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PHYSICIAN-OWNED SPECIALTY HOSPITALS

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED NINTH CONGRESS

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PHYSICIAN-OWNED SPECIALTY HOSPITALS

TUESDAY, MARCH 8, 2005

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 4:07 p.m., in Room B–318, Rayburn House Office Building, Hon. Nancy L. Johnson, (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON OVERSIGHT

FOR IMMEDIATE RELEASE
March 8, 2005
No. HL–2

CONTACT: (202) 225–1721

Johnson Announces Hearing on Physician-Owned Specialty Hospitals

Congresswoman Nancy L. Johnson (R–CT), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on physician-owned specialty hospitals, following the release of the 2005 report of the Medicare Payment Advisory Commission (MedPAC). **The hearing will take place on Tuesday, March 8, 2005, in B–318 Rayburn House Office Building, beginning at 4:00 p.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include Glenn Hackbarth, Chairman of MedPAC, and representatives from groups affected by Medicare's payment policies. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

In recent years, there has been increasing growth of specialty hospitals owned, in part, by physicians. Such facilities focus primarily on the performance of cardiac, surgical and orthopedic procedures. Proponents contend that these facilities provide a range of benefits, including increased efficiency, competition, better medical outcomes, and improved patient satisfaction. Critics of specialty hospitals contend that physician owners at these facilities select more profitable patients and procedures, which adversely impacts the resources of community hospitals. Critics also believe physician ownership creates conflicts of interest and may increase utilization and spending of services. Medicare payments for inpatient procedures at hospitals are determined by grouping medical procedures into more than 500 diagnosis-related groups (DRGs), with the goal of providing appropriate payments based on the type of medical condition and resources required to treat the condition.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (P.L. 108–173) responded to questions surrounding the growth of these facilities by imposing a moratorium until June 8, 2005, that prohibits the opening of new facilities in which a physician maintains an ownership interest. The MMA permitted existing specialty hospitals to operate. Also, the MMA requires MedPAC to issue a report by March 8, 2005, on cost differences, the financial impact of specialty hospitals on community hospitals, patient selection, and recommendations to update the DRG structure. In addition, the MMA requires the Secretary of the U.S. Department of Health and Human Services to issue a report by March 8, 2005, on in part, quality and differences in uncompensated care between specialty and community hospitals.

FOCUS OF THE HEARING:

The hearing will focus on physician-owned specialty hospitals, identification of potential problems and an examination of potential solutions. The MedPAC will present findings from its report to Congress on physician-owned specialty hospitals. The second panel will provide input from affected parties, including testimony from

witnesses with experience in specialty hospitals, community hospitals and physician-referral issues.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov,* select *109th Congress* from the menu entitled, "*Hearing Archives*" (*http://waysandmeans.house.gov/Hearings.asp?congress=17.*) Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record.*" Once you have followed the online instructions, completing all informational forms and clicking "submit" on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You ***MUST REPLY*** to the email and ***ATTACH*** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business Tuesday, March 22, 2005. **Finally,** please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below.Any submission or upplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov*.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special acc commodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman JOHNSON. Welcome everyone. We gather today to discuss the serious issue of physician-owned specialty hospitals. We will begin to explore today the results of the Medicare Payment Advisory Commission's (MedPAC), the report to Congress on physician-owned specialty hospitals. We will also hear from a representative of the Centers for Medicaid and Medicare Services regarding their preliminary results and the perspectives of various interested parties.

In recent years there has been increasing growth in the specialty hospital area. Such facilities focus on the performance or cardiac,

surgical and orthopedic procedures. Proponents contend that these facilities provide a wide range of benefits, including increased efficiency, competition, better medical outcomes, improved patient and provider satisfaction.

Critics of specialty hospitals contend that physician owners at these facilities select more profitable patients and procedures which adversely impacts the resources of community hospitals. Critics also believe physician ownership creates a conflict of interest and may increase utilization and spending on services. These issues are important, and given the nature of the facilities and treatments at issue, compel us to consider the manner in which Medicare pays for inpatient procedures at hospitals and whether changes to the payment system are needed to provide accuracy and prevent waste. The Medicare Prescription Drug Improvement and Modernization Act of 2003 imposed a moratorium until June 8th, 2005 that prohibits the opening of new specialty hospitals while allowing existing specialty hospitals to operate, and allowing those under development to apply for a waiver. The moratorium expires and is something we must consider soon.

We appreciate the efforts of MedPAC in issuing its timely report on physician-owned hospitals. MedPAC makes a variety of findings and recommendations which we will explore today. On our first panel we are happy to have MedPAC's Chairman, Mr. Glenn Hackbarth, here today with us to discuss the findings set forth in MedPAC's report. In addition, although we have been advised that the Secretary's report on specialty hospitals is not yet available, we are pleased to hear comments from Mr. Thomas Gustafson, who is the Deputy Director of the Center for Medicare Management and for the Centers of Medicaid and Medicare Services, who will provide limited testimony on their preliminary research data. His testimony will not and is not intended to provide any conclusions about the data, and is not to be considered a substitute for the Secretary's report, which we anticipate to be issued in the near future.

On our second panel we are pleased to hear from representatives from the physician hospital and specialty hospital communities. They will provide varied perspectives on physician-owned specialty hospitals, the Medicare payment structure and potential improvements to the system for the benefit of Medicare beneficiaries, providers and taxpayers. Mr. Stark, I now welcome you.

Mr. STARK. Thank you, Madam Chair. You are quite right, it is an important topic. My concern is that the growth of specialty hospital phenomena or whatever you choose to call it, could impact the structure of our medical care delivery system. In essence these facilities are pulling profit centers out of community hospitals and over time could cause a real disruption in the financing and the fiscal health, financial health of these hospitals.

There aren't many of these specialty hospitals now, but if financial incentives are motivating a lot of for-profit corporations and physicians to team up and create heart hospitals, orthopedic hospitals, surgery hospitals, and the moratorium we passed has stalled this, but I do not think we have much time to act. The industry publications indicate there could be 100 institutions waiting in the wings to jump if in fact the moratorium expires, and I expect we would have trouble putting that genie back in the bottle once it

opened. The specialty hospitals generate huge returns for their investors, mostly doctors, the other half by the people who have organized them. The question is, I do not know if there is any information that they are any better for patients. The food I understand is better, but that is hardly the issue. And are they good for the medical care delivery system as a whole? That I think is the real question.

We enacted the Physician Self-Referral Laws because of overwhelming evidence that health care providers who personally profit from referrals will increase the number of such referrals, not surprising I don't suppose to any of us. When those laws were enacted physician-owned specialty hospitals basically did not exist. We included the whole hospital exception in the law because of the broad based entities in which it would be hard to prove that ownership caused inappropriate referral patterns, but we explicitly prohibited ownership in a subdivision of that hospital, as we say, a hospital within a hospital, and because it would cause just such a conflict. I submit to you that today's physician-owned specialty hospitals are nothing more than freestanding subdivisions of a hospital.

I would like to go on record in support of the petition by the Federation of American Hospitals urging Health and Human Services to update their regulations to make clear that these physician-owned specialty hospitals do not meet the whole hospital exception. Today we will hear from MedPAC about their recommendations. I believe their proposal to readjust the payment system to eliminate the obvious financial incentives that encourage these specialty hospitals make good sense. But I still believe that realigning the payment system won't be enough to solve the inherent problem of self-interest, and it is a positive change and one we should proceed with.

MedPAC has also recommended and extension of the moratorium. At a minimum it is vital that we extend this moratorium until we have a legislative solution to the very real problems posed by the physician-owned specialty hospitals. Finally, I would like to note that we have a wide breadth of groups in agreement that something should be done to curb the growth of these physician-owned specialty hospitals. I would like to point to page 145 of the President's Budget, where it states, quote, "The Administration will seek to refine the inpatient hospital payment system and related provisions of regulations to ensure a more level playingfield between specialty and non-specialty hospitals."

On the day when Pete Stark, Chip Kahn and President Bush all agree that something needs to be done, I think we can create a policy that Congress can pass, and I look forward to hearing from the witnesses today. Thank you, Madam Chair.

Chairman JOHNSON. Thank you, Pete. Mr. Hackbarth?

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

Mr. HACKBARTH. Chairman Johnson, Mr. Stark, other members of the Subcommittee, it is good to see you again and I appreciate the opportunity. Chairman Johnson well summarized the basic issues here, the view of the proponents of physician-owned specialty hospitals as well as the opponents.

Our findings on the performance of physician-owned specialty hospitals are based on data drawn from 2002. That was the most recent data available when we began our study. In the 2002 data there were 48 hospitals that met our test for specialization and minimum Medicare volume. In addition to looking at that data, we also conducted site visits to Austin, Texas, Wichita, Kansas, and Sioux Falls, South Dakota.

The data that we have before us are limited in three important respects. First of all we have a small number of hospitals, 48 hospitals, and many of those hospitals are very small institutions. Second, 2002 was at an early stage in the development of the specialty hospital phenomenon. Third, MedPAC did not look at any data on quality of care in specialty hospitals since that assignment was given to CMS under the MMA mandate.

As was alluded to earlier, we also make recommendations on refining the payment system for hospitals overall. I want to be clear that those recommendations are not based on this limited data set, but rather on a broader analysis of Medicare claims and cost reports, so the foundation for those recommendations we think is very strong indeed. As I proceed with my comments if it is okay I will make reference to a couple of figures that are in the testimony that I hope everybody has in front of them. On page 3 of my testimony, there is a map that shows you where specialty hospitals are located, both the ones that we studies in 2002 and ones that we know of that have been developed since 2002. In 2002 almost 60 percent of the specialty hospitals were in four States, South Dakota, Kansas, Oklahoma and Texas, so they were quite concentrated. Even if you look at the hospitals that have been developed since they are still quite geographically concentrated. You can see many States have no physician-owned specialty hospitals for a variety of reasons.

Today we estimate that there are more than 100 physician-owned specialty hospitals, and more, as Mr. Stark pointed out, may be in the wings. Our findings were as follows. Heart hospitals tend to focus on diagnosis-related groups (DRGs), with a greater than average expected profit. On the other hand, orthopedic and surgical specialty hospitals tend to focus on DRGs that have a slightly less than average expected profit. All three types of specialty hospitals, heart, orthopedic and surgical, however, tend to treat patients within those diagnosis categories that are less severe cases, and as a result have higher expected profits.

If you turn to page 7 in my testimony, you will find Table 1 that summarizes the data that we found on this issue, and pardon me for how detailed and complicated it is. But the basic point is that the column labeled DRGs has a factor that describes the expected profitability based on the diagnosis of the patient. So, if you look at heart hospitals and then specialty, under the DRG column it says 1.06. So, that means if the hospital had an average level of cost just based on the diagnosis of the patients, the DRGs they are in, the expected profitability would be 6 percent above average.

The next column over labeled "Patient severity" says that if you look at the patients within any given DRG and the severity of their illness, what is the effect of that on expected profitability. So, in the case of specialty heart hospitals the patient severity factor is

another 3 percent above average expected profit. And then you combine those two in the last column to get 109 or 9 percent higher than average expected profitability. So, all three types of hospitals, as you look down that last column, have better than average expected profitability when you take into account both the DRGs and the severity of illness of the patients involved. So, that was one set of findings. A second is that in 2002, the year that we looked at, specialty hospitals tended to draw their patients from community hospitals as opposed to increasing the amount of services provided overall. So, they were taking patients that otherwise would have gone for their surgery to a community hospital, treating them in a specialty hospital, as opposed to increasing the overall amount of surgery in the community.

Now, we did find some evidence, some indications, that there might be increased utilization, but there were not enough data to allow us to draw conclusions, statistically significant conclusions. So, this is something that we think is worth watching and further study. Another finding is that the community hospitals competing with specialty hospitals are able to recover relatively quickly from the impact of losing patients to the specialty hospital through a combination of strategies, lowering costs, adding new services and the like, although that might be more difficult for hospitals, community hospitals that are in smaller communities.

Next we found that the cost of specialty hospitals are not lower than those of community hospitals, although the average length of stay for the patients is in fact lower in specialty hospitals than in community hospitals. In fact, the data showed that the cost of specialty hospitals were higher than community hospitals, but again, the differences were not statistically significant. So, you ask yourself, how can it be that they have higher cost per case and lower average length of stay? There might be a variety of reasons for that, more staff per patient, higher salaries for staff, high start up costs and the like could possibly explain that combination.

Finally, we found that specialty hospitals serve proportionately fewer Medicaid patients than community hospitals do. Based on those findings we have the following recommendations. First of all, we recommend that the DRG payment system be refined to better match payments with the expected cost of care for different types of patients. We have several specific recommendations on how to do that, several of which are directed at how the DRG weights are calculated. The weights are the factors that determine how the payments vary based on DRG. And then another recommendation is that we incorporate a severity adjustment in the system so that patients that are more severely ill, have more complicated illness, carry with them higher payments from the Medicare Program.

If you turn to page 8 of my testimony and Figure 2, a series of bar graphs, this graph illustrates the impact of proposed payment reforms. On the far left-hand side of the graph you see current policy, and what that signifies is that if you look at the middle bar over current policy, about 35 percent of the dollars paid out in the Medicare Program are in DRGs currently, where the expected profitability is between plus and minus 5 percent of the average. So, that is the status quo. That is where we are today. The different sets of bars indicate various proposed refinements to the system.

If you go all the way to the far right-hand side that is the cumulative effect of all of our proposed changes, and you see that there, as a result of the payment reforms, 86 percent of the payments would be for categories where the profitability, expected profitability is within plus or minus 5 percent of the average. So, there would be a much more accurate payment system.

We think these are very, very important changes. Indeed these are changes that we would recommend be made in Medicare even if physician-owned specialty hospitals did not exist. They make the payment system fairer to hospitals and ultimately therefore better we believe for patients. Because these changes shift dollars around in the system there are winners and losers. We recommend that they be implemented with a transition period. The winners and losers are interesting. You are familiar with how in our regular reports to Congress we analyze the impact of various proposals, and we often look at how urban hospitals are affected or rural hospitals are affected or teaching and non-teaching hospitals are affected. Well, what we find in analyzing the impact of these changes is that there would be winners and losers that cut across those categories. In other words, some urban hospitals would benefit from these changes, but some would lose Medicare dollars as a result of these changes. Some rural hospitals would benefit and some would lose. Some teaching hospitals would benefit and some would lose.

Obviously, the reason that we are proposing them is that the winners deserve more money because they are caring for patients that have higher expected cost. The ones that would be losing Medicare dollars would lose because they are carrying patients that are not expected to be as costly and so they should be receiving lower payments. Our next recommendation is that the Congress authorize the Secretary of Health and Human services to permit and then regulate what we refer to as gain-sharing arrangements between physicians and hospitals. We believe it is very important for physicians and hospitals to have the opportunity to work together and mutually benefit from successes in reducing cost and improving quality. we believe that is particularly true in that we and others are recommending that Medicare begin incorporating payment adjustments for quality. Those gains can be best accomplished through collaboration of physicians and hospitals, but right now the rules prevent them from sharing in gains in efficiency or gains in quality improvement. We think that is a barrier, an impediment to improvement, and we think that Congress ought to authorize the Secretary to permit that gain sharing, albeit within clearly-defined set of rules that would protect quality of care and prevent the dollars from being used to reward inappropriate increases in admissions and the like. This too we would recommend even if specialty hospitals did not exist.

Finally, we recommend an extension of the current moratorium on the development of specialty hospitals so Congress has ample opportunity to consider our recommendations and CMS then has ample opportunity to implement them. In addition, the extension of the moratorium would give us additional time to analyze the cost and quality of specialty hospitals. Even after our recommended changes, MedPAC has residual concerns about self-referral by physicians to hospitals in which they have an ownership interest. Our

concern is that that ownership interest could have an undue impact on clinical decisionmaking about who gets what care at what location. Rather than rule out physician-owned specialty hospitals, however, based on that alone, we think would do well to carefully examine, continue to examine whether these institutions can help us lower cost and improve quality. If in fact they were able to do that, then we would weigh those potential gains against the concerns raised by self-referral, and then make a judgment.

Right now we are concerned that the data available to reach a definitive judgment about physician-owned specialty hospitals is too limited to make a final judgment, and we could benefit from some more information. Thank you very much, and I look forward to your questions.

[The prepared statement of Mr. Hackbarth follows:]

Statement of Glenn M. Hackbarth, Chairman, Medicare Payment Advisory Commission

Chairman Johnson, Congressman Stark, 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 afternoon 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 nonphysician owned hospitals have specialized in the same services as physician-owned specialty hospitals.

