, primarily in furnishing services predominantly to inpatients. This requirement is incorporated in CMS' regulations on conditions of participation for hospitals. If any institution applies for a Medicare provider agreement as a hospital, but is unable to meet this requirement, its application will be denied. In addition, an institution that currently has a Medicare hospital provider agreement but does not presently meet the requirement of engaging in furnishing services primarily to inpatients would be subject to termination of its provider agreement.

The results of our study suggest that some entities providing specialty care may concentrate primarily on outpatient care and consequently do not meet the definition of "hospital" in section 1861(e) of the Social Security Act. While many such entities concentrate on surgical or orthopedic care, anecdotal evidence suggests that some entities specializing in cardiac care also may not meet the definition of a hospital.

CMS notes in advisory opinions, concerning whether a requesting entity is or is not "under development" and therefore subject to or exempt from the 18-month moratorium on specialty hospitals, that, among other things, the requesting entity must meet the definition of a hospital. Some entities that describe themselves as specialty hospitals may be primarily engaged in furnishing services to outpatients, and consequently might not meet the definition of a hospital. Therefore, although an entity may be "under development" for purposes of exemption from the moratorium, if we determine that it is not primarily engaged in inpatient care at the time it seeks certification to participate in the Medicare program, its application for a provider agreement as a hospital will be denied. Furthermore, if we were to determine that a specialty hospital operating under an existing provider agreement is not, or is no longer, primarily engaged in treating inpatients, the hospital may have its provider agreement terminated.

Recommendation 4: Review of Procedures for Approval for Participation in Medicare

To be approved for participation in the Medicare program, a hospital must meet the statutory definition of a hospital noted above and the hospital conditions of participation. Hospitals must also meet, for example, Federal civil rights requirements and advanced directive requirements. Compliance with the hospital conditions of participation is determined through the Medicare survey process or through accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA). Once a hospital has been found to meet all participation requirements, CMS must complete various administrative processes before a hospital can bill Medicare (e.g., issuing a tie-in notice and a provider number).

As noted earlier in this testimony, we are concerned that some specialty hospitals may not meet the definition of a hospital. We also want to be assured that, given their limited focus, specialty hospitals meet such core requirements that we determine are necessary for the health and safety of our beneficiaries. In addition, we wish to consider how EMTALA should apply to specialty hospitals, in particular with reference to potential transfer cases arising in the emergency departments of other hospitals.

To address these concerns, we plan to revisit the procedures by which applicant hospitals are examined to insure compliance with relevant standards. We will instruct our fiscal intermediaries to refrain from processing further participation applications from specialty hospitals until this review is completed and any indicated revisions are implemented. During this six-month review period, we expect to conduct a comprehensive review of our procedures. In the course of this review, we will confer with state survey and certification units, the JCAHO, and the AOA. During the same period, we will also assess whether revisions of our standards may be appropriate, in particular in connection with the EMTALA. We will solicit public input on these issues through a town hall meeting or other forums. With regard to any EMTALA changes that we may consider, we also note that we are currently operating an EMTALA technical advisory group where interested parties can also provide testimony on this issue. Depending on the results of this input and review, we will draft appropriate instructions to implement revised procedures, and we will consider whether to proceed with changes to the regulations. We expect to complete revisions to these procedures by January 2006.

CONCLUSION

Mr. Chairman, thank you for this opportunity to discuss our report on physician-owned specialty hospitals. We have been thoroughly studying this important topic, with extensive collection and analysis of the data, as part of our ongoing efforts to provide a strong factual foundation for implementing policy decisions that help patients get the highest quality health care possible at the lowest cost. As part of our careful evaluation of this multi-dimensional issue, we strive to ensure the best possible alignment of Medicare's financial incentives with our goal of improving the quality of care provided to our beneficiaries while avoiding unnecessary costs. CMS looks forward to continuing to work with you closely on this issue. I thank the committee for its time and would welcome any questions you may have.

Mr. DEAL. Thank you, Dr. McClellan.

Mr. Hackbarth, I noticed that you are a J.D., so I suppose we have fulfilled Ms. Eshoo's expectations here. We have a medical doctor on one side and a lawyer on the other. And we look forward to hearing your testimony as well.

Thank you.

STATEMENT OF GLENN M. HACKBARTH

Mr. HACKBARTH. Congressman Brown, Chairman Barton, I appreciate the opportunity to meet with the committee.

MedPAC was given a specific series of assignments under MMA, a specific series of issues on specialty hospitals that we were to examine. The findings that were included in our report published in March were based on 2002 data. You will note that we used 2002 data as opposed to 2003 data used by CMS, and that is because we began our work earlier. In the 2002 data, there were 48 physician-owned specialty hospitals that met our criteria. In addition to looking at the Medicare data base, we also conducted site visits to Austin, Wichita, and Sioux Falls.

Now the data that we had for our analysis are limited in three respects. First of all, it is a small number of hospitals, and many of these institutions are quite small. Second, 2002 is pretty early in the development of the specialty hospital phenomenon. And then third, MedPAC did not examine any data about quality of care, since that assignment was given to CMS under the MMA.

[Slide.]

Almost 60 percent of the specialty hospitals that we looked about, the group of 48, were in four States: South Dakota, Kansas, Oklahoma, and Texas. Today, there are more than 100 specialty hospitals, but they continue to be pretty geographically concentrated, as you can see from the map.

Now let me turn to our findings.

[Slide.]

The first finding is that heart hospitals tend to focus on DRGs, diagnosis-related groups, with a greater than average expected profit. And you can see that in the table up on the screen. If you look at the first column labeled "across DRG" and look at physician-owned heart hospitals, you see 1.06. And what that means is that based on the selection of DRGs, heart hospitals would be expected to have a 6 percent better than average profitability. As you go down that same column, you will notice that orthopedic and surgical hospitals, on the other hand, tend to focus on DRGs with a lower than average expected profit.

Now if you will look at the second column labeled "within DRG," these data refer to the severity of illness of the patients within any given diagnosis-related group.

Are we having a technical problem with that?

So just to recap, the first column, labeled "across DRG," reflects the profitability of the DRGs provided by the different types of specialty hospitals. So physician-owned heart hospitals would have a higher than average expected profitability based on the type of cases that they serve. Orthopedic and surgical hospitals, on the other hand, have a somewhat lower than average expected profitability based on the DRGs that they provide.

The second column, labeled "within DRG," relates to the severity of illness of the patients within any one of those categories. And here, you can see that all three types of physician-owned specialty hospitals have a lower severity patient and higher than average expected profitability as a result of that.

The last column, labeled "total," sums the two effects. So you can see that all three types of physician-owned specialty hospitals would be expected to have a higher than average profitability based on the combination of the type of cases they treat and the severity of illness of the patients within those categories.

The second finding of our work was that specialty hospitals tend to draw their patients away from community hospitals, as opposed to increase the volume of surgery within their communities. We did see a couple indications of potential increases in volume as a result of the arrival of a specialty hospital, but for the most part, those effects were not statistically significant. Now whether this would continue to be the case over time is an open question. But in 2002, we did not see widespread indications that specialty hospitals were increasing the volume of surgery in their communities.

We also found that the community hospitals facing competition from specialty hospitals tended to recover pretty quickly from the financial impact of losing those surgical patients. And they would do that through a variety of strategies. We heard in our site visits increasing revenue from new services, reducing costs and the like.

Now the ability to withstand competition from a specialty hospital may be somewhat less for a small, rural hospital than for an urban institution. And again, this finding could also change if the number of specialty hospitals were to grow significantly.

The next finding is that in 2002, the costs of specialty hospitals were not lower than other hospitals. Actually, they were higher in our data, although the difference was not statistically significant. On the other hand, the average length of stay for specialty hospital patients was actually less, significantly less than for the comparison hospitals.

Finally, we found that specialty hospitals serve proportionately fewer Medicaid and self-pay patients than community hospitals.

Based on these findings, we made a series of recommendations.

The first is a series of recommendations related to refining the DRG payment system. Several of those relate to how the DRG weights are calculated. The weights are the relative payment amounts that we pay for different types of patients. In addition to those recommendations regarding the weights and how they are

calculated, we also recommend adjusting Medicare payment rates for severity of illness.

[Slide.]

Now the net effect of our recommendations would be to significantly improve the accuracy of the Medicare payment system. And this graph illustrates the improvement. The first set of three bars is current policy. And then as you move across the bottom, we add on each of our proposed refinements in the payment system. The last column reflects the cumulative effect of all of those payment improvements combined. And as you can see, the middle bar here is steadily increasing as you move across the graph. And what that signifies is a growing percentage of our payments being within DRGs where the expected profitability is within plus or minus 5 percent of the average, which is what we use as an indicator of payment accuracy.

So currently, about 35 percent of the payments are for DRGs where the expected profitability is within plus or minus 5 percent of the average. That number would increase as a result of our reforms to 86 percent. And so we believe we would have a significantly better, more accurate payment system as a result.

I want to emphasize that the data used to do this analysis and formulate our payment recommendations is not limited to the 48 hospitals. This is based on an analysis of the entire Medicare claims and cost report data base.

These payment changes move around a significant amount of money, not just with regard to specialty hospitals, but hospitals of all types. On the one hand, the fact that a lot of money is moving around makes us want to be very careful about what we do. And as part of that, we propose a transition in implementing these payment changes so that they are not too abrupt. On the other hand, the fact that there is a lot of money being shifted around to us is a reason for urgency. That is an indication that we are currently not paying very accurately. In some cases, we are paying too much and hospitals are inappropriately profiting from that. In other cases, we are paying too little. And so we feel a sense of urgency about making these payment improvements.

The next recommendation is for a gain sharing, which several of the members referred to. Here the concept is that physicians ought to have the opportunity to work with hospital management and benefit from their collaboration with the hospital in the name of both improving efficiency and quality of care. Currently, under the rules, physicians can not share in those gains. We think that that would be an important opportunity for the program to improve quality and reduce cost, and that as a result, we recommend Congress give the Secretary the authority to permit such gain-sharing arrangements and establish a framework to assure that they do support the goals of improving quality and reducing costs.

Finally, we recommend extending the moratorium to January 1, 2007, and we do that for two reasons. One is that the various payment reforms that we recommend will take time to develop fully and implement. They will not happen overnight. In addition to that, we believe that we still need more evidence to be able to fairly and accurately evaluate the impact of specialty hospitals on both efficiency and cost. I began by emphasizing that we looked at 1

year of data, 2002, a relatively small number of hospitals, and MedPAC did not look at quality, and we are very anxious to see the CMS results on quality.

Before making a definitive judgment about what to do with specialty hospitals, we think we should get as much data on both the efficiency and quality issues as we can, and the moratorium will also give us an opportunity to do some further analysis. Then at the end, we can make a careful, reasoned judgment about whether these hospitals contribute on balance to constructive, beneficial competition or whether they are harmful to the health care system.

Thank you very much.

[The prepared statement of Glenn M. Hackbarth follows:]

PREPARED STATEMENT OF GLENN M. HACKBARTH, CHAIRMAN, MEDICARE PAYMENT ADVISORY COMMISSION

Chairman Deal, Congressman Brown, distinguished Subcommittee members. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss physician-owned specialty hospitals.

Proponents claim that physician-owned specialty hospitals are the focused factory of the future for health care, taking advantage of the convergence of financial incentives for physicians and hospitals to produce more efficient operations and higher-quality outcomes than conventional community hospitals. Detractors counter that because the physician-owners can refer patients to their own hospitals they compete unfairly, and that such hospitals concentrate on only the most lucrative procedures and treat the healthiest and best-insured patients—leaving the community hospitals to take care of the poorest, sickest patients and provide services that are less profitable.

The Congress, in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), imposed an 18-month moratorium that effectively halted the development of new physician-owned specialty hospitals. That act also directed MedPAC and the Secretary of the Department of Health and Human Services to report to the Congress on certain issues concerning physician-owned heart, orthopedic, and surgical specialty hospitals.

To answer the Congress's questions, MedPAC conducted site visits, legal analysis, met with stakeholders, and analyzed hospitals' Medicare cost reports and inpatient claims from 2002 (the most recent available at the time). From its empirical analyses, MedPAC found that:

- Physician-owned specialty hospitals treat patients who are generally less severe cases (and hence expected to be relatively more profitable than the average) and concentrate on particular diagnosis-related groups (DRGs), some of which are relatively more profitable.
- They tend to have lower shares of Medicaid patients than community hospitals.
- In 2002, they did not have lower costs for Medicare inpatients than community hospitals, although their inpatients did have shorter lengths of stay.
- The financial impact on community hospitals in the markets where physician-owned specialty hospitals are located was limited in 2002. Those community hospitals competing with specialty hospitals demonstrated financial performance comparable to other community hospitals.
- Many of the differences in profitability across and within DRGs that create financial incentives for patient selection can be reduced by improving Medicare's inpatient prospective payment system (IPPS) for acute care hospitals.

These findings are based on the small number of physician-owned specialty hospitals that have been in operation long enough to generate Medicare data. The industry is in its early stage, but growing rapidly. Some of these findings could change as the industry develops and have ramifications for the communities where they are located and the Medicare program. We did not evaluate the comparative quality of care in specialty hospitals, because the Secretary is mandated to do so in a forthcoming report.

We found that physicians may establish physician-owned specialty hospitals to gain greater control over how the hospital is run, to increase their productivity, and to obtain greater satisfaction for them and their patients. They may also be motivated by the financial rewards, some of which derive from inaccuracies in the Medicare payment system.

Our recommendations concentrate on remedying those payment inaccuracies, which result in Medicare paying too much for some DRGs relative to others, and too much for patients with relatively less severe conditions within DRGs. Improving the accuracy of the payment system would help make competition more equitable between community hospitals and physician-owned specialty hospitals, whose physician-owners can influence which patients go to which hospital. It would also make payment more equitable among community hospitals that currently are advantaged or disadvantaged by their mix of DRGs or patients. Some community hospitals have invested disproportionately in services thought to be more profitable, and some non-physician owned hospitals have specialized in the same services as physician-owned specialty hospitals.

We also recommend an approach to aligning physician and hospital incentives through gainsharing, which allows physicians and hospitals to share savings from more efficient practices and might serve as an alternative to direct physician ownership. Because of remaining concerns about self-referral; need for further information on the efficiency, quality, and effect of specialty hospitals; and the time needed to implement our recommendations, the Commission also recommends that the Congress extend the current moratorium on specialty hospitals until January 1, 2007.

HOW MANY AND WHERE

We found 48 hospitals in 2002 that met our criteria for physician-owned specialty hospitals: 12 heart hospitals, 25 orthopedic hospitals, and 11 surgical hospitals. (Altogether there are now approximately 100 specialty hospitals broadly defined, but some opened after 2002 and did not have sufficient discharge data for our analysis; others are not physician-owned or are women's hospitals that do not meet our criteria for surgical hospitals.) Specialty hospitals are small: the average orthopedic specialty hospital has 16 beds and the average surgical specialty hospital has 14. Heart hospitals are larger, averaging 52 beds.

Many specialty hospitals do not have emergency departments (EDs), in contrast to community hospitals where the large majority (93 percent) do. Those that have EDs differ in how they are used, and that may influence how much control the hospital has over its schedule and patient mix. For example, 8 of the 12 heart hospitals we examined have EDs, and the heart hospitals we visited that had EDs were included in their area's emergency medical systems' routing of patients who required the services they could provide. In contrast, even when surgical and orthopedic specialty hospitals have EDs, they are often not fully staffed or included in ambulance routings.

Specialty hospitals are not evenly distributed across the country (Figure 1). Almost 60 percent of the specialty hospitals we studied are located in four states: South Dakota, Kansas, Oklahoma, and Texas. Many of the specialty hospitals that are under construction or have opened since 2002 are located in the same states and markets as the specialty hospitals we studied. As the map shows, specialty hospitals are concentrated in states without certificate-of-need (CON) programs.

MOTIVATIONS FOR FORMING PHYSICIAN-OWNED SPECIALTY HOSPITALS AND CRITICS OBJECTIONS

Physician control over hospital operations was one motivation for many of the physicians we spoke with who were investing in specialty hospitals. In the physician-owned specialty hospitals we studied, the cardiologists and surgeons want to admit their patients, perform their procedures, and have their patients recover with minimal disruption. Physician control, they believe, makes this possible in ways community hospitals cannot match because of their multiple services and missions. Control allows physicians to increase their own productivity for the following reasons:

- fewer disruptions to the operating room schedule (for example, delays and canceling of cases that result from emergency cases),
- less "down" time between surgeries (for example, by cleaning the operating rooms more efficiently),
- heightened ability to work between two operating rooms during a "block" of operating room time, and
- more direct control of operating room staff.

The other motivation to form specialty hospitals is enhanced income. In addition to increased productivity resulting in more professional fees, physician investors also could augment their income by retaining a portion of the facility profits for their own and others' work. Although some specialty hospitals have not made distributions, the annual distributions at others frequently have exceeded 20 percent of the physicians' initial investment, and the specialty hospitals in our study had

an average all-payer margin of 13 percent in 2002, well above the 3 to 6 percent average for community hospitals in their markets.

Critics contend that much of the financial success of specialty hospitals may revolve around selection of patients. Physicians can influence where their patients receive care, and physician ownership gives physician-investors a financial incentive to refer profitable patients to their hospital. If the payment system does not adequately differentiate among patients with different expected costs, and the factors determining cost, such as severity of illness, can be observed in advance, then the physician has an incentive to direct patients accordingly. At the extreme, some community hospitals claimed physicians sometimes transferred low complexity patients out of the community hospitals to specialty hospitals that the physicians owned, while transferring high complexity patients into the community hospitals. Referrals of healthier (more profitable) patients to limited-service specialty hospitals may not harm less complex patients. Nonetheless, critics argue that referral decisions should not be influenced by financial incentives, and therefore, they object to physician ownership of specialty hospitals. Critics also argue that eventually community hospitals' ability to provide less profitable services (which are often subsidized by more profitable services) would be undermined.

Restrictions on physician self-referral have a long history in the Medicare program. The anti-kickback statute, the Ethics in Patient Referrals Act (the Stark law), and their implementing regulations set out the basic limitations on self-referral and create exceptions. The primary concern was that physician ownership of health care providers would create financial incentives that could influence physicians' professional judgment and lead to higher use of services. In addition, self-referral could lead to unfair competition if one facility was owned by the referring physician, and competing facilities were not. Because hospitals provide many kinds of services, an exception was created that allowed physicians to refer patients to hospitals in which they invest. This is the "whole hospital" exception. Physician investors have a greater opportunity to influence profits at single-specialty hospitals—which generally provide a limited range of services—than at full-service hospitals.

DO PHYSICIAN-OWNED SPECIALTY HOSPITALS HAVE LOWER COSTS?

We compared physician-owned specialty hospitals to three groups of hospitals. *Community* hospitals are full service hospitals located in the same market. *Competitor* hospitals are a subset of community hospitals that provide at least some of the same services provided by specialty hospitals in that market. And Peer hospitals are specialized, but not physician owned.

After controlling for potential sources of variation, including patient severity, we found that inpatient costs per discharge at physician-owned specialty hospitals are higher than the corresponding values for peer, competitor, and community hospitals. However, these differences were not statistically significant.

Lengths of stay in specialty hospitals were shorter, in some cases significantly so, than those in comparison hospitals. Other things being equal, shorter stays should lead to lower costs. The apparent inconsistency of these results raises questions about what other factors might be offsetting the effects of shorter stays. Such factors might include staffing levels, employee compensation, costs of supplies and equipment, initial start-up costs, or lack of potential economies of scale due to smaller hospital size. These results could change as the hospitals become more established and as the number of specialty hospitals reporting costs and claims increases.

WHO GOES TO PHYSICIAN-OWNED SPECIALTY HOSPITALS, AND WHAT HAPPENS TO COMMUNITY HOSPITALS IN THEIR MARKETS?

Critics of specialty hospitals contend that physicians have financial incentives to steer profitable patients to specialty hospitals in which they have an ownership interest. These physicians may also have an incentive to avoid Medicaid, uninsured, and unusually costly Medicare patients. Critics further argue that if physician-owned hospitals take away a large share of community hospitals' profitable patients, community hospitals would not have sufficient revenues to provide all members of the community access to a full array of services.

Supporters counter that the specialty hospitals are engaging in healthy competition with community hospitals and that they are filling unmet demand for services. They acknowledge that community hospital volumes may decline when they enter a market, but claim that community hospitals can find alternative sources of revenue and remain profitable even in the face of competition from physician-owned specialty hospitals. We found:

- Physician-owned heart, orthopedic, and surgical hospitals that did not focus on obstetrics tended to treat fewer Medicaid patients than peer hospitals and commu-

nity hospitals in the same market. Heart hospitals treated primarily Medicare patients, while orthopedic and surgical hospitals treated primarily privately insured patients.

- The increases in cardiac surgery rates associated with the opening of physician-owned heart hospitals were small enough to be statistically insignificant for most types of cardiac surgery. It appears that specialty hospitals obtained most of their patients by capturing market share from community hospitals.
- Though the opening of heart hospitals was associated with slower growth in Medicare inpatient revenue at community hospitals, on average, community hospitals competing with physician-owned heart hospitals did not experience unusual declines in their all-payer profit margin.

Note that most specialty hospitals are relatively new, and the number of hospitals in our analysis is small. The impact on service use and community hospitals could change over time, especially if a large number of additional specialty hospitals are formed.

DO SPECIALTY HOSPITALS TREAT A FAVORABLE MIX OF PATIENTS?

Specialty hospitals may concentrate on providing services that are profitable, and on treating patients who are less sick—and therefore less costly. Under Medicare's IPPS, payments are intended to adequately cover the costs of an efficient provider treating an average mix of patients, some with more and some with less complex care needs. But if differences in payments do not fully reflect differences in costs across types of admissions (DRGs) and patient severity within DRGs, some mixes of services and patients could be more profitable than others. Systematic bias in any payment system, not just Medicare's, could reward those hospitals that selectively offer services or treat patients with profit margins that are consistently above average. We found:

- Specialty hospitals tend to focus on surgery, and under Medicare's IPPS, surgical DRGs are relatively more profitable than medical DRGs in the same specialty.
- Surgical DRGs that were common in specialty heart hospitals were relatively more profitable than the national average DRG, those in orthopedic hospitals relatively less profitable, and those in specialty surgical hospitals had about average relative profitability.
- Within DRGs, the least severely ill Medicare patients generally were relatively more profitable than the average Medicare patient. More severely ill patients generally were relatively less profitable than average, reflecting their higher costs but identical payments. Specialty hospitals had lower severity patient mixes than peer, competitor, or community hospitals.
- Taking both the mix of DRGs and the mix of patients within DRGs into account, specialty hospitals would be expected to be relatively more profitable than peer, competitor, or community hospitals if they exhibited average efficiency.

Table 1 shows the expected relative profitability for physician-owned specialty hospitals and their comparison groups. The expected relative profitability for a hospital is: the ratio of the payments for the mix of DRGs at the hospital to the costs that would be expected for that mix of DRGs and patients if the hospital had average costs—relative to the national average expected profitability over all cases. It is not the actual profitability for the hospital.

Heart specialty hospitals treat patients in financially favorable DRGs and, within those, patients who are less sick (and less costly, on average). Assuming that heart specialty hospitals have average costs, their selection of DRGs results in an expected relative profitability 6 percent higher than the average profitability. Heart hospitals receive an additional potential benefit (3 percent) from favorable selection among patient severity classes. As a result, their average expected relative profitability value is 1.09.

Reflecting their similar concentration in surgical cardiac cases, peer heart hospitals also benefit from favorable selection across DRGs, though not as much as specialty heart hospitals. However, peer heart hospitals receive no additional benefit from selection among more- or less-severe cases within DRGs. Both specialty heart and peer heart hospitals have a favorable selection of patients compared with community hospitals in the specialty heart hospitals' markets, as well as with all IPPS hospitals.

Table 1

Specialty hospitals have high expected relative profitability of inpatient care under Medicare because of the mix of cases they treat

Type of hospital	Number of hospitals	Expected relative profitability due to selection of		
		DRGs	Patient severity	DRGs and patient severity
All nonspecialty hospitals	4,375	1.00	1.00	1.00
Heart hospitals				
Specialty	12	1.06	1.03	[1,2] 1.09
Peer	36	1.04	0.99	[2] 1.03
Competitor	79	1.01	1.00	1.00
Community	315	0.99	1.01	1.01
Orthopedic hospitals				
Specialty	25	0.95	1.07	[1,2] 1.02
Peer	17	0.95	1.01	0.96
Competitor	305	1.00	1.00	1.00
Community	477	1.00	1.01	1.01
Surgical hospitals				
Specialty	11	0.99	1.16	[1,2] 1.15
Peer	25	1.00	1.06	[2] 1.06
Competitor	237	0.99	1.01	1.01
Community	289	0.99	1.01	1.01

Note: IPPS (inpatient prospective payment system), APR-DRG (all-patient refined diagnosis-related group), DRG (diagnosis-related group). Expected relative profitability measures the financial attractiveness of the hospital's mix of Medicare cases, given the national average relative profitability of each patient category (DRG or APR-DRG severity class). The relative profitability measure is an average for each DRG category, based on cost accounting data. Thus, small differences (for example, 1 or 2 percent) in relative profitability may not be meaningful. Specialty hospitals are specialized and physician owned. Peer hospitals are specialized but are not physician owned. Competitor hospitals are in the same markets as specialty hospitals and provide some similar services. Community hospitals are all hospitals in the same market as specialty hospitals.

[1] Significantly different from peer hospitals using a Tukey mean separation test and a $p<.05$ criterion.

[2] Significantly different from nonpeer community hospitals using a Tukey mean separation test and a $p<.05$ criterion.Source: MedPAC analysis of Medicare hospital inpatient claims and cost reports from CMS, fiscal year 2000-2002.

In contrast to the heart hospitals, neither orthopedic specialty hospitals nor their peers seem to have a favorable DRG selection. However, by treating a high proportion of low-severity patients within their mix of DRGs, specialty orthopedic hospitals show selection that appears to be slightly favorable overall (1.02). Surgical specialty hospitals show a very favorable selection of patients overall (1.15) because they also treat relatively low-severity patients within the DRGs.

PAYMENT RECOMMENDATIONS

The Congress asked the Commission to recommend changes to the IPPS to better reflect the cost of delivering care. We found changes are needed to improve the accuracy of the payment system and thus reduce opportunities for hospitals to benefit from selection. We recommend several changes to improve the IPPS.

The Commission recommends the Secretary should improve payment accuracy in the IPPS by:

- refining the current DRGs to more fully capture differences in severity of illness among patients,
- basing the DRG relative weights on the estimated cost of providing care rather than on charges, and
- basing the weights on the national average of hospitals' relative values in each DRG.

All of these actions are within the Secretary's current authority.

The commission also recommends the Congress amend the law to give the Secretary authority to adjust the DRG relative weights to account for differences in the prevalence of high-cost outlier cases.

Taken together, these recommendations will reduce the potential to profit from patient and DRG selection, and result in payments that more closely reflect the cost of care while still retaining the incentives for efficiency in the IPPS. Figure 2 shows that the share of IPPS payments in DRGs that have a relative profitability within 5 percent of the national average would increase from 35 percent under current policy to 86 percent if all of our recommendations were implemented. At the hospital group level, under current policy, heart hospitals' expected relative profitability from their combination of DRGs and patients is above the national average profitability for all DRGs and patients. Following our recommendations, that ratio would be

about equal to the national average. Physician-owned orthopedic and surgical hospitals would show similar results.

These payment system refinements would affect all hospitals—both specialty hospitals and community hospitals. Many hospitals would see significant changes in payments, and, although our recent analysis suggests that hospitals' inpatient profitability increases as selection becomes more favorable, a transitional period would mitigate those effects and allow hospitals to adjust to the refined payment system. Thus, the Commission recommends the Congress and the Secretary should implement the payment refinements over a transitional period.

Making these payment system improvements and designing the transition will not be simple tasks. We recognize that the Centers for Medicare & Medicaid Services (CMS) has many priorities and limited resources, and that the refinements will raise some difficult technical issues. These include the potentially large number of payment groups created, possible increases in spending from improvements in coding, rewarding avoidable complications, and the burden and time lag associated with using costs rather than charges. Nevertheless, certain approaches that we discuss in this report, such as reestimating cost-based weights every several years instead of annually, could make these issues less onerous. The Congress should take steps to assure that CMS has the resources it needs to make the recommended refinements.

RECOMMENDATIONS ON THE MORATORIUM AND GAINSHARING

The Commission is concerned with the issue of self-referral and its potential for patient selection and higher use of services. However, removing the exception that allows physician ownership of whole hospitals would be too severe a remedy given the limitations of the available evidence, although we may wish to reconsider it in the future. Our evidence on physician-owned specialty hospitals raises some concerns about patient selection, utilization, and efficiency, but it is based on a small sample of hospitals, early in the development of the industry. We do not know yet if physician-owned hospitals will increase their efficiency and improve quality. We also do not know if, in the longer term, they will damage community hospitals or unnecessarily increase use of services. The Secretary's forthcoming report on specialty hospitals should provide important information on quality. Further information on physician-owned specialty hospitals' performance is needed before actions are taken that would, in effect, entirely shut them out of the Medicare and Medicaid market. In addition, the Congress will need time during the upcoming legislative cycle to consider our recommendations and craft legislation, and the Secretary will need time to change the payment system. Therefore, the Commission recommends that the Congress extend the current moratorium on specialty hospitals until January 1, 2007. The current moratorium expires on June 8, 2005. Continuing the moratorium will allow time for efforts to implement our recommendations and time to gather more information.

Aligning financial incentives for physicians and hospitals could lead to efficiencies. Physician ownership fully aligns incentives; it makes the hospital owner and the physician one in the same, but raises concerns about self-referral. Similar efficiencies might be achieved by allowing the physician to share in savings that would accrue to the hospital from reengineering clinical care. Such arrangements have been stymied by provisions of law that prevent hospitals from giving physicians financial incentive to reduce or limit care to patients because of concerns about possible stinting on care and quality. Recently, the Office of Inspector General has approved some narrow gainsharing arrangements, although they have been advisory opinions that apply only to the parties who request them.

The Commission recommends that the Congress should grant the Secretary the authority to allow gainsharing arrangements between physicians and hospitals and to regulate those arrangements to protect the quality of care and minimize financial incentives that could affect physician referrals.

Gainsharing could capture some of the incentives that are animating the move to physician-owned specialty hospitals while minimizing some of the concerns that direct physician ownership raises. Permitting gainsharing opportunities might provide an alternative to starting physician-owned specialty hospitals, particularly if the incentives for selection were reduced by correcting the current inaccuracies in the Medicare payment system.

FIGURE 1

Specialty hospitals are geographically concentrated

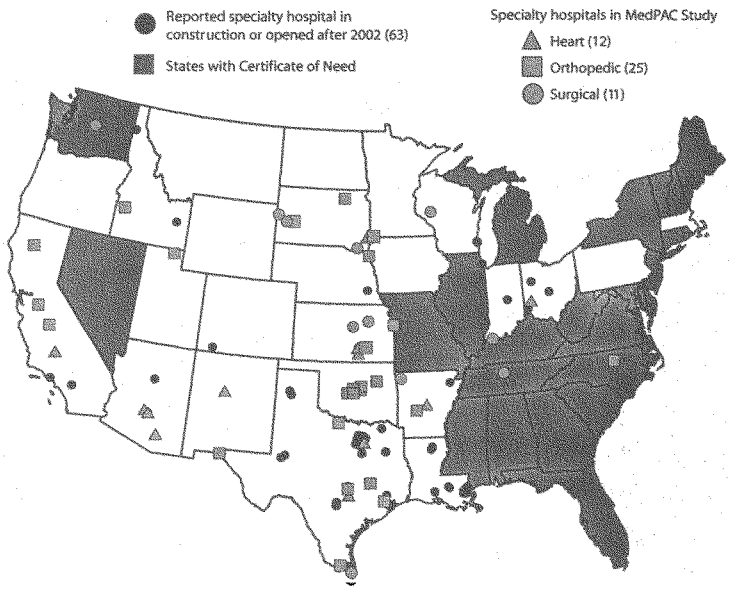
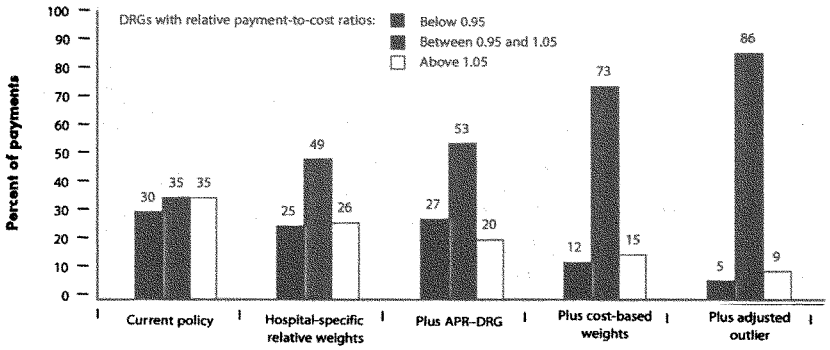


FIGURE 2

Improvement in payment accuracy from policy changes



Note: DRG (diagnosis-related group), APR–DRG (all-patient refined diagnosis-related group).

Source: MedPAC analysis of Medicare hospital inpatient claims and cost reports from CMS, fiscal year 2000-2002.

Mr. DEAL. Thank you.

Let me begin the questioning. Mr. Hackbarth, let me just see if I can follow what you are saying.

You said with regard to the specialty hospitals, there was a significantly shorter stay, length of stay in those hospitals——

Mr. HACKBARTH. Right.

Mr. DEAL. [continuing] than in the community hospital setting.

Mr. HACKBARTH. Right.

Mr. DEAL. And I presume that is a comparison of like situations?

Mr. HACKBARTH. That is right.

Mr. DEAL. All right.

But the expected profitability for the specialty hospitals was above that in a community hospital?

Mr. HACKBARTH. Yes.

Mr. DEAL. Would you reconcile those two with me, because I was always under the impression that the way we save money was to try to shorten the length of stay? If the specialty hospitals are shortening the length of stay, then how are they getting greater profitability?

Mr. HACKBARTH. Well, as you know, we have a fixed per-case payment system. All other things being equal, if a hospital shortens the length of stay, that would tend to reduce their cost and increase their profitability. However, I want to make it clear that when I talk about their expected profitability and say that specialty hospitals have a higher than expected profitability, here we are not looking at their cost structures. All of the data that I reported are simply based on their selection of patients, the type of patients that they treat. And so those gains do not reflect that a particular cardiac hospital may have a lower average length of stay. It is the result of the type of patients they treat and the severity of illness within those categories that we expect them to have a higher than average profit.

Mr. DEAL. Okay. But those issues are, of course, best addressed in looking at the DRGs and the adjustments in the payments that you have referred to and that Dr. McClellan likewise referred to——

Mr. HACKBARTH. That is right.

Mr. DEAL. [continuing] because, obviously if we are moving in the direction of pay for performance, then if you can lengthen the stay and keep the patient satisfaction and quality of care at a higher level, those are the two ingredients that you would like to see occur, is that correct?

Mr. HACKBARTH. Yes. You know, independently of this, we have strongly endorsed the idea of pay for performance whereby any institution, whether it is a specialty hospital or other, if they provide outstanding quality, we would like to see them rewarded for that.

Mr. DEAL. Thank you.

Dr. McClellan, you eluded to the fact that you are going to be looking at the specialty hospitals in terms of whether they qualify as a "hospital" or are more appropriately labeled as an ambulatory surgical center, is that correct?

Mr. MCCLELLAN. Yes, Mr. Chairman.

Mr. DEAL. Would you briefly explain to us what the cost differential would be from being classified as a hospital versus an ASC?

Mr. MCCLELLAN. That is a good question.

Under our current payment system for ambulatory surgery centers, we are relying on some classification groups that are fairly dated, that date for more than a decade ago that probably have not kept up with the complexity and range of services that could be provided on an outpatient basis today. In contrast, we have an outpatient payment system that generally provides higher payment rates that are more specifically tied to the current services being delivered in the outpatient setting, and the result is that, in many areas, for many of these procedures that can be performed on a hospital outpatient basis or alternatively in an ambulatory surgery center, the payment rates are more favorable in the hospital outpatient setting. The Medicare Modernization Act directed us to rely on a report from the Government Accountability Office and other work that we will do to refine our payment systems for ambulatory surgery centers and hospital outpatients to address these and other issues to try to get the payment systems up-to-date to make them more accurate. And I would like to get to a payment system that doesn't create incentives to, you know, formulate yourself as a hospital versus ambulatory surgery center. We ought to be focusing on how we get the best care for patients and then let the health care organizations decide the best way to provide that.

So that is where we are going with our ambulatory surgery center reforms.

Mr. DEAL. What timeframe do you anticipate that it is going to take to do this reform?

Mr. MCCLELLAN. Well, the Medicare Modernization Act directed us to complete it by January 1, 2008. We are definitely going to meet that deadline. Right now, we are waiting for the Government Accountability Office to complete its report on the details of the current payment system and where there are opportunities for improvement. We are going to use that report and public input as a basis for our refinement. So we will get this done over the next couple of years.

Mr. DEAL. All right.

Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman.

I first want to clarify something. I appreciate Chairman Barton's comments earlier, and I admire very much the way he has run this committee the last 4 months, and I just want to thank him again for that.

I was not talking in self-referral about diagnosis versus treatment, that his doctor would diagnose the flu and have to send him somewhere else for treatment. I am talking about self-referral in terms of a doctor sending someone to an institution, a specialty hospital, which has a financial interest, just to clarify. I think our agreement is closer to 100 percent on that.

So I want to get a clarification from you, Dr. McClellan, and welcome you again to this subcommittee. In page three of your testimony, you said CMS plans to review our procedures for examining such hospitals. We will instruct our State survey and certification agencies to refrain from processing further participation applications from specialty hospitals until this review is completed, and

any indicated revisions are implemented, we expect to complete this process by January 2006.

Mr. MCCLELLAN. Right.

Mr. BROWN. I want to make sure I am understanding. That means, in essence, a 6-month extension of the moratorium, correct?

Mr. MCCLELLAN. We don't anticipate approving any new specialty hospitals until January 1, and if we get done with our review sooner than that, then we will start sooner. But based on the workload that we are expecting, the public input process and so forth, we think it will take about 6 months.

Mr. BROWN. That is an important indicator, obviously, of CMS authority in this regard. Given that from what we hear Medicare legislation is unlikely this year and any administrative actions that you all could take that would address these matters would be helpful. What area of concern, as you know as the issue of physician self-referral, to these specialty hospitals in which they have ownership interests if these specialty hospitals were characterized differently and not as "whole hospitals," as we talked earlier, since they don't perform a broad range of services like community hospitals do? I believe this would address the self-referral problem, as they would no longer be able to profit from the "whole hospital" exception for self-referral. Does CMS have the authority to define a specialty hospital as a whole hospital and issue rulemaking in this regard? Do you have authority to do that?

Mr. MCCLELLAN. Well, we have been asked by a number of groups who believe we do have that authority to consider taking such actions, and we are reviewing that now. I think there are some questions about our authority to do it. I think the kinds of steps that I have outlined already are the most important ones for us to focus on to get the payment systems right to make sure our patients are getting high quality care and all patients are getting access to high quality care. So that is where our focus is right now. Doing something as broad as ending the whole hospital exception could have some potential broader ramifications.