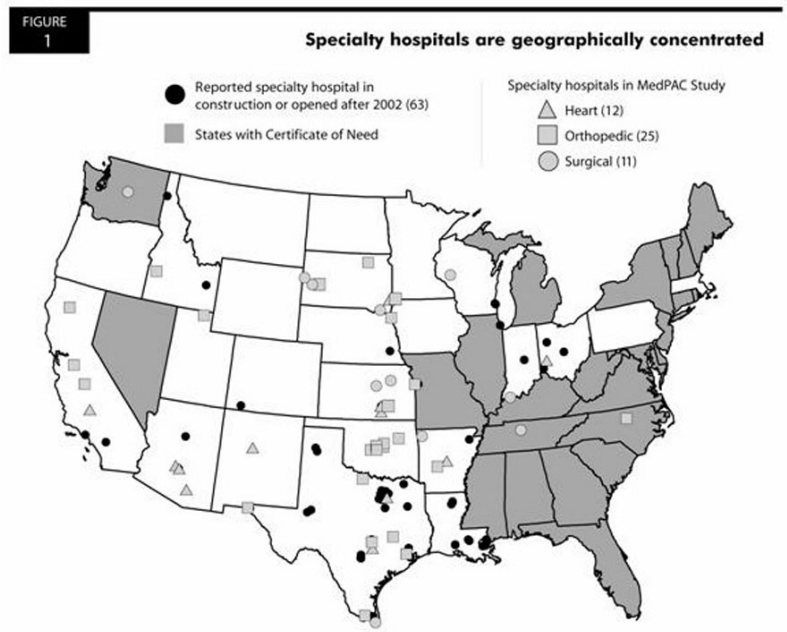
We also recommend an approach to aligning physician and hospital incentives through gainsharing, which allows physicians and hospitals to share savings from more efficient practices and might serve as an alternative to direct physician ownership. Because of remaining concerns about self-referral; need 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 critic 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 community 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 IPPS hospitals	4,375	1.00	1.00	1.00
Heart hospitals				
Specialty	12	1.06	1.03	1.09 [a,b]
Peer	36	1.04	0.99	1.03 [b]
Competitor	79	1.01	1.00	1.00
Community	315	0.99	1.01	1.01
Orthopedic hospitals				
Specialty	25	0.95	1.07	1.02 [a,b]
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	1.15 [a,b]
Peer	25	1.00	1.06	1.06 [b]
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.

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

[b] Significantly different from nonpeer community hospitals using a Tukey mean separation test and a $p<.05$ crition.

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.

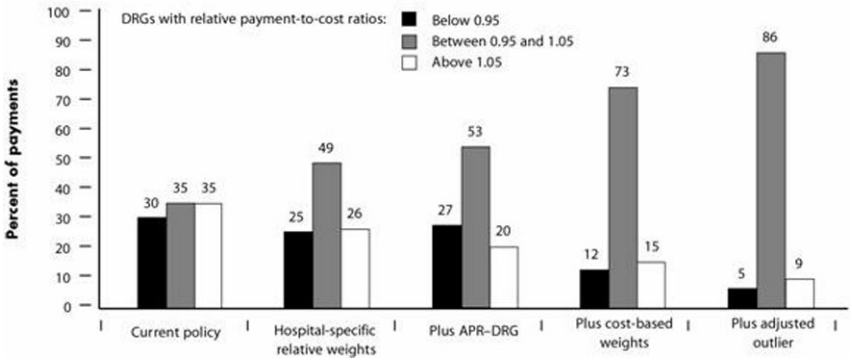
All of these actions are within the Secretary's current authority.

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.

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.

These payment system refinements would affect all hospitals—both specialty hospitals and community hospitals—and many would see significant changes in payments. 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.

Chairman JOHNSON. Thank you very much. Dr. Gustafson?

STATEMENT OF THOMAS A. GUSTAFSON, PhD, DEPUTY DIRECTOR, CENTER FOR MEDICARE MANAGEMENT, CENTERS FOR MEDICARE & MEDICAID SERVICES

Mr. GUSTAFSON. Thank you, Mrs. Johnson, Mr. Stark and distinguished Members of the Committee. I appreciate the invitation to testify today. I am here to present preliminary results from the technical analysis that will underlie the CMS report mandated by MMA that we expect to send to you shortly. I must emphasize that the quantitative findings that I will discuss here are tentative. The technicians are in the back room continue to twiddle the dials on this and the numbers may move around a little bit. But we believe that the qualitative nature of the results will not change materially, and the Administration will proceed to develop policy recommendations once this analysis is in hand.

Our study conducted a considerable amount of new data relative to the performance and impact of specialty hospitals. We made site visits to six market areas around the country. Included in these were 11 of the 59 cardiac, surgery and orthopedic specialty hospitals that were paid by Medicare at the end of 2003. These market areas were selected to represent a range of circumstances in which specialty hospitals now operate.

Within each market area we interviewed specialty hospital managers, physician owners, staff. We also talked with representatives of community hospitals in the area to assess patient satisfaction

which is one of the measures that Congress asked us to look at. We looked at patient focus groups of those beneficiaries who had been treated in specialty hospitals. We also examined referral patterns for all specialty hospitals, not just those that were in the six market areas I described, but all of the 59, using Medicare claims data for 2003, so it was a little bit later than the analysis, so the data was a little bit later than the analysis that MedPAC embarked on. And we also drew on information on financial relations based on information we acquired from the individual hospitals and for tax records.

One major conclusion which I think comports very well with what MedPAC discovered is that there are very clear differences between cardiac hospitals on the one hand and surgery and orthopedic hospitals on the other. Cardiac hospitals are larger, have a higher average daily census, about 40. They tend to have emergency rooms and other features that are usually associated with a community hospital such as community outreach programs. About two-thirds of the patients treated in these facilities were Medicare beneficiaries, which is higher than what you would expect in a community hospital. And in the hospitals in the study the ownership by physicians as a group averaged about 34 percent. Typically a national corporation or a not-for-profit hospital in the area owns the majority share of these hospitals. The average ownership share by an individual physician was about 1 percent. So, in other words, 34 percent in the aggregate, about 1 percent for each individual physician.

Turning now to surgical and orthopedic hospitals. These tended to more closely resemble ambulatory surgical centers. Their primary business appeared to be with outpatient services. They are much smaller than the other hospitals. Their average daily census is about 5. And physicians together generally own a comparatively large share. Our average showed that to be about 80 percent, and the average share for an individual physician was a little over 2 percent.

Medicare patients account for about 40 percent of the inpatient days in these facilities, which is more typical of the community hospital average. Unfortunately, the small number of inpatient cases at these hospitals, the surgery and orthopedic hospitals, prevented us from drawing very robust conclusions about this group on several of the dimensions that we were asked to look at. Turning to our preliminary results we discovered that the majority of Medicare patients in most specialty hospitals are referred or admitted by a physician owner. These physicians do not, however, refer their patients exclusively to the specialty hospitals in which they participate in the ownership. They also refer a similar, although slightly lower proportion of their patients to local community hospitals. Overall, the Medicare cardiac patients treated in community hospitals were more severely ill than those treated in the cardiac specialty hospitals in most of the study sites. There was a little bit of variation here.

Now, these results, the results I just described, held generally for patients admitted both by physicians with ownership in specialty hospitals and by other physicians in the area, indicating that we could discover no difference here in the referral patterns by physi-

cian owners and non-owners. There was a little bit of variation again with cardiac hospitals in some areas having higher average severity than the community hospitals, but the general picture was of more severely ill patients in the community hospitals and no difference in referral pattern.

For surgery and orthopedic hospitals the number of cases involved was too small to draw definitive conclusions, but the preliminary results are suggestive of a similar pattern. We then turned to claims analysis. This involved all of the hospitals that I mentioned earlier, the 59 hospitals, not just the 11 in the study areas. And we examined the claims from these hospitals against a set of quality indicators from the AHRQ and their methodology. Our preliminary findings showed that the measures of quality at cardiac hospitals were generally at least as good and in some cases better than at local community hospitals. Complications and mortality rates were lower at the cardiac specialty hospitals, even when adjusted for the severity of the caseload in the two different hospitals. We were unable to make a statistically valid assessment, or at least have not yet been able to make a statistically valid assessment because of the small number of discharges relating to surgical and orthopedic hospitals.

We examined patient satisfaction, as I mentioned earlier. This was through focus groups of the patients at the specialty hospitals. This was extremely high for all of the hospitals in questions. The Medicare beneficiaries that we talked with enjoyed large private rooms and a number of other amenities, and seemed to enjoy their experience at the hospitals. We did not do a comparison group with the community hospitals in the same areas. We used proprietary financial information we had acquired from the specialty hospitals in the study to examine the taxes that they paid and the uncompensated care as a proportion of net revenues. This was again something that we were asked to do by the MMA. And discovered that relative to their net revenues, specialty hospitals only provide about 40 percent of the share of uncompensated care that the local community hospitals provided. Balancing this, however, the specialty hospitals paid significant real estate and property taxes as well as income and sales taxes. The nonprofit community hospitals—most of the hospitals in the communities we were looking at were nonprofit—of course did not pay these taxes.

If you added this up, the total proportion of net revenue that specialty hospitals devoted to the sum of uncompensated care and taxes significantly exceeded the proportion of net revenue that community hospitals devoted to uncompensated care. You have just heard from Mr. Hackbarth about the MedPAC report. I think it would be fair to summarize our reading of it so far. It is that we don't see any particular inconsistency. I think we are finding much the same, the same underlying reality. We are looking at some different things than they were, but I think the Congress can take some comfort that we are finding things that are very, very similar. We have MedPAC's recommendations under review and will be considering those as we form the administration's recommendations. That concludes my remarks and I look forward to your questions.

[The prepared statement of Mr. Gustafson follows:]

Statement of Tom Gustafson, Ph.D., Deputy Director, Center for Medicare Management, Centers for Medicare and Medicaid Services

Chairwoman Johnson, Representative Stark, 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 have important impacts on quality and medical costs, for our beneficiaries and for 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 redirected to improve quality. To that end, Section 507 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 preliminary results from the technical analysis that will underlie the CMS report for Section 507.

CMS Study

Specifically, MMA 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 to conduct the technical analysis. At this time, we are reporting on the factual findings of the RTI analysis. Any policy recommendations on this issue will have to be developed once the report on the analysis is finalized.

While national data were used for some aspects of this analysis, some questions related to quality, cost, and community impact as mandated by the MMA required the detailed analysis of data that have not been previously available. Consequently, the analysis involved the collection of a considerable amount of new data related to the 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. To conduct this detailed analysis, site visits were made to 6 market areas (Dayton, OH; Fresno, CA; Rapid City, SD; Hot Springs, AR; Oklahoma City, OK; and Tucson, AZ) around the country These markets included 11 of the 59 cardiac, surgery, and orthopedic specialty hospitals that were in operation as approved Medicare providers by the end of 2003. These market areas were selected because they were thought to represent a range of the circumstances in which specialty hospitals operate. Within each market area, specialty hospital managers, physician owners, and staff were interviewed. Executives at several local community hospitals also were interviewed, in order to evaluate their views and concerns with respect to the specialty hospitals. To assess patient satisfaction with specialty hospitals, the study used patient focus groups composed of beneficiaries treated in cardiac, surgery, and orthopedic hospitals.

Referral patterns for all specialty hospitals were analyzed using Medicare claims data for 2003. The inpatient hospital quality indicators developed by the Agency for Health Research and Quality (AHRQ) were used to assess quality of care at the study hospitals and local community hospitals in the 6 study sites. Data obtained from Internal Revenue Service (IRS) submissions and financial reports, as well as from the hospitals themselves, were used to estimate total tax payments and uncompensated care for these hospitals.

Cardiac Hospitals Differ from Surgery and Orthopedic Hospitals

The empirical evidence clearly shows that cardiac hospitals differ substantially from surgery and orthopedic hospitals. Compared to surgery and orthopedic hospitals, cardiac hospitals tend to have a higher average daily census, an emergency room, and other features, such as community outreach programs. The average daily census of the 16 cardiac hospitals nationwide was 40 patients. All the cardiac hospitals that were operational in 2003 reported that they were built exclusively for cardiac care. Cardiac hospitals treated 34,000 Medicare cases in 2003, and Medicare beneficiaries account for a very high proportion (about two-thirds) of inpatient days in those hospitals nationwide. In aggregate, within our sample, physicians own about a 49 percent share in cardiac hospitals; typically, a corporation such as MedCath or a non-profit hospital owns the majority share. In the study hospitals, the aggregate physician ownership averaged approximately 34 percent for the cardiac hospitals in the study. The average ownership share per physician in those hospitals was 0.9 percent, with individual ownership share per physician ranging

from.1 percent to 9.8 percent, with a median of 0.6 percent and an average per physician share of 0.9 percent.

Surgery and orthopedic hospitals more closely resemble ambulatory surgical centers, focusing primarily on outpatient services. Their aggregate average daily census of inpatients is only about 5 patients. Physicians generally own a large share of the interest, averaging 80 percent in aggregate for the surgery and orthopedic hospitals in the study. 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. The balance is typically owned by a non-profit hospital or national corporation. Medicare patients account for about 40 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.

Preliminary Results

At this time, we would like to present the preliminary findings of our technical analysis. While we are still finalizing some aspects of the study, we do not expect the results to change significantly.

Our findings on physician-owner referral patterns indicate that the majority of Medicare patients in most specialty hospitals are referred or admitted by a physician owner, but that these physicians do not refer their patients exclusively to the specialty hospitals that they own. They also refer a similar but slightly lower proportion of their patients to the local community hospitals.

Overall, the Medicare cardiac patients treated in community hospitals were more severely ill than those treated in cardiac specialty hospitals in most of the study sites. This generally was true for patients admitted both by physicians with ownership in specialty hospitals and by other physicians without such ownership, indicating no difference in referral patterns for physician owners and non-owners. However, there was some variation, 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 surgery and orthopedic patients, the difference in the proportion of severely ill patients treated in community hospitals was greater for the surgery and orthopedic patients than for the cardiac patients.

The analysis of patients transferred out of cardiac hospitals did 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 patients transferred from cardiac hospitals to community hospitals who were severely ill was similar to patients in the same diagnosis related group (DRG) who were transferred between community hospitals. The number of cases transferred from surgery and orthopedic hospitals was too small to derive meaningful results on this type of analysis.

Based on claims analysis using the AHRQ quality indicators and methodology, preliminary findings show that measures of quality at cardiac hospitals were generally at least as good and in some cases were better than the local community hospitals. Complication and mortality rates were 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. Patient satisfaction was extremely high in both cardiac hospitals and surgery and orthopedic hospitals, as Medicare beneficiaries enjoyed large private rooms, quiet surroundings, adjacent sleeping rooms for family members if needed, easy parking, and good food. Patients also had very favorable perceptions of the clinical quality of care they received at the specialty hospitals.

We also used proprietary financial information provided by the specialty hospitals in the study that allowed the calculation of their taxes paid and their uncompensated care as a proportion of net revenues. Relative to their net revenues, specialty hospitals provided only about 40 percent of the share of uncompensated care that the local community hospitals provided. However, the specialty hospitals paid significant real estate and property taxes, as well as income and sales taxes, while non-profit community hospitals did not pay these taxes. As a result, the total proportion of net revenue that specialty hospitals devoted to both uncompensated care and taxes significantly exceeded the proportion of net revenues that community hospitals devoted to uncompensated care.

Medicare Payment Advisory Commission (MedPAC) Report

The MMA also required a complementary MedPAC study of certain issues related to the payments, costs, and patient severity at specialty hospitals. Based on our ini-

tial review of their report, there are several preliminary findings in our analysis that are consistent with their results:

- Both analyses found specialty hospitals generally treat less severe cases than community hospitals. The CMS analysis found this difference did not appear to be related to referrals by physician owners of less severe patients compared to referrals by other community physicians.
- Additionally, MedPAC's analysis of the payer shares for specialty and community hospitals is consistent with the CMS finding that specialty hospitals provide less uncompensated care than community hospitals as a whole. In addition, the CMS analysis found that specialty hospitals pay a substantial proportion of their net revenues in taxes, so that total payments for uncompensated care plus taxes are a higher proportion of total revenues at specialty hospitals.
- MedPAC's analysis also found large differences in relative profitability across severity classes within DRGs, which create financial incentives to select low severity patients. MedPAC has recommended refining the DRGs to reduce these incentives and we are currently evaluating their recommendations.

Conclusion

Madame Chair, thank you for this opportunity to discuss the technical findings that will be incorporated into our report on physician-owned specialty hospitals. We have been thoroughly studying this important topic, with extensive collection and analysis of new data, as part of our ongoing efforts to provide a strong factual foundation for implementing policy decisions that help patients get the high quality health care possible at the lowest cost. We will act expediently to incorporate these findings to complete our study and prepare our final results and recommendations for your review. As part of our careful evaluation of this multi-dimensional issue, we are also assessing what authority we have in this area to assure the best possible alignment of Medicare's financial incentives with our goal of improving 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.

Chairman JOHNSON. Thank you very much, both of you. I appreciate your testimony and the thoughtfulness of it and the data you have been able to develop. It does leave holes, and my conclusion is we are well down the road but we have a lot of work to do. Mr. Hackbarth, I am very interested int refining of the DRGs that you propose. I do think that we need to know more about the winners and losers, and I wonder whether MedPAC had discussed or thought through the issue of budget neutrality?

Mr. HACKBARTH. Since these are changes in the DRG weights and the severity adjustment, these would be budget neutral changes. They redistribute payments within the system in a budget neutral way to better match payments to expect a cost for different types of patients. So, yes, it is budget neutral.

Chairman JOHNSON. It is my recollection that MedPAC has commented on the growing number of negative margin hospitals or low margin hospitals, and I personally am watching a lot more very ill medical patients stay in the hospital longer, Medicare medical patients. And I hate to see yet another mechanism that attributes more money to something we can calculate and takes it from these longer-held patients who are sick but are not having operations, procedures, you know, the kind of thing that attract dollars. I think we really have to look at that as we move forward.

Mr. HACKBARTH. Could I just make a comment on that? One of the types of problems that we see in the current system is that since the DRG weights are based on charges, we think we are overpaying for services, DRGs, where there are lots of ancillary services involved. And surgical cases would be one example of that, where

we think that there might be a pattern of overpayment. By the same token we may be underpaying for patients that have a different mix of services, medical patients of various types. So, we think that there are obviously some mistakes in the system and some types of patients aren't carrying enough dollars with them, and the purpose of these refinements is to level out that playingfield, again, not just for specialty hospitals, but even among community hospitals.

Chairman JOHNSON. I think that could be very useful. It just has to be done with a lot of thought and I am not sure budget neutrality is fair or right. Your testimony, however, appears to me not to address the other half of the problem which is selection by payor, and there is some evidence that these hospitals do select not only the payors, the people who pay, as opposed to the people who don't, but the payors that pay better than the payors who pay worse. I don't see anything in your proposals that really well addresses this aspect of the disparity, because as we have talked about a number of times, occupancy is crucial to a hospital's profitability and occupancy by paying patients is crucial to a community hospital's well-being.

Mr. HACKBARTH. Consistent with our statutory assignment, MMA, we looked at how Medicare pays these institutions, and also at the number of Medicaid patients they treat. And as I reported, we found that they do care for disproportionately fewer Medicaid patients. We did not look specifically at uncompensated care, nonpaying patients, because that assignment was given to CMS.

Chairman JOHNSON. Do you have any comment on that, Dr. Gustafson?

Mr. GUSTAFSON. Yes. We did discover some information about uncompensated care. I summarized the point a few minutes ago, and the report will go into this in greater detail.

Chairman JOHNSON. Thank you. Now, did either of you look at selection amongst payors, not the government, private payors, and the variation amongst payors? There is some indication that organizations are sensitive to who are the good payors and who are the bad payors.

Mr. HACKBARTH. We did not look at that. Given the amount of time available and the resources, we focused on the narrow statutory mandate.

Chairman JOHNSON. And also I am not so sure that this was common in 2002. It may have been some enrichment in the art.

Mr. GUSTAFSON. I think we examined it only to the extent that we looked at the Medicare share and consequently the complement of that is that provided by either Medicaid or private payors or by uncompensated care. So, I believe our report will provide some detail on that, but we didn't go into it in depth.

Chairman JOHNSON. This issue of the length of stay and the failure to show any reduction in cost is a concern because if competition is to improve quality and reduce costs, and the quality jury, I will be interested to see your report in greater detail. But I would have to say that in extensive talks with thoracic surgeons, which I hope to share with the Subcommittee Members in a seminar setting. It was very interesting the tremendous progress they have made in quality, and they can make it in a community hos-

pital setting just as easily in a brandnew facility. Which I think leads us to the question of if investing in this new capital from our point of view does not result in a reduction in costs, the what are the implications of that for the overall cost of the Medicare system?

Mr. HACKBARTH. Well, because unfortunately the limited data at our disposal, the small number of hospitals and so on, as I said, we couldn't draw definitive conclusions about how costs compared. We did find that the costs were higher, not lower, but that was not a statistically significant result. So, that is the sort of question that with more time and more data we might be able to provide a more compelling answer.

Chairman JOHNSON. And last, very briefly, did you look at whether or not there were waiting lists at the existing cardiac programs that the specialty hospital then served, or was it—it is a little hard to look at this in 2002 because there was not much time—but you are saying that the community hospital recovered from the blows. There are two things that it seems to me we don't know. We don't know whether they recovered from the blow by substituting higher cost services that we will now pay for, and dropping services to low income pieces that were—we don't know whether they lost their ability to cross-subsidize Ob/Gyn wards or particularly OB wards of pediatric wards. So, I think we need to look at lot more. Did you look at that at all, Dr. Gustafson?

Mr. GUSTAFSON. I am not aware that we did, although the site visits I believe were fairly comprehensive. I didn't go on any of them myself.

Chairman JOHNSON. I think we do need more information about what happened at these community hospitals. I think we need more information about whether there were waiting lists for current services, whether this was a need induced response or whether this was a profit induced response. Thank you. And I have taken too much time, so you do not need to respond to that. Mr. Stark?

Mr. STARK. Mr. Hackbarth, has MedPAC closed the door on a future recommendation that the whole hospital exemption be eliminated, or is that still open?

Mr. HACKBARTH. No, we haven't closed that door. We would like to make a final recommendation as it were on that based on more definitive evidence on cost and quality in specialty hospitals.

Mr. STARK. Specialty hospitals that are fueled by self-referral or specialty hospitals in which——

Mr. HACKBARTH. Here I am talking specifically about the physician-owned specialty hospitals.

Mr. STARK. Do you have a concern or do you share my concern about allowing the moratorium to expire before Congress passes or CMS acts without legislation and payment changes are recommended?

Mr. HACKBARTH. Very much so.

Mr. STARK. So, you think we should keep the——

Mr. HACKBARTH. We think it is very important to extend the moratorium.

Mr. STARK. Until such time as we resolve the issue?

Mr. HACKBARTH. Yes.

Mr. STARK. Is MedPAC still concerned in general about self-referral to physician-owned facilities or these diagnostic facilities or whatever? Is there still some evidence that ownership tends to encourage higher utilization?

Mr. HACKBARTH. Yes. We are concerned about that. We are open to the possibility that specialization and the sort of engagement that you get through ownership could help improve efficiency and quality, and we don't think that we had sufficient information to reach definitive judgments on those issues. And as we have discussed often in these hearings, our view of the status quo is that it is not all that great. There is a lot of inefficiency in the system and a lot of unevenness in quality, so we don't want to definitively rule out a development that may help us on those fronts unless we have really compelling information to do so.

Mr. STARK. There has been some discussion in somebody's testimony about the fact that the specialty hospitals do better, and they perhaps have equivalent mortality. Dr. Gustafson, you only looked at four heart hospitals, right?

Mr. GUSTAFSON. On the quality measures we looked at all 15, sir.

Mr. STARK. All 15 what?

Mr. GUSTAFSON. All 15 heart hospitals.

Mr. STARK. There are only 15 of them?

Mr. GUSTAFSON. There were only 15 in 2003, sir. Actually, let me correct that. There were 16.

Mr. STARK. Did you look, Mr. Hackbarth, at the, I guess the invasiveness of the procedures? Has there been any study about whether more invasive procedures were used for somebody with the same diagnosis in one hospital or another?

Mr. HACKBARTH. What we did, Mr. Stark, was look at different types of patients, and we broke them in—we looked at all heart surgeries in general, and then we looked at three particular categories, one that we identified as a high profit type of case, and then a medium profit and a low profit, and tried to see whether the patterns of care differed in the communities where there were physician-owned specialty hospitals. And with one exception, we did not find a statistically significant difference.

Mr. STARK. I am going to ask you to comment on Mr. Gustafson's study here, but you are suggesting the mortality rate—Mr. Gustafson suggested that the mortality rate between cardiac and community hospitals was similar when adjusted for severity, but that the readmission rate for cardiac specialty hospitals was higher on average I gather.

Mr. GUSTAFSON. That is correct.

Mr. STARK. So, if we already know that you are putting the more complex sicker patients in the community hospitals and the healthier patients in the cardiac hospitals, wouldn't you expect that they would have lower readmission rates in the specialty hospitals if their quality of service is as good? I mean there is something here about doing your callbacks, for which I suspect they get to charge again. They do not do callbacks free like my Ford dealer, do they? You go back a second time, you pay a second time, right? So, I know that maybe they didn't put the drain plug in properly,

so you can come back and get another oil change, but I mean, is it—did you take that into account, Dr. Gustafson?

Mr. GUSTAFSON. Well, I mean, we think the admissions would be a source of concern, certainly.

Mr. STARK. Okay. But, so you still think that all the readmissions for healthier patients didn't make the care worse in the cardiac hospital——

Mr. GUSTAFSON. Well, I mean, it is a complex set of measures that were employed here insofar as the mortality seems to be one you would want to pay particularly close attention to, and so we did. Readmission is a different nature of problem. And I would say that the differences we are talking about here are not startling. They are significant, but not necessarily startling. And community hospitals vary a fair bit in some of these factors as well.

Mr. STARK. Mr. Hackbarth?

Mr. HACKBARTH. I just want it to be clear, the reason that I wasn't responding to your question is that the quality piece of the work was assigned to CMS. So, we did not specifically——

Mr. STARK. No, I was asking you about readmissions, though, from a cost basis. I mean, if you have some guy coming back two and three times, and they are healthier, it sounds to me like that could be more cost——

Mr. HACKBARTH. That is unquestionably a problem if that happens. The extent to which it does happen, I don't know, since we didn't look at that issue.

Mr. STARK. Thank you.

Chairman JOHNSON. Mr. McCrery.

Mr. MCCRERY. Thank you, gentlemen, for your testimony, although I must say it doesn't really tell us exactly where to go on this issue. And I hear you saying that you need more time and more resources to give us more definitive guidance—which is fine. And you are suggesting that we keep the moratorium in place until we can act on your recommendations, I suppose with respect to the DRG changes. How long do you anticipate keeping the moratorium in place? Is it totally dependent on congressional action, on the DRG front?

Mr. HACKBARTH. Our proposal is to extend it to January 1, 2007. Some of the changes that we propose could be done under existing statutory authority. One of the refinements that we propose requires new legislative authority, as we read the law. So, on some of them, as soon as CMS has the opportunity to review our work and reach conclusions about it, they could begin on today, tomorrow, whenever that point it. In terms of when we might know more, we used 2002 data because that was the most recent available when we began our study. As Tom reported, CMS, because they started a little bit later, had 2003 data. Before the end of this calendar year, we should have 2004 data, which would give us, obviously, a more significant database to look at some of these questions. So, I am not just saying somewhere out in the distant future. I think it need not be that far in the distant future.

Mr. MCCRERY. So, you are saying that the moratorium ought to be in place at least until we make the DRG changes and you have more time and more data to examine to report back to us once again on this issue.

Mr. HACKBARTH. In particular we are emphasizing that we think the moratorium ought to stay in place until we can refine the payment system so there is not an opportunity to profit simply from patient selection. That is the most important point. So, long as it is extended, that will also give us time to look at some additional data on these cost and quality issues while we are waiting. I want to be clear—the fact that we might have 2002, 2003, and 2004 data doesn't necessarily mean that we will be able to provide the absolute right answer to these questions, but we will be able to answer them with a bit more confidence than we can today.

Mr. MCCRERY. Well, one thing that I hope you will focus on with the new data is this issue of self-referral. Because the data that you have presented to us today, at least to me, doesn't indicate that self-referral is a problem with these specialty hospitals, with physician ownership averaging, I think your study says 4 percent on an individual basis and, Dr. Gustafson, yours says 2 percent or 1 percent, depending on the type of specialty hospital. That doesn't seem to me to be a huge problem in terms of self-referral.

Mr. HACKBARTH. Well, as I said in response to Mr. Stark's question, we are concerned about self-referral.

Mr. MCCRERY. In general.

Mr. HACKBARTH. Yes, as a matter of principle. We have not seen the CMS data, and so we are eager to see the information that they have developed on self-referral and quality. So, that is very much a question in our mind.

Mr. MCCRERY. But you did look at utilization rates.

Mr. HACKBARTH. We did, yes.

Mr. MCCRERY. And what were your findings there between the two?

Mr. HACKBARTH. Well, what we did was compare rates of utilization for particular procedures in communities that have physician-owned specialty hospitals and those that do not. And what we found was that the general pattern was what you would expect consistent with the physician-owned hospitals doing more high-profit things, but the differences were not statistically significant—except in one case for one procedure, we did find a statistically significant difference.

Mr. MCCRERY. Well, Madam Chair, it would be interesting to know if the percentage of physician ownership, the average percentage of physician ownership has gone up since 2002. That to me would be a very interesting piece of data for you to retrieve from your ongoing study.

Mr. GUSTAFSON. Well, if I could comment just on that briefly, the moratorium introduced by the MMA has effectively prevented that from happening.

Mr. MCCRERY. Well, but that wasn't in effect in 2003 and 2004.

Mr. GUSTAFSON. It started in—it became effective with the passage of the MMA in late 2003.

Mr. MCCRERY. All right. But you are going to have a lot more—well, was the MMA in 2003?

Mr. GUSTAFSON. December 8, 2003. Right?

Mr. MCCRERY. So, you got one more year of data, 2003, without a moratorium.

Mr. GUSTAFSON. That is correct.

Mr. MCCRERY. And it would be interesting to see the proliferation of these hospitals in that intervening year and if there has been any change in physician ownership, average physician ownership. Because the data that you have, so far to me, doesn't day anything negative about physician ownership, self-referral, utilization rates, any of that—any of the bugaboos that we were supposed to be on the watch for. So, let us see if increased data puts the lie to the data that you already have, the conclusions, at least, that can be reached based on the data you have. Thank you.

Chairman JOHNSON. To that point, though, the charts that you showed do show that these hospitals do attract less severely ill patients in their category. So, what you have to know is what is the referral mechanism here and is the referral mechanism influenced by ownership. And you don't actually comment on that in particular.

Mr. HACKBARTH. We did not look at the effect of ownership. CMS did look at that issue.

Chairman JOHNSON. Do you want to repeat your comments on that?

Mr. GUSTAFSON. The basic picture is that when we examined physician ownership patterns and referral patterns related to physician ownership, we discovered no significant difference between the behavior of physicians that were owners of the specialty hospitals and physicians that were not owners of the specialty hospitals. So, there was no there there.

Mr. HACKBARTH. You might imagine that there are at least two different types of forces at work in determining where the patients go. One theory is that they are getting less sick patients because of the ownership incentive. There are other possibilities, one of which is that specialization itself inherently means that you are going to get a different selection of patients. Because, for example, patients that have lots of co-morbidities that need services beyond the cardiac service would more naturally go to the community hospital, where there are those other services. In fact, that may be the patient's preference. Whereas if they are a pure cardiac case, the patient might say I want to go to the cardiac hospital. So, that has nothing to do with the physician's ownership, but rather how patients sort themselves out across a system where you have different types of institutions.

Chairman JOHNSON. I hope to come back to this subject. We will turn next to Mr. Doggett.

Mr. DOGGETT. Thank you, Madam Chair. Just referring back, Dr. Gustafson, to a portion of the President's budget that was already referenced in an earlier statement, where the Administration says that it will refine the payment system and related provisions to ensure a more level playingfield between specialty and non-specialty hospitals. Does that mean that the Administration believes that the playing field at present is not level or even or fair between the two?

Mr. GUSTAFSON. I would say that would be a fair characterization, sir.

Mr. DOGGETT. Is the Administration fully committed to not permitting the moratorium to expire before you have an opportunity

to complete all your technical work and make appropriate recommendations and changes?

Mr. GUSTAFSON. We have not arrived at a position on the moratorium yet, sir.

Mr. DOGGETT. Well, if the playingfield is not level or even fair at present, and you let the moratorium expire, what will be the immediate effect?

Mr. GUSTAFSON. That is a speculative question, sir. I think that it would be likely that nascent hospitals that are now expecting to enter this market may proceed to do so; on the other hand, they may be deterred by the possibility of our action or your action, and that might have a chilling effect.