And just to echo some of the things that Chairman Barton mentioned, I do think there are some advantages to having physicians involved in the consequences of their decisions, financially and otherwise. Some of these gain-sharing ideas that have been discussed would provide an opportunity to do that. The fact is that physicians' decisions do have a big impact on overall quality of care, and some of these connections can really help. For example, the physician owners in the specialty hospitals and all of their patients have told us about the benefits of having physicians more directly involved in management of the hospital. There is a very lean management team. You don't have to go through whole lots of administrative layers to get quality of care improved. If the nurses or the patient tell them something is wrong, they tend to take action. So there are some advantages from this kind of connection as well.

So we are looking at those issues, but I think the most important steps for us to take now are the ones that we have outlined and that you just summarized in your question.

Mr. BROWN. And I don't think too many of us, or maybe none of us, quarrel with the idea that specialty hospitals have a role and can do some things better. But I mean, if you have this authority

we talked about, do you think in terms of wanting to stop that self-referral?

Mr. MCCLELLAN. Well, again, I am not sure we have the authority. We are reviewing that now. I don't think that is the most important thing for us to be focusing on. I think the most important things are these refinements in the payment systems and these refinements in our process for approving hospitals. Now that we have got, you know, a new type of hospital that we are dealing with, we want to make sure those are up-to-date. So that is where we are focusing our efforts.

Mr. BROWN. Okay. Thank you.

Mr. DEAL. I recognize Chairman Barton.

Chairman BARTON. Thank you, Mr. Chairman.

Let me get this microphone.

If I were to introduce a bill to ban teaching of specialties in the practice of medicine, in other words, if I were to require that every doctor be a general practitioner and you couldn't become a heart specialist or an orthopedic specialist or an internist, would that be a good thing or a bad thing?

Mr. MCCLELLAN. For me?

Chairman BARTON. Well, for either one of you. Either one of you.

Mr. MCCLELLAN. Well, since I am a doctor, maybe I can step out on this one and say that probably is a bad thing.

Chairman BARTON. That would probably be a bad thing. Okay. What if we were to put in the Department of Defense authorization bill that we couldn't have fighters and bombers and interceptors and close-air ground support, that every plane that DOD bought had to be a general plane, they had to do everything? Would that be a good thing or a bad thing?

Mr. MCCLELLAN. A bad thing.

Chairman BARTON. A bad thing. So why is it such a good thing that we ban these specialty hospitals? Doesn't it go against everything in the American culture that specialization is good and focus on a specific issue is good whether it is that you want to be a Cadillac dealer or you want to be, you know, the quarterback coach as opposed to the line coach or whatever it is?

Mr. HACKBARTH. Can I take a crack at that?

Personally, though I am a lawyer by training, I run a large physician group, and I think that there is a lot of plausibility in both the idea that you can improve quality and efficiency through specialization, and you can improve performance through engagement with physicians as owners. I think those are very plausible ideas. But I like to see evidence. And given the relative newness of this phenomenon, unfortunately we don't have a lot of evidence in hand right now that I would consider to be definitive on either the efficiency or quality issues.

Chairman BARTON. Well, but even if they are not better. Let us assume the opposite. Let us assume that the specialization is bad. Why should we ban it? Why shouldn't we let the market sort it out?

Mr. HACKBARTH. Yeah. Well, here, I am going to actually act like a lawyer. I see this as a balancing issue. The Commission does see risk, potential risk, in self-referral.

Chairman BARTON. Well, have we not had self-referral since the practice of medicine began?

Mr. HACKBARTH. What makes this different is that the physicians are not just referring to themselves and earning a professional fee for the additional services they provide. They are sharing in institutional profits and facility fees as well.

Chairman BARTON. What did the Mayo brothers do——

Mr. HACKBARTH. And so the potential gain is larger.

Chairman BARTON. What did the May brothers do when they started their clinic? Did they self-refer or not?

Mr. HACKBARTH. Well——

Chairman BARTON. Not well. Did they self-refer? The answer is yes.

Mr. HACKBARTH. The Mayo Clinic, I believe, is organized as a not-for-profit institution.

Chairman BARTON. But it was established by doctors.

Mr. HACKBARTH. But the——

Chairman BARTON. The doctors owned it.

Mr. HACKBARTH. But the legal——

Chairman BARTON. Or how about Scott and Wyatt in Temple, Texas?

Mr. HACKBARTH. I am not familiar with their——

Chairman BARTON. Well, I am familiar with Scott and Wyatt in Temple, Texas, and it was started by a doctor, and he owned the hospital. Now if self-referral is bad, then the whole practice of medicine, since the beginning of medicine, as I know it in the modern era is bad. But having said that, I think Mr. Brown and his opening comments I agree with. We don't want specialty hospitals or doctors to just treat the healthy wealthy. That is wrong. So if we are worried about that problem, let us fix it by saying you have to treat everybody that you have the ability to treat. If they come through your door, and you are an orthopedic surgeon, and they need a surgical procedure, you do it. And if you have an ownership interest in a hospital, you do it in your hospital, if you have the ability to do it. And if you want to set some parameters on percent of Medicaid and Medicare and we can do it in a way that tracks these norms and bell curves, that is okay, too. But to say that we have had a moratorium on something that, according to everything I know about America, is the right way to go and we now want to extend it, to me, is un-American. It is wrong. And as I said in my opening statement, this is one case where doing nothing wins.

Now I am an engineer, and I made A's in statistics, and I know about probability and averages and means and medians, and I looked at all of these charts that you put up, and to me, they said nothing. It said there is a little bit of difference. A very little difference based on the sample that you took. And even there, if we need to make some changes, Dr. McClellan has said we are going to go in and review the compensation and DRGs and things like that, and if there is really an imbalance, his group, the agency, CMS, is going to make some recommendations. And I am sure this Congress will accept those. But I just absolutely see no reason, from a public policy perspective, to continue the ban on something that, according to everything that I have seen, absolutely makes sense. And you know, the community hospitals can set up a spe-

cialty hospital. The non-for-profits can set up specialty hospitals. If you have no ban and you have no moratorium, if the concept is good, we will let everybody participate in the concept, and we will do it under rules that are fair to everybody. You know. And then if somebody is trying to game the system, we will make those changes.

Mr. HACKBARTH. Mr. Chairman, just in the interest of making sure that the table is properly understood, could I get——

Chairman BARTON. Yeah.

Mr. HACKBARTH. Take the example of the physician-owned heart hospitals and the 1.09s. We are saying that the expected profitability is 9 percent higher than average based on the selection of patients. Just to put that 9 percent in context, for a hospital, a total profit margin of 2 or 3 or 4 percent is not uncommon. So if you have an expected profitability of 9 percent, just based on your selection of patients, that is quite a significant difference. That is not a small number in the context of hospital findings.

Chairman BARTON. Well, I will predict to you, sir, as somebody who has played with numbers a little bit myself, if we get that sample size larger than 12, if we get that sample size to, say, 100 or 200, and you look at your national average and the sample size is 4,375. The larger that sample size, I think the smaller that dichotomy is going to be. Now I could be wrong on that. But again, if, in fact, physician-owned heart hospitals have a profitability margin of twice the community-based hospital, I think we can do something about that. If that is the objection, if that is really the objection, specialty hospitals make too much money, by God, it is un-American to make too much money, we ought to change that, every Democrat on this committee is going to vote for an amendment to cut the profitability of specialty hospitals in half. And I will probably support it, if that is the real argument.

Mr. HACKBARTH. And on that, we completely agree, and we have laid out the ways that that ought to be done that are fair to all types of hospitals.

Chairman BARTON. But I think the real fight here is not about quality of care. It is about control and ownership. That is the elephant in the tent that nobody wants to talk about. And there are some groups that just thing doctors making decisions for themselves to treat their patients in the way they think they are best able to be treated, that somehow that shouldn't be allowed. And I think it should be allowed under the right terms and conditions so that there is not a special financial advantage to the specialty hospital.

And with that, I yield back.

Mr. DEAL. Thank you.

Mr. Gordon.

Mr. GORDON. Thank you, Mr. Chairman.

And let me say to my friend, Chairman Barton, I think that the issue goes beyond what you just mentioned. There is also a question of access in communities. There is a question, and I would say, what happens if someone with a bullet wound or a severe, Dr. McClellan, or a severe stomach problem or something else and goes into an orthopedic clinic, what are they going to say? "We can't treat you. We don't have an emergency room."

Mr. MCCLELLAN. Right. Most of the orthopedic hospitals don't have emergency rooms, and that is actually why I emphasize that we are going to be reviewing our EMTALA requirements in light of, you know, the findings of these reports. You know, for example, if there is a case where, as Chairman Barton was saying, there is a patient who can be treated most effectively in a surgical hospital or an orthopedic hospital, we want to make sure that there are appropriate ways to support that. So right now, hospitals that don't have emergency rooms are not subject to any of the EMTALA requirements. There could be a situation here, for example, where there is a hospital with an emergency room that doesn't have a relevant specialist on call but maybe there is one available at one of these other facilities. Well, we need to think through what the implications of situations like that are for our rules about payment and participation in the Medicare program. That is what we are going to be doing over the next——

Mr. GORDON. Implications of access if community hospitals that have a variety of responsibilities that they are required to, if they are not able to be profitable, then they can't have emergency rooms. They can't do the other types of community services that they are required to do. So I think there is a broader issue, not that what Chairman Barton brought up is not one of them, but I think there are broader issues to be considered today. And that is what brings me, Dr. McClellan, to where you had laid out quite a list of things you want to try to get done, both things you know you want to do and then areas of which you think you want to do but you need more information and have set, I guess, an internal moratorium until the end of the year. I like an optimist, and I try to be optimistic, but I like to try to think realistically, too, and looking at probably Congress is more a procrastinator than HHS, but I think both of us have missed deadlines. And so I am concerned about that, and so I ask you do you see any problem with the MedPAC's recommendation of having the moratorium legislatively continued until January 1, 2007?

Mr. MCCLELLAN. Oh, Congressman, we are not recommending continuation of the moratorium. We are, as you say, looking closely at our procedures.

Mr. GORDON. But by virtue of not——

Mr. MCCLELLAN. Right. And——

Mr. GORDON. And I assume these hospitals aren't going to set up if they don't get reimbursement from you?

Mr. MCCLELLAN. I think that is probably right.

Mr. GORDON. Yeah.

Mr. MCCLELLAN. And that is why I want to focus on our getting the work done. We do think we can this work done by the end of the year. I am an optimist, too. We will obviously keep——

Mr. GORDON. And if you can't, will you——

Mr. MCCLELLAN. Well, we will keep in touch with you and with the Committee about how this work is progressing, and I think this is a reasonable goal at this point, and we will obviously keep working with you to make sure we are doing it. We are following——

Mr. GORDON. That sounds more like a lawyer answer than a doctor answer. My concern is that probably some ultimate solution might very well result in some type of a grandfathering situation.

And you know, that is just typical around here. And the more you do, the more odd situations that are produced, and I really think that we would be better off to have a longer moratorium so we don't potentially get into additional grandfathering.

Mr. MCCLELLAN. Well, I agree that we want to avoid grandfathering. I mean, we want to get this right. We want to get the participation circumstances correct. We want to get our processes correct. We want to get our payment systems correct. And we are going to do that in the coming months. I just emphasize that if, as we change these processes for being able to bill Medicare for services, those changes in many ways will apply to some of the existing facilities. So if there is a specialty hospital out there that is not providing primarily inpatient services, we are not going to continue to allow that to be billed as a hospital.

Mr. GORDON. I have just got a short time, so let me just run over to Mr. Hackbarth, please.

In your recommendation, you did suggest that there needed to be this moratorium until January 1, 2007 both to implement the various regulations as well as to get more data. I assume you feel that is an accurate position.

Mr. HACKBARTH. Sure.

Mr. GORDON. And if you might expand on that, and also tell me if you are seeing threats to emergency room care and other types of community services that community hospitals are required to provide.

Mr. HACKBARTH. Well, let me tackle the second part first.

As I was just discussing with Chairman Barton, the Commission is concerned about the effects, the incentives created by self-referral. On the other hand, from my perspective, I worry about saying that the way that we are going to assure care for the uninsured, for example, is by protecting existing institutions from competition. Looking at a lot of different industries, we can see that that sort of protectionist approach to trying to get a public good is not very efficient. We end up paying a lot, a hidden price, but a substantial price. We lose potential gains in efficiency and improvements in quality that we would otherwise get from more competition. We are in favor of more competition, but we want it to be fair competition. And, among other things, that means that we need to make the payment system more accurate in the ways that we were just discussing. That is a huge step in the right direction.

Now the question that I have about the time schedule that Mark has laid out is that the payment reforms are going to take longer than to January 1, 2006. And so if we just have a hold to that point and then the market is opened up, it will be in the context of a payment system that we think is significantly inaccurate and results in overpaying specialty hospitals and some types of community hospitals and underpaying other types of hospitals. And we think there is jeopardy in that.

Mr. GORDON. If I can just conclude, I would say, to some extent, I think you already have competition by virtue of fee setting. And when the Federal Government sets fees, then I mean, that is the competition. That requires you to be more efficient to be able to produce a product where you can make a profit.

Thank you.

Mr. DEAL. Dr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman.

Just to follow up on that, I don't believe fee setting is adequate for establishing competition. We all know that, again, just the overhead costs of a community hospital that runs 24 hours a day, 7 days a week whereas a surgery center, the lights go off at 6 p.m. But to pick up on the Chairman's point, I am concerned, also, about the continuation of the moratorium. For the life of me, I don't understand. You say we are evaluating this, but it is a moving target. There have been more and more specialty hospitals and surgery centers that have come on line in recent years, so it is difficult to evaluate adequately an evolving product or a moving target, and so we put the artificial moratorium on top of it. How are we going to deal with what happens after the moratorium is removed as far as providing that evaluation?

Mr. HACKBARTH. The emphasis, in my comment, was not so much on the moving target, although that can be an issue as well, but rather on the fact that our analysis is based on 1 year of data, 2002 and a limited number of hospitals. So you have got a limited number of data points there. It is not far in the future that we will have significantly more data on even those institutions. By the end of the calendar year 2005, we would have an additional 2 years of data on those institutions, which would allow us to make more confident conclusions about their potential effect on efficiency. When we made our recommendations at MedPAC, we had not yet seen any of CMS's analysis of quality. In fact, we still haven't seen the data. We are eager to do so.

Mr. BURGESS. But the world in which you will exist will then change when the moratorium is ultimately lifted, and it won't be the same environment that you studied previously.

But let us move on from that for just a minute.

I feel obligated to talk about self-referral. My dad, a physician himself, when World War II ended, he was a general practitioner in Noranda, Canada. He did obstetrics for that brief part of his career. If he did a home delivery, he was paid $40. If he did a delivery at the hospital, he was paid $45. And he would give the patient the $5 to come to the hospital. So in a way, that was kind of self-referral back then, but I think the patient care was improved by that.

The reality is, now we are actually talking about two universes. We are talking about not-for-profit hospitals, for-profit community hospitals. Those two are actually very, very different species. I know from my own experience that to try to get an uninsured patient into a for-profit hospital to have the necessary treatment done can be a big deal and require that uninsured patient to put up a big bunch of money, because the hospital is having to cover all of that additional overhead. And the surgery center may be willing to take that patient for a significantly lower amount of money, allow her to pay that money out over time, and welcome that patient with open arms.

So yeah, I am going to self-refer to the surgery center under those circumstances. I would be crazy not to. We are looking at a situation where more and more people may be, perhaps, paying for a greater part of their care with the improvements that we have

done with health savings accounts in this country. Why not give them access to a lower-cost product in the surgery center or specialty hospital?

Mr. HACKBARTH. I would like to just emphasize the point that you made, Mr. Burgess, about how even among "community hospitals," there is a lot of variability, for example, on the amount of indigent care provided. You know, I don't think if we were to prohibit specialty hospitals tomorrow, that is not going to have a meaningful impact on the problems of indigent care in this country. There are issues that long pre-date specialty hospitals. And so I think to——

Mr. BURGESS. Sure, but, sir, if I could, now we have another option in my community in that no longer does this patient have to come up with $10,000 to pay to, I won't mention any initials, but HCA, she can pay $1,000 to come into the surgery center. And that is a big difference for someone who has no insurance, who wants to pay their bill.

Mr. HACKBARTH. Yeah, and as I said, I agree more options are a good thing. I want to see efficiency better. I want to see quality of care better. I want to see patient service better. But I want to do it in the context of a fairer payment system that doesn't overpay or underpay. And I think that that is an achievable goal.

Mr. BURGESS. And I agree with you, and I think Dr. McClellan is right on the mark with that. I will just come in favor of support of his 6-month study of this process rather than extending the moratorium. I don't think we need to take legislative action on this.

I will yield back.

Mr. DEAL. I thank the gentleman.

I recognize Ms. Capps.

Ms. CAPPS. Mr. Chairman, could I inquire of the time in terms of that I didn't make an opening statement, or are we——

Mr. DEAL. You have 8 minutes.

Ms. CAPPS. I may not need to use it all, but I wanted to be clear.

I thank you for holding this hearing. Just a comment perhaps directed more at the chair to follow-up on Mr. Gordon's timeline kind of questioning.

I appreciate the hearing on this topic. It is of great interest in my District. I am concerned that the moratorium expires in about a month, and it seems to be that Mr. McClellan has his own sort of timeline that would be internal, perhaps we could call it a moratorium, but it will take a while, perhaps. But in terms of our legislative response, it seems pretty clear that that wouldn't probably happen so that this hearing is not about that in terms of the moratorium, but rather informational.

Mr. DEAL. Well, the hearing is to examine all of the information and all of the options that are out there.

Ms. CAPPS. It would be pretty hard to——

Mr. DEAL. But there is no specific legislation that——

Ms. CAPPS. [continuing] act.

Mr. DEAL. [continuing] we are in the process of trying to mark up.

Ms. CAPPS. So if we are coming here thinking we are going to affect the moratorium, we probably are mistaken. That being said, I——

Chairman BARTON. Would the gentlelady yield?

Ms. CAPPS. Of course.

Chairman BARTON. We are not going to move a moratorium extension bill in this committee.

Ms. CAPPS. I hear you.

Chairman BARTON. Nor will I let the Appropriations Committee——

Ms. CAPPS. I suppose I should have known that before.

Chairman BARTON. [continuing] put it on an appropriation rider.

Ms. CAPPS. I hear you.

That being said, I am very grateful for the hearing on its own merits. I appreciate the testimony that you have made, particularly in light of the several opportunities that I have had to meet with representatives of the community, acute care hospitals from my District. They are all very concerned about limited service or specialty hospitals as we experience them in California, in my area. Advocates of the specialty hospitals are claiming that these facilities, and I have heard it directly from some of them who are physician owners, that these facilities can improve quality and patient satisfaction. These are laudable goals, and if they are achieved, then we certainly want to handle this topic very carefully. But I believe we need to see very real evidence of their success. And we need to be sure that the specialty hospitals experiment, if that is what we are calling this, or what is happening does not jeopardize the overall provision of health care in the country. I mean, that is where our real responsibility lies, both yours and ours. Community acute care hospitals are deeply concerned about this last point, because they are full-service providers, and they are, at least the ones that I am familiar with, very strapped financially. Inequities in Medicare and Medicaid payments have put great pressures on them. And these hospitals are the point of care for millions of uninsured who are not about to be visiting specialty hospitals. The community hospitals are where these people go when they get sick. And my community hospitals have the belief, and they need to be demonstrated otherwise if it is not true, that the specialty hospitals may "cherry-pick" relatively healthy and inexpensive patients for specific treatments. And this would leave the sicker and more costlier patients to the acute care hospitals, putting an even additional burden on them because of the way the payment structure is. And I understand that MedPAC's study of this issue indicates the community hospitals have so far been able to deal with this. But that was the reason for the moratorium, to gather more information.

So Mr. Hackbarth, I want to follow up on something that I heard Chairman Barton say in his opening statement. He talked about, and this is an important issue, competition lowering costs. I find it interesting, because we prepared the Medicare Modernization Act in this subcommittee, also, in which we have provided opportunities for overpaying managed care to provide competition with Medicare. So I think it has been said by others this is not necessarily an even playing field, but competition lowering costs is still something we believe in, if it is true. So my question to you, Mr. Hackbarth, is did MedPAC find that specialty hospitals had, indeed, lower costs than community hospitals?

Mr. HACKBARTH. No, we did not, not in 2002.

Ms. CAPPS. So, so far, there is no study that indicates that specialty hospitals do lower costs?

Mr. HACKBARTH. Well, I won't say that there is no study.

Ms. CAPPS. MedPAC's study did not.

Mr. HACKBARTH. The MedPAC analysis of the Medicare data on these hospitals found that they did not have lower costs.

Ms. CAPPS. Maybe I should ask Mr. McClellan to corroborate. Do you know of any studies, Mr. McClellan, that demonstrate that specialty hospitals lower costs?

Mr. MCCLELLAN. We didn't look at the cost issues. That was the responsibility for the MedPAC report. But just as Mr. Hackbarth said, under the Medicare payment systems now, you get paid a certain amount of money for the admission to the hospital. If we make the refinements in our payment systems, you would see lower payments for the less severely ill patients and maybe higher quality of care as well.

Ms. CAPPS. But this is still in the presupposing stage?

Mr. MCCLELLAN. Well, because we aren't done it yet.

Ms. CAPPS. Okay.

Mr. MCCLELLAN. What MedPAC has recommended, what we are going to do is refine our payment system to make it more accurate so there is less costs if there are less severely ill patients. We are going to be paying them less under the refined payment system.

Ms. CAPPS. Okay. I guess this question then, as a follow up to both of you, even if you make the changes to how Medicare reimburses these facilities, how do you ensure that the limited service hospitals will take their share of Medicaid patients? Is there a plan for that to happen?

Mr. MCCLELLAN. That is one of the issues that we are reviewing as part of updating our processes for approving these hospitals for payment. We are going to be looking at the EMTALA activities, and the way that our EMTALA regulations work, as Chairman Barton said, I think it is important that patients who have a medical need have access to the right providers for doing it. And if a hospital can provide those services, that is something that I think is an important public health goal. Also, we want to make sure that given the more limited scope of these hospitals, that they are providing the right level of safety and support for our patients.

Ms. CAPPS. And it is true that at this point we really don't have definitive answers to all of these questions?

Mr. MCCLELLAN. Well, we do have definitive answers on many aspects of quality.

Ms. CAPPS. But not all?

Mr. MCCLELLAN. Well, some very important ones, things like complication rates in these hospitals, the satisfaction the patients have, the satisfaction that nurses——

Ms. CAPPS. Right. That part I am clear about, and I have heard some anecdotal evidence to that myself.

Mr. MCCLELLAN. Yeah.

Ms. CAPPS. But that one question I asked you about making sure that specialty hospitals will take their fair share of Medicaid patients, that has not been determined, a mechanism for making sure that that happens. Am I right or are——

Mr. MCCLELLAN. They do take a lower share of Medicaid patients. That is an issue that we will look——

Ms. CAPPS. Is there fairness that needs to be discussed here?

Mr. MCCLELLAN. That is an issue that we will be looking at.

Ms. CAPPS. Okay. I guess now, would you like to——

Mr. HACKBARTH. Yeah, I would just like to make a brief comment on that.

I think it is always important to come back and remind ourselves that community hospitals are not all alike. They don't all provide equal amounts of Medicaid care.

Ms. CAPPS. True.

Mr. HACKBARTH. They don't provide equal amounts among compensation——

Ms. CAPPS. Yeah. I want to get one more question out, and I agree with you, and I think the same could probably be said for specialty hospitals.

And I guess that brings me back to the point, it was an onerous part of the Medicare bill to put in this moratorium, many people felt. And the moratorium was supposed to deliver a lot of answers. I am just not clear about whether we have enough of them yet.

Mr. MCCLELLAN. Well, we have both completed our studies, and our study did look at the best evidence we had available on quality of care. I think it is important to mention the quality.

Ms. CAPPS. Right.

Mr. MCCLELLAN. There is pretty clear evidence that the specialty hospitals do better, certainly in patient satisfaction, lower length of stay. That is probably a good thing. There are fewer complications in the hospital, more opportunities——

Ms. CAPPS. But many unanswered questions remain.

Mr. MCCLELLAN. Well, as you know, in all of these health care issues that we deal with that are important——

Ms. CAPPS. Okay. I am very sorry. I have 5 seconds. I don't actually. Mr. Hackbarth, do you want to make one quick comment to this?

Mr. HACKBARTH. Well, as I said, I think that we need more evidence on both the efficiency and quality issues.

Ms. CAPPS. Yeah.

Mr. HACKBARTH. I think what we have got is a very limited snapshot, and I don't think it is very far down the road that we will have a significant improvement in the data on this.

Ms. CAPPS. I appreciate that, and thank you.

Mr. DEAL. Mr. Ferguson.

Mr. FERGUSON. Thank you, Mr. Chairman.

I want to go back to the concept that I talked a little bit about, and you, Mr. Hackbarth, discussed as this gain-sharing. And I would like to use my 5 minutes, and maybe the two of you can divvy it up a little bit. I would like to hear some more of your thoughts, both of your thoughts, but Mr. Hackbarth first, specifically about gain-sharing, how it is different from physician self-referral. This is obviously something that I have mentioned that was being innovated in New Jersey. It, I think, shows a lot of promise. It gets doctors and hospitals working together on incentives. But maybe could you flush out a little bit more of some of the value that you think gain-sharing would have and then, Dr. McClellan,

would you add, perhaps, your thoughts on that on the other end of that?

Mr. HACKBARTH. Yeah. Well, you know, I think it is clear that physicians and hospitals can achieve more, both in terms of improving efficiency in quality together than they could achieve independently. And right now, the rules basically put up an artificial barrier from their sharing the gains from those joint efforts. One way that physicians can get that now is through the specialty hospital phenomenon, become an owner of the hospital. There you can share in the gains from improvement. But if you practice in a not-for-profit institution, that opportunity is not equally available. We think it is important that all physicians and hospitals have the opportunity to engage constructively and share the gains from that effort. Right now, the rules prohibit it. What we would like to do is see Congress authorize the Secretary to permit gain-sharing and then write rules that define the boundaries within which it can occur. Obviously, we would like to see reasonable protections for quality of care. In that same framework, we could also address concerns that some people have about this sort of mechanism being used to provide inducements for physicians to artificially increase volume or to shift patients from one institution to another. We see indications that that can be done through the Inspector General's approval now, some very specific gain-sharing type arrangements where they said this is okay so long as it proceeds within this framework. That process is too slow, you know, case by case by case. We think a much more efficient means would be a regulatory process that would establish rules for everybody that they could rely on.

Mr. MCCLELLAN. All right. I would agree with the same kind of points that Mr. Hackbarth just described. The fact of the matter is that the doctors and hospitals should be working together, because there are so many opportunities to improve quality of care to make better decisions to get the patient the services they need at a lower cost, and gain sharing has some potential to do it and these initial limited steps by the OIG are something that should be built on with further measures. The physician-owned specialty hospitals have that same kind of alignment built in. With a typical physician owner in these hospitals, they have got maybe a 1-percent share, maybe less, so it is not like their individual decisions about a particular patient are going to have a huge impact on their own revenues, but there is that connection in. I think the right question is how do we set up systems like this that promote access to care that are really focused on promoting quality and the kinds of things that we are doing with the refinements in the payment systems, with the refinements in our processes for approving specialty hospitals have those same kinds of goals in mind. So I think there are, in both of these approaches, some real opportunities to get better care at a lower cost, and that is what we are trying to achieve.

Mr. FERGUSON. Okay.

Thank you, Mr. Chairman. I yield back.

Mr. DEAL. Ms. Baldwin is recognized for questioning.

Ms. BALDWIN. Thank you, Mr. Chairman.

Just a couple of follow-ups from wanting to make sure that there is some clarity after some of the previous questions have been

asked. Just so we are clear, is there any ban on the existence of specialty hospitals right now?

Mr. MCCLELLAN. Right now, there are existing physician-owned specialty hospitals. They are largely, I think, going to continue their operations.

Ms. BALDWIN. But is there a ban right now?

Mr. MCCLELLAN. Well, there is a moratorium right now on who——

Ms. BALDWIN. Correct, but there is no ban. There was an implication earlier in questioning, and I am just trying to clarify that. Has anyone proposed a ban on the existence of specialty hospitals?

Mr. MCCLELLAN. There have been proposals of the continuation of the moratorium so that no more——

Ms. BALDWIN. So it is true that the ban is merely on the self-referral issue, not on the existence of specialty hospitals?

Mr. MCCLELLAN. That is right, only physician ownership.

Ms. BALDWIN. Okay.

Mr. MCCLELLAN. Right.

Ms. BALDWIN. Mr. Hackbarth, in your testimony you made some reference to the frequency with which specialty hospitals treat Medicaid patients. I would like to hear a little bit more in depth of MedPAC's findings with regard to that conclusion.

Mr. HACKBARTH. Yes. We did find that, again for the 48 hospitals that we looked at in 2002, that they served a significantly lower proportion of Medicaid patients. As I recall, for the specialty hospitals, for the cardiac specialty hospitals, I think it was, like, 4 percent Medicaid volume versus more like 11 or 12 percent for the comparison community hospitals. Do I have that right?

Ms. BALDWIN. That is in the cardiac. What about the orthopedic and surgical specialty hospitals?

Mr. HACKBARTH. They will give you the answer to that. While they are giving you the specific number, here again I want to emphasize that we are talking averages, and some individual hospitals may have more or less. Specifically within the orthopedic category, we found a range of Medicaid volume, and there was at least one orthopedic hospital that had a fairly significant Medicaid volume. So for hospitals, heart hospitals, the Medicaid share averaged 2 percent if they didn't have an emergency department, 3 percent if they did have an emergency department, and the peer hospitals to which we compared them had 8 percent Medicaid. For the orthopedic and surgical hospitals, actually we lumped those together, and the specialty hospitals had 5 percent Medicaid. The peer hospitals that we compared them to had 9 percent Medicaid.

Ms. BALDWIN. Okay. Thank you. You know, in looking at the MedPAC study, I know you had challenges with regard to the limited data set. I was surprised to find the MedPAC report on physician-owned specialty hospitals found that specialty hospitals had a limited impact on community hospitals, because intuitively, it seems like they would have a greater impact. Do you think that that finding was impacted by the restrictions in the data set or are you satisfied that the data set was large enough to have that be a reliable finding?

Mr. HACKBARTH. Two thoughts on that. One is that we have found through our site visits that when faced with competition

from a specialty hospital, the community hospitals didn't stand still. They responded, and the sort of responses that they could make would be generally to reduce costs to sustain their level of profitability and/or increase revenues by, for example, adding new services that the specialty hospital is not competing. For example, imaging services or rehabilitation services that themselves are reputed to have higher than average margins. And through a combination of strategies, and they would vary across hospitals, what we found typically was that the community hospitals were able to sustain their margins in the face of competition. Now whether that would continue to be the case if faced with more specialty hospitals is an open question. And in that sense, the finding is limited by the data.

Ms. BALDWIN. Okay. And quickly, I am running out of time, Dr. McClellan, in your analysis, there is certainly the statement that specialty hospitals provide benefit to communities through the payment of taxes, and I want to clarify, do all specialty hospitals pay taxes?

Mr. MCCLELLAN. Just about all of the physician-owned ones do. Those are for-profit hospitals that are paying property taxes, real estate taxes, sales taxes on income taxes.

Ms. BALDWIN. I believe in the next panel there is a representative of a not-for-profit specialty hospital, and my understanding is that they would certainly not be paying the same range of taxes as the others.

Mr. MCCLELLAN. Not-for-profit ones wouldn't, right, but in general, the physician-owned——

Ms. BALDWIN. But I am talking about specialty hospitals, not all of them pay taxes, is that correct?

Mr. MCCLELLAN. If they are non-profit specialty hospitals, that is true. They would have a different tax structure, but most of the physician-owned specialty hospitals that you have been interested in are for-profit and do pay these taxes.

Ms. BALDWIN. Thank you.

Mr. DEAL. Mr. Shadegg.

Mr. SHADEGG. Thank you, Mr. Chairman.

Gentlemen, I believe I have a very brief amount of time, so I would appreciate it if you could answer my questions as quickly as possible.

Dr. McClellan, your study found that quality and patient satisfaction were higher at specialty hospitals. Is that correct, and did you go into the issue of why?

Mr. MCCLELLAN. That is correct. I can give you just a couple of reasons to be quick. One is there do seem to be some advantage of specialization. If you talk to the nurses there and the doctors there, they really do focus on delivering care for these particular procedures and these particular conditions really effectively, and that shows up in the patients having a better understating of their illness and what to expect, and it shows up in the lower length of stay and apparently some lower rates of complications. Another reason may be the tighter management, because the physicians who are providing the care are also much more directly involved typically in the management of the hospital. There is a really tight connection between a problem that a patient might identify, a prob-

lem that a nurse might identify, and actual changes in the way that the hospital practices medicine. There is very much a culture of quality improvement at many of the hospitals that we saw in our report and that I have seen in visiting some of these facilities. That translates into higher patient satisfaction and many dimensions of care and also some improvements in some dimensions of complications.

Now that is not to say there is not high-quality care at many community-based hospitals. We are seeing lots of efforts in community-based hospitals to improve the quality of care as well. They can also do a very good job, and we want to make sure they are paid appropriately.

Mr. SHADEGG. Your study also found that mortality rates were lower at cardiac specialty hospitals and even lower than community hospitals when you factor in the severity of the case, is that correct?

Mr. MCCLELLAN. That is correct.

Mr. SHADEGG. Okay. One of the arguments about specialty hospitals is that they do not provide as much uncompensated care under EMTALA. Yet your study also found that specialty hospitals spend a greater proportion of their net revenue on uncompensated care, is that correct?

Mr. MCCLELLAN. That is right. And as Mr. Hackbarth emphasized, this does vary. Some are providing much more than others. You know, one of the hospitals, we saw Oklahoma Heart is doing a lot of uncompensated care, also taking some very severely ill patients. And again, if we get the payment incentives right, I think we can encourage more of that kind of behavior, too.

Mr. SHADEGG. One of the points I want to make is that you made a reference to the importance of making sure people can get care and that EMTALA achieves that goal. I think it does achieve that goal, and it is a societal goal that we have decided upon. Although I think it is important in this discussion to note that although EMTALA achieves that goal, it does, that in a way that many of us think is inappropriate. I think one of the huge problems in our community hospitals is a lot of people in there are getting free care, under EMTALA, for services that could be more efficiently, or at least more appropriately provided, in another venue, that is to say not in an emergency room. If you walk into an American hospital's emergency room today, whether it is a specialty hospital or a full-service hospital, you will find people in there getting treatments for the flu or the cold or a chronic pain in their leg that does not need to be treated in an emergency room. So I think we have to look at the broader spectrum of reform. For example, I have legislation that I have had for almost 10 years in pushing a refundable tax credit so that we could give the Americans in this country who need health care but can't afford it a tax credit to go buy that health care and then get it delivered in the doctor's office or a community health center or a better venue than an emergency room.

The CMS study did not find a pattern of physician owners referring more patients to specialty hospitals than community hospitals. I think at the heart of this issue is the issue of self-referral, and I would appreciate your comments on self-referral.

Mr. MCCLELLAN. Well, we did find these differences in patient severity that appear to be related to the types of cases being treated at the specialty hospitals. They do appear to be focusing on, you know, different kinds of procedures than many of the community hospitals where they deal with patients not just with heart disease but maybe with other conditions and so forth. Again, we want to pay appropriately for that, but in terms of the referral patterns, we found that physicians who were not owners in the specialty hospitals were just as likely to refer severe and not severe cases as the physician owners. Now the physician owners did have more referrals overall. That is how they provide their care, but it wasn't clearly related to any differences in severity. No selected behavior of the physician owners versus non-owners in just referring in less severe cases or something like that.

Mr. SHADEGG. My time is very limited, and I want to get in two more questions.

One, when you could see that the quality is better at a specialty hospital, the patient outcome is better at a specialty hospital, mortality rates are lower at a specialty hospital, I think you can see why it is difficult for some of us to endorse the notion of extending the moratorium, especially with the baby boom generation coming on. I understand that you don't favor extending the moratorium. I would appreciate a quick answer to that, and then I have one last question.

Mr. MCCLELLAN. Well, we have not proposed an extension of the moratorium. We have proposed some important steps to get our payment systems up-to-date, and we are going to start working on that now so that those payment changes should be getting pretty clear by next January, and then we will implement them later on in 2006. And we are also going to be implementing these changes in our processes, and that may have some important effects, not only on the specialty hospitals that end up getting payments from Medicare, but on some of the hospitals that are billing Medicare today, perhaps inappropriately.

Mr. SHADEGG. Mr. Chairman, I won't ask any more questions, but I simply want to say that I would like to submit in writing some questions to you going to the issue of a level playing field. The community hospitals have come to me and said, "Look, Congressman. We understand you think that specialty hospitals are performing a vital service, but you need to know the playing field isn't level." And they refer to some current provisions of Federal law, which, they say, make it impossible for them to compete on a level playing field with the specialty hospitals. They know my position is I don't want to put greater burdens on the specialty hospital. My solution to this problem isn't moratorium on specialty hospitals. My solution to this problem is to take some of the burdens that are currently imposed on the community hospitals off, and I would like to submit to you a series of questions of whether you have looked at those issues, what you might recommend that we could remove, and how we could, in fact, if there is an unlevel playing field with regard to the community hospitals, how we could fix that without increasing the burden on the specialty hospitals.

Mr. MCCLELLAN. We would be delighted to look into that. I think there are some important opportunities there.

Mr. SHADEGG. Thank you very much.

Mr. DEAL. Thank you.

Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman.

And again, welcome, Dr. McClellan.

It is interesting, because I find myself agreeing with my Arizona colleague and that we are correct, if there are other ways we can provide health care instead of through our emergency rooms in our community hospitals, whether it be for-profit or non-profit, you know, CAP funding to have the organization of what providers we have in communities, and of course community health care clinics that the President has plussed-up in his budget. And we are having some success, at least in the Houston area in Texas, because we have been behind the curve on that.

Since the chairman said that there will not be legislation on extending the moratorium, I just want to make sure, and I think you told Mr. Shadegg, that CMS, even without the extension, can make these changes for 2007.

Mr. MCCLELLAN. We will be making the payment changes effective for fiscal year 2007. That is actually during the fall of 2006. And we will be making these changes in our process for approving specialty hospitals for payment before then.

Mr. GREEN. Okay. I have a number of questions, and like everyone, I will try to talk as fast as I can.

The CMS study indicated specialty hospitals devote a higher portion, the net revenue taxes and uncompensated care in community hospitals, and given their for-profit status, I know these taxes go for lots of communities, not just for Harris County Hospital District, for example, in my area. Yet, without a doubt, every penny of the uncompensated care at the community hospital has to do goes to health care. Did CMS look at a study comparing that uncompensated care for the community hospitals as compared to what—maybe when there is a facility like a local tax for a public hospital system?

Mr. MCCLELLAN. Well, communities have, as you know, many priorities, including public health, and that is an important source of where local and State funding goes. We don't have any specific numbers, you know, for the hospitals in the study, but if you think about priorities, having new resources available to local county governments and other governments to meet their community needs is important.

Mr. GREEN. Well, and that is a concern, and again, some of us trying to think outside of the box not only here, but also in Texas, and looking for other ways to support the public hospitals that we have.

Mr. Hackbarth, MedPAC's study found that specialty hospitals had limited financial impact on community hospitals, however, the findings were understandably limited due to the moratorium and the relative scarcity of physician-owned specialty hospitals. Did you look at certain regions or areas that currently have specialty hospitals competing with community hospitals? And I know, for example, the example I heard was in Austin, Texas where just on the northwest corner of one of our facilities, a cardiac facility, and I have one in Pasadena, Texas that competes with Bayshore Hospital

for profit and also a for-profit specialty hospital, did MedPAC go into some of the regions of the areas to actually show that competition now?

Mr. HACKBARTH. Yes. If I could get the map up here.

[Slide.]

The red spots on the map show the 48 hospitals that we looked at. And then in addition to that, we did some site visits in Wichita, Austin, and Sioux Falls. The data about the impact on community hospitals is of two types. One, we looked at what was happening to the au pair margins of community hospitals facing competition, and we did that broadly across all of these areas.

Mr. GREEN. Okay.

Mr. HACKBARTH. And then when we went into particular markets or we did more detailed case studies, that is where we learned about some of the strategies that community hospitals might apply to try to deal with the competition. So it is broad data supplemented with some focused case study reports.

Mr. GREEN. Okay. And that is available in the report?

Mr. HACKBARTH. Yes, that is in the report.

Mr. GREEN. And following my colleague, Mr. Shadegg, on self-referral, I think the biggest issue is the concern about physicians being able to self-refer, and I think in the MedPAC study, the average physician may own 2 or 3 percent of a facility, and that they gain by self-referral. And I understand MedPAC reached a different conclusion in a report using the example of what a group of physician owners might gain through self-referral, for example, for heart surgeries. Would you elaborate on that?

Mr. HACKBARTH. Well, the point that we were trying to make is that looking just at the individual physician's percentage of ownership may not fully show what the potential impact is on the physician's decisionmaking in two respects. First of all, when you are thinking about incentives, you want to think about how does it change the physician's behavior about doing one more surgery or admitting one more patient, thinking about what happens at the margin. And the way hospital finance works is that the profit based on one more additional case is much higher than the average profit in the institution, because to do that analysis, you are just looking at the revenue from the new case compared to the variable costs of the treatment. And so the profit can be pretty significant from one additional surgery. Then in addition to that, although an individual physician's ownership piece might be small, the physicians collectively own a larger share. In the case of orthopedic and specialty hospitals, often the majority of the institutions, in the case of heart of hospitals, more like 30 or 40 percent of the institution is owned by physicians collectively.

Now if the physicians together say, "Well, let us each add one more patient," each individual physician not only gets the profits from his or her additional patient, but also a share of the group's profits. So there is some magnification, if you will, of the financial effect. So for those two reasons, we think that just talking about, oh, the physicians only own 1 percent or 2 percent may give a misimpression about the magnitude of the economic incentives.

Mr. GREEN. Okay. Dr. McClellan, I know this CMS study looked a little different. Do you agree with basically what MedPAC——

Mr. MCCLELLAN. Well, we did investigate some of the quality of care impacts, and that figure is prominently in our report. I think that, as I have said, we want to make sure that the payments are appropriate and that we have an appropriate process for approving the hospitals, so I think we agree on most of these issues.

Mr. GREEN. One of the concerns I have, and in fact in my own District, I have a problem, because of the scarcity of beds, and we see doctors oftentimes, in fact, in the one case where there is already a specialty hospital, a group of doctors are trying to form a facility because they can't get bed space at local community hospitals, so they are going together and trying to do it so they can. I think that is what I am hearing, not so much from the profitability point of view, but just so they can have adequate bed space for their patients.

Mr. MCCLELLAN. Yeah. Yeah.

Mr. GREEN. And I know that that is something both MedPAC and CMS and we are all concerned about.

Mr. HACKBARTH. Yeah, and I can relate to that. As I said earlier, I ran a large physician group, and I heard often from surgeons about their frustrations in working with hospital management and getting OR time and disruptions in the OR schedule. These are real problems for physicians in many institutions. And so I can sympathize for them wanting to have more control over their practice environment. I just want to make sure that it is a fair opportunity.

Mr. MCCLELLAN. And in our report, we did find, from the physician standpoint, much higher satisfaction with these arrangements specifically because they could get a lot more predictability about their OR time and a lot more responsiveness from the management, provide their services more efficiently, and one of the doctors told us, one of the surgeons told us about, you know, now that he is working there, he can actually go to some of his son's little league games, something that he had never been able to count on or do before because of the scheduling predictability.

Mr. GREEN. Well, and again, the patient benefit weighs into it, Mr. Chairman, because of, you know, the timeliness of getting your treatment that you need.

I thank you, Mr. Chairman, and I know I am over my time.

Mr. DEAL. Thank you.

Ms. Myrick.

Ms. MYRICK. Thank you, Mr. Chairman.

My question has two parts to you, Mr. Hackbarth, please. And it is relative to the over-utilization issue as it may relate to this self-referral problem. Has the growth of specialty hospitals increased this utilization by Medicare beneficiaries? And the second part of that, as it will relate to other issues, like other physician-owned facilities, like imaging equipment, et cetera, have you seen any increases?

Mr. HACKBARTH. Well, let me tell you about the first part. What we have found was that the arrival of a specialty hospital, a cardiac specialty hospital, in particular we looked at, does increase the volume of cardiac surgery, although the difference that we found was not a statistically significant one, with an exception for one particular type of surgery, but in general, we did not see a statistically significant increase in volume.

Mr. MCCLELLAN. What seemed to be happening more was a shift. There is a shift. The specialty hospitals do take away some of the volume from the community hospitals. Also, specialty cardiac hospitals, in particular, get a significant number of transfers in from other facilities, maybe, you know, more rural facilities for referrals as well.

Ms. MYRICK. Right.

Mr. MCCLELLAN. But it is not a substantial increase in most areas in the number of cases overall in the community.

Ms. MYRICK. How about the imaging issue? Is that one that you can address?

Mr. HACKBARTH. Well, separate from this study, in our most recent report, we published some research and recommendations related to the growth of imaging, and there we do have some concern that physician ownership of the imaging facilities may be contributing to a significant increase in imaging volume.

Ms. MYRICK. And I have a second question.

Since you found in your study that there were contrasting cardiac hospitals and that the orthopedic hospitals didn't seem to have a favorable DRG selection, if you were going to do a moratorium, would you suggest limiting the types of specialty hospitals that would fall under any extension of a moratorium?

Mr. HACKBARTH. Well, what we found is that for orthopedic and surgical hospitals, the types of patients that they treated were not, on average, more profitable. But then within those categories, they were taking the lowest-risk patients. And when you take those two factors together, their expected profitability was significantly higher than average, and we think you need to look at both.

Ms. MYRICK. Both of those?

Mr. HACKBARTH. Yes.

Ms. MYRICK. Okay. Thank you both.

Mr. DEAL. Does the gentlelady yield back?

Ms. MYRICK. I am sorry. Yes, I do yield back.

Mr. DEAL. Mr. Shimkus.

Mr. SHIMKUS. Thank you.

I hate to do that, you know. No one is here and then someone jumps out and tries to get the mic.

This is an important issue, though, and I want to ask, first of all, there are three brief questions. The first one is on the MedPAC report. Did you all do any calculations about medical liability calculations and the difference between regular hospitals and specialty hospitals? What is occurring in southern Illinois is that because individual practitioners, as I said in the opening statement, no longer can afford. The hospitals are trying to assume that and roll that into their coverage. Was there a calculation for this?

Mr. HACKBARTH. No, we didn't look at that.

Mr. SHIMKUS. I would suggest that that might be something. I mean, if you understand the argument that there may be less risk, and especially fewer, you know, cases and that the medical liability insurance may have a role in this debate as far as costs. So that is issue No. 1.

Issue two is certificate of need. Illinois is a certificate-of-need State. And I have always had a hard time understanding this, because I am a market-driven competitive marketplace, and if some-

one wants to invest and place a facility, they are assuming a lot of risk, but when you have a certificate of need, and the State says you can or can not, how does that relate in this calculation?

Mr. HACKBARTH. Well, if we could get the map put up again.

[Slide.]

You will see in this map, the blue shaded States are States that have certificate-of-need programs.

Mr. SHIMKUS. Right.

Mr. HACKBARTH. And so you can see from this that the specialty hospitals tend to be in States that do not have certificate of need. There are a few exceptions to that, but that is the general pattern. Now exactly why that is and how the programs function in each of those States is beyond the scope of our study, but there is certainly a coincidence between the two.

Mr. SHIMKUS. Believe or not, there were some members speaking about this issue on the floor before we opened. We were waiting to do some other things, and one was from Indiana, of course, a certificate-of-need State, in addressing who has them in their District and how do you define them and whether they are almost standalone facilities or couldn't they be the back room of a physician's office that has all of the equipment to do some type of surgical issues?

Mr. HACKBARTH. Yeah.

Mr. SHIMKUS. So I need you to follow up more on that for me.

Mr. HACKBARTH. Yeah. The other dimension of it is that some States also specifically prohibit physician-owned specialty hospitals, and there are various State laws on self-referral that can impact whether a specialty hospital exists in a given State. So there are potentially multiple layers of State law rules that affect whether there are specialty hospitals there.

Mr. SHIMKUS. Dr. McClellan, if we were more to closely define hospital and we define that with an ER and other types of amenities, it is my concern that that would actually address some so rural hospitals that because of trying to survive no longer have that service. Are you all thinking about that as you——

Mr. MCCLELLAN. No, let me be clear when I say we are going to review our EMTALA rules. I am not saying that we would define a hospital to require an emergency room. Many community hospitals today don't have emergency services, and they are providing critical access to care in the community, so we are not talking about that. What I do want to emphasize, though, is that some of these specialty hospitals do appear to be primarily providing outpatient services, and that does fall outside of our definition of a hospital, which is an entity that is primarily engaged in inpatient care. So we are going to look closely and make sure that the organizations that are actually providing primarily outpatient care are provided payments under our outpatient payment systems, like our ambulatory surgery payment system, in particular.

Mr. SHIMKUS. Great. Thank you.

Thank you, Mr. Chairman. I yield back.

Mr. DEAL. I thank the gentleman.

And thanks to both of you for being here, and we look forward to continuing this dialog and certainly appreciate the reports and the studies that you have provided us information about.

We will now call up panel No. 2.

Well, gentlemen, welcome. I have already introduced you in my opening statement, so I won't do that again. I will just tell you that we are moving rather rapidly on the floor, and so we will try to get your statements, at least, before we have to scoot out of here for votes.

And with that, Dr. Pierrot, we will start with you. Thank you.

Will one of staff check on his microphone for us, please? Would you check his microphone, please?

STATEMENTS OF ALAN H. PIERROT, FRESNO SURGERY CENTER; JOHN E. HORNBEAK, PRESIDENT AND CEO, METHODIST HEALTHCARE SYSTEM OF SAN ANTONIO, LTD.; JOHN T. THOMAS, GENERAL COUNSEL, BAYLOR HEALTH CARE SYSTEM OF DALLAS, BAYLOR HEALTH CARE SYSTEM; AND PETER CRAM, ASSISTANT PROFESSOR OF MEDICINE, DIVISION OF GENERAL MEDICINE, UNIVERSITY OF IOWA COLLEGE OF MEDICINE

Mr. PIERROT. Thank you.

Mr. Chairman, members of the subcommittee, I am Alan Pierrot, an orthopedic surgeon from Fresno, California and a member of the Board of Directors of the American Surgical Hospital Association, ASHA, and a founding partner of the Fresno Surgery Center, a physician-owned acute care hospital specializing in providing elective surgical services in several disciplines. Thank you for the opportunity to represent ASHA today.

I will summarize the statement briefly previously submitted for the record.

For the subcommittee to effectively consider the debate over physician-owned specialty hospitals, I think you need to have the answers to several key questions. First, why would physicians go to the time and trouble to build a surgical hospital or specialized cardiac facility? Second, can those facilities provide high-quality, efficient, and cost-effective surgical and medical care? Third, are the many allegations hurled at specialty hospitals true? Fourth, what are the legitimate issues in the debate? And finally, what action should Congress take to address them?

The primary reason that surgeons build specialty hospitals, either alone or in partnership with other hospital or corporate partner, is that they can not provide elective surgery efficiently and with the quality they desire at many general hospitals. If you look at the development of virtually every specialty hospital, it has its roots in the failure of the traditional hospital model to respond to the needs of the elective surgery patient.

You will not find specialty hospitals in every State for two reasons. First, certificate-of-need laws in some States preclude the construction of these facilities. Second, enlightened hospital management in other areas has found positive ways to address the legitimate concerns of physicians.

Do surgical hospitals provide high-quality care? The answer is no question, absolutely for sure. If you examine any measure of quality, such as nurse-to-patient ratios, infection rates, medical errors, you will find that specialty hospitals' outcomes are equal, if not superior, to the outcomes in general hospitals. I encourage you to look

at independent rating services, like health grades, to confirm this statement.

The quality of care stems from two main factors. First, the physician investors are committed to excellence and strive to continually improve their outcomes. And second, by specializing in certain areas, physicians, nurses, and other hospital staff become expert at what they do.

Have the allegations of our opponents been substantiated? I submit that the answer is no.

Let me give you some examples.

Specialty hospitals have been accused of hurting general hospitals. MedPAC found that that is not the case. No general hospital has closed or reduced essential services because of competition from an ASHA member. Certainly, if you look at the recent earnings reports of HCA, you would be hard-pressed to see that they are hurting.

Most not-for-profit systems are also doing well. The current level of hospital renovation and construction is ample proof that this is not an industry in distress. The issues that can cause financial problems for hospitals, such as high levels of uninsured patients or poor management decisions, can not be blamed on ASHA members and would not be fixed if all specialty hospitals disappeared tomorrow.

We have been accused of selecting only the best paying patients and ignoring Medicare, Medicaid, and the uninsured. This is simply not true. GAO, MedPAC, and our own internal studies show that our members accept Medicare, Medicaid, and the uninsured. It is the not-for-profit general hospitals that are being examined by Congress for their billing practices and for inadequate charity care, not us. ASHA is committed to equal access and will work with the Congress to make sure that no hospital discriminates on the basis of a patient's ability to pay.

Do we "cherry-pick" only the best paying Medicare services, ignoring the rest? Again, I think the data supports our contention that we do not selectively admit our patients. Analysis of the GAO reports shows that the differences in patient acuity between general hospitals and specialty hospitals are not significant. MedPAC has demonstrated that some surgical DRGs pay more richly than other DRGs and has recommended changes to address that imbalance. ASHA supports this MedPAC recommendation.

Physician owners have been accused of a conflict of interest. This ownership is alleged to give specialty hospitals a competitive advantage. I submit there is no conflict of interest. According to CMS, the referral patterns of investors and non-investors are much alike. MedPAC found no unusual increase in services in communities were specialty hospitals are active. Congress addressed this issue when it adopted the exception to the Stark laws, allowing physician ownership of hospitals. The American Medical Association has thoroughly examined this issue and found no conflict. We support their position and their call for full disclosure of ownership.

Other than our quality and efficiency, we have no special competitive advantage over general hospitals. In fact, we compete at a disadvantage because large hospitals enjoy a variety of advantages, such as exclusive contracts with health plans, economic credentials,

State, Federal, and property tax exemptions, and low-cost bond financing. MedPAC demonstrated that the general hospitals have responded effectively to the competition that our members provide.

The critical question in the debate is whether or not the Federal Government is serious about injecting real competition into the health care sector as one of the primary tools to improve quality and lower costs. If so, then you will encourage innovation and competition by many parties, not just specialty hospitals. If the government is not serious about competition, then you will give general hospitals additional protections they neither deserve nor need.

If you support competition, then make sure that the rules are fair and apply to all. For example, adopting the MedPAC DRG reforms is important and should be done now. Requiring all hospitals to make sure that there is no discrimination based on ability to pay is another critical step. Full disclosure of ownership is also important so that consumers can make informed decisions about their options. This includes physician ownership of specialty hospitals and hospital ownership of physician practices and control of referrals.

Finally, what should Congress do? ASHA recommends that you allow the moratorium to expire on June 8 and not extend it or allow CMS to administratively extend it by not assigning provider billing numbers for 6 months. Further, Congress should reject the CMS recommendation to eliminate specialty hospitals on definitional grounds. This recommendation would stifle the evolution of new models of care and run strongly counter to the overwhelming trend in health care to non-institutional, non-traditional models of care. You do not need to eliminate physician ownership of hospitals because no harm to Medicare has been shown. You should require all parties to disclose ownership and prohibit discrimination based on ability to pay. Congress should also adopt MedPAC's payment recommendations. These actions will encourage the competition and innovation and can lead to increased quality, efficiency, and cost savings.

Thank you, and at the appropriate time, I would be pleased to answer questions.

[The prepared statement of Alan Pierrot follows:]

PREPARED STATEMENT OF ALAN PIERROT, ON BEHALF OF THE AMERICAN SURGICAL HOSPITAL ASSOCIATION

Mr. Chairman and Members of the Health Subcommittee: My name is Alan Pierrot. I am an orthopedic surgeon from Fresno, CA and a founding member of the Fresno Surgery Center, a multispecialty physician owned surgical hospital. I am here today on behalf of the American Surgical Hospital Association (ASHA), the national trade organization representing 75 physician owned hospitals that specialize in surgical care, the vast majority of such hospitals in the United States. I served as the first president of ASHA and continue to be active on the board of directors. I appreciate the chance to represent our patients, our staff, our doctors and our facilities.

THE VALUE OF SPECIALTY HOSPITALS

The Fresno Surgery Center opened as an ambulatory surgery center in 1984, largely in response to the problem surgeons were having with operating room schedules and the efficiency at the local hospitals. Four years later we added a 20-bed inpatient care unit under a pilot project authorized by the California legislature. In 1993 we converted that unit to a licensed hospital. We promised the legislature that we could improve surgical care and patient satisfaction and we did. Physicians in

other communities have now adopted this structure as a response to their frustration with general hospital operations. Our hospital is licensed by the state of California as an acute care facility, just like all the general hospitals in the state. This is the case in other states as well.

The Fresno Surgery Center and the other members of ASHA provide cost effective, high quality surgical care in a very efficient manner. Specialty hospitals offer a choice of surgical site both for patients and physicians. Our patients are very satisfied with the care they receive, and far prefer the model we offer to that provided in the typical general hospital. We get high marks from our patients, our staff and our physicians, whether or not they are investors. Surveys of patients indicate there are five conditions they would like in a hospital experience: a private room, good food, a welcome environment for visitors, a nurse that responds promptly and control over sound, heat and light. The typical American hospital provides not one of those conditions to its patients, its customers. There is probably no industry less responsive to customers than the hospital industry.

I particularly want to emphasize the excellent patient outcomes we achieve. In Fresno our nurse to patient ratio is about 1:3.5 and it is well established that the nurse-patient ratio is a prime determinant of quality of care and medical outcome. In California hospitals generally the ratio is about 1:8 and the state had mandated a standard of one nurse for every six patients. That standard has been challenged by California general hospitals. On all measures of quality, surgical hospitals excel, including lower infection rates, few transfers to other hospitals, fewer medical errors and very low readmission rates.

ASHA believes that two factors are primarily responsible for this excellent record that is replicated across its membership. The first is physician ownership and control of the hospital's values and patient care standards. The second is the very fact of specialization that allows physicians and staff to develop proficiency in all facets of surgical care.

Physician investment in these facilities, whether alone or as part of a joint venture, is a key ingredient to our success. It means that the people whose names are on the door are responsible for setting the quality standards, the operational requirements and directing all facets of the hospital's activities. It is this group of investors who are fundamentally responsible for the existence of the hospital and the maintenance of its standards. They create the environment that is so attractive to patients and other physicians. One of my greatest points of pride about the specialty hospital concept is the number of surgeons who bring patients to the facility even though they have no investment interest. They know that their patients will be treated with skill and respect from the moment they enter until discharge.

Because these hospitals provide a focused set of surgical services, the staff is able to develop a high degree of skill in these specialized areas. This skill makes possible the efficiency of operation and the high quality of patient outcome. We succeed because we are "focused factories" designed to provide elective surgical care to otherwise healthy patients. Cardiac hospitals may care for a different population, but their adoption of heart focused, best hospital practices under the guidance of their physician investors also allows them to provide an excellent level of care to patients with serious medical conditions.

The presence of a surgical hospital in a community is positive for patients and health plans. Competition forces general hospitals to improve their own services to patients and can lead to a reduction in overall costs, as health plans are able to negotiate for lower rates. In non-competitive environments, there is little incentive to improve services and cost effectiveness, whether to please patients or payers.

THE GOVERNMENT'S REVIEW OF SPECIALTY HOSPITALS DOES NOT SUPPORT A CONTINUATION OF THE MORATORIUM

For the past four years there has been a great deal of rhetoric about specialty hospitals, but little solid information. We now have reports from the Government Accountability Office (GAO), the Medicare Payment Advisory Commission (MedPAC) and the Centers for Medicare and Medicaid Services (CMS) that shed more light on the issues in the debate.

MedPAC has looked carefully at the fundamental issue raised by general hospitals at the beginning of this debate—are specialty hospitals harming general hospitals to the detriment of patients? The current moratorium was imposed because of concern that such harm was occurring and the desire of Congress to obtain information that would let it answer this basic question.

MedPAC's report on March 8 found that general hospitals have not been harmed. They have effectively responded to the competition posed by specialty hospitals and remained as profitable as their peers in communities where no specialty hospitals

exist. This is certainly true in Fresno where the general hospitals have thrived since Fresno Surgery Center opened. I know this to be the case in other cities where specialty hospitals operate. No proof of harm to general hospitals, risk to patients or abuse of the Medicare program because of excessive or unnecessary surgery has been found. Therefore, there is no justification to continue the moratorium beyond the legislated expiration date.

I want to make an important observation about the current moratorium. I think there is a widespread view that the 18-month moratorium is benign, allowing existing specialty hospitals to proceed unhindered, while only limiting new development. This leads to the conclusion that an extension of the moratorium as recommended by MedPAC would also not harm existing facilities. In fact the moratorium is not benign, but has hurt many well-established specialty hospitals. That is because it limits the expansion of facilities, the introduction of new services and the addition of new investors in response to changing needs and circumstances in our communities. Most of our members are located in areas experiencing rapid population growth, yet they have not been able to expand the number of beds or add new specialties to meet that increased patient demand. Our ability to serve our patients has been eroded. Another moratorium would only exacerbate this situation. There is no justification for extending the moratorium on a model of care that does not harm general hospitals and that provides superior care and patient satisfaction.

Under the moratorium, hospitals that were under development were permitted to seek review by CMS to determine if the moratorium would apply. CMS announced that it expected to complete these reviews within 60 days of submission. As far as I know, only a few decisions were made in that time frame. For everyone else, it has taken months, following numerous CMS requests for detailed information, to get an answer. I have been involved in the development of a surgical hospital in Thousand Oaks, CA. It took almost ten months for CMS to finally issue an opinion, even though that facility was nearly ready to open in November 2003 when the moratorium was imposed on this industry.

I know that some concern has been expressed that there would be a rush to open surgical hospitals as soon as the moratorium expires. This is not accurate. Right now there are only about forty hospitals that are close to opening and all are currently under review by CMS to determine if they are exempt from the moratorium's restriction on referrals. To my knowledge, no corporate developer has any projects in the pipeline beyond those just mentioned. It is important to understand that it usually takes two years to launch a new surgical hospital, so physicians deciding in June 2005 that they would like to build a surgical hospital would most likely not see that become reality until 2007. The idea that hundreds of specialty hospitals will quickly open once the moratorium expires has no basis in fact.

While other hospitals have posted impressive financial gains recently, our part of the industry has been hamstrung by the moratorium which has caused harm to patients, staff, physicians and the hospitals. The harm to patients arises because they are denied the opportunity to have their elective surgery in a facility with extremely low post operative infection rates. The risk of infection at a general hospital is much higher, and post operative infections delay healing and are costly to treat.

ASHA also believes that none of the government findings would justify any change to the current law governing physician ownership of hospitals.

MedPAC's analysis of specialty hospitals did show that Medicare's inpatient hospital payment system needs substantial revision. ASHA agrees with their recommendations and urges action on them this year. We are pleased that CMS is evaluating these proposals as part of the recently published proposed rule on the inpatient payment system. If adopted these proposals would greatly reduce the need for hospitals to depend on cross subsidies to support necessary, but poorly reimbursed care. Federal healthcare dollars would be better targeted to the actual costs of providing medical and surgical services in the hospital.

ASHA also supports full disclosure of ownership, consistent with the ethical standards of the American Medical Association. I, for one, am proud of my hospital and my involvement in it. I have had no hesitation in telling my patients about my ownership. I also have never hesitated to perform their surgery in another facility if they requested that I do so.

THE WHOLE HOSPITAL OWNERSHIP EXEMPTION IN STARK II

The Federation of American Hospitals has filed a petition calling on the Department of Health and Human Services to restrict the whole-hospital exemption in the Stark law to hospitals that "provide a full range of services customarily offered by general community-based hospitals." ASHA believes that no evidence exists that should cause Congress or the Department to modify the current hospital ownership

exemption. Physician ownership of hospitals and other facilities is not new. Physicians who owned the facilities started many of today's finest medical clinics, like the Mayo Clinic, Cleveland Clinic and the Ochsner Clinic Foundation.

Certainly no evidence supporting limits on physician ownership of hospitals was found in the original studies that led to the establishment of the Stark laws. In testimony before the House Ways and Means Committee in 1991, the individuals who conducted the original Florida studies on physician ownership and referral arrangements concluded that, "Joint venture ownership arrangements have no apparent negative effects on hospital and nursing home services."

The American Hospital Association also encouraged Congress to incorporate flexibility in the law governing referral arrangements. In testimony before the Ways and Means Committee in 1989, AHA noted, "Oftentimes, joint ventures which are the subject of H.R. 939 are well intended to provide the highest quality, most accessible and most reasonably priced medical care to the community." AHA urged Congress to take a "more flexible or less proscriptive approach, allowing ventures consisting of referring physicians, if such ventures are for a legitimate business reason . . ."

In 1995, testifying before the same Committee, AHA stated that "First there needs to be careful examination of the effects of the self-referral law on the development of new, more efficient delivery systems, and elements of the law that prevent new systems from evolving must be stricken or amended." AHA went on to call for an expansion of the physician hospital ownership provisions in the Stark II law. The language that allows physicians to have ownership of hospitals is not a "loophole" in the Stark law, but a carefully reasoned provision designed to maintain flexibility in the evolution of healthcare delivery systems.

Regarding the FAH petition, an examination of the variation in services provided by general hospitals across the country quickly shows that there are many differences among those facilities that might be considered "general community-based hospitals." CMS could devote considerable energy to solving this puzzle. Does the Federation include a heart program among the obligatory "full range of services"? Most hospitals don't have one. Is Ob-gyn a requirement? There is great variation among general hospitals in how, or even whether, they provide those services. Maybe it should be based on revenue sources, but there's a problem with that also. According to a number of hospital consultants, more than 60 percent of general hospital revenue comes from inpatient surgical services. Does that mean that most "general community-based hospitals" are, in fact, surgical hospitals?

MedPAC debated whether or not to include a recommendation on the whole hospital exemption but decided not to incorporate one in their report on specialty hospitals. Among the concerns expressed during discussion of this idea was the fact that no one could predict where elimination or modification of the exception might lead. For example, physicians have purchased rural hospitals in an effort to keep them open. Those acts of community concern could be outlawed if the exemption were to be amended or eliminated. The recent purchase of a Tenet hospital in California by the physicians who had a long-standing relationship with the hospital might not be allowed. The effort of African American physicians in Atlanta to purchase and reopen a hospital serving a low income community might be frustrated. It is obvious that there is no clear line that easily distinguishes physician ownership of one hospital versus another.

ASHA is concerned that CMS has announced in the inpatient payment proposed rule that it is considering whether or not specialty hospitals provide sufficient levels of inpatient care to be considered a hospital for Medicare purposes. Just as the FAH petition raised more questions than it answered, ASHA believes that this idea is equally perplexing. Where does this leave many small, rural hospitals? Will they meet the standard, whatever that is? What about some of the more traditional specialty hospitals like eye and ear hospitals, psychiatric facilities or women's hospitals? CMS does not bother to elucidate a standard, suggesting that it has no real idea how to proceed with this concept. I want to remind the Subcommittee that every ASHA member is licensed by their state as an acute care hospital and is also certified by Medicare. Is CMS now going to ignore the lawful actions of the state licensing authorities? Will every hospital's Medicare certification be questioned and now be subjected to some new federal test, yet to be defined? Is this the way this Subcommittee wants the federal government to honor the lawful acts of state agencies? Is this how Congress intends to encourage healthcare innovation, improved quality and increased cost effectiveness, by giving new protections to costly, inefficient facilities?

SPECIALIZED HOSPITALS IN THE UNITED STATES

Specialized hospitals are not a new phenomenon in medicine and have been in existence in this country for many years. There are many hospitals, both not-for-profit and for-profit, that provide a limited array of medical services. For example, psychiatric hospitals are very focused in the kinds of patients they treat. Often they will not admit a psychiatric patient with significant physical comorbidities because they do not have the medical services that patient requires. Such individuals are admitted to general hospitals with psychiatric units. However, I have yet to hear the general hospitals accuse their psychiatric colleagues of "cherry picking." Children's hospitals and women's hospitals have a long history in this country and their services are certainly focused on those appropriate to the populations they serve. Eye and ear hospitals are just one more example of the kinds of specialization that has developed in hospitals. Again, I am not aware that general hospitals have accused eye and ear hospitals of "skimming the cream". Cancer hospitals are also facilities with a focused mission. Clearly specialization is not the issue driving the opponents of ASHA's members. Something else must be motivating their enmity.

Perhaps that enmity stems from the fact that today's physician owned specialty hospitals are not seeking out niche services of no interest to the general hospitals, but are competing directly with them across a number of valued service lines. In any other industry competition and the benefits it can bring to consumers is encouraged. Hospital services should be no different so that society can reap the benefits of innovation and cost effectiveness that accompanies competition. Yet our opponents ask Congress to protect them from that competition. ASHA urges you to resist their call for protection, since MedPAC found that general hospitals have responded effectively to the competition offered by ASHA members, even going so far as to make an effort to improve their own services to patients, physicians and hospital staff. I doubt if those enhancements would have occurred in the absence of effective competition.

A careful examination of general hospitals in this country would show that they vary widely in the types of services they offer, consistent with their facilities, staffing and the kinds of physicians present in the community. For example, few hospitals have burn units and most do not have heart programs. Level 1 trauma centers are not common. Rural hospitals routinely send complex medical and surgical cases to their larger colleagues. The less difficult cases stay behind. Yet no one is accusing rural hospitals or critical access facilities of "unfair competition" or "skimming the cream" or "cherry picking."

The reality is that every hospital tries to do those things for which it is best suited and whenever possible sends other cases to a better equipped facility. Such behavior is appropriate and in the best interests of patients. I am certain that the Members of this Subcommittee would be outraged if hospitals failed to ensure that patients were treated in the most suitable facility, whatever or wherever that might be.

As I noted, ASHA is the trade organization for specialty hospitals. We have 75 member facilities, and all have some degree of physician ownership. All specialize in surgical care. While our cardiovascular hospital members focus just on heart care, the typical ASHA member provides services in six surgical specialties. Urology, general surgery, orthopedics, gynecology, neurosurgery and ENT are commonly found in these facilities.

Our members are located in eighteen different states. GAO found that 28 states had at least one specialty hospital, but approximately two thirds were located in seven states. In MedPAC's sample, almost 60 percent were concentrated in four states. This concentration is primarily due to the presence of certificate of need (CON) laws governing hospital construction. Most specialty hospitals are in states that do not have hospital CON requirements. Since CON laws tend to protect existing facilities from new entrants into the market, it should come as no surprise that our members are usually found in states that do not have such barriers to market entry. It is worth noting that both the Department of Justice and the Federal Trade Commission have called for an end to CON because of its anticompetitive effects.

WHY PHYSICIANS ESTABLISH SPECIALTY HOSPITALS

It is important that the Subcommittee understand why physicians establish specialty hospitals. Those reasons will vary in each community, but the interest in a specialty hospital usually begins after physicians have failed to persuade the general hospitals at which they practice to make changes that will improve physician efficiency and patient care. For example, the Stanislaus Surgical Hospital in Modesto was established first as an ambulatory surgery center and later as a hospital by surgeons who could not get reasonable access to the operating rooms at the two

other hospitals in town. These hospitals were profiting from their cardiovascular and neurosurgery services. Those cases had first call on the OR. Orthopedics, urology, ENT and other surgical disciplines took what was left, and even then were often bumped by trauma and other emergency cases. The result was that elective cases were delayed until 10:00 PM or later, to the great unhappiness of patients and surgeons alike. While no one disputes the need for hospitals to deal quickly and effectively with emergencies, many hospitals have figured out ways to keep the rest of the surgical schedule moving along. However the Modesto hospitals apparently could not do that, so Stanislaus arose out of this unresolved conflict.

Fresno is a similar case. My colleagues and I believed that we could provide a better model for elective surgical care. We could not persuade the hospitals to go along with our ideas, so we built our own facility and have never regretted it. We continue to care for patients at the other hospitals in Fresno, as do our colleagues in Modesto. In fact, we require our physicians to maintain privileges at one of the other general hospitals in town. That means, of course, that we are all subject to the on call and other requirements of those hospitals. In California, like many states, insurance contracts are the dominant reason patients go to one hospital or another. Therefore, we all must have privileges at multiple facilities if we are to meet the medical and financial needs of our patients. There may be rare examples of physicians moving their entire caseload to a surgical hospital, but those are truly the exceptions to the general rule.

To me this is one of the most interesting facets of the national debate over physician owned specialty hospitals. States historically have determined what kinds of facilities can be licensed as hospitals and have established various regulatory standards in this regard. For example, not all states require hospitals to have emergency departments as a condition of licensure. That is the case with my home state of California. The federal government has respected this state role and has focused its attention on quality standards for facilities participating in federal health benefit programs, for example Medicare's conditions of participation. Yet now we are debating whether or not the federal government should usurp that state role and decide what does and does not constitute a hospital for purposes of federal health programs. ASHA would argue that absent evidence of Medicare or Medicaid fraud or grave risk to the public health, there is no need for the federal government to infringe on these state determinations

Using state law as an indicator of the will of those residents, the Subcommittee could easily conclude that an extension of the moratorium or the addition of any other restrictions on specialty hospitals would be unnecessary in CON states. In those states that have abandoned CON, such restraints on competition and innovation would probably be unwelcome.

While physician ownership characterizes ASHA members, the nature of those arrangements varies widely. GAO found that about one third of their sample was independently owned by physicians; one third had corporate partners like MedCath or National Surgical Hospitals; and one third were joint ventures between physicians and local general hospitals. ASHA's own survey of its members found similar characteristics.

Clearly not all general hospitals are hostile to specialty hospitals or joint ventures with their physicians. For example, Baylor hospital in Dallas has a variety of joint ventures with physicians, including specialized hospitals and ambulatory surgery centers. Integris Health System in Oklahoma City has a joint venture with an ASHA member hospital specializing in orthopedic services. HCA partners with physicians in numerous ambulatory surgery centers and an orthopedic hospital in Texas. Avera McKennan in Sioux Falls, SD, has a joint venture with MedCath and the cardiovascular physicians who practice there. Incidentally, Avera McKennan is across the street from the Sioux Falls Surgery Center, a physician owned surgical hospital. Both facilities have grown and prospered, and the physicians practice at both hospitals. The Fresno Heart Hospital is a joint venture between our largest not for profit hospital and local physicians.

RESPONSES TO CRITICS OF PHYSICIAN OWNED SPECIALTY HOSPITALS

I would like to turn to the main criticisms of physician owned specialty hospitals and address them. In many respects these attacks mirror what not for profit hospitals used to say about for profit institutions. Ambulatory surgery centers came under similar attack from both the for profit and not for profit hospital sectors. Years later the sky has not fallen as predicted and most hospitals across the country are doing well.

Fundamentally the allegations are that specialty hospitals hurt general hospitals financially and engage in unfair competition because they have physician owners.

There are a number of arguments used to justify these criticisms. These are (1) ASHA members have a favorable payor mix and refuse to admit or otherwise limit the number of Medicare, Medicaid and charity cases; (2) they focus on the highest paying inpatient DRGs; (3) they only take the easier cases in those DRGs; (4) physician ownership is a conflict of interest and gives specialty hospitals an unfair competitive advantage in the market; and (5) physician ownership leads to increased, and unnecessary utilization of surgical services.

Let me start with the first fundamental accusation made by our opponents—specialty hospitals have hurt general hospitals. The facts do not support that allegation. No general hospital has closed because of competition from a specialty hospital. There is no evidence that general hospitals have eliminated a critical service, like the emergency department, because of competition from a surgical hospital. MedPAC concluded based on its review of 2002 data that the financial impact on general hospitals in the markets where physician-owned specialty hospitals are located has been limited and those hospitals have managed to demonstrate financial performance comparable to other hospitals. Fresno has a 16 year history with specialty hospitals and our experience confirms the MedPAC conclusions. All Fresno hospitals have expanded since the debut of Fresno Surgery Center.

Although MedPAC tries to caveat this conclusion by noting the "small number" of specialty hospitals in its sample, the reality is that they looked at 48 hospitals, more than 50 percent of the entire complement of physician owned specialized facilities. By any statistical measure that is a more than adequate sample upon which to base sound conclusions.

I know for a fact that in Fresno the specialty hospital model has had no negative financial impact on local hospitals. The same is true in nearby Modesto, which also has a specialty hospital. The other hospitals are either expanding or have plans to expand. Kaiser is building a new hospital in Modesto. In fact hospital construction nationwide totals in the billions of dollars, hardly a sign of an industry in financial distress. General hospitals obviously have access to capital and are sufficiently sound financially that lenders continue to finance their projects.

GAO found that "financially, specialty hospitals tended to perform about as well as general hospitals did on their Medicare inpatient business in fiscal year 2001". According to GAO, specialty hospital Medicare inpatient margins averaged 9.4 percent, while general hospitals averaged 8.9 percent. This is not a significant difference in performance. The highest margins were reserved for the for-profit general hospitals, such as those operated by Tenet and HCA.

According to the Health Economics Consulting Group (HECG), "Based on a longitudinal study of general hospital profit margins in markets with and without specialty hospitals, we find that profit margins of general hospitals have not been affected by the entry of specialty hospitals. Consistent with economic theory, the models consistently showed that the most important predictor of general hospital profitability was the extent of competition from other general hospitals in the same market area—Contrary to the conjecture that entry by specialty hospitals erodes the overall operating profits of general hospitals, general hospitals residing in markets with at least one specialty hospital have higher profit margins than those that do not compete with specialty hospitals."

Let's look at the unfair competition argument next. Our accusers say that specialty hospitals engage in unfair competition because they have physician owners. That ignores the reality identified by GAO that "approximately 73 percent of physicians with admitting privileges to specialty hospitals were not investors in their hospitals." Clearly these physicians find something very attractive about the specialty hospital model, even without an investment interest. They have no motivation to engage in "unfair competition". Perhaps they are drawn to the high quality of hospital care, as evidenced by a nurse to patient ratio of one nurse for every 3.5 patients and an almost nonexistent infection rate. Possibly the ability to keep to a tight surgical schedule attracts them. Most surgeons see patients in their offices once they finish their surgery. If that schedule is disrupted so are the lives of the patients waiting not so patiently for their surgeon to meet with them.

The percent of ownership is another important factor. According to GAO, "On average, individual physicians owned relatively small shares of their hospitals. At half the specialty hospitals with physician ownership, the average individual share was less than 2 percent; at the other half, it was greater than 2 percent." MedPAC reported the range of ownership to be from 1 to 5 percent. While the return on investment can vary among physician owned facilities, the modest ownership shares and the large number of physicians who are using the facilities, but who have no investment, suggest that financial gain is a secondary consideration for most physicians. In previous testimony the House Ways and Means Committee, CMS reported that it found virtually no difference in referral patterns between physicians who were in-

vestors in specialty hospitals and physicians who used those facilities, but had no investment. Ownership is not affecting the medical judgment of physicians.