Mr. DOGGETT. Well, you would expect that there would be some additional hospitals that would take advantage of the uneven playing field, wouldn't you?

Mr. GUSTAFSON. That could very well happen, sir.

Mr. DOGGETT. Why is the Administration, given its statements, not fully committed to the extension of the moratorium?

Mr. GUSTAFSON. All I can tell you is that we have not—beyond the statement that you were just citing, we have not reached any policy conclusions relative to what our recommendations will be to the Congress. As my remarks earlier indicated, we are waiting until the analysis is complete. We expect to have a report that we are able to deliver to you within a matter of weeks. We are very cognizant that June 8th is the expiration of the moratorium and we appreciate the problem that presents us all in terms of addressing that question.

Mr. DOGGETT. Well, not only that it is the expiration date, but that the Congress needs to act to pass a law before that time.

Mr. GUSTAFSON. Yes. I appreciate that, sir.

Mr. DOGGETT. And as slow as things move around here sometimes, if we started this afternoon it wouldn't be unusual that it could take near that time if there were any dispute over this matter.

Mr. GUSTAFSON. I quite agree, sir.

Mr. DOGGETT. I am interested as well in the findings that either of you have made at this point about any differences that exist in these types of hospitals and their delivery of services—particularly uncompensated care and Medicaid care, because I have a lot of poor people in my district. Can you comment on that further?

Mr. HACKBARTH. The piece of that that we were asked to look at was Medicaid, and then CMS was asked to look at uncompensated care. And what we found on Medicaid is that the specialty hospitals treat proportionally fewer Medicaid patients.

Mr. DOGGETT. Can you quantify that?

Mr. HACKBARTH. Not off the top of my head. But the differences were quite substantial.

Mr. DOGGETT. And with reference to the uncompensated care, Dr. Gustafson?

Mr. GUSTAFSON. Yes, we did look at that, sir. And our conclusion, again preliminary here, was that specialty hospitals provided about 40 percent of the share of uncompensated care that we saw in local community hospitals in the same area.

Mr. DOGGETT. About 40 percent.

Mr. GUSTAFSON. That is correct.

Mr. DOGGETT. So, it is a pretty substantial difference.

Mr. GUSTAFSON. Yes, sir.

Mr. DOGGETT. Thank you very much.

Mr. HACKBARTH.—which table to look at. And what we found was that heart specialty hospitals had on average 4 percent Medicaid—this is share of hospital discharges—whereas community hospitals in the same market had an average of 15 percent of their discharges being Medicaid. In the case of orthopedic hospitals, specialty hospitals had 1 percent Medicaid versus 16 percent for the community hospitals.

Mr. DOGGETT. One percent versus 16 percent.

Mr. HACKBARTH. That is right. And then for the surgical, I think they were too small and there were too few discharges to really have a meaningful result.

Mr. DOGGETT. So, while there may be some notable exceptions to that with hospitals, the playingfield for poor people between these hospitals is very different.

Mr. HACKBARTH. Yes, and I think we did, in fact, find that there was some significant variation in some cases. So, there were some individual specialty institutions that had much higher Medicaid caseloads than these. But this is the average.

Mr. DOGGETT. I think I have one of those as well, where a specialty hospital is really reaching out trying to include poor people, but for the survey as a whole it looks like a rather stark disparity.

Chairman JOHNSON. Mr. Johnson.

Mr. JOHNSON. Thank you, Madam Chairman. Well, I think you all are waffling all over the place. Thank you for being here today. I am concerned about the extension of the moratorium. It is my understanding that of the 100 or so specialty hospitals, they have 1 percent of the cardiac market, 2 percent of the orthopedic market. Is that correct?

Mr. HACKBARTH. Are you talking about on a nationwide basis or within——

Mr. JOHNSON. Yes.

Mr. HACKBARTH. I don't know.

Mr. GUSTAFSON. I can confirm your figure on cardiac. It is about, in fact, .95 percent of the national market. I don't have comparable figures on the others.

Mr. JOHNSON. Well, it seems to me, you know, according to your little chart, the bulk of your specialty hospitals are around the middle of the country. How do you account for that?

Mr. HACKBARTH. I think that a significant factor in that is State law.

Mr. JOHNSON. Is what?

Mr. HACKBARTH. State law. If you look at the map, I think we show on here States that have certificate of need. They are the shaded States. And there are relatively few, if any—just a couple specialty hospitals in States that have certificate of need laws. Another factor is State licensing laws. Some of the States where in fact there are a lot of specialty hospitals have basically made accommodation for them in their licensing requirements, making it easier to develop the sort of smaller institution that may not have all of the capabilities of a full-service hospital. Then there are some

States that explicitly prohibit physician ownership of hospitals. So, there are a variety of State laws that influence this pattern.

Mr. JOHNSON. Then why does the Federal Government need to get involved? You know, it begs the question why do we need a government-mandated extension of a moratorium that the States are handling pretty well, it looks like to me, themselves. Seems like you didn't talk to, but the patients pick hospitals, too. You know that.

Mr. HACKBARTH. Yes.

Mr. JOHNSON. And especially in the area I am from, the Dallas area, you know there is a ton of them in that area. And they will choose a hospital, it doesn't matter whether it is a specialty hospital or a community hospital. They are going to go where the best docs are. I do. And I think most people do. So, I don't think that the Federal Government can prescribe how specialty hospitals operate. I mean, if you have a cardiac hospital or an orthopedic hospital or some other form of specialty hospital out there and it is competing with a larger hospital that has multiple services, and people choose to go there, what is wrong with that? This is America.

Mr. HACKBARTH. Well, the table, Table 1 on page 7, indicates why we think this is an issue for the Medicare Program. These institutions are consistently treating patients that are healthier, less severely ill, with consequences for the Medicare Program. So, what we are saying is that, at a minimum, allow the time to level the playingfield so that there aren't undue profit opportunities. At a minimum, that is what we think ought to be done through an extension of the moratorium regardless of how you come down on the issues of self-referral and whether that is good or bad.

Mr. JOHNSON. Well, if you think changing the DRG will help, you know, it seems to me you don't need a moratorium to do that. We just change the DRG and it fixes it, according to you.

Mr. HACKBARTH. I am sorry, I didn't follow that. What we are saying is that the competition ought to occur on a level playingfield——

Mr. JOHNSON. I heard you.

Mr. HACKBARTH.—that does not exist today. It will take time to accomplish that, and hence an extension of the moratorium is appropriate, from our perspective.

Mr. JOHNSON. Okay. I happen to disagree with you. Do you have a comment on that subject?

Mr. GUSTAFSON. No, sir.

Mr. JOHNSON. Thank you very much.

[Laughter.]

Mr. JOHNSON. Thank you, Madam Chair.

Chairman JOHNSON. Mr. Thompson.

Mr. THOMPSON. Mr. Hackbarth, you had mentioned in a summary that there is limited fiscal impact on community hospitals from the specialty hospitals, but you qualified it by saying "at this time" or "thus far." Is that qualifier in there because you see something coming down the road in the not-too-distant future that could in fact fiscally impact the communities?

Mr. HACKBARTH. Well, the qualifier, again, is because we are analyzing such a limited amount of data. So, what we did in this

particular instance was look at the profitability of hospitals, community hospitals that face competition from specialty hospitals, as compared to community hospitals that don't face that kind of competition, and compare their financial results. And in doing that, what we found was that they looked pretty similar. The bottom line financial performance, in other words, of the hospitals facing specialty hospital competition was about the same as those that were not facing that competition. But we have a relatively small number of data points.

Mr. THOMPSON. Do you anticipate that changing?

Mr. HACKBARTH. I honestly do not know. The second qualification, you recall, that I mentioned was that it may be more difficult for a community hospital in a smaller community to respond to the competition. Because among the strategies used are, well, we lost some of our cardiac cases, we might develop other services to help offset that loss. And if you have a small population to work with, those opportunities may be fewer.

Mr. THOMPSON. So, will you bifurcate any recommendations that might be forthcoming? Small community versus larger communities?

Mr. HACKBARTH. I don't know, Mr. Thompson. Ideally what we would have is some more information to work from.

Mr. THOMPSON. Do you have any idea—I think Mr. Doggett started on this, but if the moratorium were to expire, do you have any idea or give us any idea of what would happen in regard to the construction of additional facilities?

Mr. HACKBARTH. I don't know. I assume an important factor would be what the specialty hospital potential investors thought about the likelihood of changes might be. So, if they were convinced that, for example, these payment changes were going to be made that would take out a lot of the additional profitability of the business, that might reasonably affect their willingness to invest, their expected return on the investment. If on the other hand they saw the changes as being unlikely, then there might be a great influx. They might say, oh, we are over this hurdle, now is the time to rush in. So, a lot depends on how they read your actions and HHS's potential actions.

Mr. THOMPSON. Thank you. And Dr. Gustafson, you had mentioned this link between the amount of taxes that the specialty hospitals pay vis-a-vis the uncompensated care that they provide. What is the link?

Mr. GUSTAFSON. We were asked to look at both of those factors. It——

Mr. THOMPSON. But the taxes don't somehow offset the care that the community facilities provide—property tax and local taxes. How do they—what is the relationship between the two?

Mr. GUSTAFSON. Well, I can only speculate that the drafters of this provision were interested in the total return to the community as a whole from these hospitals, and so wanted to look at both of these factors.

Mr. THOMPSON. Thank you.

Mr. HACKBARTH. Mr. Thompson, could I just add one additional point? I mentioned that future investment might depend on what they thought was likely to happen with the payment refine-

ments. You know, another factor is the gains-sharing proposal. What we heard in our site visits was that—from physicians who invested in these hospitals, we often heard that they did it because they felt frustrated with their existing circumstances in the community hospital. And what they wanted was an opportunity, A, for change and, B, to participate in the benefit from that. And if we offered an alternative path of gains-sharing sanctioned by the program within a defined set of rules to protect quality, we might create an alternative path that would then affect decisions among physicians about whether to engage in this sort of activity.

Mr. THOMPSON. Thank you.

Chairman JOHNSON. Mr. Hayworth.

Mr. HAYWORTH. Madam Chairman, thank you. It is an honor to be on the Subcommittee and to open with this clearly non-controversial topic for us now.

[Laughter.]

Mr. HAYWORTH. Mr. Hackbarth, let me return to the topic my colleague from Texas was dealing with and try to get more amplification of your testimony. You discussed extending the moratorium until the DRG payments are reformed. But after that point, do you envision lifting the moratorium?

Mr. HACKBARTH. As I said, I think before you came in, Mr. Hayworth, even with those payment reforms in place, the Commission has some residual concern about the issue of self-referral to institutions with a physician as an ownership interest—whether that is in the interest of the patient or whether clinical decisions could be inappropriately influenced. So, that is a concern. What we would like to be able to do, on the other hand, is weigh that potential risk against whether these hospitals can improve quality and reduce costs, so that we have the pluses and minuses in a more definitive way to judge. And in order to make that definitive judgment, we think there is more information required. We have not as yet seen any of the quality information that CMS has developed. We are hearing about it for the first time today. Obviously, that is a critical factor in assessing whether this is a form of delivery that ought to be accepted or whether it is one that ought to be ruled out.

Mr. HAYWORTH. Dr. Gustafson, anything you would care to amplify from the findings that might be of interest to MedPAC and all of us assembled here in that regard?

Mr. GUSTAFSON. I don't really have too much more to say about the quality findings. We are hastening to complete our report and will have that to you as quickly as possible. I will note that we are already examining the recommendations that the Commission has put forward about revising the DRGs. We have our analysts at work on this. There are a number of complexities within that sphere that we are going to have to examine and will take us a while not only to reach conclusions about the desired direction, but to do the technical work necessary to implement that in the system. So, that you can see the statement in the President's budget indicated our receptivity to these ideas. We will probably not be able to push it too far for the next cycle of rulemaking, but would be anticipating it at a process level, assuming the policy will is there to be able to move more energetically for fiscal year 2007.

Mr. HAYWORTH. Gentlemen, for both of you, this question. As the community hospital attracts patients with more co-morbidities, what do you see as the most equitable way to compensate for that?

Mr. HACKBARTH. Two points. First of all, I want to be clear that not all community hospitals are alike. You know, we are always talking about averages and there is a tendency to say, well, everybody in that average is the same. Community hospitals differ significantly in the mix of patients, including the severity of illness. That is why we believe that these payment changes we are talking about are important to make, even if physician specialty hospitals didn't exist. Then in direct response to your question, we think that these payment changes will directly address that question. If patients are sicker, they will come with more dollars attached to them, under our proposals. If they are less sick, the amount that the hospital is paid would go down relative to today. The system would be much more accurate in matching payments to the expected costs of different types of patients.

Mr. HAYWORTH. Dr. Gustafson, any thoughts on that?

Mr. GUSTAFSON. I have nothing to add, sir.

Mr. HAYWORTH. Okay. I thank you. Madam Chairman, I thank you for the time.

Chairman JOHNSON. Thank you. Mr. Stark has a follow-on question?

Mr. STARK. Yes, I wanted to direct this to Mr. Hackbarth just to see if you would speculate for us a little bit. Set aside the kickback or the referral thing, which I think is a separate issue, almost, from the specialty hospitals. They are combined in much of this, but they can be separate issues.

If you take the specialty hospital's pitch to its end point, you are basically deconstructing—or cannibalizing, depending on what you think about it—a community hospital. If you took that to its extreme, you might hear some of that from Baylor, but you might find that our community hospitals become a series of—you know, free-standing emergency room, a block away from the rest of it, but a free-standing emergency with its own kitchen, its own laundry. And a free-standing—there are some free-standing birthing hospitals, basically what Columbia used to be. And a free-standing—so you get a whole bunch of these little pods around town, each with its own—I see some overhead problems there. They each have to have their own kitchen, their cleaning crew, their landscaping crew. But this would be a sea change in how hospitals operate and how they are financed. And I am not sure the hospitals are ready for that. And I am not sure we are ready to, in effect, suggest that or allow it to happen without some concern.

So, I guess what I want to know is, do you see just in the overall financial survival of all hospitals, whether it is teaching hospitals or little 10-bed rural hospitals, that have been built over the years on cost-sharing or cost-shifting—and they have, just like the profit guy has gone out and started other services to bring in extra revenues to help carry the hospital. Now, if we deconstruct them, are we going to cause a whole bunch of problems that maybe we are better off not doing? And I just see, you know, if one group could pull out, another can pull out. And then pretty soon ought we not to, if that is going to happen, do it with some foresight so it just

doesn't accidentally end up costing us a lot more or cause a lot of problems for, say, inner-city community hospitals that deal mostly with the poor? What would happen to them? Do you have any sense—forget about the referrals—just on what—is this a good trend?

Mr. HACKBARTH. Well, I am not sure that it logically goes to that end, where every full-service hospital is taken apart into component parts—for the reasons that you mention. I do know that there are some economies of scale. Patients present not always with one illness, but maybe multiple illnesses that require convergence of different services. And so I can more readily envision a world where we have a mixture of full-service and specialty institutions. In that world, the key to determining whether it is a harmful development or a positive development is, is the payment system fair? So, when the full-service hospital treats that patient that has not just heart disease but also diabetes and, you know, multiple things, are they fairly compensated for that difficult case? Our concern is that in the current Medicare payment system, they are not, and that is why we want to refine the system to more accurately pay. If you have more accurate payment in place, then I think that the potential for full-service to compete evenly with specialized institutions is much greater. If you don't have that in place, it could be harmful. That is why we recommend extending the moratorium until we can improve the payment system.

Mr. STARK. Thank you. Thank you, Madam Chair.

Chairman JOHNSON. Mr. McCrery has a follow-on.

Mr. MCCRERY. Well, just to underscore that point, you stated that you would be in favor of changing the DRG even if it weren't for the existence of specialty hospitals.

Mr. HACKBARTH. That is right.

Mr. MCCRERY. And it seems to me that among all of your conclusions that you have been able to draw, based on the data you have been able to retrieve, that is really the only problem that stuck out to you, was the disparity in the severity of cases between the specialty hospitals and the community hospitals.

Mr. HACKBARTH. Yes. And part of the reason that we can be so much more definitive about that issue is, as I said at the outset, when we were looking at the DRG refinement, the payment refinement, we are not looking just at a database of 48 hospitals in 2002. We are looking at the overall Medicare claims in a cost report database. And so we can say with great conviction that the system needs improvement.

Mr. MCCRERY. Thank you.

Chairman JOHNSON. All right, to follow up on their two comments—I appreciate and understand the gains-sharing recommendation and the enrichment of the DRGs. But all you are talking about in enrichment of the DRGs is a level playingfield in orthopedic surgery or heart problems. I am interested in equal responsibilities. What do you do if the community hospital has bigger responsibilities for which we don't pay? How are you going to fix your DRGs to take into account hospital delivery of non-Medicare services on which the community depends? OB is a big loser, usually; pediatrics is a loser; psychiatric is a loser. The emergency rooms often are a loser. LifeStar is a loser. So, if we fix that in one

area but we don't notice that we rely on our community hospitals for a lot more, I have thought a lot about how could we compensate the big community hospitals for their larger responsibilities. I haven't found any way, actually, to do that accurately.

Now, if you are going to leave them with higher overhead for all these things that the community depends on them for, then they are never going to be competitive. With the managed care payers, you know, they are never going to be competitive; they will always be able to undercut, do a better deal. So, I think the long-term implications of not being able to create a competition that is fair is very serious and, in the end, will be an access issue for us.

Mr. HACKBARTH. I understand and share your concerns. Two reactions to it. First of all, I think it is critically important to keep coming back to the fact that not all community hospitals are alike. That is sort of a catch-all category.

Chairman JOHNSON. Right.

Mr. HACKBARTH. It is not uncommon, setting aside physician-owned specialty hospitals, for there to be debates within the community-hospital community, as it is here defined, about who is caring a disproportionate share of these public-good burdens—for-profit community hospitals against not-for-profit community hospitals, or one not-for-profit community hospital in the suburbs compared to one in the inner city. These issues are important issues, but they long predate physician-owned specialty hospitals. Stopping physician-owned specialty hospitals won't solve those problems.

Chairman JOHNSON. No, but allowing any—I mean, this was a problem with surgery centers. Allowing someone to pull out the high profit does have a consequence for everybody else. I won't pursue that, but I do think that is a big issue that we need to know about because access is reduced. There is some indication that overall demand increases quite substantially as you create more opportunities for service, and we had that from Wenberg and others. So, if we just let all these opportunities for service develop, we can expect to pay a lot more for a lot more services. But I wanted to ask you, Dr. Gustafson, because as I understand it, these specialty hospitals do not have to reveal who their investors are. I was interested that you seem to have figured out who the investor/doctors were. And do you also know whether or not the other doctors were allowed to invest? I mean, are we seeing something in which only the doctors who could bring referrals are allowed to invest, or are all doctors allowed to invest?

Mr. GUSTAFSON. The information we had on ownership of these hospitals was derived from our case studies. We don't have any regular reporting mechanism that provides that information to us. We basically had to go and ask the folks what the answers were. And they were generally forthcoming on that subject. I don't know if we have nay information on the second matter you raised about who was allowed to invest.

Chairman JOHNSON. The sort of word on the street is that only those who can bring referrals are allowed to invest, and I needed to know whether that is true or not true. Thank you very much, gentlemen. I hope you will pursue some of the issues that we have been unable to get complete information on. Thank you very much. Very interesting.

Chairman JOHNSON. The next panel, please. Next and last panel. Jon Foster, President and Chief Executive Officer of St. David's HealthCare Partnership, Austin, Texas; Bill Plested, American Medical Association; William Brien, Cedars-Sinai Hospital, Los Angeles; Jamie Harris, MedCath Corporation, Charlotte, North Carolina; Gary Brock, Chief Operating Officer of Baylor Health Care System.

Gentlemen, we are going to proceed right through all of your testimony so we will be able to hear it all before we have to go vote, and then we will invite questions. So, we will start with Mr. Foster, the CEO of St. David's HealthCare Partnership in Austin, Texas.

STATEMENT OF JON FOSTER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, ST. DAVID'S HEALTHCARE PARTNERSHIP, AUSTIN, TEXAS

Mr. FOSTER. Thank you, Madam Chairman and Mr. Stark, members of the Subcommittee. My name again is Jon Foster. I am the President and CEO of the St. David's HealthCare Partnership, which is a four-hospital system providing high-quality care to the 1.4 million residents of Austin and central Texas. I am pleased to be here today to discuss one of the most critical issues, I believe, facing community hospitals, which are physician-owned specialty hospitals. My remarks will focus on four key points: First, physician-owned specialty hospitals operate more like subdivisions or departments of full-service hospitals. Second, physician ownership of subdivisions or departments of hospitals are already illegal. Third, physician ownership coupled with their ability to self-refer represents a conflict of interest and it is anti-competitive. And, fourth, Medicare payment adjustments are not a solution to this problem but, rather, closing the legal loophole that allows for these facilities is.

Specialty hospitals largely limit their care to just one type of service, often cardiac, orthopedic, or surgical services, which guarantee high profit margins while avoiding essential but unprofitable community services such as emergency rooms. Studies by the GAO and MedPAC found that a majority of specialty hospitals do not have fully functioning, fully staffed, 24-hour emergency rooms. The reason, of course, is because emergency rooms are the primary portal through which indigent and Medicaid patients get admitted to most hospitals. In 2003, 41 percent of the 200,000 patients seen in St. David's emergency departments were indigent or Medicaid patients. Clearly, specialty hospitals are not whole hospitals but, rather, more like subdivisions or departments of hospitals that focus on the most profitable patients.

Under current law, physicians are permitted to have an ownership interest in an entire whole hospital but not a subdivision of a hospital. The regulatory theory here is that any referral by a physician who has a stake in an entire hospital would not financially benefit as directly from the referrals he or she makes to that hospital, and as such, it would dilute the potential conflict of interest that exists.

However, a physician's ownership in a subdivision of a hospital is deemed to be illegal due to the ability of the owning and refer-

ring physician to more directly control the financial results of that subdivision. In my professional opinion, specialty hospitals are not whole hospitals; rather, they are more like subdivisions of hospitals, essentially cardiac, surgical, or orthopedic wings that have been removed from full-service hospitals. As such, I believe physician referral to specialty hospitals in which they have an ownership interest is as much a violation of the anti-referral laws as would be physician ownership in a hospital subdivision.

Let me be clear. As a business leader in central Texas, 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 medical technologies. However, true competition requires a level playingfield. The business model of a physician-owned specialty hospital depends upon the control of referrals by its physician owners. Highly lucrative specialty hospital investment opportunities are typically granted only to physicians able to refer patients and not to investors from the general public. Not long ago, I came across one such deal in an offering to physician investors for a specialty facility in Austin, Texas. The offering suggested that physician investors investing an initial amount of $4 million could project to earn $55 million over 6 years, and that is an astounding 1,400-percent return on their investment.

It eludes me how there can be free and fair competition when under Federal law St. David's is prohibited from offering physician ownership in specialty wings of hospitals, but specialty hospitals can do so and induce patient referrals through physician ownership. MedPAC was certainly correct in recognizing the problems inherent in physician ownership of specialty hospitals. However, its policy response, which focuses exclusively on refinements to DRG payment systems, is, I believe, inadequate. I would like to State again that as President and chief executive officer of the fifth largest employer in Austin, where we employ over 5,000 people throughout central Texas, I welcome competition. However, the underlying economics of these facilities which rely upon referrals from physician owners would not change materially simply because of refinements to the DRG payments. I fear that a wholesale refinement of the DRG system could have the unintended consequence of doing more damage to full-service hospitals, even hospitals in markets where currently no specialty hospitals exist. As such, it is my belief that not only should the current specialty hospital moratorium be extended, but it is also my hope that Congress will close the loophole in the anti-referral law that allows for the exploitation of the whole-hospital exception, which is, of course, the very behavior that anti-referral laws were attempting to prevent. Thank you for your time, and I would be happy to answer any questions.

[The prepared statement of Mr. Foster follows:]

Statement of Jon Foster, President and Chief Executive Officer, Saint David's Healthcare Partnership, Austin, Texas

Good afternoon. My name is Jon Foster, and I am the President and CEO of St. David's HealthCare Partnership [the "Partnership" or "St. David's"]. The Partnership is an affiliation between the not-for-profit St. David's HealthCare System and the Hospital Corporation of America, the nation's largest provider of health care. We are proud to provide high quality, compassionate care through four full-service acute-care hospitals, ranging in size from 150 to 500 beds, in Austin, Texas—St. David's Medical Center, North Austin Medical Center, South Austin Hospital, and

Round Rock Medical Center. We are a regional system with an eighty-year history of serving the more than 1.4 million residents of Central Texas. Recognizing the importance of our role in the community, not only do we provide a vital charity care program, but we also have made significant investments in essential state-of-the-art health care services, such as transplant, open heart, neurosurgery, rehabilitation, psychiatric care, and neonatal intensive care.

I am delighted to be here this afternoon 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 decisions.

Within the past several years, physician-owned specialty hospitals have emerged to capitalize on an unintended loophole in the anti-referral laws. The business model of a physician-owned specialty hospital depends upon the control of referrals by its physician owners. More to the point, these arrangements tilt the competitive playing field by providing 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 the local community hospitals.

Physicians owning a financial interest in a specialty hospital tend to direct to their facilities only the most attractive patients—those with private health insurance and those who are less sick. However, those same specialists tend to refer underinsured or uninsured patients, as well as those with higher acuity, to full-service community hospitals for treatment, which is administered with little to no reimbursement of costs. Full-service hospitals then are left without adequate resources to treat the sickest patients. The unethical practice of patient selection does not serve the American health care system, it does not serve community hospitals, and most importantly, it does not serve the best interests of the patients in our care.

I believe that the only way to solve this problem is to close the loophole in federal law 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 anti-referral laws are attempting to prevent.

Being the 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 insurance premiums, pressures of managed care, demanding regulatory burdens, and on-call requirements, just to name a few. 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 aiming to reform 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.

Self-Referral At Issue

As the CEO of four full-service community hospitals in a vigorous healthcare market, I am committed to supporting free and fair competition. True competition, however, requires a level playing field. St. David's, 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 service—often cardiac, orthopedic, or surgical care—which guarantees high profit margins, while avoiding essential but unprofitable community services, such as emergency rooms and burn units.

Ownership interest in these facilities is typically granted only to physicians who are able to refer patients, not to any investors from the general public. Referring physicians are given sweetheart equity arrangements at bargain basement rates. For example, in a proposal offered to potential physician investors in Austin Sur-

gical Hospital, referring specialists with an initial investment of $4 million were projected to earn $55 million over six years—an amazing 1,400 percent return on investment.

By contrast, full-service hospitals, like those in the Partnership, are prohibited by federal laws from offering physicians an ownership interest in the specialty wings or subdivisions of our hospitals. In fact, offering a physician any "inducement" for referrals would land me in jail. These laws prohibit me from giving specialists at my hospital more than $300 in gifts per year, none of which could be given in exchange for a referral. Fair competition under the interpretation of existing rules simply would be impossible.

The "whole hospital" loophole in the anti-referral laws permits specialty hospitals to cherry pick only the most profitable patients, leaving high-cost patients, individuals on Medicaid, and the uninsured to community hospitals. The Government Accountability Office ("GAO") and the Medicare Payment Advisory Commission ("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.

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 our capacity to provide emergency care and other vital health services over time.

St. David's believes that maintaining a fully functioning and fully staffed twenty-four hour emergency department is part of our commitment to the community. In 2003, we received 204,023 visits to our emergency department. From what I have witnessed in Austin, and from what I have seen nationwide, 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.

As the Members of this Committee are well aware, America's hospital emergency rooms 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 rooms must provide medical evaluation and required treatment to everyone, regardless of their ability to pay. Since the advent in recent years of these physician-owned specialty hospitals, which skim profitable service areas for low-risk patients, this burden has grown even heavier. 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 St. David's, 41 percent of patients that visited our emergency department in 2003 were 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.

A 2003 study by the GAO 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 rooms. The GAO study reveals that while nine in ten of all full-service community hospitals maintain an emergency department to address any medical concern that walks or is carried through its doors, half of 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. For example, at the Heart Hospital of Austin, only six percent of those admitted through their "ED" in 2003 were Medicaid or indigent patients; in contrast, 25 percent of those admitted through St. David's ED were Medicaid or indigent patients. This practice is highlighted in a recent quote from Patricia Porras, President and CEO of Austin Surgical Hospital who 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.

Fiscal Impact on St. David's HealthCare Partnership

The loss of specialists willing to cover on-call responsibilities poses a significant cost to community hospitals nationwide. Prior to the development of physician-owned specialty hospitals within the Austin area, our specialists largely accepted on-call responsibilities as a pro-bono commitment to their community. However, the development of these facilities has further forced the Partnership to pay certain of our specialists $1,000 per night for their emergency on-call services, even though we have already lost their profitable referrals to one of the three physician-owned specialty hospitals.

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. 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. At St. David's alone, the cost of lost patient volume, the cost of recruiting additional specialists and nurses, and the cost of on-call coverage will total a staggering $20.3 million per year. These health care resources would better have been spent to meet other essential community healthcare needs.

Physician-Owned Specialty Hospitals Are Diverting Needed Resources from Full-Service Community Hospitals

Full-service community hospitals long have used funds generated by profitable services to subsidize the losses suffered by unprofitable services. Only by maintaining the successful product lines are full-service hospitals able to subsidize other critical but less profitable services, such as trauma and burn centers, as well as fund special programs for delivering care to uninsured and underinsured patients. By removing the most profitable 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.

Solution: Self-Referral Loophole Closure

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 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 Com-

mittee that simply adjusting the DRG's will only marginally reduce the profitability of self-referral. It is the owner and referral relationship that creates patient selection. The underlying economics of these facilities, which relies upon referrals from physician owners, would not change materially. Furthermore, while some modifications 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 St. David's and for hospitals nationwide demands an amendment to the anti-referral laws. These laws generally prohibit physician referrals for services to entities in which the physician has an ownership interest. The intent of this prohibition was to establish and maintain 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 inpatient hospital, but not a subdivision of a hospital. 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.

The "whole hospital" exception was intended to allow physician ownership in a comprehensive health facility, as long as that ownership interest is in the entire facility, not merely a subdivision. Congress never contemplated the emergence 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 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 violation of the anti-referral laws 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 anti-referral legislation that allows for self-referral to these facilities. 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, and I'd be glad to answer any questions.

Chairman JOHNSON. Dr. Plested?

STATEMENT OF WILLIAM G. PLESTED III, M.D., AMERICAN MEDICAL ASSOCIATION, CHICAGO, ILLINOIS

Dr. PLESTED. Thank you, Madam Chair. Madam Chair, Mr. Stark, and Members of the Committee, my name is Bill Plested. I am the immediate past Chair of the Board of Trustees of the American Medical Association and a practicing thoracic and cardiovascular surgeon in Santa Monica, California. The AMA would like to express our appreciation to you for calling this hearing. Recently, several factors have led to an increase in physicians' desire to invest in specialty hospitals. In particular, many physicians are frustrated with hospital control of management and investment decisions that directly affect quality of patient care. Physicians too

often have little or no involvement in governance and management, control over how to reinvest profits, and influence over scheduling and staffing needs.

Physicians need more control over the care their patients receive. Investing in specialty hospitals enables physicians to increase productivity, improve scheduling of procedures for patients, maintain desired staffing levels, increase nurse-to-patient ratios, and purchase state-of-the-art equipment, all of which improve the quality of patient care.

Studies support the premise that focusing on a specific area of service can lead to higher quality and lower cost as a result of more expert and efficient care. By performing high volumes of specific services, specialty hospitals perfect those tasks, increase accountability for the quality of patient care, lower fixed costs, quickly respond to patient needs, and re-engineer the delivery process as necessary. The bottom line is that patient satisfaction with specialty hospitals is extremely high. The recent growth in the number of specialty hospitals has led to concern among general hospitals, and that concern is competition. Although some hospitals have started their own specialty hospitals, the hospital industry has responded mainly by attacking physician ownership of the hospitals in an attempt to eliminate competition. General hospitals claim that physicians have a conflict of interest when they invest in specialty hospitals where they refer patients. They claim that such referrals amount to channeling patients to these hospitals. Ironically, hospitals are the one that channel patients because they cannot refer patients.

They channel patients in several ways: by purchasing physician practices and directing physician referrals to the hospital; by operating health plans with network referral requirements; and by adopting policies that force physicians to only refer patients to their facilities. We have provided examples of these channeling practices as an exhibit to our written statement. There is no data to support the claim that physician ownership of and referrals to specialty hospitals conflicts with the best interests of their patients. Physicians are ethically and legally permitted to own a hospital and to refer patients there if they treat patients at that hospital.

General hospitals also claim that competition from specialty hospitals will hurt them financially by reducing their most profitable services, which they use to subsidize unprofitable services. The data does not support this claim either. MedPAC's analysis found that general hospitals that compete with specialty hospitals have demonstrated financial performance that is comparable to other general hospitals. Even if a hospital could prove financial harm, the answer is not to eliminate competition and support cross-subsidization of services. The answer is exactly the opposite: to support competition and to eliminate cross-subsidization.