One cannot look only at a single side of a competitive market. Congress needs to consider the tools that general hospitals have to compete against specialty hospitals. According to the December 2004 report on specialty hospitals of the American Medical Association's Board of Trustees, these include (1) revoking or limiting medical staff privileges to any physician who invests in a competitive facility; (2) hospital-owned managed care plans denying patients admission to competing specialty hospitals; (3) exclusive contracting with health plans to exclude specialty hospitals; (4) refusing to sign transfer agreements with specialty hospitals; (5) requiring primary care physicians employed by the hospital to refer patients to their facilities or to specialists closely affiliated with the hospital; (6) requiring subspecialists to utilize the hospital for all of their medical group's referrals; (7) limiting access to operating rooms for those physicians who invest in competing facilities; and (8) offering physicians guaranteed salaries to direct or manage clinical services and departments in the general hospital.

In addition, not-for-profit facilities have significant advantages because of their special tax status. Society has given not-for-profit hospitals special tax benefits in part to compensate them for the essential community services they offer. If they fail to hold up their end of the bargain, they should lose this special treatment. An analysis by Harvard professor Nancy Kane suggests that as many as 75 percent of not-for-profit hospitals receive more in tax relief than they provide in charity care.

Much has been made of the unfair burdens that weigh down general hospitals that are not shared by specialty hospitals. Often cited is the fact that specialty hospitals are less likely to have emergency departments. The burden of EMTALA is frequently raised. General hospitals often talk about the need to support burn units or other costly services and how competition from specialty hospitals affects their ability to do that.

State law determines whether or not a hospital is required to have an emergency department. Surgical hospitals that are in states requiring emergency facilities have them and they are thus subject to EMTALA. If they are not required, surgical hospitals that treat only elective cases are not likely to have an ER, since it is an unnecessary expense and not consistent with the model of care provided. Heart hospitals, on the other hand, almost always have emergency departments because of the nature of the diseases they treat.

To the extent that such disparities are widespread, the payment changes recommended by MedPAC would relieve them by moving Medicare dollars from high pay to low pay cases, evening out the differences. However, Congress needs to remember that most general hospitals do not have burn units, level 1 trauma centers or even heart programs. In fact, most hospitals must transfer burn patients or cardiac cases to another facility with the capacity to care for those individuals. No one challenges that practice as "cherry picking". It is widely regarded as appropriate medical practice because the facility is not designed to care for that particular individual or condition.

The situation at most surgical hospitals is no different. They are designed to provide elective surgery to otherwise healthy patients. Patients needing such surgery who have multiple comorbidities would not be good candidates for a surgical hospital. Good medical judgement requires that the patient be admitted into the appropriate facility. In 1987-1988 I served on the California committee that developed the regulations for recovery care centers. The primary charge of the committee was to develop standards that would assure patient safety by preventing the admission of higher acuity patients to those specialized facilities. We fulfilled our mandate and developed rules to prevent high acuity patients from being inappropriately admitted to recovery care centers. Yet today those same actions would be characterized as "skimming the cream".

Heart hospitals are different in that many of their cases will be emergent, so they are designed to accommodate them. Emergency departments and ICUs or CCUs are commonly part of these facilities. They are likely to offer a broader array of supporting medical services, consistent with the medical needs of their cardiovascular patients.

Payor mix has been another contested area, with accusations lodged that specialty hospitals don't take Medicare or Medicaid patients. This simply is not true. According to the HECG, the average specialty hospital earns 32.4 percent of its revenue from Medicare, 3.7 percent from Medicaid, 46.4 percent from commercial payors, 18.1 percent from other sources, and provides charity care equal to 2.1 percent of total revenue. Cardiac hospitals have even higher Medicare rates. In addition the average specialty hospital paid nearly $2 million in federal, state and local taxes.

According to MedPAC, there was wide variation in Medicaid admissions among hospitals, although on average the rate of Medicaid was lower in specialty facilities when compared to general hospitals. Several factors account for the difference. First, hospital location is a major determinant of the level of Medicaid and charity care. Second, because surgical hospitals tend to focus on elective surgeries and have fewer emergency admissions, they may not see the same level of Medicaid traffic as a general hospital with a busy emergency department, which often serves as the source of primary care for the uninsured or those on Medicaid. Third, many states have moved to managed care in Medicaid and have limited Medicaid patients' access to certain facilities. If a hospital is not on the approved list, it will not see very many Medicaid patients, and those that do show up will have to be transferred to another hospital that is on the state's list. This is the case in Fresno, where nearly all Medicaid patients are directed to a single hospital.

The disparities in the distribution of Medicaid and uncompensated care were recognized at MedPAC when Chairman Hackbarth said on January 12 that "I think all of us would agree that right now the burden of providing care to Medicaid recipients or uncompensated care is not evenly distributed. That's an issue that long predates specialty hospitals and it's an issue that has very important implications for the system. And to say that stopping specialty hospitals is going to materially alter that problem, fix that problem, I don't think that's the case."

Specialty hospitals may indeed have a different payor mix than many general hospitals, but that does not mean that the general hospital is being harmed. Hospitals with higher levels of Medicare and Medicaid are eligible for DSH payments in compensation. If their Medicare caseload is more complex, another point of contention, then the outlier payments can offset the higher costs. In California, Medicare is one of the best payers for inpatient surgery. No hospital, whether specialty or general, limits Medicare admissions in California.

ASHA members do not discriminate based on a patient's insurance or ability to pay. While our payer mix may be different than some other hospitals, it is not because of efforts to select the best insured individuals. As someone who spent many years in medical practice, I can assure you that most physicians know very little about the insurance an individual patient may, or may not, have. ASHA has committed to the Chairman of the Energy and Commerce Committee that our members will not discriminate based on ability to pay, and we will work with Congress to make sure that reality is true for every hospital. I offer the same pledge to the Subcommittee today.

Specialty hospitals have been challenged on the basis that they select only the highest paying DRGs. While MedPAC has demonstrated that some of the DRGs are more profitable than others, many of the cases treated in specialty hospitals are not drawn from the "rich" DRG pool. In fact many surgical DRGs are no more or less profitable than other services. To the extent that this is an issue, however, the payment recommendations of MedPAC would correct any disparities between rich and poor DRGs.

Within DRGs, the case is made that surgical hospitals select the easiest cases, thus maximizing the profit that can be obtained in any DRG. There are some differences in patient acuity, but they are slight, and would be addressed by MedPAC's payment recommendations.

When GAO looked at this issue, its analysis revealed little real difference in acuity of admissions. For example, among admissions to surgical hospitals, two percent of the cases were in the highest acuity groups, while general hospitals had four percent of their admissions for the same surgery fall into the most severe classification. In other words, 98 percent of admissions to surgical hospitals were healthy and 96 percent of admissions for the same services to general hospitals were in equally good health.

In hospitals that specialized in orthopedic care, 95 percent of admissions were in the lesser acuity categories, while 92 percent of comparable admissions to general hospitals had the same severity classification. In heart hospitals GAO found only a five-percent difference in acuity between specialized facilities and general hospitals.

These are not large differences. The only conclusion one can draw is that patients having elective procedures are generally healthy, no matter what kind of hospital they are in. If there are differences in the profitability of specialty hospitals versus general hospitals, it must be for reasons other than patient selection.

Let me now turn to the allegation that physician ownership of surgical hospitals has generated additional surgical volume, some of it of dubious medical necessity. The facts do not support this accusation.

MedPAC has determined that specialty hospitals do not add to the volume of surgery. The Commission could not find evidence that the increase in service volume

experienced in communities with specialty hospitals was higher than that found in areas that had no specialty hospitals.

I would like to conclude by examining the allegations that physician ownership of hospitals is a conflict of interest and gives specialty hospitals a competitive edge over the general hospitals in their communities. I would argue that there is no conflict of interest when a physician owns the facility in which he or she provides services to patients. That issue was thoroughly debated when Congress considered the Stark laws and Congress chose to allow physician ownership of hospitals, ambulatory surgery centers, lithotripsy facilities and a number of other sites where the physician provided the service in question. The AMA has also addressed the potential conflict of interest at length and concluded that no conflict exists in these circumstances. AMA also recommends additional safeguards to protect patients and some of those have been incorporated in various safe harbors developed by the Inspector General.

AMA also raises an issue that I believe the Subcommittee must explore if it is going to consider whether physician ownership creates a conflict of interest that should be addressed in federal legislation. That is the conundrum of hospital ownership of physician practices, their employment of physicians (particularly specialists), and the ownership of health insurance plans by hospital systems. If one is to argue that physician ownership of hospitals is a conflict of interest, then one is surely bound to agree that hospital ownership of physician practices or employment of physicians raises the same concerns. If one arrangement is outlawed, then all should be dealt with in the same way.

There is one other resource that I urge you to look at as you consider the issue of physician owned specialty hospitals, and that is the more than 20 years' experience that Medicare has with ambulatory surgery centers (ASCs). There are now about 4,000 Medicare certified ASCs in this country, providing millions of surgical services every year. Nearly every ASC has some physician owners. Yet in the history of Medicare's coverage of ASCs, there is virtually no evidence that physicians performed unnecessary services or engaged in behavior that placed patients at risk. Nor is there any evidence that an ASC forced a hospital to close or curtail essential community services. Medicare's ASC experience should be a strong predictor to Congress that physician owned specialty hospitals also pose no risk to Medicare, to patients or to general hospitals.

A great challenge to the Subcommittee and to Congress generally will be digging through the layers of rhetoric, spin and cant to get to the real facts. It amazes me that so much has been said or written, much of it wrong or false, about fewer than 100 hospitals that make up about one percent of Medicare inpatient payments. However, it will be worth the effort to get past the rhetoric and examine the facts because there is solid information available to you on many points in the debate. I hope you will rely on that data to make any decisions about legislation that might impact the future of specialty hospitals.

In summary, after thorough government study the allegations against specialty hospitals have not been proven. Therefore, ASHA urges the Subcommittee to allow the moratorium to expire as scheduled in June. The reforms to Medicare's inpatient payment system suggested by MedPAC would greatly benefit the Medicare program and should be adopted. However there is no evidence to justify putting specialty hospitals under another moratorium during the period these needed changes are implemented or imposing any other limit on physician ownership of hospitals. ASHA will also work with Congress to address any concerns about disclosure of ownership or alleged discrimination based on ability to pay.

Mr. Chairman, ASHA appreciates the opportunity to present this testimony, and I would be pleased to answer any questions the Members of the Subcommittee may have.

Mr. DEAL. Thank you.

Mr. Hornbeak.

STATEMENT OF JOHN E. HORNBEAK

Mr. HORNBEAK. Thank you, Chairman Deal, Ranking Member Brown, and members of the subcommittee.

My name is John Hornbeak, and I am President and CEO of the Methodist Healthcare System. We are a partnership between the not-for-profit Methodist Ministries of South Texas and Hospital Corporation of America. We are a comprehensive, community

health care system serving the San Antonio, Texas market and the 25 surrounding counties.

My remarks regarding this critical issue will focus on four key points. First, physician-owned specialty hospitals operate as if they were a subdivision or department of a full-service hospital. Second, physician ownership of subdivisions or departments of hospitals is, in fact, illegal. Third, physician ownership, coupled with their ability to self-refer, represents a conflict of interest that is anti-competitive because their deal can not be legally duplicated by existing hospital competitors. And fourth, Medicare payment adjustments are not the solution to this problem, but rather closing the legal loophole that allows these facilities and their physician ownership that is.

In contrast to full-service community hospitals, specialty hospitals largely limit their care to just one of the most lucrative services hospitals provide, like cardiac, orthopedic, spine, or surgical services. And this guarantees them high profit margins while allowing them to avoid essential but unprofitable community services, such as emergency rooms, as just one example.

This point is underscored by studies conducted by the GAO and MedPAC, which found that a majority of specialty hospitals do not have fully functioning, fully staffed, 24-hour emergency rooms. Specialty hospitals avoid full-blown emergency rooms, because the emergency rooms are the primary portal through which indigent and Medicaid patients get admitted to most hospitals. For example, last year, 41 percent of the 180,000 patients that visited Methodist Healthcare System's different ED, emergency departments, 41 percent of those 180,000 were indigent, self-pay, or Medicaid.

Specialty hospitals are not "whole hospitals" but rather subdivisions or departments focusing on the most profitable patients and services. Now why is that important? Under current law, physicians are permitted to have an ownership interest in an entire or "whole hospital," but not a subdivision of the hospital. Now why is this? The regulatory theory is that a physician who has a stake in an entire hospital would not materially benefit from the referrals that they make to that hospital, and as such, their potential conflict of interest would be diluted. However, a physician's ownership in a subdivision of the hospital, such as a surgical or cardiac wing, is deemed to be illegal due to the ability of their referrals in that instance to produce material financial gains.

Let me be clear as a business leader in San Antonio. I am committed to free and fair competition. Community hospitals routinely compete for patients on the basis of quality, service, physician relations, and the latest in medical technologies. However, true competition requires a level playing field. That is, in part, why groups such as the U.S. Chamber of Commerce, the National Black Chamber of Commerce, and the Business Roundtable are all supporting either a continuation of the current moratorium or an outright ban on physician self-referral to specialty hospitals.

The business model of a physician-owned specialty hospital depends upon the control of referrals by its physician owners. Remember, it is the physician that is the gatekeeper and ultimately decides where patients receive their care, not hospitals. And it is the physician that is entrusted by vulnerable patients to help guide

them through this decisionmaking process under oftentimes difficult and highly emotional circumstances. That is why highly lucrative specialty hospital investment deals are granted only to physicians able to refer patients and not to investors from the general public. You have to understand the anatomy of these deals. As an example, a 60-bed cardiac hospital will cost $60 million to build. It is about $1 million per bed. The parent company will typically loan the local partnership 90 percent of that amount, or $54 million. Now keep in mind, the doctor investors aren't on the hook for the $54 million, because they are just limited partners. They can only lose the money that they put into the deal. The general partner is on the hook. If it goes bankrupt, the general partner is on the hook for that $54 million, 90-percent loan.

Well, with that kind of loan, it leaves only $6 million in equity to be split by the parent company and the referring physicians. So for example, 60 to 75 physician partners will become owners of half of a $60 million cardiac hospital, sharing all of the profits and equity for only about a $40,000 to $50,000 personal investment for each one. Those are huge rewards, millions of dollars at virtually no risk and very little real investment compared to the gains. The physician partners are not recruited for their investment. They are recruited for their referrals. The ownership structure is not an arms-length business arrangement but a sweetheart deal that induces patient referrals. It is not free and fair competition when, under Federal law, the Methodist System is prohibited from offering physicians ownership in specialty wings of its genuine whole hospitals, but specialty hospitals can effectively do that by masquerading as whole hospitals.

Finally, MedPAC was certainly correct in recognizing the problems inherent in physician ownership of specialty hospitals. However, its public policy response, which focuses on future payment refinements in the DRG payment is, I believe, inadequate. It is inadequate because the underlying economics of these facilities are so powerful that refinements to the DRG payments would not change the referring physician's behavior, that is selecting the healthy wealthy and privately insured.

It is my belief that the current specialty hospital moratorium should be extended, and it is also my hope that Congress closes the loophole in the self-referral prohibition law that allows for the exploitation of the whole hospital exception.

Thank you for your time. I will be happy to answer your questions.

[The prepared statement of John E. Hornbeak follows:]

PREPARED STATEMENT OF JOHN HORNBEAK, PRESIDENT AND CEO, METHODIST HEALTHCARE SYSTEM

INTRODUCTION

Good Morning. My name is John Hornbeak, and I am the President and CEO of the Methodist Healthcare System of San Antonio. I am delighted to be here today to testify on behalf of the Methodist system, the Hospital Corporation of America (HCA, Inc.), and the Federation of American Hospitals.

The Methodist Healthcare System is a taxable partnership between the not-for-profit Methodist Ministries and HCA, Inc., the nation's largest provider of health care. The Methodist Healthcare System comprises five full-service acute care hospitals, with more than 1,500 beds. We serve the San Antonio, Texas, market as well as twenty-five surrounding counties.

I am delighted to be here this morning to discuss the unique problems created by physician ownership of, and self-referral to, specialty hospitals. I view this as one of the most critical issues facing full-service community hospitals today. By injecting self-referral into the clinical process, physician-owned specialty hospitals undermine and complicate the delivery of responsible, effective health care.

BACKGROUND

Let me begin by stating that as CEO of a large health care system, I certainly understand the pressures faced by both hospitals and physicians. We all must overcome numerous obstacles just to keep open the doors to quality patient care—the constraints of often unpredictable and inadequate Medicare and Medicaid reimbursement, increasing medical liability insurance premiums, pressures of managed care, demanding regulatory burdens, and on-call requirements, are just a few of the challenges. Within this demanding environment, it is understandable that some physician specialists would be seduced by a specialty hospital's promise of incomparable personal financial gain. However, I believe that each of these challenges requires a comprehensive solution aimed at reforming a fractured health care system, not an anti-competitive solution in the form of self-referral to specialty hospitals, which ultimately impacts patient access to health care. By not confronting the underlying public policy problems of allowing physician ownership and self-referral, we are creating a potentially devastating trend in the way health care is delivered, the long term results of which are far worse than the underlying issues which in part have caused them.

I am deeply concerned about the effect physician-owned specialty hospitals are having on our health care system, and how their continued proliferation will impact the ability of full-service hospitals to continue to offer the services communities need and expect. I am also concerned about the duplicative nature of these facilities, which invariably leads to increasing health care costs at a time when our public health care infrastructure is financially stressed on both the state and federal levels.

When Congress enacted the physician self-referral ban, it did not envision the development of facilities whose business model relied upon the control of referrals by its physician-owners. However, within the past several years, physician-owned specialty hospitals have emerged to capitalize on an unintended loophole in this law. The business model arrangements provide physician-owners with strong monetary incentives for referring carefully selected patients to the facilities in which the physicians have ownership interests, while leaving less profitable cases to be handled by local community hospitals.

As both the independent Medicare Payment Advisory Commission (MedPAC) and Government Accountability Office (GAO) found, physicians owning a financial interest in a specialty hospital tend to direct to their facilities only the most attractive patients—those who are not on Medicaid or those who are less sick. However, those same specialists tend to refer underinsured or uninsured patients, as well as those with higher acuity (more complexity), to full-service community hospitals for treatment. The care provided to underinsured or uninsured patients at the full-service community hospital is often administered with little to no reimbursement of costs. Consequently, full-service hospitals then are left without adequate resources to treat the sickest patients.

This practice of patient selection is unethical, and does not serve the best interests of the American health care system, community hospitals, and most importantly, the patients in our care.

I am not alone in expressing these concerns. Study after study continues to reach similar conclusions and raise questions about the manner in which these facilities operate. These studies include: GAO reports from April 2003 and October 2003; MedPAC report from March 2005 ; Dr. Peter Cram's recent analysis in the New England Journal of Medicine; Dr. Jean Mitchell's analysis of specialty hospitals in Arizona and Oklahoma markets; report from O'Melveny & Myers LLP and KPMG dated July 3, 2003; McManis Consulting case studies of markets in South Dakota, Nebraska, Oklahoma and Kansas; and Cara Lesser with the Center for Health System Change analysis of inappropriate utilization, to name just a few. The gravity of the issues highlighted in these studies, the long term health care cost implications, and the striking potential for the creation of a tiered health care delivery system is dividing the physician community and is leading other, non-hospital groups to express their opposition to physician-owned specialty hospitals. In fact, the American Academy of Family Physicians , American College of Emergency Physicians, the U.S. Chamber of Commerce, and the National Black Chamber of Commerce have all recently expressed their support for extension of the moratorium on new physician-owned specialty hospitals. The U.S. Chamber of Commerce, in a letter

from Thomas Donohue to Chairman Bill Thomas states: "The Chamber favors a market-based health care system that is rooted in competition based on the highest possible (sic) quality, excellent outcomes and reasonable price." He concludes his letter by saying, "The Chamber believes further evaluation of this topic is warranted, and thus urges an extension of the current moratorium." More recently, in a May 2, 2005 front page article, the Wall Street Journal raised questions about the concept of self-referral and the link to utilization of services.

It is my understanding that the specialty hospital industry is prepared to move forward with the development of new facilities if the moratorium expires in June 2005. As stated in a November 15, 2004 issue of *Modern Healthcare*, "Donald Burman, Chief Executive Officer of the 27-bed Orthopedic Hospital of Oklahoma in Tulsa, said he believes that there are at least '100 facilities out there ready to go if the moratorium' is lifted next June. 'You could see 250 more in the next few years.'" This is entirely consistent with what I am hearing throughout Texas.

The only way to solve this problem is to close the loophole in federal self-referral prohibition by permanently banning physician ownership of, and self-referral to, specialty hospitals. The success of these facilities depends entirely upon the physician owners' referrals, and this type of relationship is exactly what the self-referral ban is designed to prevent.

SELF-REFERRAL IS THE ISSUE

As the CEO of five full-service acute care community hospitals in a vigorous healthcare market, I am committed to supporting free and fair competition. True competition, however, requires a level playing field. Methodist Healthcare System, and other full-service community hospitals nationwide, routinely compete for patients on the basis of quality of care, physician recruitment, and provision of the latest medical technologies. Yet the recent proliferation of physician-owned specialty hospitals in Texas and across the country has dramatically altered the delivery of health care services by stifling fair competition and even threatening the viability of certain vital health care services nationwide.

The *existence* of specialty hospitals is not the problem. Instead, it is the *physician ownership of and self-referral* to these facilities that creates an uneven playing field and directly harms full-service community hospitals. In recent years, physician-owned specialty hospitals built across the country are distorting the marketplace wherever they appear. These facilities limit their care to just one type of high-margin service—often cardiac, orthopedic, or surgical care—which guarantees high profit margins, while avoiding essential but unprofitable community-based services, such as emergency departments and burn units.

Ownership interests in these facilities are typically granted only to physician-investors who are able to refer patients, not to any investors from the general public. Referring physicians are given sweetheart equity arrangements, with little risk, at bargain basement rates. In contrast, offering a physician any "inducement" for referrals would land me in jail under the anti-kickback law. These laws together prohibit me from giving specialists at my hospital more than $300 in gifts per year, none of which could be given in exchange for an induced referral. Fair competition under the current interpretation of the self-referral ban is simply impossible.

The "whole hospital" loophole in the self-referral prohibition permits specialty hospitals to cherry pick only the most profitable patients, leaving to community hospitals high-cost patients, individuals on Medicaid, and the uninsured. GAO and MedPAC have found clear evidence of this behavior, concluding that physician ownership and self-referral result in favorable patient selection. Because of their adverse financial impact, self-referrals to physician-owned specialty hospitals threaten the long-term viability of our full-service community hospitals.

QUALITY

Proponents of physician-owned specialty hospitals often suggest that quality is superior in these settings. Until very recently, no independent, non-industry supported, data existed to support or refute this assertion. However, Dr. Peter Cram from the University of Iowa found in a study recently published in the *New England Journal of Medicine* that quality is in fact no better in a specialty hospital setting. Specifically, Dr. Cram found that "there is no definitive evidence that cardiac specialty hospitals provide better or more efficient care than general hospitals with similar procedural volumes." Moreover, Dr. Cram found that specialty heart hospitals treat fewer seriously ill patients than community hospitals, creating the illusion they provide better care, and "given that we found no significant differences in outcomes between specialty and general hospitals with similar volumes or be-

tween specialty cardiac hospitals and specialized general hospitals, it could be argued that the specialty-hospital model itself does not yield better outcomes."

The findings of the study also reinforce previous conclusions found by MedPAC and GAO that specialty hospitals cherry pick healthier patients. In an interesting development, Dr. Cram also found that patients receiving care in physician-owned specialty hospitals "resided in ZIP Code areas with somewhat higher socio-economic status, as evidenced by higher mean home values and higher per capita income." I find it troubling that specialty hospitals, when injecting physician ownership into the equation, are creating a foundation for the development of an "economically-tiered" health care delivery system.

COMMITMENT TO COMMUNITY

In this anti-competitive environment, full-service community hospitals struggle to achieve the level of care that we desire to provide, and that our communities expect. When specialty hospitals drain essential resources from full-service community hospitals, they particularly harm, over time, our capacity to provide emergency care and other vital health services.

The Methodist Healthcare System believes that maintaining a fully functioning and fully staffed twenty-four hour emergency department is part of our commitment to the community. In 2004, we received 180,000 visits to our emergency department. Physician-owned specialty hospitals simply do not share in the full compliment of critical ED services, which full-service hospitals consider as a responsibility and commitment to their communities. In fact, during one site visit, MedPAC noted that a specialty hospital had to turn on the light to show what it claimed as its emergency department. Many others have no emergency department at all.

As the Members of this Committee are well aware, America's hospital emergency departments are quickly becoming our *de facto* public healthcare system, the primary point of access to quality healthcare services for the nation's uninsured. Hospitals equipped with emergency departments must provide medical evaluation and required treatment to everyone, regardless of their ability to pay. Since the advent in recent years of physician-owned specialty hospitals, which skim profitable service areas for low-risk patients, the emergency department burden has grown significantly greater. While specialty hospitals treat the most profitable patients, full-service hospitals are left with the task of handling uninsured and high-risk patients within their community. At Methodist Healthcare System, 41 percent of patients who visited our emergency department in 2004 were self-pay/indigent or Medicaid patients. Maintaining this essential community service for those who need it most also means contending with a regular population of those with little or no health care options. Moreover, this population often seeks emergency room care only once an illness has reached a level of acuity that makes their case more complex and costly to handle.

A 2003 GAO study sheds considerable light on the attitude of specialty hospitals toward emergency services. According to the GAO, a majority of specialty hospitals do not have fully functioning, fully staffed, twenty-four hour emergency departments. The GAO study reveals that while nine in ten of all full-service community hospitals maintain an emergency department to address any medical situation that walks or is carried through its doors, half of all specialty hospitals do not provide emergency services. Even among those specialty hospitals that do have emergency departments, GAO found that the care provided was almost entirely within the specialty hospital's field. By opting not to operate fully functioning emergency departments, specialty hospitals enjoy a high degree of self-selection, which allows them to treat a healthier and better paying patient population with fewer complications and shorter lengths of stay. In my market, I regularly see specialty hospitals avoid this commitment to our community. For example, while the local MedCath facility does maintain an ED, it states quite openly that it is only for cardiac emergencies. In addition, the President and CEO of Austin Surgical Hospital, Patricia Porras, stated "Structurally, there is an ED department. However, we will not pursue a public ER, and we will not be tied into an EMS system."

Moreover, GAO and MedPAC separately found that specialty hospitals treat a much smaller share of Medicaid patients than do community hospitals within the same market area. In its results, MedPAC found that physician-owned specialty hospitals treat far fewer Medicaid recipients than do community hospitals in the same market—75 percent fewer for heart hospitals and 94 percent fewer for orthopedic hospitals.

The departure of specialists who relocate their practices from full-service community hospitals to physician-owned specialty facilities causes an additional strain on specialty coverage for full-service hospitals. Communities expect full-service hospital

emergency departments to maintain a complete state of readiness around the clock, every day of the year. On-call requirements for specialists ensure adequate staffing outside normal work hours, as well as on holidays and weekends for hospital emergency departments. The lack of physician specialists to provide coverage at full-service community hospitals has compromised the ability of those hospitals to provide twenty-four hour emergency services and to meet the significant obligations hospitals face under the Emergency Medical Treatment and Active Labor Act.

Recognizing the importance of our role in the community, the Methodist Healthcare System also provides a vital charity care program, and has made significant investments in specialized, essential state-of-the-art health care services, such as transplant, open heart, neurosurgery, children's health care, rehabilitation, psychiatric care, and neonatal intensive care. It is important to note that the Methodist Healthcare System is a proponent of specialization and its benefits; however, it is equally important to note that none of these inpatient specializations are physician-owned. The benefits of specialization can be achieved without the inherent conflict of interest found in physician-owned specialty hospitals.

IMPACT ON METHODIST HEALTH SYSTEM

Like full-service community hospitals nationwide, the loss of specialists willing to cover on-call responsibilities poses a significant cost to community hospitals nationwide, and directly threatens patient care. Prior to the development of physician-owned specialty hospitals within the San Antonio area, our specialists largely accepted on-call responsibilities as a member of the volunteer medical staff and pro-bono commitment to our community. However, following the development of the Spine Hospital of South Texas, in particular, the Methodist Healthcare System has been unable ensure on-call participation of those orthopedists who are part-owners in the specialty facility.

The Methodist Healthcare System prides itself in working with all physician specialists within the community and ensures their access to our facilities. Nevertheless, this is often done at a significant cost to our hospital. Many of the cardiac surgeons with ownership in the MedCath facility direct the healthier, less complex patients away from our hospital and admit them to the MedCath facility in which they have an ownership interest. The only time we see those patients again is when complications arise.

Proponents of physician-owned specialty hospitals claim that their presence in a community generates efficiencies and lowers costs. This could not be further from the truth. MedPAC found that specialty hospitals do not have lower Medicare costs per case, even though they treat healthier patients for a shorter period of time than full-service community hospitals do. In addition, when specialty hospitals enter a community, their services are generally duplicative and impose significant cost burdens on the full-service hospitals, which must both compete and continue to meet the needs of the community that specialty hospitals shun.

PHYSICIAN-OWNED SPECIALTY HOSPITALS ARE DIVERTING NEEDED RESOURCES FROM FULL-SERVICE COMMUNITY HOSPITALS

Full-service community hospitals long have used funds generated by higher margin services to subsidize the losses suffered by less financially desirable services. Only by maintaining the successful product lines are full-service hospitals able to subsidize other critical but (less financially advantageous) services, such as trauma and burn centers, as well as fund special programs for delivering care to uninsured and underinsured patients. By removing the highest margin services from full-service community hospitals, physician-owned specialty facilities have a monetary incentive to refer only those better-funded and less severely ill patients. This leaves the uninsured, underinsured and more severely ill patients to be treated by community hospitals, often without adequate (or any) compensation. While paying and less severely ill patients are diverted to physician-owned specialty facilities, community hospitals are left with the burden of caring for a higher percentage of the uninsured, underinsured, and the sickest patients, yet with fewer resources to cover the vast and unreimbursed costs involved.

FEDERATION OF AMERICAN HOSPITALS' PETITION

Fundamental to understanding the proliferation of physician-owned specialty hospitals is recognizing how this industry has abused the whole hospital exception to the physician self-referral ban. As this Committee is aware, the self-referral ban was intended to prohibit questionable conflict of interest arrangements between physicians and providers that could lead to an abuse of the Medicare program. This law generally prohibits physician referrals for Medicare services to entities in which

the physician has an ownership interest. The intent of this prohibition was to establish and maintain a thriving marketplace for health care, free of conflicts of interest and protecting the integrity of the Medicare program. Under current law, physicians are permitted to have an ownership interest in an entire full-service inpatient hospital, but not a subdivision of a hospital. The logic behind the exception is that any referral by a physician who has a stake in an entire hospital would produce little personal economic gain, because hospitals tend to provide a diverse and large group of services. However, a physician's ownership in a subdivision of a hospital would not sufficiently dilute the potential conflict of interest and, instead, would constitute a material conflict of interest regarding improper influence over physician referrals.

Clearly, the intent of Congress was to prohibit physician ownership of and referral to subdivisions such as cardiac, surgical or orthopedic wings. It is difficult for me to imagine how a facility that has five beds or even twenty-five beds is a full-service hospital. The average bed size of a surgical hospital, according to MedPAC, is 15 beds. These facilities, however, have taken advantage of state hospital licensing laws which allow them to be considered "whole hospitals," circumventing the intent of the whole hospital exception in the anti-referral law.

There is no question, in my professional opinion, physician-owned specialty hospitals are effectively subdivisions of full-service hospitals. It is my hope that Congress will revisit this issue and address this new type of facility legislatively. In the meantime, it is important to recognize the role the Department of Health and Human Services (HHS) can play in re-examining the definition of a whole hospital. To this end, our trade association, the Federation of American Hospitals, petitioned HHS on February 28, 2005, to define a whole hospital. The Federation argues that because Congress did not intend to protect physician-owned limited service facilities under the whole hospital exception, HHS is obligated to take action so its regulations adapt to changing circumstances. Specifically, the Federation's petition recommends refining the whole hospital exception to apply only to "full-service hospitals."

Physician-owned specialty hospitals are clearly different from community hospitals, and therefore, should be analyzed separately and addressed in the regulation under the whole hospital exception. In the petition, the Federation urges the whole hospital exception regulation be changed to include a more refined definition of whole hospital that focuses on demographics and service mix, in addition to state licensure status. I believe that continuing to allow physician-owned specialty hospitals to qualify as whole hospitals under this regulation is a triumph of form over substance and thwarts Congressional intent to protect the Medicare program from over-utilization and self-induced demand.

SOLUTION: CLOSE THE SELF-REFERRAL LOOPHOLE

Allowing for the continuation of these unethical financial arrangements between referring physicians and specialty hospitals is tantamount to purchasing admissions. I understand that Congress is weighing recommendations by MedPAC that would seek to level the playing field through Medicare payment adjustments. While I would certainly advocate for more accurate and appropriate Medicare reimbursement, I think it is important to recognize that Medicare payment adjustments alone will not level the playing field and will not solve the exploitation of this loophole.

MedPAC was correct in recognizing the problems inherent in physician ownership of specialty hospitals, and the need to prevent such conflicts of interest; however, its recommended policy response, which focused on refinements of Medicare's DRG payment system, is inadequate. As an operator of acute care hospitals, I can assure the Committee that simply adjusting the DRG's will only marginally reduce the profitability of self-referral. It is the ownership and referral relationship that creates patient selection. The underlying economics of these facilities, which rely upon referrals from physician-owners, would not change materially. Furthermore, while some modifications of the DRG payment system may be warranted, we have to be careful that the wholesale refinement of the DRG system, which MedPAC proposes, could threaten the original reasons for, and subsequent achievements of, the Prospective Payment System we have in place today—that is, rewarding efficient providers. While payment refinements will not solve the self-referral problem, I can tell you that the massive redistribution of funds nationwide would have the unintended consequence of hurting some full-service community hospitals, even in markets where there are now no physician-owned specialty hospitals. We have to be extremely careful about a solution this broad in scope that in my opinion does not address the central problem of physician self-referral.

CONCLUSION

Ultimately, the only effective solution for the Methodist Healthcare System and for hospitals nationwide demands an amendment to the physician self-referral prohibition. The "whole hospital" exception was intended to allow physician ownership in a comprehensive health care facility, as long as that ownership interest is in the entire facility and not merely a subdivision. Congress never contemplated the proliferation of specialty hospitals, which essentially have turned the entire concept of the "whole hospital" exception on its head. In my professional opinion, specialty hospitals are not whole hospitals; rather they are akin to subdivisions of hospitals—essentially cardiac, surgical, or orthopedic wings—that have been removed from the full-service hospital. As such, I believe physician referral to specialty hospitals in which they have an ownership interest is as clear a violation of the anti-referral law as would be physician ownership in a hospital subdivision. Simply put, under the present interpretation of the "whole hospital" exception, physician-owned specialty hospitals are exploiting an unintended loophole to engage in precisely the financial arrangement that Congress intended to prohibit. This situation must be changed.

Not only must the current moratorium be extended, but also it is my hope that Congress will close the loophole in the physician self-referral ban that allows for self-referral to physician-owned specialty hospitals. The whole hospital exception loophole is not in the best interest of our patients, and it will continue to undermine the vital health care services your communities expect from your full-service community hospitals.

Thank you for your time. I would be glad to answer any questions.

Mr. DEAL. Thank you.

Mr. Thomas.

STATEMENT OF JOHN T. THOMAS

Mr. THOMAS. Mr. Chairman, members of the committee, my name is John T. Thomas. I am the general counsel at Baylor Health Care System based in Dallas-Fort Worth, Texas.

Baylor is a 101-year-old, faith-based institution with strong ties to the Baptist General Convention of Texas.

It is an honor for me to address you today on behalf of the Baylor Health Care System and to ask you to allow the moratorium on the development and growth of physician-owned specialty hospitals to end June 8, without renewal.

Baylor Health Care System is the corporate sponsor of 13 non-profit hospitals. Our flagship, Baylor University Medical Center, is located in downtown Dallas, an inner-city hospital, is a 1,000-bed, quadenary teaching hospital with a Level I trauma center. We treat more penetrating trauma victims than Dallas County's tax-supported Parkland Hospital. Baylor University Medical Center has the largest Neonatal ICU in the Southwest, and one of the five largest organ transplant programs in the country. Baylor is deeply committed to its mission as a non-profit hospital. Last year, we provided more than $240 million in community benefits at cost, not including bad debt. Charity care is provided under the most generous charity care/financial assistance policy among all Dallas-Fort Worth hospitals, including Parkland.

One of the most effective strategies Baylor has ever implemented is partnering with physicians economically, and more importantly, clinically in the design, development, and operation of ambulatory surgery centers, surgical hospitals, and heart hospitals. Today, Baylor has an ownership interest in 25 facilities partnered with physicians. Over 2,000 physicians actively practice at these facilities while only about 500 have an ownership interest. Texas Health Resources, the other large, major non-profit hospital system in Dal-

las-Fort Worth, also has a number of hospitals and facilities partnered with physicians.

Five of Baylor's facilities are affected by the moratorium. Three are surgical hospitals, two are heart hospitals. Each is critically important to the mission of Baylor, and in each case, we have followed the guidelines developed by the Internal Revenue Service and Revenue Ruling 98-15 for partnerships between tax-exempt organizations like Baylor and for-profit organizations, or individuals like physicians. The IRS requires the tax-exempt entity to have certain governance controls with respect to the partnership and for the partners to agree, by contract, that "charitable interests" will prevail over for-profit interests. All of our facilities participate in Medicare and Texas Medicaid, and they all agree, by contract, to take all patients, regardless of their ability to pay. While physicians contribute their time, energy, and capital, Baylor, through lay members of the community, including pastors and other community leaders, actively participate and oversee this strategy and have determined that partnering with physicians is in the best interest of our mission and the communities we serve.

With respect to our surgical hospitals, a Baylor-controlled entity owns at least 50 percent of the equity in the partnership that owns and operates a licensed hospital, a fully licensed, accredited hospital. For our two heart hospitals, the Baylor-controlled entity is actually the adjacent Baylor hospital. Our flagship hospital, Baylor University Medical Center, owns 51 percent of the Baylor Jack and Jane Hamilton Heart and Vascular Hospital, located adjacent to and physically attached to Baylor University Medical Center, again an inner-city hospital. Cardiologists and vascular surgeons invested the capital necessary to own the remaining 49 percent of the equity in that facility. In North Dallas, the Baylor Regional Medical Center at Plano owns 51 percent of the Texas Heart Hospital of the Southwest, LLP, and 83 cardiologists, cardio-thoracic surgeons, and vascular surgeons own the remaining percentage. Notably, the Texas Heart Hospital physicians agreed the hospital would be committed to the Texas State law requirement for charity care for tax-exempt hospitals. The physicians made this commitment to the community despite the fact that as a for-profit facility the hospital is not subject to the charity care law, which requires tax-exempt hospitals to provide charity care equal to 4 percent of net patient revenue.

Mr. Chairman, our model of partnering with physicians has now been in operation for over 6 years, with Baylor's inner-city Heart Hospital open for almost 3 years. The results have far exceeded our expectations. This hospital has the highest rated heart program for quality reported on the CMS website, HospitalCompare.gov. By partnering with physicians, Baylor delivers on its mission. The fact is, we can not deliver on all aspects of that mission without aligning with physicians. That alignment takes several forms, but in the end, each has delivered to the patient better, safer care at a lower cost.

We urge you to allow the moratorium on physician ownership and development of specialty hospitals to end June 8. The moratorium has not been benign, and a continuation will be even worse. This moratorium has affected our ability to meet our mission: spe-

cifically the inner-city Heart Hospital needs to expand to meet the demand for the services provided as well as to continue to attract physicians to practice at this inner-city hospital that provides the emergency heart services for our Level I trauma center. The moratorium has prevented Baylor from bringing higher quality heart and vascular care to Plano, where heart disease remains the No. 1 killer. The moratorium has prevented the Baylor-Frisco Medical Center from expanding to provide obstetrics and other women's services to one of the fastest growing communities in the United States.

We would also note the Texas legislature has been reviewing this issue this spring, and the Texas Senate has rejected all efforts to impose any moratorium. In fact, the Texas Hospital Association testified at the Texas Senate hearing: "Baylor and Medcath are not the problem." We urge you not to pass the legislation that will renew the moratorium and urge you not to pass legislation now or in the future that prevents physicians from aligning with the community to bring higher quality and safer care. Physicians are part of the solution and must be at the table to help all of us improve quality, safety, patient satisfaction, and to lower costs.

And last, in response to the previous comments, nothing in the law prevents Methodist, or any other hospital in the United States, from pursuing strategies and alignment like Baylor has.

Thank you.

[The prepared statement of John T. Thomas follows:]

PREPARED STATEMENT OF JOHN T. THOMAS, SENIOR VICE PRESIDENT-GENERAL COUNSEL, BAYLOR HEALTH CARE SYSTEM

Mr. Chairman, Members of the Committee, my name is John T. Thomas, and I am the General Counsel of Baylor Health Care System, based in Dallas-Fort Worth, Texas. Baylor is a 101 year old, faith based institution, with strong ties to the Baptist General Convention of Texas.

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At the same time, Baylor has a long history of innovation. In the early 1900s, Baylor developed the "pre-paid hospital plan," which today operates as the Blue Cross Blue Shield Association. With the changes in medical practice, Baylor has sought, and continues to seek, new and innovative ways to lower the cost of the delivery of care, while improving quality, safety and satisfaction.

One of the most effective strategies Baylor has implemented is partnering with physicians economically and, more importantly, clinically, in the design, development and operation of ambulatory surgery centers, surgical hospitals, and heart hospitals. Today, Baylor has an ownership interest in 25 facilities partnered with physicians. Over 2000 physicians actively practice at these facilities, while only about 500 have an ownership interest. Texas Health Resources, the other major non-profit hospital system in Dallas-Fort Worth also has a number of hospitals and facilities partnered with physicians.

Five of Baylor's facilities are affected by the Moratorium. Three are surgical hospitals. Two are heart hospitals. Each is critically important to the mission of Baylor

Health Care System, and in each case, we have followed the guidelines developed by the IRS in Revenue Ruling 98-15 for partnerships between tax-exempt organizations like Baylor and for-profit organizations (like individual physicians). The IRS requires the tax-exempt entity to have certain governance controls with respect to the partnership and for the partners to agree, by contract, that "charitable interests" will prevail over for-profit interests. They all participate in Medicare and Texas Medicaid and they all agree to take all patients regardless of their ability to pay. While physicians contribute their time, energy and capital, Baylor, through lay members of the community, including pastors and other community leaders, actively participate and oversee this strategy, and have determined partnering with physicians is in the best interest of our Mission and the communities we serve.

With respect to each of our surgical hospitals, a Baylor controlled entity owns at least 50.1% of the equity in a partnership that owns and operates a licensed hospital. For our two heart hospitals, the Baylor controlled entity is actually the adjacent Baylor hospital.

Our flagship hospital, Baylor University Medical Center, owns 51% of the Baylor Jack and Jane Hamilton Heart and Vascular Hospital, located adjacent to and physically attached to BUMC, in the inner city of Dallas. Cardiologists and vascular surgeons invested the capital necessary to own the remaining 49% of the equity in the facility. In north Dallas, the Baylor Regional Medical Center at Plano owns 51% of the Texas Heart Hospital of the Southwest, LLP, and 83 cardiologists, cardio-thoracic surgeons and vascular surgeons own the 49% interest. Notably, the Texas Heart Hospital physician partners agreed the hospital would be committed to the Texas state law requirement for Charity Care for tax-exempt hospitals. The physicians made this commitment to the community, despite the fact that as a for-profit facility, the hospital is not subject to the law, which requires tax-exempt hospitals to provide charity care equal to 4% of net patient revenue.

Mr. Chairman, our model of partnering with physicians has now been in operation for over six years, with Baylor's inner city Heart Hospital open for almost three years. The results have far exceeded expectations. This hospital has the highest rated heart program for quality reported on the CMS website, HospitalCompare.gov. By partnering with physicians, Baylor delivers on its mission. The fact is, we cannot deliver on all aspects of that mission without aligning with physicians. That alignment takes several forms, but in the end, each has delivered to the patient better, safer, care—at a lower cost.

We urge you to allow the Moratorium on physician ownership and development of specialty hospitals to end June 8. The Moratorium has not been benign and a continuation will be even worse. This Moratorium has affected our ability to meet our Mission—specifically, the inner-city heart hospital needs to expand to meet the demand for the services provided as well as to continue to attract physicians to practice at this inner-city Trauma Center. The Moratorium has prevented Baylor from bringing higher quality heart and vascular care to Plano, where heart disease remains the number 1 killer. The Moratorium has prevented the Baylor-Frisco Medical Center from expanding to provide obstetrics and other women's services to one of the fastest growing communities in the United States.

We would also note the Texas legislature has been reviewing this issue this Spring, and the Texas Senate has rejected efforts to impose any moratorium. In fact, the Texas Hospital Association testified to the Texas Senate "Baylor and Medcath are not the problem."

We urge you NOT to pass legislation that will renew the Moratorium, and urge you NOT to pass legislation now or in the future that prevents physicians from aligning with the community to bring higher quality and safer care. Physicians are part of the solution, and must be at the table to help all of us improve quality, safety, patient satisfaction, and to lower cost.

Thank you.

Mr. DEAL. Thank you.

Dr. Cram.

STATEMENT OF PETER CRAM

Mr. CRAM. Thank you.

I would like to begin by thanking Chairman Deal and Ranking Member Brown for inviting me to speak today. I would also like to acknowledge that I haven't received any relevant funding from interested parties for this work, nor, for that matter, do I have material investments in specialty hospitals or for-profit hospitals.

Briefly, my testimony will cover a bit about my background, an overview of the debate, some summary of research we have conducted on this issue, some unanswered questions that should be considered in the future, and some recommendations.

I am a physician research at the University of Iowa. I have clinical training as a general internist as well as a Masters in Business from the University of Michigan. Of note, there are no specialty hospitals currently located in the State of Iowa, and we do have a certificate-of-need regulation.

To summarize the debate, basically the supporters seem to be, as best we can tell, contending that specialty hospitals and specialization breeds improved efficiency and the specialization also is leading to improved clinical outcomes, while opponents are suggesting that specialty hospitals are selecting healthier and more lucrative patients and that specialty hospitals fail to deliver improved clinical outcomes.

Over the past 18 months, I have been leading a research team at the University of Iowa conducting investigations into the quality of care in specialty and general hospitals. Our first manuscript detailing preliminary results was recently published in the New England Journal of Medicine.

To summarize our findings, we compared characteristics and outcomes of Medicare beneficiaries who underwent angioplasty and bypass surgery in specialty cardiac and competing general hospitals during 2000 and 2001. Our results were generally similar to the results Dr. McClellan discussed and found earlier today. In short, patients who underwent angioplasty and bypass surgery in specialty hospitals were healthier than those who underwent the same procedures in general hospitals. So, for example, patients who are being treated in specialty hospitals are less likely to have congestive heart failure, less likely to have kidney failure, less likely to be admitted with an acute heart attack than patients who are treated in those general hospitals. And those differences were quite significant.

Second, we found that specialty hospitals perform many more procedures, and that is angioplasties and bypass surgeries, per hospital per year. And that is significant, because there is a well-recognized relationship between volume of procedures and outcomes. The more you do, the better you do. Specialty hospitals do more.

Then what we found is that unadjusted mortality for angioplasty and bypass surgery was lower in specialty hospitals, but when you accounted for the fact that specialty hospitals were caring for healthier patients, this eliminated much, but not all, of the specialty hospital advantage.

And finally, when we accounted for the healthier patients and the greater procedural volumes that the specialty hospitals were performing, specialty cardiac and general hospitals had similar mortality rates.

So what questions haven't been answered?

Well, No. 1, if specialty hospitals are admitting healthier patients, as data suggests, how and why is this occurring? So are healthier patients choosing to go to specialty hospitals or are specialty hospitals choosing or seeking out those healthier patients? The implications will be quite different.

How do specialty hospitals "acquire" the large number of patients they are performing cardiac procedures on? Are these patients being drawn from small hospitals, as some data suggests, or alternatively, are some of these patients who previously weren't undergoing bypass surgery or angioplasty at all?

Third, the data is much more robust for specialty cardiac hospitals. How do orthopedic specialty hospitals compare with their competing general hospitals?

And finally, how do specialty and general hospitals compare in other outcomes? So patient satisfaction, in particular. Dr. McClellan eluded a bit to some data on that.

And what is the long-term financial impact of specialty hospitals on general hospitals? We have some relatively short-term data suggesting that the impact is not significant. But in the long-term, we don't know what that effect would be.

So in terms of possible recommendations, No. 1, extending the moratorium on new specialty hospitals to allow for further study is reasonable, and a further study is desired. Funding sources should be created to fund this research. But the moratorium should not be permanent and, if it were extended, should be done to allow for updating of the Medicare payment system, as this could reduce the financial incentives that are driving specialty hospitals to seek out healthier patients.

And finally, a premature ban on specialty hospitals could hinder regionalization of care and could ultimately harm patient care in this country.

Thank you.

[The prepared statement of Peter Cram follows:]

PREPARED STATEMENT OF PETER CRAM, ASSISTANT PROFESSOR OF MEDICINE, UNIVERSITY OF IOWA

INTRODUCTION

Hello. My name is Peter Cram. I am a physician, health services researcher and Assistant Professor of Internal Medicine at the University of Iowa Carver College of Medicine. I would like to thank Chairman Deal and Ranking Member Brown for inviting me to speak today.

My research involves three principal areas: cost-effectiveness of new medical technologies; medical errors in the outpatient setting; and measuring quality of care in hospitals. Over the past 18 months, I have conducted investigations in cooperation with researchers at the Iowa City Veterans Administration Hospital assessing the quality of care provided by specialty cardiac and general hospitals. In terms of conflicts-of-interest, I have none to disclose. In particular, I do not receive funding from any specialty hospital associations or the American Hospital Association. There are no specialty hospitals located in Iowa, where I am employed.

My testimony today will briefly cover 5 specific topics related to specialty hospitals: 1) the history of hospital specialization; 2) the specialty hospital controversy; 3) available data on specialty hospitals; 4) areas of uncertainty; 5) recommendations to the committee.

THE HISTORY OF HOSPITAL SPECIALIZATION

While specialty hospitals are a relatively new phenomenon, it is important to recognize that hospital specialization *per se* is not a new development. The healthcare management, health economics, and health services research literature have been addressing the potential benefits of hospital specialization for years.[1-4] For example, in the past healthcare management would have considered a free-standing rehabilitation hospital to be a specialty hospital while today such free-standing hospitals are considered commonplace.[5] Analyses in health economics have provided additional evidence that hospital specialization is not a new phenomenon, but rather that general hospitals have become increasingly specialized over decades;[4,6,7] inter-

estingly, the majority of these studies have found evidence that hospital specialization is associated with improved efficiency.[8,9] Finally, studies from the health services research literature have focused less on hospital specialization and more on the relationship between hospital procedural volume and patient outcomes. These studies have demonstrated a consistent relationship between volumes of procedures such as bypass surgery or esophageal surgery and lower patient mortality.[14-20] Some policy makers have suggested that based upon this evidence, certain high risk procedures should be triaged to specialized hospitals that perform large numbers of these procedures (a.k.a. regionalization).[19,21,22] Thus, while specialty hospitals can in many ways be considered a new development, hospital specialization has actually been progressing for decades.

That being said, the new generation of specialty hospitals appears to be different for at least three reasons: first, and foremost, their focus on procedural aspects of medicine that tend to be more lucrative than "cognitive" aspects of medicine; second, their focus on healthier patient populations within their areas of specialization (e.g., cardiac care, orthopedic care); third, physician investment/ownership of specialty hospitals.

THE SPECIALTY HOSPITAL CONTROVERSY

Despite the widespread concern about the emergence of specialty hospitals, the absolute number of specialty hospitals remains relatively small. By most estimates there are no more than 100 such hospitals in operation currently.[23,24] Nevertheless, the 300% growth rate in the number of specialty hospitals between 1990-2000 and the purported economic impact of these new hospitals on existing general hospitals merits discussion.

The controversy concerning specialty hospitals ultimately can be distilled down to a limited number of issues.

Supporters of specialty hospitals claim that:

- Specialty hospitals perform higher volumes of procedures.
- By focusing on narrow procedural areas, specialty hospitals deliver improved outcomes relative to general hospitals.

Opponents of specialty hospitals allege that:

- Specialty hospitals preferentially select healthier patients for admission (a.k.a. "cherry picking").
- Specialty hospitals do not generate any improvement in patient outcomes.
- Specialty hospitals reduce the profitability of general hospitals.

Available Data

While 18 months have passed since Congress passed their initial moratorium on further specialty hospital development, high-quality data remain limited. This underscores the complexity of measuring the impact of specialty hospitals on general hospitals and the possible value that specialty hospitals add to the health care delivery system.

I will now enumerate each of the major areas of controversy and will summarize both the available data addressing each concern and the major gaps in these data that should be answered before rendering a binding decision on this issue.

1) *Specialty hospitals admit healthier patients than general hospitals.*

There are four studies that have compared the severity-of-illness of patients admitted to specialty hospitals and general hospitals. A study performed by the Lewin Group for MedCath Inc. found that MedCath specialty cardiac hospitals admitted sicker patients than those admitted to competing general hospitals.[25] Alternatively, three studies have found evidence that specialty hospitals admit healthier patients than general hospitals.[23,24,26] In an analysis we recently published in the New England Journal of Medicine, we found that Medicare beneficiaries admitted to specialty cardiac hospitals had lower rates of kidney failure, heart failure and were less likely to be admitted with myocardial infarction ("heart attacks"') than patients admitted to general hospitals.[26] In aggregate these studies suggest that specialty hospitals admit healthier patients than competing general hospitals.

A recently released report by MedPAC provides some data to explain why specialty hospitals (and, in actuality, all hospitals) prefer admitting these healthier patients.[24] Under the Medicare Prospective Payment System (PPS), there is a well recognized variation in profitability of caring for different patients with the same diagnosis.[27-29] This variation in profitability occurs because Medicare typically pays hospitals a single "lump-sum" payment for providing care to a specific patient based upon the patient's diagnosis.[30] To the extent that among patients with the same diagnosis, some are sicker (and hence more expensive to care for) and others are

healthier (and less expensive to care for), but Medicare payments are similar for both patient groups, healthier patients become more profitable for hospitals than sicker patients. Hospitals that could consistently attract healthier patients without attracting the sicker patients could make excess profits.

Thus, the balance of the available data suggest that specialty hospitals care for patients with less severe disease than competing general hospitals. This behavior is likely to be motivated by inefficiencies in the Medicare PPS.

There are, however, a number of important and unanswered questions:

- How do specialty hospitals attract healthier patients?
- Do healthier patients seek care from specialty hospitals or do physician-investors preferentially admit healthier patients to the specialty hospitals?

2) *Specialty hospitals perform higher volumes of procedures than competing general hospitals.*

Two studies have provided data on the volumes of procedures performed by specialty and general hospitals. A report by the GAO (Government Accountability Office) found evidence that specialty hospitals perform significantly greater numbers of cardiac and orthopedic procedures than their general hospital competitors.[31] Our research published in the *New England Journal of Medicine* found that cardiac specialty hospitals performed significantly more angioplasty procedures and coronary bypass surgeries on average than general hospitals on average, confirming the GAO report. This is important, given the large body of evidence that has found that patients experience better outcomes in higher volume hospitals. However, it is important to note that we also found wide variation in the volumes of procedures performed by individual hospitals.

The balance of data suggest that the average specialty hospital performs greater numbers of procedures (e.g., bypass surgery and angioplasty) than the average competing general hospitals.

There are a number of important unanswered questions concerning the volumes of procedures performed by specialty and general hospitals:

- Do the differences in procedural volume demonstrated for specialty cardiac hospitals and general hospitals also apply to other types of specialty hospitals (e.g., orthopedic hospitals)?
- How do new specialty hospitals generate the high volumes of procedures they perform? Does the specialty volume represent a consolidation of patients formerly treated in many low-volume general hospitals within the new specialty hospital? Do these patients come from large general hospitals? Or does the specialty hospital volume represent an increase in the number of procedures performed on groups of patients who were not receiving procedures previously?

3) *Specialty hospitals generate improved patient outcomes compared to general hospitals.*

Data comparing the outcomes of patients receiving care in specialty and general hospitals are very limited. A study by the Lewin Group reported that patients treated in MedCath cardiac hospitals had a 17% lower risk of death than patients treated in community hospitals.[25] Our analyses found that Medicare beneficiaries who underwent angioplasty or bypass surgery in specialty cardiac hospitals had approximately a 30% lower risk of death before we accounted for the fact that the average patient in a specialty hospital was healthier than the average patient in a general hospital. However, once the analyses accounted for the fact that specialty hospitals were caring for healthier patients, mortality rates in specialty cardiac hospitals were 15% lower and this difference was no longer statistically significant. Finally, once we accounted for the healthier patients and the fact that specialty hospitals perform significantly greater numbers of angioplasty and bypass surgery than general hospitals, mortality rates in specialty and general hospitals were nearly identical.

Thus, the available data suggest that mortality rates in specialty cardiac hospitals and general hospitals are similar once patient characteristics and hospital procedural volume have been accounted for. From this perspective, it is reasonable to say that there is nothing inherent in the specialty hospital model that produces improved outcomes. Alternatively, it could be argued that mortality rates in specialty cardiac hospitals are approximately 10-15% lower because of the fact that specialty cardiac hospitals perform significantly more procedures than the average general hospital.

There are a number of unanswered questions that remain. In particular:

- How do specialty and general hospitals compare for other non-cardiac procedures (e.g., orthopedic procedures)?
- How do specialty and general hospitals compare with respect to outcomes other than mortality (e.g., patient satisfaction, functional status)?

4) *Specialty hospitals reduce the profitability of general hospitals.*

While there is widespread concern and anecdotal reports that specialty hospitals are reducing the profitability of competing general hospitals, available data are limited. A study by the GAO did not find clear evidence that this was occurring. Similarly, preliminary analyses by Schneider et al. found evidence lacking that specialty hospitals significantly harm general hospital profitability.[31,32]

Thus, available data have not demonstrated that specialty hospitals reduce general hospital profitability in the short term.

However, there are a number of questions that remain regarding the impact of specialty hospitals on the profitability of general hospitals. In particular:

- What is the long-term effect of specialty hospitals on the financial performance of general hospitals?
- Does the entry of specialty hospitals limit the ability of general hospitals to perform important social missions such as charity care?

SUMMARY OF AVAILABLE DATA AND AREAS OF UNCERTAINTY

Specialty hospitals appear to admit healthier patients than competing general hospitals and on average specialty hospitals perform many more procedures per-year than competing general hospitals. For cardiac procedures (e.g., bypass surgery, angioplasty) unadjusted mortality is significantly lower in specialty hospitals than general hospitals, but this difference is no longer statistically significant once the analyses have accounted for the fact specialty hospitals treat healthier patients. Adjusting for patient characteristics and hospital procedural volume demonstrates similar mortality rates in specialty cardiac and general hospitals. In short-term analyses, specialty hospitals do not appear to reduce general hospital profitability.

There are a number of important areas of uncertainty that require further investigation. First, it is unclear how and why healthier patients concentrate in specialty hospitals. Second, it is unclear whether the findings we have demonstrated with respect to hospital procedural volume and patient mortality can be extrapolated from cardiac hospitals to other types of specialty hospitals. Third, it is unclear how specialty and general hospitals compare in other important types of outcome measures such as patient satisfaction or functional status. Finally, the longer-term financial impact of new specialty hospitals on existing general hospitals is uncertain.

6) Recommendations and Conclusions.

In summary, I agree with the recent recommendations that the Medicare Payment Advisory Commission (MedPac) presented to The Congress in March, 2005.

First, I believe that extending the current moratorium on further specialty hospital development to allow for time for investigation of the remaining questions about specialty hospitals and their impact on general hospitals is reasonable. Furthermore, if the moratorium on specialty hospitals is extended to allow for further study, The Congress should consider making funds available either through Medicare or the National Institutes of Health to facilitate these studies. Second, I agree with the MedPAC conclusion that updating the current Medicare PPS could reduce the financial incentives that may encourage hospitals to focus on admitting healthier (more profitable) patients. Third, I believe that any legislation prematurely banning specialty hospitals could hinder regionalization of high-risk medical procedures and could ultimately harm patient care.

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Mr. DEAL. Thank you all. Very interesting testimony.

As we promised, we are all over the board of this one.

Mr. Thomas, I think yours is a unique situation. You have explained to us how, under the tax law, you can, in a collaborative effort, work with specialty hospitals, and it appears to be working rather well with your overall encompassing of that, is that correct?

Mr. THOMAS. Absolutely.

Mr. DEAL. Mr. Hornbeak, is your hospital an HCA hospital?

Mr. HORNBEAK. We are a partnership with HCA as one of the partners and the Methodist Health Care Ministries of South Texas being the other, a non-profit organization.

Mr. DEAL. So you have got a combination even met.

Mr. HORNBEAK. I do. I sure do.

Mr. DEAL. Yet you——

Mr. HORNBEAK. But the doctors don't own any piece of it.

Mr. DEAL. I thought HCA started out with the doctors owning it?

Mr. HORNBEAK. Well, they started their company, but they don't refer patients. Dr. Friss does not refer any patients to HCA hospitals. He is an owner.

Mr. DEAL. Are you partnering with any ambulatory surgical centers in HCA?

Mr. HORNBEAK. Yes, sir. I do have ambulatory surgery centers, and three of them are joint-ventured with surgeons.

Mr. DEAL. Well, would you distinguish for me the difference between you condemning the hospital situation and then now being in an ambulatory surgical center setting? What is the difference?

Mr. HORNBEAK. Yes, sir, I would be happy to.

Our participation in joint-ventured ambulatory surgery centers is as inconsistent as the public policy that governs ambulatory surgery centers versus specialty hospitals. Ambulatory surgery centers, unlike hospitals, are not a designated health service under the anti-referral laws, so they are not covered. Ambulatory surgery centers, unlike hospitals, operate under a specific safe harbor within the fraud and abuse laws. The fraud and abuse laws establish specific guidelines that ASCs have to follow that they must meet, and our ASCs are operated within those guidelines. Specialty hospitals, on the other hand, exploit a loophole in the law, and this is the issue that we have been asked to address. Self-referral and ownership do present a risk, under any arrangement, including ASCs, and if the guidelines change, we would adjust our model. But hospitals have been faced with you either play according to those joint-venture guidelines or you get out of the business, you default away your ambulatory surgery business. The composite——

Mr. DEAL. Okay. Let me let this to——

Mr. HORNBEAK. Yes.

Mr. DEAL. [continuing] Dr. Pierrot, first of all a comment on that and then Mr. Thomas after that on what you make your distinction.

Mr. PIERROT. Yes, sir.

On the distinction between owning an interest in a surgery center and the surgical hospital, I don't see a distinction.

Mr. DEAL. Okay. Mr. Thomas?

Mr. THOMAS. There is no distinction. The only distinction that I can think of is in when the patient needs to spend the night and

has additional ancillary services required of a hospital, and the other the patient doesn't spend the night and doesn't need those ancillary services that a hospital setting provides. That is the only difference.

Mr. DEAL. One of the suggestions I think that Dr. McClellan made that he is going to be doing is looking at some of the specialty hospitals and see if they actually are more closely aligned with the definition of ACS. Is there a problem with that approach to it? Do you see any problems that might be inherent in that? Dr. Cram, I will let you comment, too. Maybe I will start with you.

Mr. CRAM. I think that when we first started looking at this, actually, we thought everybody knows what a specialty hospital is, we can all agree. But as you can tell, we can't. And specialty hospitals probably represent a continuum. Let me give you an example. When we started our research, there were some Catholic hospitals in particular, faith-based, I would say. I am not sure if they are actually Catholic, but faith-based hospitals, which were actually extremely specialized. So these were not in the traditional mold of a specialty hospital, but yet they were behaving in every manner like a specialty hospital. Does a specialty hospital have to be for-profit? Maybe, maybe not. Does a specialty hospital have to have physicians in the owner investors? Maybe, maybe not. Deciding what is and what isn't a specialty hospital, or even a hospital and an ambulatory surgical center, is, you know, not cut and dried.

Mr. DEAL. Okay. Well, it seems to me that that is an area that would be fruitful to explore and, quite frankly, Mr. Hornbeak, the distinctions that you make, from a practical standpoint, to me, sound like, on the one hand, you would be arguing for the specialty hospitals because of the arguments you have made in support of the ambulatory surgical centers. I mean, it seems to me we ought to clear all of that up and maybe it will be done administratively by Dr. McClellan and his staff.

My time is, really, almost gone, but I will simply say this. You all have given us a really unique view of the issue. I come from a certificate-of-need State, also, so we don't have the issue developing there. But I do say, and I see more and more, that patients are demanding that they have better services, and sometimes it appears that the overall administrative hierarchy of the hospital setting is going to force even States like mine that have certificate-of-need laws to address that question. When doctors are saying, "I can't get operating time." When doctors say, "There is no ability to plan a schedule, because I get bought by emergencies in the normal hospital setting," which is certainly understandable, and nobody argues that the emergencies should take priority, but I think there is an issue that is continuing to develop around this, and you all have helped to shed light on it, and I thank you for that.

Mr. Gordon.

Mr. GORDON. Thank you, Mr. Chairman.

I want to concur; this has been a very good hearing. I think we have had diverse speakers that have helped us answer a few questions but that have also opened up a lot more, and we need to learn more about this.

Mr. Hornbeak, just a couple of questions for you, please.

Mr. HORNBEAK. Yes, sir.

Mr. GORDON. Are you providing services like charity care and other services to your local community that are not provided by specialty hospitals? And do you have regulatory obligations that do not apply to specialty hospitals? And if so, what is the impact, if any, that these hospitals are having on your ability to be able to continue these services and charity care?

Mr. HORNBEAK. Yeah, we certainly provide charity care. Our write-offs in the past year totaled over $49 million. That is about 2 percent of our gross revenue. Twenty-two percent of our patient admissions are Medicaid and self-pay. I already mentioned 41 percent are ER visits in that category. All five Methodist hospitals are Medicare and Medicaid disproportionate share providers. We provide free clinics. We provide transportation. We provide services all over town, so we do that in spades.

But we have seen some really deleterious effects from the specialty hospitals that have come to our town, and so I will mention just a couple of those.

We have seen a deterioration in our volumes, payer mix, and net income. The Heart Hospital has affected us to the tone of about $1 million a month. Patients are "cherry-picked" right out of the ERs and in the hospital, and this is often very subtle. A patient might even have his calf, be told he is going to be needing a surgery. The surgeon comes in and says, "But you need to go home." And then when that patient is appointed for the surgery, it is not done at the Methodist Hospital where the patient came in through the ED, but it is done at the Heart Hospital. ER call coverage problems have been exacerbated because of the exodus of particularly orthopedics in the case of the spine hospital, and full-service SA hospitals have seen a steady stream of transfers from specialty hospitals when patients have complications.

If the green flag comes out on June 8, I think you will see the systematic dismantling of the community hospital safety net in this country, or at least in the States where this is rampant. We have at least two more teeing up in San Antonio. I understand there are five in Houston, and I understand there are at least three or four in Dallas. I am not sure if that counts all of the Baylor ones or not. They are going to be huge, and you haven't seen huge deleterious effects among the community hospitals. We can defend and patch leaks for a while, but when heart goes, when neuro goes, when spine surgery goes, when oncology goes, the cumulative effects within a few years will be gargantuan.

And outpatient surgery actually gives us a real idea of how this is going to play out, because what happened in outpatient surgery is hospitals did outpatient surgery centers starting 30 years ago. And first of all, the surgeons didn't own any of it. Entrepreneurs came to town in round one and said, "Doctors, you ought to own 25 percent of this." So they did what I call the round one, 25-percent deals. Hospitals said, "We either do 25-percent deals with our surgeons or we lose it." A few years later, they came back for round two, and said, "We are going to do 50 percent." You know, these hospitals are only allowing you to do 25 percent. So they did 50-percent deals. We upped our model in the mid-1990's to 50-percent joint ventures in surgery centers. Now the Foundation Surgical Corporation out of Oklahoma is back just this last year, and now

the surgeons are being told, "You need to get 80 percent." As long as I still have a significant chunk of outpatient surgery, even in my own joint-ventured surgery centers, the entrepreneurs will come back to town to take each successive chunk until there is absolutely nothing left. In the foundation proforma that we got hold of, the surgeons are flocking like bees around it, because it is $5,000 and a first year return of $237,000. I don't blame them for doing it, either, but it is wrong.

Mr. DEAL. Dr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman.

And perhaps we could continue on that just for a moment, Mr. Hornbeak.

Mr. HORNBEAK. Yes, sir.

Mr. BURGESS. Now when you did your joint-venture surgery center with your doctors in San Antonio, what percentage of ownership was the hospital and what percentage of ownership was physician?

Mr. HORNBEAK. Originally, we did the 20 or 25-percent physician ownership. Then we had to up it in successive surgery centers to the 50-percent model.

Mr. BURGESS. And do you currently have any joint ventures on the drawing board?

Mr. HORNBEAK. We have three currently. We don't have any on the drawing board. We are worried about the three that are being emptied out by that Foundation 80-percent deal. We are thinking of turning them into bowling alleys. That will be about the use we will have left for them, because we have already got mothball surgery centers at other hospital systems who have been decimated. This business is just moving from one place to the other to the other.

Mr. BURGESS. You said, what, you had a $49 million write-off last year? Did I understand that correctly?

Mr. HORNBEAK. Yes, sir; that is just the charity care, not the community benefits and also not what our non-profit parent also does in addition to that. But yes, $49 million is the number.

Mr. BURGESS. Okay. What were your earnings last year?

Mr. HORNBEAK. Community hospitals, as was stated earlier, are making about a 2- or 3-percent margin. HCA margins over the last several years have been in the 4- to 7-percent range. And our margin is in that range, the upper end of that range.

Mr. BURGESS. Could you give us any idea what that figure would be in dollars?

Mr. HORNBEAK. Yeah, it is $90 million in 2004.

Mr. BURGESS. Okay. And please don't misunderstand me. I love HCA. I practiced in an HCA hospital for all of my professional life, and I think highly of the mission that you all have and the good work that you do and all of the good people that work for you.

Mr. HORNBEAK. Thank you.

Mr. BURGESS. Now Mr. Thomas, of course, I am very familiar with your program as well, being just down the street in Dallas, and I think it is a very attractive middle ground that you have staked out, and I am grateful for you for being up here today and telling that great story that Baylor has partnering with physicians.

Mr. THOMAS. Thank you.

Mr. BURGESS. I think it only makes sense, and for the life of me I don't understand why it has not been copied with every for-profit hospital chain in the country, given what Mr. Hornbeak is up against. How is this different from what Mr. Ferguson was talking about with the gain-sharing?

Mr. THOMAS. We wouldn't be opposed to gain-sharing, but gain-sharing is a very limited, targeted example of how to capture costs or reduce cost, and you know, the joint-venture model we do is a permanent reduction in cost. It is a permanent solution to having the physicians continuously improving the quality and the cost-savings and monitoring costs in the hospital and providing efficient care. So gain-sharing is very limited. The physician has nothing to lose. They don't invest any capital. And if the gain-sharing program is not monitored closely, the physician is really incentivized just to cut costs, period, without any impact on safety or quality. The Baylor model, the physician is completely at risk not only financially, but their reputation, and it is a continuous improvement in monitoring that cost.

Mr. BURGESS. So clearly, you see that as a superior model to the gain-sharing model?

Mr. THOMAS. Yes, sir.

Mr. BURGESS. Now is there anything that we are doing at the legislative end that is injurious or pernicious to your model to allow that to fully develop and go forward, besides the obvious, the moratorium?

Mr. THOMAS. Well, the moratorium has been very devastating to our furtherance of the model. As I mentioned, the inner-city Heart Hospital needs to expand to provide more care to, you know, an emergency room. About 40 percent of the patients who come to that hospital have no ability to pay.

Mr. BURGESS. Now just for my own edification, as far as this percentage breakdown of hospital-doctor ownership, what are your current models providing as far as hospital and doctor ownership percentages?

Mr. THOMAS. Our models, and we firmly do the 51 percent, at least 51 percent, through Baylor or a Baylor-controlled entity, and physicians up to 49 percent.

Mr. BURGESS. And are you feeling the same pressure from the Foundation Health that Mr. Hornbeak spoke about, the Oklahoma company?

Mr. THOMAS. We feel competition from all of the community hospitals, and you know, all kinds of models. We have pursued this successfully, and again, the physicians talk to each other in the success of one center and in working with an organization like Baylor, like United Surgical Partners, they want to work in those settings. And one, you know, 6 years ago has turned into 25 facilities today.

Mr. BURGESS. Yeah, I wish we had had that in the 1970's.

Finally, Mr. Thomas, do you do Medicare in your facility?

Mr. THOMAS. Yes, sir. Medicare——

Mr. BURGESS. And do you do Medicaid?

Mr. THOMAS. Medicaid and all of our facilities operate under the same Baylor charity care policy as our non-profit hospitals do.

Mr. BURGESS. And so you see uninsured patients where there is little hope of recovering the fee?

Mr. THOMAS. Yes, sir.

Mr. BURGESS. Okay. I see my time is up, so thank you, Mr. Chairman.

Mr. DEAL. Thank you.

Ms. Myrick.

Ms. MYRICK. Thank you, Mr. Chairman.

Mr. Thomas, just a point of clarification because of the mix that you have. You said you have complied with all of the laws——

Mr. THOMAS. Yes, ma'am.

Ms. MYRICK. [continuing] but are the joint-venture for profit specialty hospitals for profit or are they non-profit?

Mr. THOMAS. Well, they are for-profit. They have physician partners as investors, so they have it structured as——

Ms. MYRICK. So they are treated the same way as a for-profit hospital?

Mr. THOMAS. They are for-profit hospitals. The physicians pay taxes, and they pay property taxes, just like the other for-profit hospitals that don't have physician owners.

Ms. MYRICK. And then are you familiar with other models in the country that are doing the same thing you are, other hospitals?

Mr. THOMAS. Yes, ma'am. The Sisters of Mercy has an Oklahoma heart hospital. The Ascension, which is the largest Catholic faith-based hospital system in the world, I think, has many joint ventures like Baylor has pursued. The largest heart program in the State of Illinois is a joint venture between St. John's, a Catholic institution, and physicians in the Springfield community, and a number of other similar non-profit physician partnerships around the country.

Ms. MYRICK. I appreciate it.

Thank you.

Mr. THOMAS. Yes, ma'am.

Ms. MYRICK. I yield back.

Mr. DEAL. I thank the gentlelady.

Mr. Hall.

Mr. HALL. I thank you, Mr. Chairman.

I will ask Mr. Thomas. I think Baylor operates a couple of specialty hospitals in my District, the largest one is up in Frisco, and then there is one in Rockwall County, which is my home county, in this little city called Heath there. And it is a pretty important issue for them. Although they are not in my District anymore—they were for the last 15 years—a Texas spine and joint hospital in Tyler was part of my District.

Is Baylor the only non-profit hospital to form a joint venture with physicians?

Mr. THOMAS. No, sir. As I have mentioned, the——

Mr. HALL. The doctor asked you about that just a moment ago?

Mr. THOMAS. No, that is okay. But Texas Health Resources, which is the other Presbyterian hospital system in Dallas and Harris Methodist in Fort Worth, they partner with physicians in similar facilities.

Mr. PIERROT. If I might comment, the GAO study showed that one-third of the specialty hospitals that they studied were not-for-

profit joint ventures or solely owned. And in our community, there is another 51/49 percent. The Fresno Heart Hospital has the same model. The largest community hospital is the joint venture partner in that.

Mr. HALL. Has the legislature in Texas passed any legislation banning physician ownership of hospitals?

Mr. THOMAS. No, sir. In fact——

Mr. HALL. Have they had it up before them? Have they had bills introduced to that effect?

Mr. THOMAS. Yes, sir; they have. And the Texas Senate specifically has rejected that proposal.

Mr. HALL. And what would happen to Baylor if Congress repealed the "whole hospital" exception? And what would happen to these specialty hospitals, the one in my county and the two in my District?

Mr. THOMAS. Yes, sir; they would have to be unwound. The physicians would have to be bought out, and I am not sure we would be able to continue to provide those services or those facilities in those communities.

Mr. HALL. I think, Mr. Chairman, that is what I wanted to hear, and I thank you.

I yield back my time.

Mr. DEAL. Would the gentleman yield to Mr. Gordon for a question that he would like to ask?

Mr. HALL. Well, I wouldn't want to, but I will.

Mr. GORDON. Thank you, Mr. Hall. I will be quick.

Mr. Thomas, you believe that Baylor Hamilton provides superior care for cardiac, don't you?

Mr. THOMAS. Yes, sir.

Mr. GORDON. Does Baylor Hamilton Heart Hospital treat all cardiac care, or are some of those referred to the Baylor University Medical Center?

Mr. THOMAS. When you say cardiac care, there is cardiac surgery, there is transplant surgery, and then there is interventional cath and vascular——

Mr. GORDON. Well, are you referring some of the things that Baylor Hamilton can do? Are you referring some of those to——

Mr. THOMAS. No, sir. That was my point. For the cardiac services provided, Baylor Hamilton is the only hospital on that campus that provides those services.

Mr. GORDON. So you would only refer someone to the medical hospital that that service could not be provided at Baylor?

Mr. THOMAS. That is correct.

Mr. GORDON. Is that correct?

Mr. THOMAS. That is correct. And 35 percent of Hamilton's patients come from the medical center, because they don't provide that service.

Mr. GORDON. Okay. Thank you.

Mr. HALL. Mr. Chairman.

Mr. DEAL. Yes, sir.

Mr. HALL. If I have any time left, I would like to yield it to Dr. Burgess.

Mr. DEAL. You may do so.

Mr. BURGESS. I just wanted to ask, Mr. Thomas, you heard Dr. McClellan's testimony and his plans. Now I understand you don't want to see the moratorium extended, but what he was talking about, the 6-month look at the payment schedules and the payment formulas, is that going to be deleterious to your business?

Mr. THOMAS. We would support that look, and we think hospitals ought to be appropriately compensated for the services they provide, and it sounds like that is where they are headed.

Mr. BURGESS. And do you feel you will be able to maintain profitability in your joint ventures if, indeed, the Medicare pricing is altered?

Mr. THOMAS. Well, I would obviously like to see the pricing, but let me say, our hospitals have significantly reduced the costs to provide those services. The Heart Hospital downtown reduced the cost to provide that service $12 million the first year it was in operation.

Mr. BURGESS. Very good.

Thank you, Mr. Hall, and Mr. Chairman. I will yield back.

Mr. HALL. I yield back my time, Mr. Chairman.