The Federal Trade Commission and the Department of Justice share this view. They recommend the elimination of this cross-subsidization. The AMA supports the changes in the DRG payments to more accurately reflect the relative costs of hospital care and eliminate the need for cross-subsidization of services by general hospitals. We strongly support and encourage competition as a means of promoting high-quality, cost-effective health care. There-

fore, the AMA believes that the moratorium on physician referrals to specialty hospitals should not be extended. Patients should continue to benefit from increased choice and the competition that results from specialty hospitals. Thank you again for the opportunity to provide our views.

[The prepared statement of Mr. Plested follows:]

Statement of William G. Plested III M.D., American Medical Association, Chicago, Illinois

Chairman Johnson and Members of the Subcommittee, the American Medical Association (AMA) appreciates the opportunity to provide our views today regarding physician owned specialty hospitals.

The AMA would like to take this opportunity to commend you, Chairman Johnson, for holding this hearing on physician owned specialty hospitals. 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 has grown significantly. This growth has led to concern among general hospitals who must compete with these facilities.

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 AMA Council on Ethical and Judicial Affairs Opinion E–8.032, we support health facility ownership and referral by physicians 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.

The AMA also supports changes 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. In addition, we support policy changes that would help ensure the financial viability of safety-net hospitals so they can continue to provide adequate access to health care for indigent patients. Together, these changes would ensure the continued financial stability of general and safety net hospitals. Therefore, the AMA believes there is no need to extend the moratorium on physician referrals to specialty hospitals.

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—hospitals that focus on cardiac, orthopedic, women's medicine, or on surgical procedures. 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. 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.

[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).

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 or technical component payments 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.
- Availability of business partners to provide capital and management expertise.

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.[3]

Managers of specialty hospitals consistently report the factors they perceive as critical to achieving high quality patient outcomes: high volume and high nursing intensity.[4]

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 tend to 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.

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

[3] Kelly J. Devers, Linda R. Brewster and Paul B. Ginsburg, *Specialty Hospitals: Focused Factories or Cream Skimmers?* HSC Issue Brief Number 62, April 2003.

[4] *A Comparative Study of Patient Severity, Quality of Care and Community Impact at MedCath Heart Hospitals*, The Lewin Group, February 2004.

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.[5] Patient satisfaction with specialty hospitals has been very 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 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.[6] 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.[7]

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 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 total loss of the service.
- 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 "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).

The hospital industry has engaged in numerous focused strategies to prohibit physicians from opening a competing facility. At the state level, hospitals have initiated several different types of legislative 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)

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[5] Editorial, *In the (Specialty) Hospital*, *Wall Street Journal*, Jan. 3, 2005.

[6] *A Comparative Study of Medicare Payments Per Episode of Cardiac Care for Patients at MedCath Heart Hospitals and Other Hospitals With Open Heart Surgery Programs*, The Lewin Group, July 2002.

[7] *Impact of MedCath Heart Hospitals on MSA Cardiology Inpatient Utilization Rates*, The Lewin Group, August 2001.

- 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 implemented a variety of strategies and tactics to discourage members of their medical staff from investing in competing physician-owned specialty hospitals. These initiatives include, but are not limited, to the following (See also Exhibit A):
- 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.
- Requiring subspecialists to utilize the hospital/vertically integrated delivery systems facilities for all of their medical group's referrals, for specified services such as outpatient surgery and procedures, all imaging and laboratory work, therapy, and inpatient admissions.
- Hiring in-house specialists to build "centers of excellence" or service lines, sometimes intentionally competing with its own medical staff members.
- Limiting access to operating rooms and cardiac catheterization labs of those physicians that have a financial interest in a competing entity.
- Removing competing physicians from extra assignments at the hospital, such as directors of departments 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, physicians are ethically and legally permitted to invest in and refer patients to health facilities.

Current public policy generally prohibits physicians from profiting from their referral decisions absent a legitimate justification for the referral. 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.[8]

[8] 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 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.

In addition to ethical policy, physician self-referral laws and other fraud and abuse laws, such as the federal anti-kickback statute, permit physician ownership of treatment facilities and referrals to such facilities under various circumstances.[9]The physician self-referral law, for instance, permits physician ownership and referral of patients to hospitals where the physician is authorized to perform services at that hospital. The hospital associations refer to this exception as a "loophole" to bolster their efforts to eliminate the ability of physician owned facilities to compete with their member hospitals. Yet, the exceptions and safe harbors have been carefully enacted and promulgated over the years. **There is no data to support hospital industry claims that physicians are inappropriately referring their patients to 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."[10]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. (See Exhibit A)

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.

Hospital efforts to control referrals would pose as much a concern as would physician self-referral if it were proven that such referrals led to an inappropriate increase in utilization. Worse yet, by dictating to whom physicians may refer, the hospital governing body or administration takes medical decision-making away from physicians. This runs counter to patient expectations, 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.

The AMA is very concerned about efforts by hospitals and health systems to control physician referrals and believes they pose a number of significant concerns. To reduce the 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 assertions. The Medicare Payment Advisory Commission (MedPAC) found no evidence that overall utilization rates in communities with specialty hospitals rose more rapidly than 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.[11] Therefore, the vast majority of physicians who admit patients to specialty hospitals receive no additional 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. Most nonprofit hospitals also receive Medicare and Medicaid DSH payments.

On the whole, the impact of specialty hospitals has not proven to be harmful to patients or to general hospitals. Specialty hospitals represent about two percent of

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[9] See generally 42 U.S.C. 1395nn., 42 CFR 411.350–411.361, 42 U.S.C. 1320a–7b, and 42 CFR 1001.952.

[10] Charles N. Kahn III, *A Health-Care Loophole*, Washington Times, February 3, 2005.

[11] GAO, *supra* note 2.

all short-term, acute care hospitals.[12] The most recent Medicare discharge data indicate that the 80 specialty hospitals in existence in 2001 accounted for slightly less than one percent of Medicare spending for inpatient services. MedPAC also found that the financial impact on community hospitals in the markets where physician owned specialty hospitals are located has been limited. These hospitals have managed to compensate for any losses of patients and revenues and demonstrate financial performance comparable to other community hospitals. 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.[13] 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. If general inefficiencies exist in the hospital industry, this type of market response will create an incentive for general hospitals to increase efficiencies to compete. If the cross-subsidies that hospitals use from profitable services are truly enabling them to provide unprofitable services, these cross-subsidies should be eliminated by making payments adequate for all services.

The Center for Studying Health System Change, Professor Ted Frech (Department of Economics, University of California at Santa Barbara), the Federal Trade Commission (FTC) and the Department of Justice (DOJ) believe there are inherent problems in using higher profits in certain areas of care to cross-subsidize uncompensated care and essential community services. Recommendation 3 of the July 2004 FTC/DOJ Report on Competition and Health Care 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.[14]

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 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, Congress should change the Medicare Hospital Prospective Payment System to minimize the need for cross-subsidization and accurately reflect relative costs of hospital care.

MedPAC is expected to recommend 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 will also recommend that Congress give the Secretary the authority to adjust the DRG relative weights to account for differences in the prevalence of high cost outlier cases. Finally, MedPAC will recommend that Congress and the Secretary should implement the case mix measurement and outlier policies over a transitional period.

The AMA supports such recommendations and believes that such payment changes will go a long way towards leveling the playing field and promoting full and

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[12] Id.

[13] Schneider, et al., *supra* note 4.

[14] Federal Trade Commission and Department of Justice, *Improving Health Care: A Dose of Competition,* July 23, 2004.

fair competition in the market for hospital services. Consistent with Council on Ethical and Judicial Affairs Opinion E–8.032, the AMA supports health facility ownership by physicians if they directly provide care or services at the facility. The AMA also supports competition between and among health care facilities because it promotes the delivery of high-quality, cost-effective health care.

In addition, the AMA 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 adequate 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 and FTC/DOJ recommendations and the limited data currently available on physician ownership of specialty hospitals, **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. After 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 Congress to consider the recommendations we have discussed today. We are happy to work with the Subcommittee and Congress as it considers these important matters.

Chairman JOHNSON. Thank you very much, Dr. Plested. Dr. Brien?

STATEMENT OF WILLIAM W. BRIEN, M.D., CEDARS-SINAI MEDICAL CENTER, LOS ANGELES, CALIFORNIA

Dr. BRIEN. Madam Chairman, Mr. Stark, Members of the Subcommittee, I am Dr. William Warren Brien, director of orthopedic

surgery and the clinical chief of the Department of Surgery at Cedars-Sinai Medical Center in Los Angeles. I am here today to share my concerns about the impact physician-owned, limited-service hospitals can have on patient access to essential medical services.

As an orthopedic surgeon, I have a unique perspective on today's topic. Several of the physician-owned, limited-service hospitals were started by orthopedic surgeons. But let me be clear. Many physicians do not agree with the practices of some of our colleagues who own these hospitals and exploit a loophole in the Federal law by referring carefully selected patients to their own facilities. This raises serious concerned about conflicts of interest, a physician's own financial interest versus the best care for patients. Of equal concern is the impact on our broader health care system, in particular, how these practices threaten the Los Angeles' already fragile emergency and trauma care system.

Cedars-Sinai Medical Center is a 900-bed, not-for-profit, full-service hospital that serves as a local community hospital, a tertiary regional referral center for complex patient care, a Level I trauma center, and a major research, education, and training hospital. Each year we provide about $100 million in charity care. As a Level I trauma center, we are required to have physicians on call 24 hours a day, 7 days a week in all of our departments. Last year, we treated more than 75,000 people in our emergency Department and handled an additional 1,500 trauma cases, half involving uninsured patients.

Los Angeles' physician-owned, limited-service hospitals offer no trauma care and only severely limited emergency services, if at all. In my opinion, they should not even be called "hospitals" but, rather, be called "limited-access facilities." The physicians who own them carefully select and refer only those patients with private, commercial, or Medicare health coverage. The only services they offer are high-revenue-producing surgical procedures. In the last 2 years, nine community hospitals in the Los Angeles area closed. Last year, the county closed the Level I trauma center at the Martin Luther King, Jr., Medical Center. These losses have created a significant strain on the Los Angeles County trauma system and the Cedars-Sinai participation in this trauma system and raised serious access-to-care issues that will only worsen if limited-access facilities are allowed to proliferate.

Some existing community hospitals will close their high-cost emergency rooms. Others will close altogether because they cannot remain financially solvent. Our area's trauma system would face a complete collapse as fewer hospitals are left to handle an increased number of emergency cases. Fewer operational trauma centers mean more patients will die needlessly during longer transports in search of the available trauma centers. limited-access facilities also jeopardize general emergency care for everyone. Physicians who own them often refuse to participate in emergency on-call duty at other community hospitals, leaving full-service hospitals struggling to maintain specialty coverage in their emergency departments. And Los Angeles is not the only place in the country where this is a problem.

As a physician, I also worry about the safety of some of our patients treated by limited-access facilities which often treat only sin-

gle conditions. When patients suffer complications following surgeries at these facilities, such as blood clots or heart attacks, they must transfer them to full-service hospitals for treatment. Both the GAO and MedPAC have found disturbing patterns in the operation of physician-owned, limited-access facilities that reflect exactly what Congress feared: physician owners refer only healthier patients with good health insurance, were less likely to offer emergency services while focusing on well-paying medical procedures. And MedPAC found that these facilities are not less expensive than full-service community hospitals.

Despite what our opponents say, full-service hospitals do not take issue with the formation of limited-access facilities when supported by community need, and we do not take issue when physicians own them. It is when physicians refer their patients to the facilities that they own. This creates a conflict of interest with serious health and economic repercussions for communities everywhere. Madam Chairman, I respectfully urge Congress to protect health care access for all patients by extending the current moratorium on these limited-access facilities until a permanent ban on physician self-referral to physician-owned, limited-access facilities can be put into place. Thank you, and I will be happy to respond to your questions.

[The prepared statement of Mr. Brien follows:]

Statement of William Brien, M.D., Cedars-Sinai Hospital, Los Angeles, California

Good afternoon, Madam Chairman. I am Dr. William Warren Brien, director of orthopedic surgery and the clinical chief of the department of surgery at Cedars-Sinai Medical Center in Los Angeles. I also serve as a state commissioner on the California Health Policy and Data Advisory Commission. I appreciate the opportunity to testify today on the issue of limited-service hospitals.

In many communities, certain physicians are exploiting a loophole in federal law, and own limited-service hospitals to which they refer their own patients. This activity raises serious concerns about conflict of interest, fair competition, and whether the best interests of both patients and communities are being served.

To protect patients and the health care safety net, Congress should close the loophole in the federal Stark law by continuing the ban on the ability of physicians to self-refer to limited-service hospitals.

As an orthopedic surgeon, I may bring a unique perspective to this debate. Many of the physician-owned limited service hospitals operating today were opened by orthopedic surgeons. I would like to be clear. Many physicians do not agree with the practices of some of our colleagues. Physicians who own these limited services hospitals and refer their patients there have potential conflicts of interest—their own financial interests with the interest of the best care for patients. And government data shows this to be the case. Of equal concern, is the impact on our broader health care system.

My testimony will focus on concerns related to patient access to essential health care services and the adverse consequences that would surely result if the current moratorium on physician self-referral of Medicare patients to new limited-service hospitals were permitted to sunset in June. If the continued growth of these limited service hospitals is allowed, it will have a profound impact on overall patient access to life-saving hospital care.

The Situation in Los Angeles

Cedars-Sinai Medical Center is a 900-bed, not-for-profit, full-service hospital that serves as a local community hospital, a tertiary regional referral center for complex patient care, a Level I Trauma Center for the County of Los Angeles, as well as a major research, education and training hospital. Our mission has always centered on providing quality patient care and community service.

The medical center annually provides about $100 million of charity care. We deliver primary health care services directly to inner-city children and adults through mobile units. We offer community clinics to uninsured patients and those covered

by Medi-Cal—the state's Medicaid program—with more than 29,000 clinic visits annually. In fact, Cedars-Sinai is one of the top five Medi-Cal providers among private hospitals in L.A. County and is one of the largest Medi-Cal providers in the state of California.

As a Level I Trauma Center, we are required to have physicians on call 24-hours a day, seven days a week in all of our departments. In a major urban area like Los Angeles, trauma injuries affect everyone from the wealthy, the poor and the insured to the uninsured. Last year, we treated more than 75,000 people in our emergency department and we handled an additional 1,500 trauma cases. Approximately half of those trauma cases involved uninsured patients.

In sharp contrast, the physician-owned limited-service hospitals currently operating in Los Angeles offer no trauma care and only severely limited emergency services if anything at all. In my opinion, they should not even be called hospitals—but rather *limited-access facilities*. The physicians who own these limited-access facilities carefully select only patients with the right type of health insurance coverage—private or commercial insurance or Medicare—and then refer them to those facilities that they own. Poor patients covered by Medi-Cal or those without insurance at all are not welcome. These limited-access facilities also offer only high-revenue-producing surgical procedures. They do not offer the many services that we and other full-service community hospitals do that are seldom self-supporting, such as pediatric and obstetrical care, mental health programs, or services specifically targeting care for the poor and the elderly.

Meanwhile, the full-service community hospitals provide those services and more—emergency services for all of the area's patients, including the poor, the uninsured and those in need of costly, intensive care.

The Effects of limited-access Facilities

During the last two years, nine community hospitals in the Los Angeles area closed their doors forever. In 2004, the County of Los Angeles closed the Level I Trauma Center at Martin Luther King Jr. Medical Center. The loss of those nine hospitals and their emergency departments combined with the closure of the Martin Luther King Trauma Center has created a significant strain on the Cedars-Sinai trauma system and raises a serious access-to-care issue for the people of Los Angeles.

Our already fragile health care system in Los Angeles will only be made worse if physician-owned, limited-access facilities are allowed to proliferate. Some existing community hospitals will certainly close their high-cost emergency rooms. Other, smaller community hospitals will likely not be able to maintain their financial solvency and will fold. Both scenarios would inevitably lead to a complete collapse of our area's trauma system as fewer remaining hospitals are left to handle an increased number of emergency cases.

Imagine being involved in a serious traffic accident at 5 p.m. on a Friday in Los Angeles' notoriously bad rush hour traffic. Rather than arriving at a trauma center within 10 to 20 minutes, the trip now takes 30 minutes to an hour because the closest emergency rooms have since closed up shop for good. I am not an alarmist, but in trauma cases where every second counts, that scenario means that patients will die unnecessarily. That is a risk that we cannot afford to take.

limited-access facilities also jeopardize general emergency care available to everyone in Los Angeles. Physicians who own limited-access facilities often refuse to participate in emergency "on call" duty at other community hospitals, leaving the full-service hospitals struggling to maintain specialty coverage in their emergency departments. This means that a patient who needs emergency surgery in the middle of the night, may not get it because the needed specialists will not care for the broader needs of the people of Los Angeles. It could also mean that emergency patients must be transported much farther away to get access to care.

And this isn't just happening in L.A. Struggles to maintain specialty coverage in the emergency department are jeopardizing care across America. In Oklahoma City, for example, specialty physicians practicing in limited-access facilities reduced or eliminated their participation in emergency on call duty at Oklahoma University Medical Center, bringing their trauma center—the state's only Level 1 Trauma Center—to the brink of closure. And in Rapid City, South Dakota, the neurosurgeon owners of the limited-access facility in the community stopped providing emergency coverage at the full-service hospital, causing significant access problems for the region for emergency neurosurgery.

Because limited-access facilities often treat only a single condition, I worry as a physician about the safety of some patients treated there. Patients are placed at an increased risk when they suffer complications following surgeries at limited-access facilities, such as blood clots and heart attacks, and must be transferred to the full-

service hospitals for treatment. Care for those patients cannot be well-managed and coordinated.

If limited-access facilities are permitted to expand in number, they will certainly have significant adverse consequences for the ability of Cedars-Sinai and other community hospitals to continue to provide the high quality of patient care that we provide today to the Los Angeles community. Patient access will inevitably suffer.

Government Concerns

Both the Government Accountability Office (GAO) and the Medicare Payment Advisory Commission (MedPAC) in separate studies revealed disturbing patterns in the operation of physician-owned, limited-access facilities. Specifically, they found that physician owners do exactly what Congress feared—they selectively refer only healthier patients with good health insurance coverage to those limited-access facilities they own, refusing to treat others. As a result, full-service hospitals are left to treat a greater number of poor and uninsured patients with more serious health conditions. Further, the GAO and MedPAC also found that the limited-access facilities were much less likely to offer emergency services and tend to offer only highly profitable services. And MedPAC found that limited-access facilities are not less expensive.

Based on its concerns over the rapid growth of physician-owned, limited-access facilities and potential conflicts of interest posed by physician-ownership of the facilities, Congress implemented in 2003 a moratorium prohibiting physicians from referring Medicare patients to new, physician-owned limited-service hospitals as part of the Medicare Modernization Act. That moratorium is set to expire in June, but based on their findings, MedPAC has recommended that the moratorium be extended to Jan. 1, 2007.

This Is Not About Competition—It's about Conflict of Interest

Our opponents have argued that full-service hospitals do not want limited-access facilities to exist in our market-driven health care system. Let me set the record straight. Full-service hospitals do not take any issue with the formation of limited-access facilities, where supported by community need. Nor do they take issue with physician ownership in a hospital that the physician *does not* refer to. Rather, full-service community hospitals strongly oppose the conflict of interest that results when a physician is an owner and controls patient referrals. Those two elements—ownership and patient referral—lead to very serious concerns about the health and economic interests of a community, including higher health care costs, duplication of services, patient cherry-picking, reduced emergency care coverage, inappropriate use of procedures, patient selection, and more.

Conclusion

In closing, Madam Chairman, I respectfully urge Congress to extend the moratorium until the permanent solution of banning physician-self-referral to physician-owned limited-access facilities is in place. I firmly believe that these limited-access facilities have significant adverse consequences on the health care that patients expect and deserve. And their negative impact will be felt by everyone.

Chairman JOHNSON. Thank you, Dr. Brien. Mr. Harris?

STATEMENT OF JAMIE HARRIS, EXECUTIVE VICE PRESIDENT AND CHIEF FINANCIAL OFFICER, MEDCATH CORPORATION, CHARLOTTE, NORTH CAROLINA

Mr. HARRIS. Madam Chairwoman, Mr. Stark, and Committee members, my name is Jamie Harris. Thank you for the opportunity to testify today. I am Executive Vice President and CFO for MedCath. We operate fully licensed acute-care hospitals that focus on cardiovascular care. All of our hospitals are owned in partnership with physicians, and in two cases a local community hospital system.

Each of our hospitals operates a staffed emergency Department which is open 24 hours per day, 7 days per week. Our hospitals include approximately 175 to 300 physicians who are not cardio-

vascular doctors and who are not owners of the hospital. As a result, we are capable of treating a broad range of patients, regardless of their ability to pay or their condition.

In fact, in the last year alone, we treated more than 60,000 patients in our emergency departments; 63 percent of these patients were not cardiovascular patients. We do not believe the evidence suggests a conclusion that any financial incentive associated with physician ownership determines patient or payer mix. Our internal data shows a small amount of our patients come to our hospitals from physician owners. As the chart that we have put up illustrates, in 2002, our internal statistics show that approximately 69 percent of our patients came to our hospitals through sources that were not directly from a physician referral: 31 percent came from the emergency departments at our hospitals; 24 percent came from transfers from other hospitals, many of which were from rural communities; and 14 percent came from non-owner physicians. Only approximately 30 percent came directly from physician owners.

We believe that patients and physicians use MedCath hospitals because we achieve better outcomes, with fewer complications, and have earned the confidence of our communities. In fact, the Lewin Group found that our hospitals, when compared to peer hospitals, have a 16-percent lower in-house mortality rate for Medicare cardiac cases and approximately 25 percent more of our patients are discharged directly to their home versus a skilled or other care facility. The Lewin Group estimates this saves Medicare approximately $1.5 million per facility per year. Imagine the billions of dollars that we could save Medicare if these results were the standard of care across the country.

We believe physician ownership is the key contributor to these quality outcomes. Physicians become owners because of dissatisfaction with the quality of care, the efficiency, and much of the bureaucracy of community hospitals. Ownership and their role in governance motivates them to help design and operate our hospitals in a manner which has a direct, positive impact on patient care and patient satisfaction. Community hospitals in our markets have improved services as a result of our competitive presence. MedPAC concluded that physician-owned specialty hospitals serve as a wake-up call for the community hospitals to improve services and efficiencies. They also concluded that specialty hospitals have little impact on the profitability of community hospitals. They found that community hospitals were able to make up lost cardiac revenue from other sources or by reducing their costs, and they also concluded there was no significant increase in utilization after the entry of a specialty heart hospital into a market.

We do also provide care to the Medicaid and uninsured patients. We believe there are three important reasons, however, why our hospitals receive fewer Medicaid patients. First, 42 percent of the Medicaid discharges are for obstetrics; only 9 percent are for cardiac care. Second, the volume of Medicaid patients is not uniformly distributed across all hospitals, regardless of whether they are community hospitals or specialty hospitals. In fact, in most communities only one or two hospitals primarily serve all the Medicaid—a primary amount of the Medicaid patients. And, third, several States that we operate in administer their Medicaid programs

through a capitated payer arrangement which we do not have access to. Further, the Lewin Group found that in all markets with comparable data, our hospitals ranked in the top half of volume for cardiac care provided to indigent patients. The MedPAC study found that our costs were not lower. However, we believe a more thorough analysis is required. The Lewin Group replicated and has expanded on this particular study and found the following factors:

First, our hospitals are new facilities and, thus, our depreciation costs are substantially higher. Second, because we are new, they have higher interest costs in the early stages of development. And, third, our hospitals are not tax-exempt; therefore, we are required to pay significant levels of property, real estate, and income taxes. After accounting for these differences, this study found that our average operating cost per discharge was about 6 to 7 percent lower. A growing number of not-for-profit hospital systems are also embracing physician ownership as well. For example, our partner Avera McKennan in South Dakota and Carondelet in Tucson, Arizona, are good examples of not-for-profit systems that recognize the benefits of an innovative model with physician owners.

In conclusion, the advantages of competition to the health care sector are essential to meet the growing demand for cardiovascular services. The moratorium merely endorses the failings of the status quo and should be allowed to expire in order to stimulate the much needed competition. We agree that CMS should focus on revising the DRG pricing system to be more aligned with actual costs of certain procedures and diagnoses, as long as it is done fairly and comprehensively. The public policy issue here is not about limiting specialty hospitals through a moratorium even if it is temporary. The public policy issue is about the need to meet the emerging health care requirements of our population. We believe our model is an innovative approach to meet those needs. I thank you for the time and welcome questions.

[The prepared statement of Mr. Harris follows:]

Statement of Jamie Harris, Executive Vice President and Chief Financial Officer, MedCath Corporation, Charlotte, North Carolina

INTRODUCTION

My name is Jamie Harris. I currently serve as Executive Vice President and Chief Financial Officer for MedCath Corporation (MedCath). Thank you for the opportunity to speak on behalf of our company, our physician partners, our nurses, our professional staff, and the patients who have utilized MedCath's hospitals. Based in Charlotte, North Carolina, MedCath is a national provider of cardiovascular services. We build and operate fully licensed acute care hospitals, and other clinics and centers focusing on cardiovascular care. All of our 12 hospitals are owned in partnership with physicians and, in certain instances, a local community hospital.

We have established an outstanding reputation for innovation and for our focus on providing high-quality cardiovascular care. We believe that patients with cardiovascular disease in the communities we serve receive better care as a direct result of the presence of our hospitals in those communities.

As part of my written statement, I review the recent findings by the Medicare Payment Advisory Commission (MedPAC) concerning physician-owned specialty hospitals, and note where we agree and disagree with their analytic results. For the most part, MedCath-sponsored studies confirm MedPAC's results. There are several important instances, however, where we disagree with their conclusions and study inferences. As an example, in assessing physician behavior, the MedPAC analysis fails to completely investigate and understand the source of referrals and the patient selection process at specialty hospitals.

THE NEED FOR HIGH-QUALITY CARDIOVASCULAR SERVICES

According to the American Heart Association, cardiovascular disease is one of the leading killers in America, especially among women. While the current health care system is already feeling the stress from this demand, the aging baby boomer population is expected to place increased pressure on the system. Yet, of the more than 6,000 hospitals that exist across the United States, only approximately 18 percent have an open-heart surgical program.

Furthermore, according to the American College of Cardiology, by 2010, the shortage of cardiologists could become a serious public health problem if the supply of high-quality cardiology care cannot meet the demands of the population—particularly from the aging baby boomers. It is imperative that we make the current population of cardiologists more productive in their professional lives if we are to meet this demand; something MedCath hospitals are designed to do.

WE ARE FULL SERVICE HOSPITALS THAT PROVIDE EMERGENCY CARE

Each of our hospitals operates a staffed emergency department that is open 24 hours a day, 7 days a week, equipped with an average of eight Intensive Care Unit beds, in addition to the inpatient beds to which patients can be transferred. As a result, MedCath heart hospitals are capable of treating nearly every patient regardless of their condition or ability to pay.[1] We are capable of doing this because each of our hospitals includes a medical staff of 175–300 specialists, sub-specialists, and primary care physicians (most of whom are not owners of the hospital) who are available to care for patients that walk through our doors, whether they are a patient with a heart problem or not.

In fact, in the most recent 12-month period ending September 30, 2004, morethan 60,000 patients were treated in the emergency departments of MedCath's hospitals. Approximately 63 percent of those treated were *non-cardiac patients.* Only 2.84 percent of these non-cardiac patients were transferred to another hospital—a common practice among hospitals across the United States as not every acute care hospital, not even the large systems, offers specialized services such as trauma, burn, or psychiatric care. Our hospitals admitted, treated, and/or released the remaining 97.16 percent of these patients.[2]

PATIENT SEVERITY AND PATIENT MIX ARE A RESULT OF APPROPRIATE COMMUNITY REFERRAL PATTERNS

The MedPAC report found that specialty hospitals treat less severe patients than community hospitals. Our own internal data shows similar patient severity results, but the differences in patient severity across hospitals are not due, as MedPAC suggests, to the intentional selection of patients for financial gain. Rather, these differences are due to community referral patterns that place patients in the appropriate setting for their required treatment conditions. We do not believe the evidence supports a conclusion that any financial incentive associated with physician ownership is a key determinant of patient (and payor) mix.

Ultimately, the MedPAC study fails to reflect a complete investigation and understanding of the source of our referrals and the patient selection process at our hospitals. While the critics of our model would have you believe that a significant majority of the referrals to our hospitals are from physician-owners, our internal data shows that these referrals actually represent a *minority* of the referrals to our hospitals. For the study year 2002, MedCath statistics show that:

- Only approximately 30 percent of our referrals are from physician-owners.
- Approximately 24 percent of MedCath's in-patient admissions came as referrals from other hospitals, *particularly those located in rural areas.* These referrals were from hospitals that either did not have the capacity or the expertise to treat the patients.[3]
- Approximately 31 percent of MedCath's hospital admissions arrived through our emergency departments.
- Approximately 14 percent of MedCath's referrals were from physicians who did not have an ownership interest in our hospitals, but who prefer to practice there.

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[1] Hospitals with Emergency Departments must comply with the regulations required by the Emergency Medical Treatment and Labor Act (EMTALA) and provide services to anyone coming to our hospitals seeking emergency medical care, regardless of their condition and their ability to pay.

[2] Trendstar discharge-based data October 1, 2003—September 30, 2004.

[3] Trendstar admission source data October 1, 2003—September 30, 2004.

- All totaled, **approximately 69 percent of MedCath's patient admissions arrive at the hospital through sources other than our physician partners.** Patients come to our hospitals for the quality of care, our expertise, and our efficiency.

What the MedPAC study overlooked is that non-investor physicians, largely primary care physicians, are typically the first point of contact that a patient has with the physician community. Not only is the primary care physician the primary source of many services, he or she also coordinates the logistics of many specialists (*i.e.*, cardiologists) for the patient. While MedPAC has suggested that the hospital selection is made by physicians for financial reasons, it is clear that our country's medical triage system is structured so that the first point of contact is with the primary care physician, and thus he or she becomes the most significant decision-maker in the hospital selection process. Ultimately, patients receive care from the provider or institution best suited for their medical needs.

The most egregious cases of improper physician referrals and financial incentives are not occurring at hospitals with physician ownership, but from non-physician owners who are using "professional fees" and other questionable forms of remuneration as inducements to refer. We find it ironic that some of the for-profit hospitals who have been charged, in some cases criminally, with these practices are now leading a charge against physician ownership.

PHYSICIAN OWNERSHIP IS A KEY CONTRIBUTOR TO HIGHER QUALITY OUTCOMES AND IMPROVED EFFICIENCY

Despite assertions by MedPAC that physicians become owners in specialty hospitals for financial gain, the reality is that physicians become owners because of dissatisfaction with the quality of care, efficiency, and bureaucracy of their local hospitals, and to have an opportunity to make dramatic improvements in the delivery of health care. With ownership in the facility and a significant role in the governance and operation of the hospital, physicians are motivated to design and operate highly efficient care delivery systems that have a direct, positive impact on patient care. This increased control over clinical protocols and the quality of care process naturally motivates physicians to send their patients to these facilities—where they have confidence in the care provided.

The involvement of our physician partners in the governance and operations of our hospitals is a critical factor that contributes to quality patient care and is a logical by-product of their status as owners and board members. MedCath partners with local physicians who have established reputations for clinical excellence. We believe this alignment of interest between the physicians and the hospital operator is a primary reason MedCath hospitals have been able to improve the quality of care, reduce the average length of stay, save money for government payors, and achieve high levels of patient satisfaction.[4] MedCath has found that the economic commitment of physicians, under a physician ownership model, is in the best interest of the communities served and has resulted in the provision of a higher level of care and cost efficiencies.

In the case of MedCath's partnerships, all investors must assume financial risk and accountability for the hospital and the care provided. As startup businesses, all of our hospitals experience significant early stage losses, and there is no assurance they will subsequently be able to turn profitable. For some of our doctors, this has led to a financial return on their investment. For others, it has led to no financial benefit and in the case of one of our hospitals, which we had to close due to the anti-competitive tactics of the surrounding general hospitals, a loss of almost all of their investment. Ownership also causes the physician to have a greater incentive to self-police their peers—ensuring their use of the facility is appropriate.

The weight of the evidence contradicts any finding that our physicians become owners simply for financial gain. We find it hypocritical for community hospitals to criticize physicians for having ownership interests in hospitals because it may influence referrals, when it is commonplace for these same hospitals to own practices and employ physicians at least in significant part for the purpose of directing referrals to their facilities. We also find it ironic that the federal agency with responsibility for enforcing the anti-physician referral statute has issued several advisory opinions approving "gainsharing" arrangements, which permit physicians, with no capital at risk, to receive distributions based on their "personal cost-saving efforts."