Mr. DEAL. I thank all of you. I would like to thank the members who are here. Regrettably, we have lost some of our members over the course of this morning, but I do thank you all. Your testimony has been presented in written form to everyone's office and to their staff. And as this issue continues to become significant, and I think it will even with the expiration of the moratorium, I think it will take on some new significance, and certainly with the review that Dr. McClellan is going to go forward with, I think that is an important review. And I think your participation in going forward with his efforts will be significant as well.

Thank you all for being here. Thanks for your patience for waiting this long.

The hearing is adjourned.

[Whereupon, at 1:02 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF SURGEONS

The American College of Surgeons (College) is pleased to submit a statement for the record of the Subcommittee on Health's hearing on specialty hospitals. This is a very important issue for the College and its members. As you know, surgeons provide patient care in all of America's hospitals. The College strongly believes that maintaining care in all types of hospitals, including specialty hospitals, is necessary to sustain full patient access to the highest quality of surgical care.

Surgeons advocate the following policies for addressing the issue of specialty hospitals:

- We oppose elimination of the whole hospital exception, either by legislation or regulation;
- We oppose extension of the MMA moratorium temporarily or permanently; and
- We support refining the hospital DRGs to ensure that Medicare payments properly reflect the cost of providing care.

Specialty hospitals are an important marketplace innovation. Indeed, when the hospital prospective payment system was implemented in 1982, it was widely expected to lead to hospital specialization in order to increase efficiency and improve the quality of care. This is exactly what is happening today with the establishment of specialty hospitals. These hospitals provide more choices for patients and they provide high-quality care. Patients frequently choose these hospitals and they report high satisfaction with their care and experience.

Physician-ownership of specialty hospitals is a positive trend. It is the joint ventures among physicians, hospitals, and other investors that are making possible the

growth of specialty hospitals and the improvements they bring. Frequently, the initiative to create a specialty hospital comes from a physician group, often a group recognized in the community for its clinical excellence, as Regina Herzlinger notes in her case study of MedCath.[1] Physicians and hospitals working together, and with shared incentives, are able to make important changes in the delivery of health care.

The College is concerned about the misplaced emphasis that some attach to financial gain as the prime motivator for physicians becoming involved in these ventures. Physicians are motivated to form specialty hospitals because they recognize the potential to increase productivity and efficiency while also improving quality of care and patient satisfaction. Sometimes physicians have been frustrated while trying to achieve these goals in existing community hospitals. At a MedPAC meeting last September, a MedPAC analyst reported on site visits, saying, *"We repeatedly heard about the frustrations physicians had with community hospitals. Many community hospital administrators acknowledged they had been slow to react to the issues raised by their physicians."*[2]

We want to emphasize that physicians have experienced very significant gains in productivity and efficiency through their involvement in specialty hospitals. According to a MedPAC staff report, *"Physicians . . . told us that they can perform about twice as many cases in a given time period at specialty hospitals as at community hospitals. Physicians mentioned operating room turnaround times at specialty hospitals of 10-20 minutes, compared with over an hour at the community hospitals where they also practice. . . . At one specialty hospital, we were told that physician incomes had increased by 30 percent as a result of increased productivity."*[3]

Finally, the entry of a specialty hospital into a community can be a powerful force for change and improvement. Efficiency and quality are the result of competition, which is healthy for the marketplace. In fact, the Federal Trade Commission recently reported that state certificate-of-need laws have an adverse impact on health care because they stifle competition. Further evidence comes from MedPAC, which reported that community hospitals in areas it visited responded to marketplace pressure created by specialty hospitals and improved their own performance. Specialty hospitals provide efficient, high-quality care, and patient satisfaction is high. They bring value to local health care systems.

Indeed, quality and efficiency are the prime motivators for surgeons who choose to practice in these hospitals—including those who have no ownership interest. They can be more productive and have greater access to specialized equipment and staff than is possible in a general hospital. The end result is higher quality at lower cost.

The criticisms of physician-owned specialty hospitals are not well founded. Critics say that they lead to increased utilization and unnecessary services, but there is no evidence to support this claim. Critics also say specialty hospitals do not serve low-income patients or those who lack health insurance coverage. While it is true that specialty hospitals tend to treat relatively few Medicaid and uninsured patients, this is because of the markets where they are located. Investors tend to build specialty hospitals in financially stable suburban areas, where community hospitals also tend to treat fewer Medicaid and uninsured patients. Further, unlike most hospitals in these markets, specialty hospitals support their communities through the taxes they pay.

Finally, critics say that specialty hospitals tend to treat less severely ill—and more profitable—patients, thus leaving the less profitable patients to community hospitals that provide a full range of services to all types of patients. Many of these services tend to be unprofitable. Unprofitable services, for example, include medical admissions rather than surgical ones, emergency and trauma care, and burn care. Thus, critics are concerned that specialty hospitals will drain resources from full-service community hospitals and perhaps hurt them financially.

The College would share this concern, but we do not believe that this will occur or that prohibiting specialty hospitals is the most appropriate way to address the issue. As you know, the College has long championed improvements to our nation's emergency medical systems and trauma care systems, and we continue do so. We also support the DRG changes that will address this issue of unprofitable services, as recommended by MedPAC in its March report to Congress.

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[1] Herzlinger RE. MedCath Corporation. Harvard Business School case 9-303-041. Cambridge, Mass.: Harvard University, 2003

[2] Transcript of public meeting: Medicare Payment Advisory Commission, September 10, 2004, Washington, D.C; available at www.MedPAC.gov

[3] Specialty hospital study meeting brief: prepared for meeting of Medicare Payment Advisory Commission, September 9-10, 2004, Washington, D.C.

It is also important to recognize that, by their nature, specialty hospitals can only treat patients whose medical needs can be met by their resources. Patients with underlying conditions beyond a hospital's capabilities must be referred to more comprehensive facilities. The same is true for ambulatory surgical centers (ASCs)—some patients cannot be cared for appropriately in these facilities and must be referred to general or tertiary care hospitals. We also note that some comprehensive hospitals have denied privileges to physicians who practice in competing hospitals or ASCs, a development that clearly should cause concern among patients.

Like nearly all hospitals, specialty hospitals are paid based on DRG payments that vary according, to patient diagnosis, complications, procedures, and the average resources required to treat comparable cases. The recent MedPAC reports describe flaws in the Medicare DRG system that cause payments for some cases to be higher than would be dictated by the average cost of providing services and, conversely, to pay less than would be indicated for other cases. These discrepancies can provide an opportunity for any hospital, whether specialty or comprehensive, to select patients that are more profitable and to provide fewer services—or even none at all—for less profitable patients. The College believes that these perverse incentives ought to be addressed and so we strongly support the recommendations advanced by MedPAC in its recent reports to Congress.

We also are pleased that, as reported in the President's budget for FY 2005, CMS plans to adopt MedPAC's recommendation by initiating a DRG refinement process. Done properly, this process will ensure that Medicare payments accurately reflect the cost of providing care and that *all* hospitals are paid fairly and appropriately for their services to Medicare patients. We believe that these changes should resolve concerns that have been raised about the impact that specialty hospitals can have on community hospitals. In effect, the changes will create a level playing field in which healthy competition can operate, leading to enhanced quality and efficiency in the delivery of all healthcare services. The College believes that improvements like those recommended by MedPAC must be implemented in order to ensure the financial viability of providing emergency and trauma care as well as the broad range of care provided by tertiary care centers and other comprehensive hospitals.

In closing, we want to emphasize that specialty hospitals are not new—physicians and others have been establishing them for 75 years. In fact, some of the nation's finest hospitals are specialty specific. Also, it is worth noting that the average physician investor has a very small financial stake in specialty hospitals, and the majority of surgeons who work in physician-owned hospitals have *no* ownership interest. Further, a ban on physician ownership of specialty hospitals will not stop the trend. Corporations, including hospitals, are building them and they will continue to do so. Clearly, any action to prohibit specialty hospitals would be an action to limit the competition that is so vital to keep the healthcare system improving its efficiency, quality of care, and patient satisfaction. This is healthy competition and it is an example of the values that have been promoted by the Administration and by Congress. We must work together to preserve specialty hospitals, support healthy competition, and end distortions in our payment systems that can interfere with patient access and harm providers.

Surgeons remain committed to community health care. Teaching hospitals, tertiary care centers, trauma and burn centers, and the network of community hospitals are all vital to the well-being of surgical patients. Considering this, the American College of Surgeons encourages all physician hospital owners to practice according to the following principles:

- Specialty hospitals should accept all patients for which they can provide appropriate care, without regard to source of payment.
- Patient selection should be based on medical criteria and facility capabilities. Those patients with needs that extend beyond a facility's resources should be referred to a tertiary care center or other hospital that is appropriately equipped and staffed.
- Surgeons practicing in specialty hospitals should maintain their commitment to providing the emergency services needed in their communities and should take calls in community hospital emergency departments, as necessary.
- The issue of whether specialty hospitals should have their own emergency rooms is, and should remain, a matter of state law and community need.
- Physician investors should disclose their financial interest to patients they propose to treat in a specialty hospital.

Thank you for the opportunity to share the views of the American College of Surgeons. Questions and comments may be directed to the College's Washington Office, at 202-337-2701.

PREPARED STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION

Chairman Deal, Ranking Member Brown, and Members of the Energy and Commerce Committee, Subcommittee on Health, the American Medical Association (AMA) appreciates the opportunity to provide our views regarding specialty hospitals.

The AMA commends the Subcommittee for holding this hearing on specialty hospitals and their role in the delivery of quality health care. As you may know, hospitals that provide care for a specific type of a patient or a defined set of services are not new. Specialty hospitals have been in existence for most of the latter half of the twentieth century. Yet more recently, numerous market and environmental factors have led to the increase in physicians' desire to own and operate these hospitals. Since 1995, the number of specialty hospitals that focus on cardiac, orthopedic and surgical services has grown. This growth has led to concern among general hospitals who must compete with these facilities. The hospital associations and many general hospitals are vigorously attempting to eliminate this competition.

The AMA strongly supports and encourages competition between and among health facilities as a means of promoting the delivery of high-quality, cost-effective health care. Consistent with medical ethics, we support physician ownership of health facilities, and referrals by physician owners, if they directly provide care or services at the facility. The growth in specialty hospitals is an appropriate market-based response to a mature health care delivery system and a logical response to incentives in the payment structure for certain services and the increasing medical needs of elderly patients.

Physician owned specialty hospitals have not harmed general hospitals financially. They have improved care for Medicare beneficiaries and other patients, and patient satisfaction with these hospitals is extremely high. Specialty hospitals increase competition in the hospital industry by providing patients with more choice and forcing general hospitals to innovate. Therefore, the AMA believes there is no need to extend the moratorium on physician referrals to specialty hospitals.

The AMA does believe, however, that changes are needed in the inpatient and outpatient Medicare prospective payment systems to more accurately reflect the relative costs of hospital care, thus eliminating the need for cross-subsidization of services by general hospitals. In addition, we support policy changes that would help ensure the financial viability of "safety-net" hospitals so they can continue to provide access to health care for indigent patients. Combined, these changes would ensure the continued financial stability of general and safety net hospitals, further enhancing competition in the market for hospital services.

BACKGROUND

As this subcommittee is aware, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) imposed an 18-month moratorium on referrals of Medicare and Medicaid patients by physicians investors in certain specialty hospitals not already in operation or under development as of November 18, 2003.[1] The MMA required the Medicare Payment Advisory Commission (MedPAC), in consultation with the Government Accountability Office (GAO), and the Secretary of the Department of Health and Human Services (HHS) to conduct studies of specialty hospitals and report their findings and recommendations to Congress.

According to the GAO,[2] there are 100 existing specialty hospitals that focus on cardiac, orthopedic, women's medicine, or on surgical procedures.[3] Of the 100 specialty hospitals identified by the GAO and 26 others under development in 2003, there were various owners/investors, including both hospitals and physicians. Seventy percent had some degree of physician ownership. One-third of these specialty hospitals were joint ventures with corporate partners, one-third were joint ventures with hospitals, and one-third were wholly owned by physicians.

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[1] The MMA defined specialty hospitals as those primarily or exclusively engaged in cardiac, orthopedic, surgical procedures and any other specialized category of services designated by the Secretary.

[2] *See* U.S. General Accounting Office, *Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served,* GAO-03-683R (April 18, 2003); and U.S. General Accounting Office, *Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance,* GAO-04-167 (October 22, 2003).

[3] This number excludes numerous other specialty hospitals that have been in existence for some time, such as eye and ear hospitals, children's hospitals, and those that specialize in psychiatric care, cancer, rehabilitation, and respiratory diseases.

FACTORS CONTRIBUTING TO THE GROWTH OF SPECIALTY HOSPITALS

There are numerous market and environmental factors that have contributed to the growth of specialty hospitals, including:

- Many physicians are frustrated over hospital control of management decisions and investment decisions that affect their productivity and the quality of patient care. Physicians often have little or no involvement in governance and management, control over reinvestment of profits in new equipment, or influence over scheduling and staffing needs for cases performed in the operating room. They believe that hospitals are not collaborating with them to align hospital processes or engage in joint ventures. Physicians who invest in specialty hospitals are able to increase their productivity, improve scheduling of procedures for patients, maintain appropriate staffing levels, and purchase desired equipment—all of which improve the quality of patient care.
- Medicare and private insurer payment rates are perceived to be relatively high for certain services, often exceeding hospital costs associated with these services, and relatively low for other hospital services.
- Payments for physician professional services have declined while the costs of medical practice, such as professional liability premiums, have continued to escalate substantially. As a result, some physicians have sought to increase their practice revenues with the facility fees derived from investment in a specialty hospital.
- Advances in technology (e.g., minimally invasive surgery) have allowed care to be provided in a variety of settings.
- Data shows that facilities that focus on certain procedures and perform a significant number of them have better quality outcomes.
- Business partners willing to provide capital and management expertise are more readily available.

EFFICIENCY, QUALITY AND PATIENT SATISFACTION

For various reasons, specialty hospitals have achieved better quality, greater efficiency, and higher patient satisfaction than general hospitals. Specialty hospitals are able to achieve production economies by taking advantage of high volumes of a narrow scope of services, and by lowering fixed costs by reengineering the care delivery process. Managerial and clinical staff at specialty hospitals focus on a relatively narrow set of tasks, thus providing the capability to perfect those tasks and benefit from increased accountability for the quality of care provided to patients. According to the Center for Studying Health System Change, the health services literature supports the premise that "focused factories" can lead to higher quality and lower costs as a result of more expert and efficient care.[4]

Managers of specialty hospitals consistently report the factors they perceive as critical to achieving high quality patient outcomes: high volume and high nursing intensity.[5]

Specialty hospitals tend to have higher nurse-patient ratios despite the fact that physicians at specialty hospitals contend that they spend about 30% of their operating expenses on labor, compared to 40 to 60% for general acute-care hospitals.

Physician control and facility design also increase productivity and quality. Specialty hospitals improve patient access to specialty care by providing additional operating rooms, cardiac-monitored beds, and diagnostic facilities. Specialty hospitals offer newer equipment, more staff assistance and more flexible operating room scheduling, thereby increasing productivity and physician autonomy over their schedules. Patients are therefore able to benefit from the higher productivity and increased flexibility in scheduling their procedures.

Preliminary findings from the 2005 HHS study suggest that measures of quality care at specialty heart hospitals were at least as good and in some cases better than general hospitals.[6]

In addition, complication and mortality rates were lower, even when adjusted for severity. Furthermore, HHS found that "patient satisfaction was extremely high" in

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[4] Kelly J. Devers, Linda R. Brewster and Paul B. Ginsburg, *Specialty Hospitals: Focused Factories or Cream Skimmers?* HSC Issue Brief Number 62, April 2003.

[5] John E. Schneider, PhD, et al., *Economic Policy Analysis of Specialty Hospitals,* February 20, 2005.

[6] Thomas Gustafson, Ph.D., Deputy Director, Center for Medicare Management, Centers for Medicare and Medicaid Services (CMS), testimony before the Senate Committee on Finance, March 8, 2005.

the specialty hospitals studied, and patients had very favorable perceptions of the clinical quality of care they received.[7]

Specialty hospitals are well positioned to address projected increases in demand for cardiac, orthopedic, and surgical services because they are a more efficient and effective way to deliver the services. In 2002, for example, 500,000 patients were diagnosed with congestive heart failure. With the estimated number of Americans at risk of cardiovascular disease projected to mushroom over the next decade, cardiovascular surgeons and cardiologists will need to see twice as many patients in ten years as they see today. Aging of the population, population growth, higher functioning and higher quality of life expectations associated with the baby boom generation are driving increased demand for cardiac, orthopedic, and surgical services. The greater efficiency of specialty hospitals will better enable physicians to care for these patients. Furthermore, the GAO found that 85 percent of specialty hospitals are located in urban areas and tend to locate in counties where the population growth rate far exceeds the national average.[8]

Patient satisfaction with specialty hospitals is extremely high. They enjoy relatively greater convenience and comfort, such as lack of waiting time for scheduled procedures, readily available parking, 24 hour visiting for family members, private rooms, more nursing stations that are closer to patient rooms, decentralized ancillary and support services located on patient floors, and minimized patient transport. Specialty hospitals have engaged in extensive collection of data on quality and patient satisfaction, and use the data to modify care processes. Because of the smaller size and narrow focus of specialty hospitals, they are more nimble and flexible to quickly respond to modify care processes as perceived necessary.

HOSPITAL INDUSTRY STRATEGIES AND ANTICOMPETITIVE TACTICS IN RESPONSE TO INCREASED COMPETITION

As physicians began seeking greater involvement in the governance and management of patient services provided at hospitals, many who ultimately became investors in specialty hospitals tried initially to form joint ventures with hospitals to expand the availability of cardiology and orthopedic services. In many cases, the hospitals declined to enter into joint ventures with physicians. In other cases, the hospitals opened units or specialty hospitals of their own. By and large, however, general hospitals have become staunch opponents of physician owned specialty hospitals.

According to the GAO, the financial performance of specialty hospitals tended to equal or exceed that of general hospitals in fiscal year 2001.[9] The 55 specialty hospitals with available financial data tended to perform better than general hospitals when revenues and costs from all lines of business and all payers were included. When the focus was limited to Medicare inpatient business only, specialty hospitals appeared to perform about as well as general hospitals.[10]

General hospitals and their respective national and state hospital associations feel threatened by the growth of specialty hospitals and physician-owned ambulatory facilities, (e.g., ambulatory surgery centers, GI labs, imaging facilities, radiation oncology centers). Although they claim to support healthy competition, general hospitals have recently engaged in an aggressive assault on facilities owned and operated by physicians which they have characterized as "niche-providers."

The hospital industry has engaged in numerous focused strategies to prohibit physicians from opening a competing facility. Three core strategies the hospital industry is employing to address physician ownership of specialty hospitals are:

- Preemptive strike strategy—The hospital establishes its own specialty hospital and addresses some of the physician concerns, but does not offer physicians an opportunity for investment. Some hospitals also implement this strategy when a competing hospital or health system decides to build its own specialty hospital.
- Joint venture strategy with local physicians—The hospital recognizes a competitive threat from members of its medical staff or other local physicians and decides to engage in a joint venture with them rather than facing a reduction in the services.
- Fight physicians that try to open a competing facility by building barriers—The hospital aggressively limits the potential for developing competing services by implementing actions to restrict physicians' capabilities to do so (e.g., adopting

[7] *Id.*
[8] GAO, *supra* note 2.
[9] *Id.*
[10] *Id.*

"economic credentialing" or "exclusive credentialing" policies that revoke or refuse to grant medical staff membership or clinical privileges to any physicians that has an indirect or direct financial investment in a competing entity).

At the state level, hospitals have initiated several different types of anti-competitive strategies to limit physician-owned specialty hospitals. These initiatives include, but are not limited to, the following:

- Adopting legislation banning the creation of any facility that focuses on cardiac care, orthopedic services or cancer treatment. (Florida)
- Proposing legislation prohibiting physicians from having a financial ownership in specialty hospitals. (Ohio and Washington)
- Proposing legislation to expand Certificate of Need (CON) requirements to include other physician-owned facilities such as ambulatory surgery centers and diagnostic imaging facilities. (Minnesota)
- Resisting efforts to repeal CON legislation. (Iowa)
- Proposing legislation and or regulations requiring specialty hospitals (but not other hospitals) to provide emergency departments and/or accept Medicare, Medicaid, and uninsured patients. (Washington)

Individual general hospitals have also implemented a variety of anti-competitive strategies and tactics to discourage their medical staff from investing in competing specialty hospitals or to harm the medical practice of those who do make such investments. These initiatives include, but are not limited, to the following:

- Adopting economic/exclusive credentialing/conflict of interest policies and medical staff development plans that revoke or refuse to grant medical staff membership or clinical privileges to any physicians or other licensed independent practitioner that has an indirect or direct financial investment in a competing entity.
- Hospital-owned managed care plans denying patient admissions to competing specialty hospitals.
- Requiring health plans to sign an exclusive managed care contract or otherwise discouraging them from contracting with competing facilities.
- Removing physicians that have a financial interest in a competing facility from their referral and on-call panels.
- Refusing to cooperate with specialty hospitals, (i.e., refusing to sign transfer agreements).
- Requiring primary care physicians employed by the hospital or vertically integrated delivery system to refer patients to their facilities or those specialists that are closely affiliated with the hospital/health care delivery system regardless of the needs of the patient.
- Limiting access to operating rooms and cardiac catheterization labs of those physicians who have a financial interest in a competing entity.
- Removing competing physicians from extra assignments at the hospital, such as serving as department directors or reading EKGs, ultrasounds, echocardiography, and x-rays.

The hospital industry's overarching message is that physicians who invest in a specialty hospital have a conflict of interest. They use this to justify their strategies to eliminate legitimate competition. **However, it is both ethical and legal for physicians to invest in and refer patients to health facilities.**

AMA ethical opinion E-8.032, "Conflicts of Interest: Health Facility Ownership by a Physician," delineates two scenarios where physicians may appropriately make patient referrals to health facilities in which they have an ownership interest. First, it sets forth a general rule that physicians may appropriately make such referrals if they directly provide care or services at the facility in which they have an ownership interest. Second, it describes a separate situation where physicians may appropriately make such referrals, which arises when a needed facility would not be built if referring physicians were prohibited from investing in the facility. In the latter case, the appropriateness of the referrals would not depend upon whether the physicians have personal involvement with the provision of care at the facility, but whether there is a demonstrated need for the facility. Physician ownership of specialty hospitals and referral of patients for treatment at such facilities fits squarely within this ethical opinion.[11]

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[11] The hospital associations, however, claim otherwise by distorting AMA ethical opinion E-8.032. They claim that it prohibits physician referrals to facilities in which they have an ownership interest unless there is a demonstrated need in the community. (July 6, 2004 letter to members of Congress from the Federation of American Hospitals (FAH) and the American Hospital Association (AHA)) The AMA quickly set the record straight, but the hospital associations continue to distort AMA policy. (August 4, 2004 letters from Michael D. Maves, MD, MBA to House Energy and Commerce Committee, House Ways and Means Committee and Senate Finance Committee.) Although a demonstrated need in the community is one ethical justification

In addition to ethical policy, physicians are legally permitted to own health care facilities and refer patients to them. The physician self-referral law and the federal anti-kickback statute both set forth very broad prohibitions that generally prevent physicians from receiving any form of remuneration in exchange for referrals. Because the laws contain such broad prohibitions, that effectively prevent many legitimate forms of remuneration, they also contain exceptions or safe harbors that define permissible forms of remuneration. Both laws permit physician ownership of treatment facilities and referrals to such facilities under various circumstances.[12] The physician self-referral law, the "Stark law," explicitly permits physician ownership of a hospital, and referral of patients to the hospital, if the physician is authorized to perform services at that hospital and the ownership interest is in the "hospital itself" and "not merely in a subdivision of the hospital."

The hospital associations, however, claim that physicians who own specialty hospitals should not be permitted to make referrals to those hospitals under that exception because they claim a specialty hospital is equivalent to a subdivision of a hospital. They call the use of this exception a "loophole" to bolster their efforts to eliminate the ability of physician owned facilities to compete with their member hospitals.

This claim is simply unfounded. Specialty hospitals are entire hospitals, not subdivisions of a hospital. **They are independent legally-organized operating entities that provide a wide range of services for patients, from "beginning-to-end" of a course of treatment including specialty and sub-specialty physician services, and a full range of ancillary services.** A significant number of specialty hospitals also have primary care services, intensive care units and emergency departments.

The protection of referrals to an entire hospital, and not just a "subdivision of a hospital," was intended to prevent circumvention of the ban on referrals of laboratory services. As originally enacted, "Stark I," only prohibited referrals for laboratory services to facilities physician owned.[13] It would not have made sense to prohibit ownership of and referral to a laboratory, but permit ownership of and referral to a hospital subdivision that provided only laboratory services. The Centers for Medicare and Medicaid Services (CMS) (then HCFA) confirmed this intent in its 1992 proposed regulations interpreting the original Stark law. CMS explained that the exception protected referrals when the physician's ownership interest is in the entire hospital and "not merely a distinct part or department of the hospital, such as the laboratory."[14]

In the 1995 Final Rule, there is a protracted discussion of what constitutes a hospital and a distinct part or department of a hospital.[15] CMS defined "hospital" for purposes of the Stark law as "any separate legally-organized operating entity plus any subsidiary, related, or other entities that perform services for the hospital's patients and for which the hospital bills . . ."[16] A specialty hospital fits squarely within this definition.

In 1993, Congress enacted amendments, referred to as "Stark II," expanding the ban on physician referrals from just clinical laboratory services to an entire list of ancillary services referred to as "designated health services."[17] The hospital ownership exception was appropriately retained in Stark II, permitting physicians to refer patients to a hospital they own and where they practice medicine, but prohibiting referrals to a hospital "subdivision" they own. This was so the referring physician could still refer patients to a hospital he or she owns for a course of treatment, but not circumvent the intent of the prohibition by referring patients to a subdivision of a hospital that only provides one or more of the designated ancillary services.

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for a referral to a facility that one owns, it is a mischaracterization of AMA ethical opinion to state that it is the only justification.

[12] *See generally* 42 U.S.C. 1395nn., 42 CFR 411.350-411.361, 42 U.S.C. 1320a-7b, and 42 CFR 1001.952.

[13] Public Law 101-239, December 19, 1989.

[14] 57 Fed. Reg. 8588, 8598 (March 11, 1992).

[15] 60 Fed. Reg. 41913, 41956 (August 14, 1995).

[16] 60 Fed. Reg. at 41956-41957.

[17] Public Law 103-66, August 10, 1993. These ancillary services include clinical laboratory services, physical and occupational therapy, radiology services (including MRI, axial tomography, and ultrasound), radiation therapy services and supplies, durable medical equipment supplies (DME), parenteral/enteral nutrients, prosthetics/orthotics supplies, home health services, outpatient prescription drugs, and inpatient and outpatient hospital services.

As noted, the designated health services are ancillary services, not physician services.[18] **The Stark laws prevent referrals for ancillary services, not professional services performed by a physician.** Furthermore, the Stark laws specifically prohibit referrals of these services at locations where the referring physician is *not directly involved in the care of the patient.* Under the Stark laws, no referral restriction is imposed if the referring physician personally performs a service, even if it is an ancillary service that would otherwise be prohibited by the law. There is also an exception for referrals of ancillary services rendered by another physician in the referring physician's group practice, or supervised by that physician, as long as it is in the same building where the referring physician regularly practices or a centralized building used by the referring physician for some or all of the designated health services performed by the group practice. Thus, the Stark laws prohibit physicians from making referrals for ancillary services at facilities where they do not practice and that provide only ancillary services.

A specialty hospital is an entire hospital that provides a wide range of services for patients. In addition, physicians who invest in these hospitals and refer patients to them also treat patients at the hospital. Moreover, **specialty hospitals do not provide only ancillary services.** As stated previously, specialty hospitals provide a spectrum of care, from "beginning-to-end" of a course of treatment, including specialty and sub-specialty physician services, a full range of ancillary services, and often including primary care services, intensive care units, and emergency departments. Therefore, **a specialty hospital is not equivalent to a hospital subdivision.**

There is no credible data to support the hospital industry's claims that physicians are inappropriately referring their patients to specialty hospitals. Physicians have an ethical and legal obligation to refer patients to the facility that best meets the needs of the individual patient. Preliminary findings from the HHS study contained no evidence that physicians who have an investment interest in a specialty hospital inappropriately refer patients.[19] In fact, the study showed no difference in referral patterns between physician investors and non-investor physicians regarding referrals to both general hospitals and specialty hospitals.

In fact, it is disingenuous for the hospital industry to claim that physicians have a conflict of interest when many general hospitals engage in self-referral practices. One hospital association claims that a "community hospital that tried to buy admissions in this way would be outlawed."[20] Ironically, however, general hospitals often channel patients to their facilities and services. They do this mainly by acquiring primary care physician practices or by employing primary care physicians, and requiring those physicians to refer all of their patients to their facilities for certain services such as x-ray, laboratory, therapy services, outpatient surgery, and inpatient admissions. They also require such referrals by physicians under certain contractual arrangements or by adopting policies that require members of the medical staff to utilize their facilities.

Hospitals value these controlled referral arrangements to such a degree that they maintain them despite the fact that many of these primary care practices and other physician arrangements operate at a loss for the hospital. The hospitals are frequently willing to subsidize these practices with profits derived from other departments and services provided by the hospital or health system.

The AMA is very concerned about efforts by hospitals and health systems to control physician referrals as they pose a number of significant concerns. By dictating to whom physicians may refer, the hospital governing body or administration takes medical decision-making away from physicians. This introduces financial concerns into the patient-physician relationship, imposes upon the professionalism of physicians, and can run counter to what the physician believes is in the best interest of the patient. These hospital self-referral practices also limit patient choice.

To reduce this interference in the patient-physician relationship, the AMA believes that disclosure requirements for physician self-referral, where applicable, should also apply to hospitals and integrated delivery systems that own medical practices, contract with group practices or faculty practice plans, or adopt policies requiring members of the medical staff to utilize their facilities and services.

Despite claims by the hospital associations that physician ownership of specialty hospitals is a conflict of interest, the data does not support their

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[18] Radiation therapy and certain radiology services often encompass a professional component as well as a technical component, but there is no carve out for the professional service. CMS notes, however, that in most cases these services will fall under the exceptions for physician service or will not be a referral because they are personally performed by the physician.

[19] Gustafson, *supra* note 6.

[20] Charles N. Kahn III, *A Health-Care Loophole,* Washington Times, February 3, 2005.

assertions. MedPAC found that overall utilization rates in communities with specialty hospitals were similar to utilization rates in other communities. In addition, of the specialty hospitals identified by the GAO with some degree of physician ownership, the average share owned by an individual physician was less than two percent. Of particular significance, the GAO found that the majority of physicians who provided services at specialty hospitals had no ownership interest in the facilities. Overall, approximately 73 percent of physicians with admitting privileges at specialty hospitals were not investors in those hospitals.[21] Therefore, the vast majority of physicians who admit patients to specialty hospitals receive no financial incentives to do so. Further, of those physicians who do have an ownership interest in the hospital, there is no evidence that their referrals are inappropriate or have increased utilization.

Specialty hospitals with physician investors believe that the playing field is actually tilted in support of nonprofit hospitals. Nonprofit hospitals are exempt from federal and state income taxes and local property taxes and have access to tax-exempt financing. In fact, according to preliminary findings from the HHS study, the total proportion of net revenue that specialty hospitals devote to both uncompensated care and taxes "significantly exceeds" the proportion of net revenues general hospitals devote to uncompensated care.[22] Most nonprofit hospitals also receive Medicare and Medicaid DSH payments to help defray the costs of uncompensated care.

There is no evidence that general hospitals are suffering as a result of the growth of physician owned specialty hospitals. MedPAC found that the financial impact on community hospitals in the markets where physician owned specialty hospitals are located has been limited. These hospitals have demonstrated financial performance comparable to other community hospitals.[23] Another study found that general hospitals residing in markets with at least one specialty hospital actually have higher profit margins than those that do not compete with specialty hospitals.[24] MedPAC also found that specialty hospitals have forced community hospitals to become more competitive, and that specialty hospitals are an attractive alternative for patients and their families.

COMPETITION SHOULD BE PROMOTED AND CROSS-SUBSIDIES SHOULD BE ELIMINATED

The AMA continues to have serious concerns about the tactics being employed by hospitals in their attempts to eliminate competition by prohibiting physician referrals to specialty hospitals in which they have an ownership interest. The AMA believes that the growth in specialty hospitals is an appropriate market-based response to a mature health care delivery system and a logical response to incentives in the payment structure for certain services. This type of market response will create an incentive for general hospitals to increase efficiencies to compete. In fact, it already has. Specialty hospitals have admittedly been a "wake-up" call for general hospitals in certain communities.[25]

The cross-subsidies that hospitals use from profitable services to provide unprofitable services should be eliminated by making payments adequate for all services. The Federal Trade Commission (FTC), the Department of Justice (DOJ), the Center for Studying Health System Change, and others believe there are inherent problems in using higher profits in certain areas of care to cross-subsidize uncompensated care and essential community services. In the July 2004 FTC/DOJ Report on Competition and Health Care, Recommendation 3 states:

> Governments should reexamine the role of subsidies in health-care markets in light of their inefficiencies and the potential to distort competition. Health-care markets have numerous cross subsidies and indirect subsidies. Competitive markets compete away the higher prices and profits needed to sustain such subsidies. Competition cannot provide resources to those who lack them, and it does not work well when providers are expected to use higher profits in certain areas to cross-subsidize uncompensated care. In general, it is more efficient to provide subsidies directly to those who should receive them to ensure transparency.[26]

Support for specialty hospitals in no way diminishes the important role of the general hospital in the community. Emergency and safety net care are important

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[21] GAO, *supra* note 2.
[22] Gustafson, *supra* note 6.
[23] MedPAC, "MedPAC Report to the Congress: Physician-Owned Specialty Hospitals," March 2005.
[24] Schneider, et al., *supra* note 4.
[25] MedPAC, *supra,* p. 10.
[26] Federal Trade Commission and Department of Justice, *Improving Health Care: A Dose of Competition,* July 23, 2004.

and necessary aspects of hospital care—and general and non-profit hospitals should be adequately reimbursed for these and other essential services. The AMA does not believe that cross-subsidization by high-profit service lines is the appropriate method to fund community health and medical services. To ensure that hospital payments better compensate for these services so that safety-net hospitals receive proper funding, HHS should make changes to the Medicare hospital prospective payment system to minimize the need for cross-subsidization and accurately reflect relative costs of hospital care.

MedPAC recommends that CMS improve payment accuracy in the hospital inpatient prospective payment system (PPS) by refining the hospital Diagnosis Related Group (DRG) payments to more fully capture differences in severity of illness among patients, basing the DRG relative weights on the estimated cost of providing care rather than on charges, and basing the weights on the national average of hospitals' relative values in each DRG. MedPAC also recommends that DRG relative weights be adjusted to account for differences in the prevalence of high cost outlier cases.[27]

The AMA supports such recommendations and believes that such payment changes will ensure full and fair competition in the market for hospital services. The AMA also believes that further policy changes are necessary to protect America's public safety net hospitals. Safety-net hospitals provide a significant level of care to low-income, uninsured, and/or vulnerable populations. Public hospitals in the largest metropolitan areas are considered key safety-net hospitals. **These hospitals make up only about 2% of all the nation's hospitals, yet they provide more than 20% of all uncompensated care.** Compared with other urban general hospitals, safety-net hospitals are nearly five times as likely to provide burn care, four times as likely to provide pediatric intensive care, and more than twice as likely to provide neonatal intensive care. Safety-net hospitals are also more likely than other urban general hospitals to offer HIV/AIDS services, crisis prevention, psychiatric emergency care, and other specialty care.

Safety-net hospitals rely on a variety of funding sources. However, to finance the significant portion of uncompensated care, safety-net hospitals rely on local or state government subsidies, Medicaid and Medicare Disproportionate Share Hospital (DSH) payments, cost shifting, and other programs. As a group, safety-net hospitals are in a precarious financial position because they are uniquely reliant on governmental sources of financing.

The AMA believes that CMS should correct the flawed methodology for allocating DSH payments to help ensure the financial viability of safety-net hospitals so they can continue to provide access to health care for indigent patients. In addition, the current reporting mechanism should be modified to accurately monitor the provision of care by hospitals to economically disadvantaged patients so that policies and programs targeted to support the safety net and the populations these hospitals serve can be reviewed for effectiveness. Medicare and Medicaid subsidies and contracts related to the care of economically disadvantaged patients should be sufficiently allocated to hospitals on the basis of their service to this population in order to prevent the loss of services provided by these facilities. The AMA recognizes the special mission of public hospitals and supports federal financial assistance for such hospitals, and believes that where special consideration for public hospitals is justified in the form of national or state financial assistance, it should be implemented.

CONCLUSION

There is no evidence that general hospitals are suffering as a result of the growth of physician owned specialty hospitals. Specialty hospitals increase competition in the hospital industry and provide patients with more choice—forcing existing hospitals to innovate to keep consumers coming to them. This is a win-win situation for patients. Supporting health delivery innovations that enhance the value of health care for patients is the only way to truly improve quality of care while reigning in health care costs.

Based on the MedPAC, HHS and FTC/DOJ findings and recommendations, **the AMA believes that patients will be better served if Congress does not act to extend the moratorium on physician referrals to specialty hospitals in which they have an ownership interest. While the payment changes take effect, MedPAC, HHS and others should continue to monitor specialty hospitals and the impact on general hospitals and patient care.**

We appreciate the opportunity to testify on this important issue. We urge the Subcommittee and the House to consider the recommendations we have discussed today. We are happy to work with Congress as it considers these important matters.

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[27] See MedPAC, supra, note 23.

PREPARED STATEMENT OF JANE ORIENT, EXECUTIVE DIRECTOR, ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS

Mr. Chairman and Members of the Committee: The Association of American Physicians and Surgeons was founded in 1943 to preserve private medicine. We represent thousands of physicians in all specialties nationwide, and the millions of patients that they serve. I am the executive director.

Members of the Association of American Physicians and Surgeons are pleased that this subcommittee has undertaken this hearing as a means to assess the role of specialty hospitals in the delivery of quality health care. The AAPS membership can attest to the quality of health care these hospitals deliver and we regard them as a sensible and proper element of American health care delivery.

We collectively agree that Congress should not extend, make permanent or broaden the moratorium on physician-owned specialty hospitals contained in the Medicare Modernization Act. A resolution to this effect was passed without dissent at our 2004 annual meeting.

Responsible competition and the dynamics of the free-market encourage innovation and reduce costs. Furthermore, specialty facilities have consistently delivered superior results in terms of patient outcomes, operating efficiency, and patient satisfaction; therefore AAPS believes that it is not in the best interests of patients, physicians or taxpayers for government to arbitrarily limit the growth of physician-owned single-specialty hospitals.

A joint study by the Federal Trade Commission and the Department of Justice strongly endorsed expansion of competitive, free-market choice as a means for delivering excellent medical care and containing costs. Their conclusion was echoed by the Medicare Payment Advisory Commission (MedPAC) at a recent presentation of preliminary study findings in which they acknowledged that specialty hospitals can serve as a "wake up call" for community hospitals to improve quality of care and service.

The growth of physician-owned specialty hospitals over the last 10 years represents a free-market trend that should be encouraged, not stifled by Congress.

In the relatively short number of years that specialty hospitals have been a part of the medical landscape, innovation is one of the words that are consistently applied to their work. Innovation drives quality improvements. These physician-owned hospitals show innovation in a number of ways. First, they utilize the newest, cutting-edge technology and equipment. They also operate with a high nurse-to-patient ratio. And the care at these facilities is specifically designed to meet and exceed patient expectations.

Not only do these facilities provide premium care, because of their efficient business models, physician-owned specialty hospitals are able to pass cost savings on to patients and taxpayers while maintaining the highest quality of care. These innovative facilities encourage quicker turn-around in operating facilities, lower labor costs and ease patient transportation. Because the physician-partners at specialty hospitals are involved in decision-making, hospitals are able to introduce and adapt to new procedures and methodology, resulting in innumerable cost-saving measures.

The choice of these physicians is deliberate and it is based largely on the management model of the specialty hospitals. Traditional hospital management is based on the bureaucracy of hospital administrators making decisions, rather than physicians who are aware of patients' needs. At physician-owned facilities, decisions are always based on the need of the patient, rather than the preference of an administrator. At these facilities, because physicians are involved in all steps of the decision-making progress, a premium is placed on maximizing efficiency.

The physician ownership model couples doctors with administrators to oversee everything from quality to operations to purchasing. Because of this, physician-ownership proves to be the most cost effective business model for hospitals.

The U.S. Congress continues to enact onerous regulations effecting physicians under the guise of reducing costs to the taxpayers. The moratorium on specialty hospitals is one example. Such hospitals could help reduce the cost of federal health programs paid for by the taxpayers, while enhancing access to the highest quality of health care that the American taxpayers expect.

Please do all you can to lift the moratorium.

PREPARED STATEMENT OF THE FEDERATED AMBULATORY SURGERY ASSOCIATION

The Federated Ambulatory Surgery Association (FASA), which represents more than 1,600 ambulatory surgical centers (ASCs) and the professionals who deliver care and the patients who seek care in ASCs concurs with CMS Administrator McClellan's statement that "An important goal of Medicare's planned reform of the

ASC fee schedule is to reduce such divergence of payment levels between these settings [ASCs and hospital department outpatient departments] when resource costs consumed in producing the same service in the two settings are similar."

ASCs will provide more than 12 million procedures in 2005, more than 30 percent to Medicare patients. ASCs save both the Medicare program and its beneficiaries money. A recent study by the well-respected Moran Company, which analyzed actual hospital outpatient departments (HOPDs) claims data found that Medicare would have paid ASCs an average of $320 less than HOPDs for each claim. Because Medicare beneficiary copayments for ASCs are always 20% and copayments for HOPD vary and sometimes exceed 40%, patients save money when they choose an ASC over a hospital. In 2005, Medicare will pay $1.1 billion less as a result of care provided in ASCs. ASCs have led the way in innovation with regards to outpatient surgery contributing to even larger savings.

However, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) threatens access to these cost-effective institutions by placing a six-year payment freeze on ASCs. ASCs confront the identical inflationary pressures as hospital outpatient departments—attracting and retaining nurses, IT improvements, overhead, and medical supplies. Yet because hospitals are receiving the full market basket every year, by 2009 hospital outpatient departments will receive payments that are 27% higher than ASCs. This is based on a hypothetical procedure where payments for the procedure were equal in 2000, the year when the HOPD prospective payment system was first implemented.

FASA supports a transition from the current ASC payment system to one based on the HOPD payment system. This would provide a more refined payment system and address concerns raised by Administrator McClellan. FASA believes that ASCs should be transitioned to the HOPD system in all respects—the ambulatory payment classification system, outlier payments and the annual market basket updates. Of course, appropriate transitions would be needed. Just as important, CMS should implement the MedPAC recommendation reforming how CMS determines which procedures it will reimburse ASCs for providing. The existing list denies Medicare beneficiaries access and limits Medicare savings. Instead as MedPAC recommends, CMS should develop a list of those procedures it will not reimburse and determine which procedures to put on such a list using only two criteria—the procedure is unsafe when performed in an ASC or an overnight stay is required. These two reforms would enhance Medicare beneficiaries access to ASCs and the benefits they offer and save the Medicare program money.

Regrettably, some are attempting to drag ASCs into the specialty hospital debate. ASCs are distinct from specialty hospitals. Since their inception in 1970s, ASCs have provided millions of Americans access to high quality cost effective care. The major difference between specialty hospitals and ASCs is that ASCs are not hospitals. ASCs are not licensed as hospitals, are not reimbursed as hospitals and do not provide inpatient services. Physicians practicing at ASCs typically provide some services in the ASC and others, including inpatient services, at a community hospital. ASCs have been in existence and in many communities have co-existed with hospitals since the seventies. Many hospitals, including non-profit ones, joint venture to form ASCs with physicians. More than half of ASCs are multi-specialty, performing an array of surgeries in different specialties. The reasons for promoting ASCs for Medicare beneficiaries have long been recognized the the HHS Office of Inspector General. Indeed the Office of Inspector General (OIG) stated in the November 19, 1999 Federal Register, "We agree that ASCs can significantly reduce costs for Federal health care programs, while simultaneously benefitting patients. The HCFA has promoted the use of ASCs as cost-effective alternatives to higher cost settings, such as hospital inpatient surgery. Where the ASC is functionally an extension of a physician's office, so that the physician personally performs services at the ASC on his or her own patients as a substantial part of his or her medical practice, we believe that the ASC serves a bona fide business purpose and that the risk of improper payments for referrals is relatively low." For these reasons, ambulatory surgery was not included as a designated health service under the Stark law nor were ASCs included in the hospital moratorium.

In conclusion, ASCs provide cost-effective care for Medicare beneficiaries and other patients. Policy makers have recognized the appropriateness of physician ownership of ASCs. Because ASCs' costs continue to rise every year, though their payments are frozen, Medicare beneficiaries access to ASCs is threatened. Congress should eliminate the onerous payment freeze in the context of modernizing the ASC payment system by transitioning it to one based on the HOPD system. FASA looks forward to working with Congress and CMS to implement a new ASC payment system that allows Medicare beneficiaries full access to the benefits of ASCs while saving beneficiaries and the program money.

PREPARED STATEMENT OF THOMAS C. HOWARD, PRESIDENT, MCBRIDE CLINIC, INC.

Thank you for the opportunity to testify. I am Thomas C. Howard, M.D., and an Orthopedic Surgeon practicing in Oklahoma City. I serve as President of the McBride Clinic, Inc. Our medical group is developing a specialty hospital in Oklahoma City. I am submitting this testimony to provide information regarding the quality of care made available to patients, including Medicare beneficiaries, at specialty hospitals.

McBride Clinic is a medical group with 24 physicians who specialize in orthopedics, arthritis and physical medicine. Physicians who are members of McBride Clinic comprise substantially all the active medical staff of Bone & Joint Hospital, which is an orthopedic specialty hospital that has been in operation in Oklahoma City since 1924. McBride Clinic physicians account for over 99% of the patient's admitted, treated, and discharged at Bone & Joint Hospital.

McBride Clinic physicians have practiced at Bone & Joint Hospital since 1924, when Bone & Joint Hospital began operations. Bone & Joint Hospital consistently satisfies patients and performs impeccably when tested by quality measurement standards, patient satisfaction, and clinical outcomes. With McBride Clinic physicians, Bone & Joint hospital serves patient needs on a community, statewide and regional basis for orthopedic and arthritis care. Bone & Joint Hospital maintains the state-of-the-art medical technology. For a variety of reasons—demographics, population aging and growth—more specialty beds are needed in our service area.

There are a number of quality of care factors associated with specialty hospitals, and I'm happy to provide examples for you today. Specialty hospitals provide excellent patient outcomes. Our physicians provide care for patients with acute problems at Bone & Joint Hospital. Specialty hospitals maintain specialized equipment and technology. Our experience is that state-of-the-art implants are available to patients without restrictions or barriers to care that might be imposed at other hospitals. At specialty hospitals, physicians can rely on ancillary support personnel—nurses, technicians, rehabilitation techs, and physical therapists—and can entrust their patients to these professionals with the utmost confidence. Clinician preferences and satisfaction are also high. Physicians find ease in scheduling patients for admissions and surgery. Operating efficiencies allow physicians to concentrate on delivering excellent patient care with a complete focus on the patient, as well as improved productivity in the delivery of care to patients. Specialty hospitals also allow focused peer review. Our facility facilitates specialized training and education in patient care for physicians, residents, medical students, nurses, and ancillary support personnel. Bone & Joint Hospital, as a specialty hospital, provides direct care for orthopedic emergencies and does not compromise the evaluation of other systems. Significantly, specialty hospitals provide patient choice.

McBride Clinic, which has used Bone & Joint Hospital for patient's hospital services, has been a victim of its own success. Patients needing specialized orthopedic and arthritis care overwhelms the Bone & Joint capacity. Delays in scheduling, cancellations of admissions, cancellation of procedures, prolonged waiting time for admissions, and diversion of patients to other facilities have caused patients unnecessary discomfort and inconvenience. These concerns have arisen as a result of the success, not shortcomings of Bone & Joint Hospital. They are evidence that additional specialty care facilities—not general acute care facilities—are needed.

To meet the demands of the ever-increasing aging and rural populations in our state, McBride Clinic will open an orthopedic hospital in Oklahoma City. McBride physicians intend to continue to provide care and treatment to patients at Bone & Joint Hospital. However, due to the lack of capacity of Bone & Joint Hospital, McBride Clinic determined several years ago that additional specialized orthopedic and rehabilitation inpatient beds were needed.

McBride Clinic physicians expect to continue the tradition of providing high quality care at the new hospital, which is scheduled to open in August 2005. The McBride Clinic Orthopedic Hospital will have 40 inpatient beds and 40 rehabilitation beds, in addition to an emergency department that will be available to provide comprehensive emergency care and treatment for all patients with an emergency orthopedic condition. McBride Clinic physicians, through McBride Clinic Orthopedic Hospital, which has been in the process of development since 2002, will address the increasing orthopedic care needs of patients, including the elderly and rural populations throughout Oklahoma and neighboring states.

If you or your child or grandchild had an emergency orthopedic condition—a fracture, a dislocation, a significant soft tissue injury—would you prefer to seek emergency care at a general community hospital or at a specialized orthopedic hospital?

If you or a loved one have the choice of a hospital that concentrates on cardiac care, would you go there for chest pain, evaluation, or surgery? Or, would you

choose a facility that provides heart catheterization and surgery procedures without assurance of the care and support from professionals who have specialized training, patient concerns, care, and passion for your special needs?

Recent studies have criticized utilization in specialty hospitals. Physician utilization is not our motive. The reason we are building a specialty hospital is because there is increased patient demand and increased patient need. The very number of patients we treat and provide care for has and will continue to increase as our population ages. In reflecting and self-assessing, our group has been and will continue to be extremely cautious that we do not extrapolate data and reach inappropriate conclusions based on information that is biased against our patient population needs. I suppose a simpler way of saying this is that more patients are going to need more medical care. Therefore, the number of patient encounters, surgeries, procedures, and diagnostic studies will necessarily increase, unless something happens that restricts patients from access to care.

McBride Clinic and the McBride Clinic Orthopedic Hospital appreciate the opportunity to present this testimony.

PREPARED STATEMENT OF KAREN KERRIGAN, PRESIDENT AND CEO, SMALL BUSINESS AND ENTREPRENEURSHIP COUNCIL

Chairman Deal, Ranking Member Brown and Members of the House Energy and Commerce Committee, I am pleased to provide this written testimony with respect to physician-owned specialty hospitals on behalf of the Small Business & Entrepreneurship Council (SBE Council) and its nationwide membership of small business owners and entrepreneurs.

The SBE Council is a nonpartisan small business advocacy organization with more than 70,000 members nationwide. For more than ten years the SBE Council (formerly the Small Business Survival Committee) has worked to advance policies that protect small business and promote entrepreneurship. We are proud to count physician owners/investors of specialty hospitals among our diverse members. My name is Karen Kerrigan and I serve as President & CEO of the SBE Council.

As you know, the Medicare Payment Advisory Commission (MedPAC) recently presented a report to Congress on the costs, utilization rates, and practice patterns of physician-owned specialty hospitals as compared to full-service general hospitals. While MedPAC made some positive recommendations, including changes to the diagnostic related group (DRG) payment system, they also recommend the extension of the 18-month moratorium on physician-owned specialty hospitals. Such an extension is pointless and would be a serious mistake.

On behalf of the SBE Council, we urge Committee members to reject legislative efforts that would hamstring these innovative hospitals from fully providing the health care services that patients need and want. Patients deserve quality health care, not needless meddling by government.

Opponents of specialty hospitals, including the American Hospital Association (AHA) and the Federation of American Hospitals (FAH), have unfortunately resorted to spreading misinformation in an effort to suppress the healthy competition provided by specialty facilities.

Opponents of competition have made numerous, inaccurate accusations regarding specialty hospitals. These fallacious claims were addressed by Dr. John C. Nelson, president of the American Medical Association (AMA), in a recent letter-to-the-editor in *The Washington Times.* As Dr. Nelson points out, the hospital industry is offering "a blizzard of skewed statistics" yet conveniently ignores straightforward economic principles with respect to the benefits of specialty hospitals—namely, that "...Competition works. **And in the hospital industry, the addition of specialty hospitals to the mix gives patients more choice, forcing existing hospitals to innovate to keep patients coming to them. This is a win-win situation in providing better quality of care.**"[1]

The *Wall Street Journal* editorial board also expressed its forthright assessment when it wrote, "**what the critics really want is to take away consumer choice**, forcing patients into treatment at less-optimal facilities for no reason other than to prop up the current system. But the other side of the equation is ensuring that consumers have a choice of places to spend those dollars, which means competition among hospitals."[2]

Not only are specialty hospitals important to the marketplace because they provide competition to incumbents, but they are well regarded by patients, who give

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[1] Dr. John C. Nelson, "Competition works", *The Washington Times,* 2/10/05

[2] Editorial, "In the (Specialty) Hospital", *Wall Street Journal,* 1/3/05.

them high marks. Specialty hospitals have a very high rate of successful procedures; higher nurse-to-patient ratios; and with their innovative care and extra attention to customer service they serve as a welcome development for health care consumers. Furthermore, physicians are attracted to specialty hospitals because they provide faster, surer access to operating rooms with fewer bureaucracy-induced delays, quality nursing staffs, readier access to the latest medical and information technologies, and well-trained support personnel.

Communities are welcoming specialty hospitals with open arms because of their exceptional patient care and economic development attributes such as good jobs, property and sales tax revenues, as well as the care they give to indigent patients. Specialty hospitals often offer emergency services and attract patients from afar who are drawn by the specialty services.

Specialty hospitals succeed because, as part owners, physicians not only treat patients, but they also make sure facilities operate efficiently. **Physician partners are true small business owners,** weighing cost-effectiveness, return on investment and quality and efficiency along with traditional factors relative to patient care. They take an active part in decision-making on issues such as capital expenditures on medical/surgical equipment, patient billing and protocols of care.

The entrepreneurial physician owners behind specialty hospitals are working hard to take health care delivery in a new and refreshing direction. An extension of the federal government's moratorium on specialty hospitals would be, at its core, an act of protectionism that stifles progress and innovation.

"Tweaking" and micromanaging health care delivery by the government has already proven to be expensive and inefficient, littered with unintended consequences for consumers. Industrial planning has failed at every attempt—there is absolutely no reason to believe that the government will be successful in this modern day initiative to micromanage what is a very positive development in the hospital industry.

Again, we thank you Chairman Deal for hosting this important hearing. I urge you to give every consideration to legislation that would hamper the ability of specialty hospitals to deliver their innovative, efficient and live-saving services to patients. As *The Washington Times* editorial board recently advocated, "In the new Congress, the **Republican leadership should make sure choice and competitiveness in health care trump special interests like the AHA's . . . We hope to see a law that keeps specialty hospitals going and ignores MedPAC's advice**." [3]

We couldn't agree more, and the SBE Council urges you, and committee members, to oppose the extension of the moratorium on specialty hospital development.

PREPARED STATEMENT OF SEAN PARNELL, VICE PRESIDENT-EXTERNAL AFFAIRS, THE HEARTLAND INSTITUTE

INTRODUCTION

The issues surrounding specialty hospitals and the soon-to-expire moratorium on the development of new physician-owned medical facilities [1] are many and complex. Over the past several months, I have researched and written on this subject for Health Care News, a monthly newspaper covering public policy. I have attached to my written testimony excerpts from the three articles published in the October and December 2004 as well as the January and May 2005 issues of *Health Care News.*

These four articles focus on issues relating to quality of care, the historical development of specialty hospitals, the charges leveled against specialty hospitals by industry rivals, and the potential benefits of allowing specialty hospitals to resume their expansion.

In my written testimony, I would like to focus on two particular areas relevant to the moratorium: the argument that specialty hospitals create what is known as "induced demand," and arguments that Certificate-of-Need legislation is an appropriate policy to keep specialty hospitals from competing with general hospitals. Nearly all of my research is based on publicly available documents, including several produced or commissioned by the federal government and state governments.

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[3] Editorial, "Bolstering specialty hospitals", *The Washington Times,* 1/24/05

[1] Technically, the moratorium is only on referral of Medicare patients to facilities in which a physician has an ownership interest. However, since the effective result is that no new facilities are likely to be developed due to Medicare representing a substantial share of potential patients, it is generally referred to as a moratorium or even a "ban" on all new development of such facilities.

INDUCED DEMAND

One major concern of the American Hospital Association (AHA) is that because specialty hospitals are typically owned by doctors, there is an incentive for doctors to recommend treatment and refer patients to a specialty hospital in order to generate profits, regardless of what is in the best interest of patients.[2]

This problem is connected to the economic ideas of agency, asymmetric knowledge, and supplier-induced demand. Dr. Douglas Popp, Chair of the Department of Emergency Medicine at Advocate-General Lutheran Hospital in Chicago, described the problem as follows:

> . . . agency refers to . . . where one person with unique knowledge (e.g. the physician agent) is given the authority to make decision by, and for the less informed principal (patient) . . . [The] physician can order expensive tests and/or medications for the patient, based on asymmetric knowledge, while transferring the financial risk to the patient or third party payer (insurance company) for that decision . . . This creates the opportunity for supplier induced demand where the physicians is increasing the cost of care (e.g. ordering more tests) with the ulterior motive presumably being to positively impact their own wellbeing (e.g. personal income).[3]

In layman's terms, the concern is that most patients don't have the medical knowledge necessary to know if medical treatment is needed or not, so doctors may order excessive and unneeded health care in order to generate more income for themselves. The American Hospital Association notes physician ownership of specialty hospitals "can create an inherent conflict between the clinical needs of the patient and the financial interests of the physician."[4]

The risk of such a conflict, however, seems remote. Doctors earn their incomes almost entirely through fees charged for medical services, not profits at medical facilities they may have an ownership stake in. Whatever incentive exists for an unethical doctor to induce demand, the incentive is irrelevant to whether the surgery is performed in a general hospital or a specialty hospital.

As recent GAO reports demonstrate, the potential profits from referring any one case to a specialty hospital are relatively small. Margins at for-profit specialty hospitals average about 12.4% for Medicare patients and about 9.7% for all payers. These margins are not significantly out of line with those of for-profit general hospitals, which average 14.6% for Medicare patients and 9.2% for all payers.[5]

Also according to the GAO, 72.5% of physicians with admitting privileges at specialty hospitals had no financial interest in the hospital[6] and at 70.4% of hospitals the largest share owned by a physician was 6% or less.[7] The median ownership share for an admitting physician with an ownership interest was 2%.[8]

Putting together the modest operating margins and the low physician ownership stakes typical of specialty hospitals, and factoring in the relative income potential from surgeon's fees vs. hospital profits, the incentive created by physician ownership of specialty hospitals to induce is extremely small.

Consider the case of a relatively expensive surgical procedure, coronary bypass surgery. There are two primary DRG's for Medicare reimbursement of coronary bypass, 107 and 109. According to MedCath, a national chain of 12 specialty hospitals focusing on cardiac care, the average reimbursement for DRG 107 is $26,434 and represents approximately 64% of bypass surgeries performed in their hospitals, and the average Medicare reimbursement for DRG 109 is $23,499, representing the remaining 34% of procedures performed.[9]

MedCath also reports that the reimbursement for participating surgeons under DRG 107 is $3,622 and for DRG 109 it is $2,910.[10]

By applying the information on operating margins and physician ownership of specialty hospitals to the data on reimbursement, we can get an idea of what the potential increase in income would be for a surgeon who is recommending unneeded

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[2] "Impact of Limited-service Providers on Community and Full-service Hospitals," September 2004 issue of *TrendWatch,* published by the American Hospital Association, p. 2

[3] *Macroeconomics of Healthcare,* Dr. Douglas Propp, online at the IL College of Emergency, http://www.icep.org/edsurvival/documents/HealthcareEconomics—000.doc.

[4] "Impact of Limited-service Providers on Community and Full-service Hospitals," September 2004 issue of TrendWatch, published by the American Hospital Association, p. 2.

[5] "Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance," October 2003, United States General Accounting Office, pp. 25—26.

[6] "Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served," April 2003, United States General Accounting Office, p. 10.

[7] Ibid.

[8] Ibid.

[9] Information from Alanna Porter, MedCath Inc., received March 3, 2005 via e-mail.

[10] Ibid.

treatment. Performing an unnecessary DRG 107 coronary bypass, a for-profit specialty hospital could expect an operating margin of $3,277.82 (12.4% avg. operating margin x $26,434). If the surgeon performing the procedure owns 2% (the median ownership share), their share of that would be $65.66. These raw figures are before taxes and other expenses—the actual amount of profit is even less than these numbers might indicate.

Comparing the surgeon's expected fee of $3,622 to the potential profits from an ownership share of a specialty hospital, it is hard to imagine that these few extra dollars would be sufficient incentive to induce demand.The case of Richard Mathews [11], an executive at a benefits consulting company in Michigan, is a real life example of how the induced demand argument made against specialty hospitals does not stand up in the real world.

Mathews had reconstructive knee surgery in February of 2004 at the Beaufort Surgical Center, a specialty orthopedic hospital in Beaufort, South Carolina. His insurance company paid the entire bill, approximately $1,227 for hospital charges and $2,059 for the surgeon's and anesthesiologist's fees plus other expenses. Reviewing the hospital bill, Mathews noted that "There is simply no way that there is any huge profit in using his hospital. There may be a little—but the real advantage is for better patient service and excellence."

Even if the surgeon operating on Mathews was one of the very few in the country who has an ownership interest of 15% or more in a specialty hospital [12], the potential income gains are too small to realistically think a doctor would recommend unnecessary treatment. Assuming a 9.7% margin on this procedure, a doctor with a 15% stake in the hospital would gain less than $18 in income through that ownership, minuscule compared to their share of the nearly $2000 in doctors fees. A doctor with the average 2% ownership stake would stand to gain less than $2.38. Again, these potential gains are before taxes and other expenses.

Mathews also described the strict disclosure standards that his surgeon followed. As a patient, he had to sign a disclosure acknowledging he was aware of the surgeon's financial interest in the hospital.

Adding to his description of his surgery, Mathews said "My doc told me straight out that he and [his] peers started their specialty hospital solely for access to excellence "... they control the entire surgical team and every part of the process. They simply cannot get the excellence they need to have and offer to patients from local area hospitals."

Plainly, the charge that physician ownership of specialty hospitals create incentives for doctors to abuse their position and recommend unneeded treatment is not supported by the facts.

CERTIFICATE OF NEED

The issue of Certificate-of-Need (CON) laws is relevant to the issue of specialty hospitals for two reasons:

- The American Hospital Association, one of the main advocates for extending the moratorium on specialty hospitals, noted that what they call "limited service providers" [13] are mostly located in states without CON laws.[14] A reasonable assumption is that should the moratorium end as it is scheduled to, the AHA and other opponents of specialty hospitals will turn their lobbying efforts to enacting CON laws at either the federal or state level in order to impede competition.
- The history of CON laws demonstrates succinctly how attempts to limit or prevent competition between health care facilities does not benefit patients or control costs, and more often only protects the market share and profits of existing providers.

CON laws were first enacted in 1964 in New York as a response to rising health care costs driven in part by what was then a common health insurance reimbursement system known as retrospective reimbursement, also called "cost-plus." Under retrospective reimbursement, insurers would pay hospitals an amount equal to their costs, plus a certain percentage above cost for profit and overhead.

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[11] Based on interview with Richard Mathews on 2/15/05.

[12] "Specialty Hospitals: Information on National Market Share, Physicians Ownership, and Patients Served," April 2003, United States General Accounting Office, p. 10.

[13] "Limited-service provider" is the AHA's term which they (and others) apply to both specialty hospitals, which generally require overnight stays, and ambulatory surgical centers, which do not.

[14] "Impact of Limited-service Providers on Community and Full-service Hospitals," September 2004 issue of *TrendWatch,* page 2, published by the American Hospital Association.

With the cost-plus system, there was little if any incentive for medical providers to become more efficient or for patients to be price sensitive. CON was a clumsy way to try to stop the inevitable spending binge the system created.

In 1972, Congress voted to require states review and approve all capital expenditures of $100,000 or more, as well as changes in bed capacity or what they termed a "substantial change" in services. By 1980, all 50 states had imposed CON laws

By 1986, it was evident that CON laws were not succeeding in keeping health care costs down, and by limiting competition were even contributing to rising costs. Congress repealed the federal CON requirement. Since then, fourteen states have followed by repealing CON entirely, and six more have repealed it for everything except nursing homes and long term care services.

Some of the most extensive research on CON laws has been done by Christopher Conover, Ph.D., and Frank Sloan, Ph.D., with Duke University's Center for Health Policy, Law, and Management. Their research, originally done for the Delaware Health Care Commission in 1996, was published in a June 1998 article in the *Journal of Health Politics, Policy and Law.*[15]

Conover and Sloan found that CON laws had no effect on overall health care spending. While they found a modest reduction in hospital costs, this decline was offset by an increase in physician costs.[16] They also note that CON laws "result in a slight (2 percent) reduction in bed supply but higher costs per-day and per admission, along with higher hospital profits."[17]

In a later study prepared for the Michigan Department of Community Health, Conover and Sloan confirmed their earlier findings. Among their major conclusions was that repeal of CON laws does not "lead to a 'surge' in either acquisition of new facilities or medical expenditures."[18] They also found evidence to suggest that CON results in an increase in costs, contrary to the goal of these laws.[19]

Another study, prepared by the University of Washington's school of public health for the state legislature, had similar findings. The authors found "strong evidence that CON has not controlled overall health care spending or hospital costs."[20]

The Federal Trade Commission (FTC) and U.S. Department of Justice (DOJ) have also weighed in on the impact of CON laws. In a July 2004 report jointly prepared by the two agencies, they concluded that there is "considerable evidence that [CON laws] can actually drive up prices by fostering anticompetitive barriers to entry."[21]

This is only a sampling of the literature available on the failure of CON laws to restrain health care costs. CON today is little more than a shield that protects incumbent providers from competition, allowing entrenched interests to maintain market share and profits. Congress rightly repealed this law in 1986, although it remains on the books in many states.

GENERAL HOSPITALS FACE REAL CHALLENGES

The final issue I would like to address, if only briefly, is the condition many general hospitals find themselves in.

Although I do not find most of the American Hospital Association's charges against specialty hospitals to be either credible or relevant, I recognize that they face real and pressing challenges. Competition from smaller specialty hospitals, which often provide superior care at a lower overall cost, is just one of the challenges that general hospitals must deal with. Some of these challenges are self-inflicted, while others are largely imposed by a dysfunctional health care market burdened by excessive regulation, third-party payment, bureaucratic central planning, price controls, and monopsony power.[22]

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[15] "Does Removing Certificates-of-Need Regulations Lead to a Surge in Health Care Spending?" Christopher Conover, Ph.D., and Frank Sloan, Ph.D., June 1998 *Journal of Health Politics, Policy and Law,* pp. 455

[16] Ibid, p. 463

[17] Ibid, p. 466.

[18] "Evaluation of Certificate of Need in Michigan," by Christopher Conover, Ph.D. and Frank Sloan, Ph.D, May 2003 report to the Michigan Department of Community Health, p. 74.

[19] Ibid, pp. 30.

[20] "Effects of Certificate of Need and Its Possible Repeal," Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine, January 8 1999 report to the State of Washington Joint Legislative Audit and Review Committee, p. 9.

[21] "Improving Health Care: A Dose of Competition," July 2004 report prepared jointly by the Federal Trade Commission and the U.S. Department of Justice, p. 302.

[22] Monopsony power exists where there is a single or dominant purchaser of a good or service. Just as monopoly power allows a single *seller* of a good or service to demand higher prices than would exist in a competitive market with multiple sellers, monopsony power allows the buyer to dictate lower prices than would exist in a competitive market with multiple buyers.

Many procedures hospitals perform are reimbursed at less than cost by both private insurers and government payers like Medicare and particularly Medicaid. To a limited extent this can be offset by generous margins for other procedures, reimbursed well above cost. However, many of the financial difficulties experienced by hospitals today are the result of a mix of patients where profitable procedures do not make up for losses caused by unprofitable procedures.

Another challenge facing many hospitals is a series of lawsuits stemming from a pricing system that bears little resemblance to reality.[23] These lawsuits have been filed against both non-profit and for-profit hospitals over pricing practices that frequently charge the highest prices to uninsured patients while large insurers and government programs get substantial "discounts" from "list prices" for the same procedures. These pricing practices are difficult to defend, since they often impose large bills on low-income individuals.

Congress would be wise to review and examine policies imposed on hospitals that contribute to these challenges. The reality of these challenges and others, however, should not justify preferential treatment from Congress or state legislatures that would shield them from competition and protect their market share and profits.

CONCLUSIONS AND RECOMMENDATIONS

On the two points I specifically address two conclusions are warranted:

- Physician ownership of specialty hospitals does not create a significant incentive for physicians to perform unnecessary procedures.
- The history of Certificate-of-Need laws demonstrates that polices that restrict or prevent competition among health care providers do not benefit patients or lower costs, and unnecessarily protect the profits and market share of incumbent firms.

On the broad question of whether to continue the moratorium on physician ownership of new specialty hospitals, I would urge the Congress to take the following steps:

1. Allow the moratorium to expire in June 2005, as it is presently scheduled to do.
2. Monitor and take action where needed to ensure the U.S. Department of Justice is examining potential anti-competitive actions by existing providers attempting to use Certificate-of-Need laws to restrain trade in violation of anti-trust laws.
3. Continue to collect, examine, and make available information regarding the quality of care provided by specialty hospitals, ambulatory surgical centers, and general hospitals.
4. Review and consider revising laws and regulations imposed on health care providers, particularly general hospitals that create unneeded burdens and financial difficulties.

I believe that if Congress takes these actions, the result will be increased excellence and lower costs for health care.

PREPARED STATEMENT OF JOHN W. STRAYER III, NATIONAL CENTER FOR POLICY ANALYSIS

Mister Chairman and Members of the Subcommittee: Placing a moratorium on physicians referring patients to specialty hospitals is the latest example of a negative third party influence. Physician-owned specialty hospitals are innovative centers of medical care that increase the quality of care, without jeopardizing access, while striving to keep costs competitive and affordable.

Physician-owned specialty hospitals are a major force for introducing greater competition and innovation into the American health care system. Just as greater competition has served us well in so many other sectors of the American economy, free-market solutions can be a force for delivery of more benefits in the health care field as well.

Because of their very nature, physician-owned specialty hospitals are designed to maximize efficiency and quality of care, resulting in better patient outcomes. At a time when the U.S. Congress is debating "performance pay" based on patient outcomes, an easing of the moratorium on physician referrals to physician-owned specialty hospitals would seem most appropriate in helping to attain better outcomes.

At physician-owned specialty hospitals, physicians choose to practice in an environment where sound medical decisions can be made without third-party second guessing due to bottom line considerations. The unique atmosphere of a specialty

[23] "6 More Class Action Lawsuits Filed Against Nonprofit Hospital Systems and Hospitals By Uninsured Patients," August 27, 2004, *MedicalNewsService.com*

hospital offers physicians the opportunity to work where they can be most effective and where they have access to cutting edge technology and specialized support staff.

The growth of specialty hospitals is an example of how new and innovative entrants in an existing market help fuel competition for cost, quality and access. When a superior product or service goes into existing markets, competitors are forced to raise quality and re-examine costs. The final result is a higher rate of productivity, translating to lower costs and better quality to the patient. That point cannot be overemphasized. And the specialty hospitals are the new market entrants that make it possible.

Patients should be afforded the choice of facility with the newest equipment, and best record of results. They deserve the best treatment available. That is why patients in increasing numbers are choosing a facility with the best outcomes and quality of care. That is why they are choosing specialty hospitals.

With a majority of specialty hospital staff dedicated to a specific field and focused on efficient methodology, time between operative procedures and post-procedure turnaround is reduced, resulting in increased productivity in all aspects of the hospital.

Such productivity is one of the hallmarks of specialty hospitals.

The General Accountability Office (GAO) looked at specialty hospitals and the impact that they had on neighboring general and community hospitals. The GAO found that the cost effectiveness and the rate of high positive outcomes at specialty hospitals outweigh any perceived disadvantages experienced by general and community hospitals.

A study by the Lewin Group compared MedCath facilities, a group of 12 heart hospitals across the country, to peer hospitals which conduct open-heart surgery and found MedCath hospitals measured better in a broad range of categories. According to the Lewin Group, MedCath patients experienced shorter stays and were more often discharged to home, rather than to short-term care facilities. This is important because it means reduced costs to Medicare and Medicaid. In turn, with the decrease in Medicare/Medicaid costs, taxpayers are less apt to subsidize treatment at specialty hospitals.

At a time when the federal budget deficit requires the U.S. Congress to vigorously pursue any and all avenues of potential savings, Congress must revisit the onerous regulations that increase the cost of health care, discourage improvements in patient outcomes, and place an undue burden on precious taxpayers' dollars.

Given the many benefits that specialty hospitals are delivering to patients, I believe our laws and government related enabling regulations must be written to allow for an expansion of the physician-owned specialty hospitals network. On behalf of those in need of medical care in America today, I ask that you act accordingly.

Questions for Dr. Mark McClellan,
Administrator,
Centers for Medicare & Medicaid Services
From the Honorable Joe Barton,
House Committee on Energy and Commerce
Subcommittee on Health
Regarding the May 12, 2005, hearing entitled
"Specialty Hospitals: Assessing Their Role in the Delivery of Quality Health Care"

Question:
The CMS report recommends a new administrative review of the procedures for approving specialty hospitals, which includes suspending approval of specialty hospitals for a limited time period. Please provide answers to the following questions:

1. **What is your authority for this administrative review?**

Answer:
As you know, CMS plans to review its current standards for approval for participation and payment, to determine whether additional or different standards should apply to specialty hospitals in light of the focused nature of their services. Specifically, CMS intends to continue meeting this summer with State survey agencies, JCAHO, and AOA, the organizations that accredit hospitals, to discuss standards for determining whether a specialty hospital meets statutory requirements to be a hospital under Medicare. CMS also plans to seek public comment on the appropriate standards for specialty hospitals from the EMTALA Technical Advisory Group (TAG) and on certification issues related to specialty hospitals in an Open Door Forum in September 2005. In the context of this review, CMS will also seek public input on how it can best support all types of hospitals in achieving further quality improvements and efficiency gains.

Depending on the results of this input and review, we will draft appropriate instructions to implement revised procedures, and we will consider whether to proceed with changes to the regulations. We expect to complete revisions to these procedures by January 2006.

The Social Security Act and our regulations provide that an institution that meets the definition of a hospital and meets the other conditions for participation as a hospital can enroll in Medicare as a hospital. The Act and regulations, however, do not place a time period in which we act to enroll an applicant, and we believe six months is a reasonable time in which to suspend processing of applications while we complete our review. Section 1861(e) of the Social Security Act provides that an institution must be primarily engaged in furnishing inpatient services in order to participate in the Medicare program as a hospital. The same section also provides that such an institution must also meet such other requirements as the Secretary finds necessary for the health and safety of individuals treated at the institution. Additional and specific conditions of participation appear in our regulations. We believe we have the legal authority to deny a Medicare provider agreement to a specialty hospital that does not meet current requirements as well

as to apply any new substantive criteria for participation to institutions that have a pending application for a Medicare provider agreement.

2. **Will you be publishing a firm date for completion of the review and the subsequent lifting of the suspension?**

Answer:
Over the next six months, CMS will review its procedures for enrolling specialty hospitals in the Medicare program. CMS plans to complete its review process by January 2006. In addition, CMS will undertake a series of steps to reform Medicare payments that may provide specialty hospitals with an unfair advantage over other types of providers, such as community hospitals and ambulatory surgical centers.

3. **Will you be suspending only new applications? What about those hospitals that have already submitted applications?**

Answer:
The suspension does not apply to those specialty hospitals that, prior to June 9, 2005, submitted an enrollment application or requested an advisory opinion from CMS concerning whether they were subject to the moratorium under section 507 of the MMA. During this review, CMS is instructing its regional offices not to issue new specialty hospital provider agreements or authorize an initial survey by the state survey agency for new specialty hospitals. Medicare fiscal intermediaries have been instructed not to process new provider enrollment applications for specialty hospitals until further notice. CMS plans to complete its review process by January 2006.

4. **Would current specialty hospitals be permitted to expand their buildings and services during this suspension?**

Answer:
Specialty hospitals that already have provider agreements and were not allowed to expand during the specialty hospital moratorium, as well as new specialty hospitals, will now be allowed to do so.

Questions for Dr. Mark McClellan,
Administrator,
Centers for Medicare & Medicaid Services
From the Honorable John Shadegg,
House Committee on Energy and Commerce
Subcommittee on Health
Regarding the May 12, 2005, hearing entitled
"Specialty Hospitals: Assessing Their Role in the Delivery of Quality Health Care"

1. As I said during the hearing, I have met extensively with representatives of community hospitals and they have argued that these hospitals are disadvantaged under federal laws. This creates an unlevel playing field on which community hospitals are unable to compete. Specifically, they mentioned laws in two areas: anti-referral and anti-kickback statutes.

The federal government's anti-referral policy is largely the result of the Ethics in Patient Referrals Act, known as the Stark laws). While Stark carries grave penalties, including civil penalties, Stark violations can also trigger prosecution under anti-kickback laws or fraud and false claims statutes. Should the Stark laws be amended to allow physician ownership in hospital departments to which they refer? How can we amend both Stark and other federal laws to create a more level playing field?

Answer:
CMS has no position at this time on whether the Stark law should be amended. We would be glad to provide technical assistance to Congress if Members should wish to consider this option.

We do believe the Stark law has been effective in deterring providers from entering into the types of business arrangements that may be vulnerable to inappropriate referrals for designated services.

We also believe that concerns about specialty hospitals can be – and are being – addressed in other ways. On June 9, CMS announced steps it will take to promote a more level playing field for all types of hospitals. Specifically, we plan to review over the next six months the procedures for enrolling specialty hospitals in Medicare, and we will examine whether specialty hospitals meet the definition of a "hospital" contained in the Social Security Act. We also plan to reform Medicare payments to address any unfair advantages for specialty hospitals over community hospitals or ambulatory surgical centers.

2. Are there cases where hospital administrators or physicians have been prosecuted for something that would have been essentially permissible if that action took place in a specialty hospital?

Answer:
We understand this question to mean: Has CMS pursued sanctions under the physician self-referral law against any hospitals or physicians in relation to referrals to a hospital in which the referring physicians (or their immediate family members) had a financial interest in less than the "whole hospital" (e.g., in only a surgical, orthopedic, or cardiac unit of the hospital)?

We are unaware of any instances in which physicians have an ownership interest in any subdivision of a hospital.

3. Could you talk about "gain-sharing," the arrangements under which hospitals seek to share profits with physicians? My understanding is that the Department of Health and Human Services Inspector General must approve these arrangements on a case-by-case basis. How widely is this being used? Are there lessons we can learn from the Inspector General's evaluation of gain-sharing requests? Can we make changes through gain-sharing to level the playing field with specialty hospitals?

Answer:
The MMA-mandated study we conducted did not examine the issue of gainsharing between physicians and institutional providers. However, MedPAC's Report to Congress on the MMA-mandated study recommended statutory changes to permit certain gainsharing arrangements. If the MedPAC recommendation to allow for gainsharing were to be accepted, it would require either congressionally approved demonstration authority permitting a waiver of the Civil Monetary Penalty, 42 USC sec.1320a-7a(b), or an amendment to that statute.

The OIG has recently published letters allowing for narrowly drawn gainsharing programs. For example, thoracic surgeons could share in the savings from standardizing and reducing the purchase of supplies for cardiac surgery. Whereas what OIG has recently approved is admittedly narrow in scope and time-limited, CMS thinks that broader approaches to align incentives of cooperating providers, if implemented with appropriate safeguards, could have significant promise of improving efficiency and quality of care. We are in favor of gainsharing if the gains result from eliminating services that are not medically necessary.

4. While your report found that specialty hospitals spend a greater portion of their income on uncompensated care, you indicated during the hearing that varied from hospital to hospital. Are there measures we need to take to ensure that hospitals are not using the whole-hospital exception for specialty hospitals to shirk their EMTALA responsibilities?

Answer:
Specialty hospitals, like for-profit community hospitals, pay real estate and personal property taxes, as well as income taxes (unless organized as a partnership in which case the owners pay income taxes on their profits) and some sales taxes. Non-profit community hospitals do not pay any of these taxes Real estate and personal property tax payments stay in the local community, as does a share of sales tax payments in most areas. In fact, we found that overall, the proportion of net revenue that specialty hospitals devote to both uncompensated care and taxes significantly exceeds the proportion of net revenues that community hospitals devote to uncompensated care. Real estate and property tax payments stay in the local community, as does a share of sales tax payments in most areas. It should be noted that although the proportion of net revenues that specialty hospitals devote to uncompensated care and taxes significantly exceeds the proportion of net revenues that community hospitals devote to uncompensated care, the total amount of dollars that specialty hospitals devote to uncompensated care is typically far less than that of community hospitals, due to the relatively small size of specialty hospitals. It should also be noted that the physician-owned specialty hospitals visited reported very little Medicaid utilization, which, on average, ranged from zero to six percent, or charity care.

The "whole hospital exception" allows physicians to refer patients to hospitals in which the physician (or an immediate family member) has an ownership or investment interest if the physician practices at the hospital and the investment is in the whole hospital and not in a subdivision of the hospital.

EMTALA imposes certain obligations on hospitals and physicians to screen for and stabilize emergency medical conditions, within the hospital's capability, without regard to whether, or by whom, a patient was referred to that facility. It may appear that EMTALA has no special effect on specialty hospitals. However, concerns have been raised about the effect specialty hospitals may have on the on-call practices of physician specialists. Some observers suggest that more lenient on-call requirements at specialty hospitals have led specialists to shift their practices to these facilities, thereby reducing community hospitals' capacity to treat emergency patients as required by EMTALA. That is, practicing at a specialty hospital, may not generally include any on-call responsibility since most patients are scheduled for a particular procedure during the daytime hours on a weekday. Thus, such physicians can be relieved of on-call responsibilities. This physician drain from community hospitals to specialty hospitals has caused community hospitals to work much harder to acquire on-call physicians and also to have to pay physicians to be on-call.

We are concerned about whether specialty hospitals should maintain an on-call capability to accept appropriate transfers from community hospitals who (lacking sufficient on-call specialists) are unable to meet EMTALA obligations themselves. We are also interested in whether specialty hospitals have obligations under EMTALA to receive patients seen at emergency rooms of community hospitals for conditions that are within the specialized capabilities of specialty hospitals.

The MMA mandated the establishment of an EMTALA Technical Advisory Group (TAG). Staff presented the above issues to the TAG at its most recent meeting, and the TAG expressed interest in them. However, it should be noted that concerns related to specialty hospitals are only a small part of larger on-call and other issues being considered by the TAG.

5. Many hospitals have a substantial financial role in Ambulatory Surgical Centers (ASCs), many of which, in turn, allow physicians to purchase an ownership share in that ASC. Is physician ownership and self-referral acceptable in the context of ASCs acceptable?

Answer:
Physician ownership of, and referral to, an ASC may not create any self-referral problems. ASC services are not Designated Health Services (DHS) under the physician self-referral statute and thus the self-referral prohibition does not apply to ASC services. However, under Medicare rules, an entity is an ASC only when it furnishes ASC services. Thus, an entity that is enrolled in the Medicare program as an ASC, but which furnishes non-ASC services such as radiology services in addition to ASC services, would not be considered an ASC for purposes of the radiology services (but rather could be considered an independent diagnostic testing facility for purposes of such services.) Because certain non-ASC services, such as radiology services, are DHS, a physician owner of an entity furnishing radiology services may not refer a Medicare patient to this entity for such services unless an exception applies.

6. In your testimony you say, quality of care in cardiac hospitals is as good as or better than quality of care in community hospitals and that patient satisfaction is very high in cardiac hospitals. Could you elaborate on why this may be?

Answer:
Indeed, we found that quality in specialty hospitals was "generally at least as good and in some cases better than the local community hospitals." We examined quality on several dimensions. For some of these dimensions—such as readmissions—the community hospitals marginally outperformed the specialty hospitals. On measures such as in-hospital or 30-day post-admission mortality rates—the specialty hospitals performed better. The cardiac hospitals also had lower complication rates compared to community hospitals. Note that the study of quality used the entire population of specialty hospitals, and not only the 11 hospitals in the CMS study sample. However, overall, very few patients in either type of hospital were readmitted with complications.

In our assessment of patient satisfaction with focus groups of specialty hospital patients, we also asked about quality. However, our major findings on the relative quality of care furnished by specialty and community hospitals were based on our analysis of clinical measures using claims data.

Specifically, three measures of quality were used to assess differences between specialty hospitals and competitor hospitals:

- Mortality, both during hospitalization and within 30 days of discharge from the hospital.
- Complications during hospitalization.
- Readmission within 30 days of discharge; and discharge disposition.

These measures were analyzed using the 2003 Medicare claims data from both the entire population of specialty hospitals and their area competitors. The site visit and patient interviews were used to corroborate the results of the claims analysis.

7. Why are you proposing only a 6-month review period of CMS' procedures for approving specialty hospital applications when the Medicare Payment Advisory Commission recommended extending the moratorium until January 1, 2007? Do you think CMS has sufficient time to get the procedures right?

Answer:
During the 6-month review period, CMS will review the procedures for enrolling specialty hospitals in Medicare, in order to determine whether different or additional criteria should apply, given the specialized nature of their services. CMS will also examine whether specialty hospitals meet the definition of a hospital contained in the Social Security Act. We believe that six months is a sufficient amount of time for these tasks. The Medicare Payment Advisory Commission recommended extending the moratorium until January 1, 2007 in order to provide enough time to make changes to the inpatient hospital payment system.

8. In your testimony you state that CMS will refrain from processing further participation applications from specialty hospitals until this 6-month review period is completed and any indicated revisions are implemented. How does CMS legally deny Medicare certification to any hospital that has received a hospital license from a state and met all other Medicare qualifications?

Answer:
Section 1861(e) of the Social Security Act provides that an institution must be primarily engaged in furnishing inpatient services in order to participate in the Medicare program as a hospital. The same section also provides that such an institution must also meet such other requirements as the Secretary finds necessary for the health and safety of individuals treated at the institution. Additional and specific conditions of participation appear in our regulations. We believe we have the legal authority to deny a Medicare provider agreement to a specialty hospital that does not meet current requirements as well as to apply any new substantive criteria for participation to institutions that have a pending application for a Medicare provider agreement.

9. On June 8, 2005 the statutory definition of a "specialty hospital" expires. Therefore, I would presume that CMS would revert back to using the definition of a hospital prior to the passage of MMA. How can CMS instruct their fiscal intermediaries to refrain from processing further participation applications from specialty hospitals, when the definition of a specialty hospital has expired?

What is CMS's position with regard to the 40+ hospitals that are currently waiting letter opinions on a determination of "under development" for purposes of the specialty hospital moratorium? Once the moratorium expires there is no need for these hospitals to obtain an opinion from CMS. Does CMS intend to keep these facilities segregated and treat them differently for purposes of Medicare certification? Does CMS plan to deny a Medicare number to hospitals that are JCAHO accredited?

Answer:
As you know, in the Medicare Modernization Act of 2003, Congress instructed CMS to prohibit physician-investor referrals to specialty hospitals for a period of 18 months, ending June 8, 2005, unless the hospitals were already under development as of November 18, 2003. Congress mandated that during this moratorium, the Medicare Payment Advisory Commission (MedPAC) and the Department of Health and Human Services (HHS) conduct separate studies, with MedPAC focusing on payment issues raised by specialty hospitals, and HHS focusing on such issues as referral patterns, quality of care, and impact on the provision of uncompensated care.

CMS indicated in the cover note to its Specialty Hospital Report to Congress that we would "review procedures for approving hospitals for participation in Medicare and closely scrutinize processes for approving and starting to pay new specialty hospitals." Under Medicare, a hospital must primarily furnish care to inpatients. CMS has expressed concern that some specialty hospitals may concentrate primarily on outpatients and may therefore fail to meet the Medicare definition. Accordingly, the May 4, 2005 proposed rule updating the Hospital Inpatient Prospective Payment System for Fiscal Year 2006 indicated that, if specialty hospitals are not primarily engaged in inpatient care, new applications for hospital provider agreements will be denied and existing provider agreements may be terminated.

During this review period, which we expect to be complete by January 2006, CMS will review its current standards for approval for participation and payment, to determine whether additional or different standards should apply to specialty hospitals in light of the focused nature of their services. Specifically, CMS intends to continue meeting this summer with State survey agencies, JCAHO, and AOA, the organizations that accredit hospitals, to discuss standards for determining whether a specialty hospital meets statutory requirements to be a hospital under Medicare.

CMS also plans to seek public comment on the appropriate standards for specialty hospitals. Specifically, CMS has already asked for advice from the EMTALA Technical Advisory Group (TAG) and will solicit public input on certification issues related to specialty hospitals in an Open Door Forum in September 2005. In the context of this review, CMS will also seek public input on how it can best support all types of hospitals in achieving further quality improvements and efficiency gains.

During this review, CMS is instructing its regional offices not to issue new specialty hospital provider agreements or authorize an initial survey by the state survey agency for new specialty hospitals. Medicare fiscal intermediaries have been instructed not to process new provider enrollment applications for specialty hospitals until further notice. The suspension does not apply to those specialty hospitals that, prior to June 9, 2005, submitted an enrollment application or have requested an advisory opinion from CMS concerning whether they were subject to the moratorium under section 507 of the MMA.

It is our intention that once this review period is over, we will have a better understanding of the effect of specialty hospitals on a community's ability to furnish emergency medical services and also whether these entities are inappropriately circumventing Medicare rules so that they may receive an inappropriate higher level of payment. We will also be ready to act upon our knowledge.

We are continuing to process requests for advisory opinions from specialty hospitals that, prior to June 9, 2005, were open and furnishing services to Medicare patients. Such hospitals need to know whether they were "under development" as of November 18, 2003 or otherwise were exempt from the moratorium in order to know whether they may bill Medicare for services rendered prior to June 9, 2005. Hospitals that were not open prior to June 9, 2005 have only a limited interest in obtaining an advisory opinion. We are contacting each such hospital to ask whether it wishes to withdraw its request for an advisory opinion, or (if it is concerned that Congress may reinstitute a moratorium and make it retroactive) whether it wishes us to place its request on inactive status,

10. Under Key Recommendations in your testimony, it states that CMS will review specific diagnosis-related groups (DRGs) that are alleged to be overpaid and may create incentives for physicians to create specialty hospitals.

According to MedPAC the payment system would need to be reformed regardless if specialty hospitals were in existence or not. Would you agree that the entire payment system should be updated so all procedures are reimbursed adequately? Is it the goal of CMS to update the entire payment system or target specific DRGs only affecting cardiac, orthopedic and surgical procedures?

Answer:
In general, CMS agrees with MedPAC that the accuracy of IPPS payment rates should be improved, and the emergence of specialty hospitals clearly illustrates the need for such change. Among the changes that CMS recommends in its Specialty Hospital Report to Congress is "reform payment rates for inpatient hospital services through changes to the DRG system." CMS will evaluate potential changes to the inpatient prospective payment system (IPPS). The changes will be implemented to more accurately reflect the severity of a patient's illness in setting the payment level. CMS will also review specific DRGs such as cardiac, orthopedic, and surgical DRGs that are alleged to be overpaid and that may therefore create incentives for physicians to create specialty hospitals. CMS expects to implement most of these IPPS changes by fiscal year 2007.

11. In your testimony you made it clear that CMS has ample authority to act alone in updating the DRG system. MedPAC asked Congress to grant CMS the necessary authority. Given the conflicting statements could you clarify under what authority gives CMS the ability to act alone in updating the DRG system?

Answer:
Among the changes that CMS and MedPAC each recommended in their separate Reports to Congress was improving payment accuracy in the hospital inpatient prospective payment system (IPPS) by refining the current DRG system. CMS has initiated analysis of MedPAC's recommendations and intends to simulate the changes so we can explore the impacts on hospitals. Consequently, CMS addressed this issue briefly in the preamble to the notice of proposed rulemaking for the FY 2006 update to the IPPS. Specifically, CMS will evaluate these changes to the IPPS to more accurately reflect the severity of a patient's illness in setting the payment level. CMS will also review specific DRGs such as cardiac, orthopedic, and surgical DRGs that are alleged to be overpaid and that may therefore create incentives for physicians to create specialty hospitals. CMS expects to implement most of these IPPS changes by fiscal year 2007.

MedPAC also recommended that the Congress give the Secretary authority to adjust the DRG relative weights to account for differences in the prevalence of high-cost outlier cases.

12. As stated in your testimony "Section 1861(e) of the Social Security Act provides that in order to be a hospital, an institution must be engaged, among other things, primarily in furnishing services predominantly to inpatients. This requirement is incorporated in CMS' regulations on conditions of participation for hospitals. If any institution applies for a Medicare provider agreement as a hospital, but is unable to meet this requirement, its application will be denied. In addition, an institution that currently has a Medicare hospital provider agreement but does not presently meet the requirement of engaging in furnishing services primarily to inpatients would be subject to termination of its provider agreement."

It remains unclear if you intend to apply this added scrutiny of the definition of a hospital to all hospitals or just specialty hospitals? Can you clarify if CMS is including all hospitals under their review of compliance with the definition of a hospital, or how EMTALA is applied?

Answer:
CMS has expressed concern that some specialty hospitals may concentrate primarily on outpatients and may therefore fail to meet the definition of a hospital contained in section 1861(e) of the Social Security Act Accordingly, the May 4, 2005 proposed rule updating the Hospital Inpatient Prospective Payment System for Fiscal Year 2006 indicated that, if specialty hospitals are not primarily engaged in inpatient care, new applications for hospital provider agreements will be denied and existing provider agreements may be terminated. During the next six months we plan to examine the question of what it means to be primarily engaged in furnishing inpatient services. Although the issue has arisen recently in the context of specialty hospitals, and although our immediate focus is on specialty hospitals, the "primarily engaged" requirement is applicable to all institutions that wish to participate in Medicare as a hospital.

As noted above, EMTALA imposes certain obligations on hospitals and physicians to screen for and stabilize emergency medical conditions, within the hospital's capability, without regard to whether, or by whom, a patient was referred to that facility. We have recently asked the EMTALA TAG to address the issue of on-call requirements for specialty hospitals and the extent to which specialty hospitals may have obligations to receive patients who have been seen in emergency rooms of other hospitals and who have conditions that fall within the expertise of the specialty hospitals. The EMTALA TAG continues to study on-call and other issues as they relater to non-specialty hospitals.

13. Also can you define "primarily engaged in" as it relates to Section 1861(e) of the Social Security Act that in order to be a hospital, an institution must be engaged, among other things, primarily in furnishing services to inpatients? How will "primarily engaged" be measured? By case volumes? Revenues?

Answer:
During the 6-month period, we will be examining the question of what specific factors should be taken into account, and in what measure, for purposes of defining "primarily engaged." A comparison of the number of inpatient cases relative to the number of outpatient cases, or the amount of inpatient revenue relative to outpatient revenue, are but two possible approaches that we may consider.

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June 15, 2005

Chairman Nathan Deal
U.S. House of Representatives
Committee on Energy and Commerce
Subcommittee on Health
Washington, D.C. 20515-6115

Re: Response to Questions following the May 12, 2005 hearing, "Specialty Hospitals: Assessing Their Role in the Delivery of Quality Health Care"

Mr. Chairman:

Thank you for the opportunity to testify at the hearing on May 12th. Baylor Health Care System firmly believes we must have physicians engaged and aligned to address the issues facing the U.S. health care system, particularly to improve the quality and safety of our health care and to make it more accessible to everyone. Baylor has made great improvements in all three areas, by aligning with physicians in a number of ways, including joint ventures of specialty hospitals and ambulatory surgery centers.

Congressman Allen has asked us to respond to the following:

"Mr. Thomas, it is clear from your testimony that you obviously believe that the Baylor Medical Center joint venture is a desirable model. Yet, I have seen 2002 cost report data that shows these physician-owned hospitals within the Baylor corporate structure have zero, repeat zero percent Medicaid.

MedPAC's data shows 75 and 94 percent fewer Medicaid patient case loads for specialty hospitals.

1. What is it about physician-owned specialty hospitals that they do not treat Medicaid or indigent patients?

2. Do you think that is healthy for our health care system?"

In response, we believe it important to understand the timing of the development of our Specialty Hospitals, but also the structure. Baylor Heart and Vascular Hospital, the joint venture hospital controlled by Baylor and partnered with physicians, located on our downtown Dallas, inner city campus, was only open for roughly 45 days in Baylor's 2002 fiscal year ended June 30, 2002. Frisco Medical Center was also only open for a few months in 2002. The other Baylor "specialty hospitals" were not open in 2002.

More importantly, however, the Cost Report data does not present an accurate picture of Baylor Heart and Vascular Hospital (BHVH), a fully licensed inpatient hospital on the campus next to Baylor University Medical Center. BHVH is physically attached to BUMC's Level 1 Trauma Center. Because the cardiology and vascular services provided by BHVH are no longer provided by BUMC, when BUMC has an emergency patient or other inpatient who requires BHVH services, BUMC's registered patient is treated by BHVH and BHVH's medical staff.

Thus, Medicaid and Self-pay (charity or otherwise self-pay) patients who come from BUMC will not be identified as BHVH's Medicaid and Self-Pay in Cost Report filings. We do track this information, of course, and BHVH's percentage of Medicaid and Managed-Medicaid has averaged just over 4% of patient discharges from BHVH every year since it opened in 2002. When you add self-pay (again, Charity and otherwise) the percentage increases to roughly 9% on average, with the number climbing every year since 2002, to a total rate of 9.5% through March 31, 2005.

In terms of charges, Medicaid, Medicaid Managed Care and Self Pay represents 6.2% of BHVH's Gross Charges on average during this 4 year period. System wide, Medicaid and Self-Pay represent about 14% of our total system wide gross charges for services provided. While that variance may appear high, the difference is driven by the large Neonatal Intensive Care Service, Obstetrics and Level 1 Trauma Service we provide—primarily at Baylor University Medical Center. In fact, we would submit that the clinical and cost effective care provided by BHVH, helps us to provide more (not less) of these high cost, low reimbursement services to the Medicaid and Charity Care population.

The amount of Medicaid services provided by a facility is driven by a number of factors, but geographic location, and whether or not obstetrics or Trauma is provided, are the largest single factors. The Frisco Medical Center, arguably not even a "specialty hospital" but a physician partnered community hospital, was opened in 2002 in Frisco, Texas, one of the fastest growing communities in the country. Frisco, had much need for inpatient hospital services (this was the first hospital in that community) but has a low Medicaid or indigent population. Thus while Frisco Medical Center's Medicaid and self-pay/charity charges have averaged 1-2%, that is reflective of the population in that community (largely middle and upper class and insured), and not an effort to prevent access to the Medicaid population. Ironically, the Medicaid percentage of patients for

Frisco would have been higher, if we had been able to provide obstetrical services at that facility. We had plans to expand that facility to provide obstetrics and women's services before November 17, 2003, but we could not proceed with those plans without CMS approval that the plans were "under development" (and that request has been on file with CMS and pending for over a year).

All of Baylor's specialty hospitals and ambulatory surgery centers provide access to all, for the services they provide, including Medicare, Medicaid and charity care.

Lastly, we would point out that the only material hospital capacity added to the Dallas inner-city with a substantial uninsured, indigent and Medicaid population, in the past five years, was the Baylor Heart and Vascular Hospital joint venture.

Question 1-Answer: As mentioned above, many factors determine whether a hospital treats many Medicaid patients---with Geographic Location, and whether or not the hospital provides a trauma service, obstetrical or neonatal services, being the most relevant factors. As to geography (with the exception of the Baylor Heart Hospital joint venture), to our knowledge, very few hospitals, physician owned or not, are being built or expanded in locations with a heavy Medicaid or indigent population—with most new construction being in suburbs.

Similarly, hospitals are reducing their participation in trauma. There are less than 170 trauma centers nationwide, and the number is declining. This is caused by a number of factors, but in part because CMS relaxed the "on call" requirements for physicians practicing at non-trauma designated hospitals, thus increasing the burden on hospitals that provide designated trauma services.

Obstetrics and neonatal services are not being expanded, generally, in communities across the country due to the medical liability crisis resulting in fewer physicians and hospitals willing to provide those services. Again, we would have added these services and broadened Medicaid access in Frisco, but for the Moratorium in the MMA of 2003.

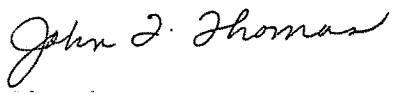
Question 2: Answer: We need more physicians and more hospitals providing services to the Medicare, Medicaid, and Uninsured Population. ***Banning physician ownership in specialty hospitals or ASCs, however, will have no effect in the amount of Medicaid services provided.*** In fact, Baylor has found just the opposite to be true. By using hospital-physician joint ventures to keep physicians aligned with the Baylor Mission to provide care to all, including the uninsured and Medicaid population—we have kept physicians engaged in our trauma services in downtown Dallas, built and operate what has become the highest rated heart hospital for quality in the Country (see CMS'

HospitalCompare.gov, website), and have expanded services to areas of our community that are not served.

In conclusion, there are over 5000 hospitals in the United States, and less than 200 (by any definition) specialty hospitals. The Physician Owned Specialty Hospitals are not the cause of the 45 million uninsured, nor is banning physician ownership the cure to providing access to care for those uninsured and the Medicaid population----rather, we would submit, alignment with physicians can improve quality, safety and increase access, while lowering cost for those that pay for health care services.

We appreciate the opportunity to participate in the Hearing and responding to these questions. We would very much like to work with you on meaningful ways to increase access for the Medicare, Medicaid and indigent population. For example, meaningful medical liability reform, reduction of the administrative burden to participate in the Medicare and Medicaid programs, and market and governmental reforms to increase the number of insured, would all have a positive benefit.

Sincerely,



John T. Thomas
Sr. VP-General Counsel

Cc: Chairman Joe Barton
Joel T. Allison, President and Chief Executive Officer, BHCS
Kristi Sherrill, Director of Government Affairs

June 13, 2005

Subcommittee on Health, May 12, 2005
"Specialty Hospitals: Assessing Their Role in the Delivery of Quality Health Care"
Responses to Questions from the Honorable Tom Allen
Submitted by Alan H. Pierrot

Summary of Question 1:
"Let me ask you Dr. Pierrot, does that hospital sound familiar to you? I ask, because those are the 2003 figures reported to the California Office of State Health Planning by the Fresno Surgery Center."

Although not put in the form of the question, the first two paragraphs appear to suggest that a whole hospital should be defined as providing *"... a wide range of services and treats a representative number of Medicaid and indigent patients."* The commentary suggests that Fresno Surgery Center is not a "*whole hospital*" because it "*reports no Medicaid, no discharges or revenue for Medicare managed care or MediCal managed care, has no discharges or revenue for the county indigent program, no charity care, a provision for bad debt that is less than one percent of total gross patient revenue and no emergency room....*"

Response:
Each state determines what entities qualify to be licensed as hospitals. That is true in California, as well as Maine. The federal government has relied on the states to make these judgments because hospitals are dynamic institutions, with wide variation in scope of service and delivery models. Any attempt to "define" a hospital in a single way will disadvantage many institutions. The most vulnerable will be those small rural facilities that have limited case loads and specialized facilities like psychiatric hospitals. Reliance on the state licensing process has been an effective strategy that has allowed the hospital sector to diversify in productive ways over the life of the Medicare program.

Both CMS and MedPAC have reported that the specialty hospital model is a promising one deserving of more study. CMS found what doctors, nurses and patients have known for years, that specialty hospitals have higher quality and higher patient satisfaction. Why would the government seek to develop complicated definitions to discourage a model that is producing higher quality, higher patient satisfaction and which, according to MedPAC, has not caused financial harm to any community hospital? Medicare policy should encourage innovation, encourage new models of healthcare delivery, reward quality, service and higher patient satisfaction. The Federation of American Hospitals' petition regarding the definition of a hospital is a self serving, protectionist effort to eliminate promising new competitors and a superior model of care that its members view as a threat.

There are a number of reasons why FSC has few MediCal patients. Like psychiatric, cancer and rehabilitation hospitals, FSC has a very narrow focus, providing surgical services to healthy adults undergoing elective surgery. Children make up roughly half of the local MediCal population. FSC does not provide surgical services to children. Another major

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source of MediCal inpatient work is obstetrics. Approximately 70% of the deliveries in Fresno County are covered by MediCal. FSC does not offer obstetrical services. To my knowledge, there is no published breakdown of the percentage of hospital revenue that comes from elective surgery in adults by type of surgery or by payer group. I suspect that the MediCal revenue of most California hospitals is for services other than elective surgery in adults and, therefore, comparisons of the MediCal revenue of those hospitals to FSC is an invalid and meaningless comparison. If hospitals have a higher percentage of MediCal revenue than FSC because they offer services to children or delivery services or other services not offered by FSC, the comparisons of MediCal revenue percentages are meaningless.

Because of exclusive contracting confined to Fresno's largest healthcare system, the Fresno Surgery Center ("FSC") is unable to serve any HMO patients. FSC cannot get access to any HMO contracts (something to consider when the unlevel playing field comes up). This is not only true for MediCal and Medicare managed care, it is also true for commercial HMO patients. The majority of MediCal patients in Fresno County are enrolled in two HMOs, Blue Cross and Health Net, and FSC has no access to these patients. FSC does serve non HMO MediCal and Medicare patients.

Fresno County has a contract with Community Medical Centers to provide indigent care. Indigent patients are channeled to Community Medical Center facilities. The results of this program and also MediCal and Medicare managed care contracting practices are shown in the following table of information taken from California Managed Care Review 2002

Hospital	Staffed Beds	Medicare Days	MediCal Days	County Indigent	Total Margin
Fresno Community	745	31.6%	35.9%	5.8%	10.5%
University Medical Center	334	18.3%	40.9%	14.7%	15.7%
Clovis Community	100	32.9%	12%	0.2%	-6.1%
St. Agnes	326	61.7%	8.6%	0.0%	6.3%
Kaiser	119	43.5%	0.1%	0.0%	NA
Fresno Surgery Center	20	24.9%	0.1%	0.0%	5.1%

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There are a number of possible conclusions from the data shown in the table:

1. The most profitable hospitals in Fresno County are those with the highest indigent care and MediCal percentage of revenue. Perhaps the compensation mechanisms for MediCal and indigent care such as Disproportionate Share funds are working. Perhaps they are excessive.
2. FSC's indigent care days are virtually identical to those of three not for profit hospitals in Fresno: Kaiser, St. Agnes Medical Center and Clovis Community Hospital.
3. For profit FSC assumes no greater MediCal burden than Kaiser and no greater indigent care burden than Kaiser, St. Agnes and Clovis Community.
4. If a hospital must treat "a representative number of Medicaid and indigent patients" as suggested by Congressman Allen, the Kaiser hospital would be eliminated from the Medicare program along with FSC. Should St. Agnes and Clovis Community be eliminated also?

In order to be treated as a not for profit hospital under IRS rules, a facility must comply with a community service standard. Except for FSC, all of the hospitals shown in the table are not for profit hospitals. Among the not for profit hospitals, there are considerable differences in the MediCal and indigent care burden, yet all enjoy the same tax exemptions and the same access to low interest, tax free bond financing. All are allowed to build huge tax exempt endowments which frequently provide more net income than their operations.

FSC is a for-profit entity and must pay state, federal and property tax and higher interest rates for debt financing. In the recent CMS study, it was found that when the tax revenues paid by for profit specialty hospitals are added to their indigent and Medicaid revenue, the total, as a percent of net revenue, exceeds the charity services provided by not for profit hospitals. Studies performed by Harvard professor, Nancy Kane, and confirmed in her congressional testimony, indicate that 75% of tax exempt, not for profit hospitals in the United States receive more in tax benefits than they provide in indigent care.

As a nation, we subsidize not for profit hospitals in numerous ways in exchange for receiving a community benefit from those hospitals. We have no such contract with for profit hospitals. In the case of Fresno Community Hospital and University Medical Center, the subsidies are so effective that these hospitals have the highest margins in the area (see table).

FSC does not have an emergency room because an emergency room is not a requirement for hospital licensure in the state of California and because it makes no sense to add an emergency room to a specialty hospital that focuses on elective surgical procedures. For the same reason, it makes no sense to add an emergency room to a psychiatric hospital or a rehabilitation hospital. Should any emergency situation arise at FSC, the attending physician transfers the patient to the appropriate facility for follow up care.

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According to a July 2003 study by the California Healthcare Foundation (www.chcf.org), California's emergency rooms are profitable. That is, there is an average loss per patient seen in the emergency room in 2002 of $84 BUT one patient in seven was admitted from the emergency room and the average profit per emergency room admission was $1,220. Specialty hospitals do not provide emergency services because the service is not appropriate to the model, not because emergency services are unprofitable, a favorite misleading position promulgated by large hospitals.

Summary of Question 2:

"Dr. Pierrot, you mention many reasons why physicians establish specialty hospitals, but profit is not listed as one of them. I find that very disingenuous. I have seen literature that shouts about the huge profits physicians can make from self-referral. Do you truly believe that profit has nothing to do with the proliferation of these facilities?"

Response:

Certainly profit is a consideration when anyone makes an investment. People do not risk capital without the prospect of a return on investment. But in my experience, profit is not the primary reason physicians pull together to build specialty hospitals or surgery centers. Opponents of specialty hospitals are fond of the simplistic argument that specialty hospitals are proliferating solely because of physician profit motive. The issue is a great deal more complicated than catch phrases like "skimming the cream" and "physician self-referral." In my experience, the usual driving force behind a specialty hospital is the total frustration of physicians with the inadequacies of the traditional hospital model in responding to the needs of the elective surgery patient and the needs of the surgeons who perform that surgery.

FSC is an illustrative example. In 1984, 76 Fresno physicians built FSC as an ambulatory surgery center and we found that it was more efficient, more pleasant, had better equipment and our patients raved in their appreciation of the higher level of service. When I was doing surgery, I could do six procedures at FSC in the same time it took to do four identical cases at the large community hospital. In 1984, unlike today, the majority of surgical cases were inpatient cases. We surgeons had learned from FSC that there was a better way to deliver elective surgery services than the traditional hospital model but our patients could only enjoy the benefits of that model if they were outpatients. We petitioned the state legislature to allow us to add beds to our surgery center and were allowed to add 20 beds in 1988. For more than a year that bed unit was not profitable and for the last two years it has not been profitable. But it has consistently provided superior care for our patients, lower infection rates, higher patient satisfaction, higher quality and a more efficient environment for surgeons.

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Physicians do not build specialty hospitals to lose money. Bankers won't lend money to a project that does not look like it will be successful. But more importantly they also build them because they know the model provides superior care, higher quality, a more efficient, more effective, work environment, all points substantiated by the CMS report. Since there are no specialty hospitals in Maine, Congressman Allen has probably not had the opportunity to talk to the patients who have enjoyed specialty hospital care, or talk to the families of patients or talk to the non investor surgeons who use the facility or talk to the nurses who work at specialty hospitals. I invite the Congressman to visit FSC so he can have the opportunity to gather facts firsthand

Summary of Question 3:

"Dr. Pierrot, you talk about the efficiency of specialty hospitals, and yet MedPAC found that costs were not lower. In fact, MedPAC evidence indicates they were higher. Can you tell us how you measure efficiency at the Fresno Surgery Center?"

Response:

The first place we look to measure efficiency is what is called the turnover time. That is the time that passes from one patient leaving the operating room until the next patient enters the operating room. One major reason a surgeon can accomplish more cases in a given day in a specialty hospital than in a community hospital is that specialty hospitals generally have shorter turnover times.

We also look at the quality of the outcomes compared to the cost of providing the service. That is, the value being provided. If specialty hospitals deliver higher quality, better outcomes for the same cost, I would argue that they are a better value. It is clearly documented that specialty hospitals provide more nurses/patient than the traditional hospital. Physicians and nurses know a higher nurse to patient ratio results in better care and when they are in charge of staffing decisions, they invest in quality and outcomes by providing more nurses per patient. In California, the nurse union was forced to seek staffing standards from the legislature because hospital managements, in response to manage care cost pressures, were accepting unsafe staffing levels. Specialty hospitals in California have always voluntarily exceeded the minimum nurse staffing standards now required by law.

CMS found what we have found at FSC in the last 16 years, that the specialty hospital model provides superior care and higher patient and physician satisfaction. We also know that it provides much higher nurse satisfaction. If MedPAC is correct, that specialty hospitals costs are about the same as traditional hospitals, and CMS is correct that quality is higher at specialty hospitals, I conclude that specialty hospitals provide a clearly superior value. This is absolutely consistent with my own extensive clinical observations.

JOHN HORNBEAK

PRESIDENT & CEO OF METHODIST HEALTHCARE SYSTEM

RESPONSES TO SUPPLEMENTAL QUESTIONS

ISSUED BY THE SUBCOMMITTEE ON HEALTH

OF THE HOUSE COMMITTEE ON ENERGY AND COMMERCE

Question 1. Mr. Hornbeak, I am interested in pursuing a little further your statement about ownership and referral. I want to be sure I understand it and hope you can clarify your position. Are you opposed to specialty hospitals and/or specialization of services or is it the referral and ownership linked together?

Answer: I am not at all opposed to specialty hospitals and/or specialization of services. In fact, at Methodist in San Antonio, we operate the following specialty hospitals or services:

- A 37 bed Surgery Hospital (without physician ownership)
- A 120 bed Heart Hospital (without physician ownership)
- A 158 bed Children's Hospital (without physician ownership)
- A 200 bed Specialty and Transplant Hospital (without physician ownership)
- The Texas Transplant Institute (without physician ownership)
- The Texas Neurosciences Institute (without physician ownership)
- A 90 bed Women's Pavilion (within the Medical Center) (without physician ownership)
- A 47 bed Women's Pavilion (on the downtown campus, under construction) (without physician ownership)

We operate these specialty hospitals and services at the very highest level of competence, performance and outcomes. We have strong competitors is all these areas and are fully prepared to compete on the basis of quality and costs.

The core problem, however, is the sweetheart ownership deals that provide remuneration to the doctor for directing the right patients to their "private game preserve." As a practical matter, only doctors admit patients to hospitals. The overwhelming majority of patients rely on doctors to select "the best" hospital for their situation, but assume that their doctors are making the choice based on well-known quality issues. They further assume that doctors are not receiving "kickbacks" or monetary inducements of any kind from the hospital that their doctor chooses. While patients may be aware that a doctor earns fees based on professional services provided at the hospital, they rationally would assume that those fees will be the same no matter which

hospital the doctor chooses. Doctors' local ownership of a single specialty service (such as a heart hospital) constitutes the largest, most material conflict of interest found in healthcare today.

A well-compensated professional assuming the role of "honest broker" on behalf of the consumer (here, the patient) should avoid even the *appearance* of such a conflict of interest. There are outright prohibitions against such self-dealing for other professions acting in the "honest broker" role: stock brokers; financial advisors, independent insurance agents, real estate brokers, etc.

Even given these prohibitions, as well as punishments, codes of conduct, disclosure requirements and scrutiny of regulators, we continue to see a number of such professionals succumb to the temptations inherent in this position of sacred trust. Although the proponents of doctor-owned specialty hospitals claim that there are (and should be) no prohibitions of their conflicts of interest, their position simply is indefensible.

Question 2: I'm trying to get a whole picture of what differentiates you from physician-owned specialty hospitals. Can you tell me what special services your hospitals provide to the community? What is your level of charity care? What percentage of your patients is Medicaid beneficiaries?

My response to Question #1 contains a list of our specialty hospitals/services, but Methodist also provides almost every other hospital service imaginable. Even within our heart hospital, some services and programs lose money or barely break even, such as heart transplant, children's congenital heart surgery, heart failure clinics (for the medical management of patients with end-stage heart disease who are not surgical candidates) and bridge-to-transplant assist devices.

Why is this germane? Because the heart hospital joint venture between MedCath's and its cardiologists performs none of these services. They concentrate only on the most lucrative of heart services. So the "cherry picking" occurs at two levels: first, selecting a cardiology focus, to the exclusion of other healthcare services; and second, identifying the most profitable patients, who offer the highest margin DRG reimbursement.

Other money-losing services include the medical intensive care unit and the downstream intermediate and routine care medical units that treat stroke, emphysema, kidney failure, chronic obstructive pulmonary disease (COPD), liver disease and a host of other conditions requiring medical management. Further examples include care of end-stage cancer patients, psychiatric patients, substance abuse patients, peripheral vascular disease, most children's services, trauma patients via our emergency rooms, and orthopedic major joint replacement of hips and knees.

On the out-patient side, these services include emergency patients transported via EMS, the sexual assault program, family health centers, rural health clinics, referrals from the federally-qualified health clinics (FQHCs), Methodist Ministries' medical and dental clinics, and free transportation services for patients in need.

In 2004, Methodist provided charity care totaling $49 million; 22% of our admissions are Medicaid or self-pay, as are 41% of emergency room visits. The number of Medicaid and indigent Medicare patients treated are so high that all of our full-service hospitals are certified as both Medicaid and Medicare "disproportionate share providers."

Question #3: Mr. Hornbeak, in your oral testimony you outlined how a specialty hospital facility recruits physician investors and what the level of investment of each physician might be. Why can't the Methodist Healthcare System offer their physicians this same type of investment opportunity?

Congress included self-referral prohibitions in the Fraud and Abuse laws to prevent physicians from referring patients to facilities where they have a financial conflict of interest. In the community hospital setting, the equity stake of any single physician would be diffused across every department at the hospital. In this context, the correlation between a physician's decision-making and financial gain would be attenuated. Therefore, Congress adopted the "whole hospital" exception to allow physician investment in full-service community hospitals, because individual referrals would not economically benefit a physician owner.

Limited-service specialty hospitals essentially are hospital departments—like cardiology, orthopedics, or surgery—that have been removed from full-service community hospitals. Unlike investing in an entire full-service hospital, an individual physician's equity stake and control over net profits in these facilities can be substantial. By enticing physician investors with the promise of such lucrative returns for patient referrals, specialty hospitals are exploiting a loophole in the "whole hospital" exception to the Fraud and Abuse laws. In this respect, specialty hospitals rely upon a business model that plainly contradicts congressional intent.

We believe there to be substantial risk implicit in adopting a business model that is based upon a conspicuous loophole that could—and should—be remedied.