A "WAKE-UP" CALL TO COMMUNITY HOSPITALS

While competition, regardless of the industry, is not always welcomed, the communities where MedCath hospitals are located have benefited significantly from our

competitive presence. As indicated by MedPAC's findings, physician-owned specialty hospitals often serve as a "wake-up call" for the traditional acute care hospitals in a community to improve services and efficiencies. Specifically, MedPAC found that specialty hospitals focus community hospitals on the issues of hospital operations and physician relations. Community hospitals in these markets have made constructive improvements, including extended service hours, improved operating room scheduling, standardization of supplies in the operating room, and upgraded equipment. This is evidence that community hospitals are responding to the new competitive pressures from specialty hospitals in a way that benefits patients, doctors and the entire community.

A recent report released by the Federal Trade Commission and the United States Justice Department's antitrust division similarly calls for vigorous competition in the health-care marketplace and elimination of protectionist policies that are preventing consumers from gaining access to high quality health care. Hardly a rush to judgment, this report was put together over a two-year period from 6,000 pages of transcripts, over 27 days of joint hearings and workshops, from the testimony of more than 250 panelists—including many hospital and health system executives and association leaders. The report found that "[e]ntry by single specialty hospitals [into the marketplace] has had a number of beneficial consequences for consumers who receive care from these providers."

A recent editorial in the Wall Street Journal also supports the concept of "market-oriented health-care reform."[5] Discussing specialty hospitals in particular, the article notes that their focused mission allows these hospitals to limit costs, increase quality, and give consumers greater choice over health decisions. Noting the recent attempts at limiting specialty hospitals, the article argues that critics of these hospitals want to limit consumer choice and "forc[e] patients into treatment at less-optimal facilities for no reason other than to prop up the current system."

Furthermore, the independent Lewin Group reported that MedCath's eight hospitals that were open in 2002 on average saved Medicare between $12.2 million and $15.2 million per year. This is an average of $1.5 million to $1.9 million per hospital and resulted from our hospitals' ability to discharge more patients to their homes versus to sub-acute care facilities or skilled nursing facilities.[6] Imagine the billions of dollars that the national healthcare system could save if the higher quality of care and lower cost structure that our hospitals have achieved could be replicated by other hospitals. Yet some of the large hospital systems are insisting that Congress enact barriers to this type of innovation and competition.

MEDCATH'S HOSPITALS DO NOT ADVERSELY IMPACT PROFITABILITY AND UTILIZATION

Our own independent studies confirm MedPAC's significant finding that specialty hospitals have "little impact" on the profitability of community hospitals. In fact, MedPAC found that community hospitals were able to "make up" lost cardiac revenue from other sources or reduce their costs. MedPAC found, for instance, that community hospitals with a heart hospital in their market actually have a higher profit margin (3.4 percent) in 2002 than community hospitals without a heart hospital (2.7 percent) in their market. This is a critical point that we think is important for Congress to recognize.

Our independent studies also confirm the MedPAC finding that there was no statistically significant increase in utilization after the entry of a specialty heart hospital into a market.[7] In our opinion many of the markets where we have hospitals were significantly under served prior to our entry into the community and that we met a much-needed demand, thus bringing the market up to parity with other markets. We believe that this unfulfilled need that our hospitals have met has had a very positive impact in the communities where we are located.

ANTI-COMPETITIVE TACTICS IN RESPONSE TO COMPETITION FROM OUR HOSPITALS

Even though MedCath has experienced improvements in the level of cardiac care in communities served, this competition clearly draws many anti-competitive tactics by the community hospitals which obviously do not appreciate the entrance of a new competitor into their market. In many markets across the country, community hospitals are retaliating against physician-owners. Often, once a physician decides to invest in a hospital, he or she may be removed from reading panels and certain call

[7] *Impact of MedCath Heart Hospitals on MSA Cardiology Inpatient Utilization Rates,* The Lewin Group, August 2001.

rotations, fired from a medical director position, or given the least desirable times in the catheterization lab or surgery suite.

Another example is the community hospitals engaging in economic credentialing or granting privileges based on financial reasons rather than qualifications. In Little Rock, Arkansas, six cardiologists filed suit against Baptist Health System (Baptist) alleging that the hospital's policy of economic credentialing violated state laws against Medicaid fraud and deceptive trade practices, and the federal anti-kickback law. All six cardiologists are shareholders in Little Rock Cardiology Clinic, which holds a 14.5 percent ownership interest in the Arkansas Heart Hospital, a competitor of Baptist. Two of the doctors were told their medical staff privileges at Baptist would be terminated because of their clinic's stake in the Arkansas Heart Hospital, and the others are expecting similar notices.

We believe this debate is clearly about competition. We believe the retaliatory actions in many of the markets demonstrate the anti-competitive strategy of our competitors—to totally dominate the market place, rather than to provide patients with the opportunity to seek quality care from the provider of their choice.

MEDCATH HOSPITALS HAVE BETTER OUTCOMES AND FEWER COMPLICATIONS

The Lewin Group has confirmed that:

- MedCath hospitals provided **better care on average** (as measured by lower in-hospital mortality rates and lower rates of complications) **in a shorter period of time** than the peer community hospitals.
- After adjusting for risk of mortality, MedCath heart hospitals on average exhibited a **16 percent lower in-hospital mortality rate** for Medicare cardiac cases compared to the peer community hospitals, including major teaching facilities.
- MedCath heart hospitals also had **shorter average lengths of stay** for cardiac cases (3.81 days) than the peer community hospitals (4.88 days) after adjusting for severity.
- Approximately 90% of our patients are discharged to their home instead of being discharged to a subacute care facility, home health agency, or skilled nursing facility. Not only is this better for the patient, the Lewin Group also estimates it saves Medicare approximately $1.5 million per facility per year.

As evidence of our commitment to providing quality care, we advocate for a performance based payment system that provides incentives for delivering top quality health care.

MEDCATH HOSPITALS CONTRIBUTE TO THE CARE OF THE UNINSURED AND OUR LEVELS OF MEDICAID PARTICIPATION ARE NOT ATYPICAL

While the MedPAC report suggests that a financial motive drives patient selection, the reality is vastly different. Acute care licensed facilities, such as MedCath's, are required by law to treat patients regardless of their ability to pay.[8] While this may be the law, MedCath also believes it is a community responsibility to treat anyone who walks in our doors and needs medical care.

In fact, a Lewin Group study found that in all four markets where comparable data was available, MedCath hospitals ranked in the top half of area hospitals for the volume of cardiac care provided to indigent patients.[9] Approximately 75–85 percent of the self-pay/uninsured care is provided without compensation. Despite this large amount of uncompensated care, our hospitals and their services are available to all patients in need of quality cardiovascular care.

Similarly, allegations that we do not provide services to the Medicaid and self-insured populations are plainly incorrect. In fact, our payor mix for the 12-month period ending September 30, 2004 is as follows:

Medicare	51.2 %
Medicaid	4.0 %
Self-pay/Uninsured	6.0 %
Private insurance and other	38.8 %

These percentages, especially the levels of Medicaid and self-insured/uninsured, are very similar to the typical general acute care hospital's cardiovascular services.

[8] *See* note 1 *supra*.

[9] *A Comparative Study of Patient Severity, Quality of Care between MedCath Heart Hospitals and Peer Hospitals in The MedCath Market Area*, The Lewin Group, March 2004.

In terms of Medicaid in particular, MedPAC's findings are misleading for several reasons. First, the volume of Medicaid patients is not uniformly distributed across hospitals (including both general and specialty hospitals). In most communities, only one or two hospitals serve the vast majority of Medicaid patients with the other hospitals in the community serving the remainder. Based upon 2002 Medicare hospital cost report data, only 10 percent of hospitals provided nearly 60 percent of inpatient care for Medicaid patients.

Second, heart hospitals are inherently less likely to draw Medicaid patients because these patients, comprised primarily of younger women and children, do not typically require cardiac care. In fact, only about 9 percent of total Medicaid discharges nationally are for cardiac care while 42 percent of Medicaid inpatient care is for obstetrics.

Lastly, Medicaid programs in certain states in which we operate provide care for their beneficiaries through capitated arrangements with managed care plans. Because we are often blocked from participating by our competitors, we do not have contractual arrangements with these managed care plans in some of the areas that we operate. For example, in Arizona we have been involuntarily excluded from participation with these plans and, as such, our Medicaid levels are naturally comparatively lower.

As MedPAC Chairman Hackbarth noted at the January 12, 2005 public meeting of the commission, ". . . 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. Among community hospitals, some do a lot of uncompensated care, have a lot of Medicaid patients. Others do a few. So that's an important issue. But to address it you need measures that are appropriate to its scope. And it's huge."

START-UP COSTS AT MEDCATH'S HOSPITALS EXPLAIN COST DIFFERENCES

The MedPAC study found costs at our hospitals to be higher than those of other community hospitals, although it was not statistically significant. The MedPAC study, however, fell short of investigating and presenting the factors that account for these differences. In a draft report, the Lewin Group has replicated and expanded on the MedPAC analyses, and found the following factors that account for cost differences between our hospitals and other community hospitals:

- Because most of our hospitals are relatively new facilities with most beds being intensive care beds and equipped with state-of-the-art medical equipment, our depreciation costs are substantially higher than that of the average community hospital. As our hospitals age, however, we believe depreciation expenses will become more aligned to those of community hospitals.
- Our newly-built hospitals require financing of working capital until they can become fully operational, which we refer to as "startup" or "ramp up" costs. The interest cost on this debt and construction debt is very significant and substantially higher than the average community hospital. As our hospitals ramp up operations, repay this debt and become fully operational, however, these interest costs will become more aligned to those of community hospitals.
- MedCath hospitals are required to pay property and income taxes, which is not required of not-for-profit hospitals due to their tax exempt status, thus our cost per discharge is inherently higher.

After accounting for differences in depreciation, interest, and taxes (*i.e.*, capital costs) between our hospitals and other community hospitals in our market areas, the Lewin Group found that our average adjusted Medicare operating cost per discharge was 6–7 percent lower than community hospitals in our market areas. Finally, most of our hospitals are relatively new and have not yet reached their optimum occupancy rates. Once occupancy rates increase for our hospitals, average costs per discharge will decline.

As a final point, we note that our diagnosis related group (DRG) payments from Medicare are the same irrespective of our costs.

PHYSICIAN OWNERSHIP IS BEING EMBRACED BY NOT-FOR-PROFIT SYSTEMS AND COMMUNITY HOSPITALS

A growing number of not-for-profit healthcare systems around the country have embraced the concept of physician ownership—seeing the opportunity for improving the quality of care and cost effectiveness within their own healthcare systems. For example, Baylor Health Care System (Baylor), located in Texas, is one of our na-

tion's largest and most respected not-for-profit, faith-based systems. While not a MedCath partner, Baylor (along with other not-for-profit systems around the country) understands the importance of aligning physicians and their hospitals. As such, systems such as Baylor's are partnering with physicians who have ownership in order to provide higher quality healthcare services to their communities. Clearly, physicians must be an integral part of solving the nation's health care crisis.

Indeed, two of MedCath's most successful hospitals are three-way partnerships between a community hospital, MedCath and the local physicians. Avera McKennan, MedCath, and local physicians in Sioux Falls, South Dakota, built and opened the Avera Heart Hospital of South Dakota in March 2001, which is currently delivering high quality cardiovascular care to the patients of South Dakota and surrounding states. Carondelet Health Network, MedCath and local physicians in Tucson, Arizona are partners in the Tucson Heart Hospital.

Both of these partnerships embrace the collective expertise of each group and align all interests to deliver high-quality care to the community and to patients. We believe partnerships like these are critical to the future of delivering high-quality health care to a rapidly aging population.

CONCLUSION

In conclusion, the advantages of competition to the health care sector provided by specialty hospitals are both undeniable and essential to meeting the growing demand for cardiovascular services as a result of the aging baby boomer population. The moratorium should be allowed to expire in order to further spur much needed competition and to address this growing demand. To ensure reimbursement rates are appropriate, CMS should focus on revising the DRG pricing system to be more aligned with the actual costs of certain procedures and diagnoses.

While the community hospital providers are aggressively attempting to frame this debate about conflict of interest and "limited service" providers, we believe their real motive is about limiting competition from facilities that have spurred innovation while delivering high quality health care with significantly better quality results.

In our view, the public policy issue here is not the necessity of curtailing specialty hospitals through a moratorium which effectively endorses the failings of the status quo, but rather the need to efficiently meet the emerging health care requirements of our aging population. We believe the MedCath hospital model is an innovative model that meets those needs.

Chairman JOHNSON. Thank you. Mr. Brock?

STATEMENT OF GARY D. BROCK, CHIEF OPERATING OFFICER, BAYLOR HEALTH CARE SYSTEM, DALLAS-FORT WORTH, TEXAS

Mr. BROCK. Thank you, Madam Chairman, Members of the Committee. My name is Gary Brock, and I am the chief operating officer of the Baylor Health Care System based in the Dallas-Fort Worth region in Texas. I have been a hospital executive for 28 years, have a master's degree in public health from the University of Oklahoma. 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 8th, without renewal.

Baylor Health Care System is the corporate sponsor of 13 not-for-profit hospitals, with its flagship, Baylor University Medical Center, located in downtown Dallas, Texas. Baylor University Medical Center is a 1,000-bed quaternary teaching hospital, with a Level I trauma center that provides care to 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 solid organ transplant

programs in the United States. Baylor Health Care System is deeply committed to its mission as a not-for-profit hospital. Last year, we provided more than $240 million in community benefits, at cost, and this does not include bad debt. Charity care is provided under the most generous charity care/financial assistance policy among all Dallas-Fort Worth hospitals.

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 at the same time improving quality, safety, and patient satisfaction. One of the most recent effective strategies Baylor has implemented is partnering with physicians economically and, more importantly, clinically in the design, development, governance, and operation of ambulatory surgery centers, surgical hospitals, and heart hospitals. Today, Baylor has an ownership interest in 25 facilities partnered with physicians.

Five of these facilities are affected by the moratorium. Three are surgical hospitals. Two are heart hospitals. Each is critically important to the mission of the Baylor Health Care System, and in each case we have followed the guidelines developed by IRS in Revenue Ruling 98–15 for partnerships between tax-exempt organizations like Baylor and for-profit organizations. The IRS requires the tax-exempt entity to have certain governance controls with respect to the partnership and for the partners to agree that charitable interests will prevail over for-profit interests. With respect to each of our surgical hospitals, a Baylor-controlled entity owns at least 50.1 percent of the equity in a partnership that owns and operates the licensed hospital. For our two heart hospitals, the Baylor-controlled entity is actually the adjacent Baylor hospital.

Thus, 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. Cardiologists and vascular surgeons own the remaining 49 percent of equity in the facility. In north Dallas, the Baylor Regional medical Center at Plano owns 51 percent of Texas Heart Hospital of the Southwest, and 83 cardiologists and cardio-thoracic surgeons owns the 49-percent interest. The governing board of each partnership has a majority of Baylor-appointed representatives, who are lay volunteers from the community, and if ever a conflict arises between the for-profit interests of the partners and Baylor's charitable mission, the board and partnership must defer to the charitable mission.

The three surgical hospitals have a similar ownership structure, and all five facilities have adopted the charity care and financial assistance policy of Baylor. They all participate in Medicare and Texas Medicaid, and they all agree to take all patients regardless of their ability to pay. In our newest partnership, the Texas Heart Hospital of the Southwest, the 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 it is not subject to the law, which requires tax-exempt hos-

pitals to provide charity care equal to 4 percent of net patient revenue.

Madam Chairman, our model of partnering with physicians has now been in operation for over 6 years, with Baylor's downtown Dallas Heart Hospital open the last 3 years. The results have far exceeded expectations. By partnering with our physicians, Baylor delivers on its mission, and delivers to the patient better, safer care at a lower cost. Baylor's vision is to become the most trusted source of comprehensive health care services by the end of this decade. We urge you to allow the moratorium on physician ownership and development of specialty hospitals to end June 8th. This moratorium has affected our ability to meet our mission and vision due to the need to grow these services to meet the demands of the fast-growing population in the Dallas-Fort Worth region. Thank you.

[The prepared statement of Mr. Brock follows:]

Statement of Gary Brock, Chief Operating Officer, Baylor Healthcare System, Dallas, Texas

Mr. Chairman, Members of the Committee, my name is Gary Brock, and I am the Chief Operating Officer of Baylor Health Care System, based in Dallas-Fort Worth, Texas. I have been a hospital administrator for more than 28 years and have a Masters in Public Health from Oklahoma University.

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, with its flagship—BaylorUniversityMedicalCenter—located in downtown Dallas. BUMC is a 1,000 bed quadenary teaching hospital, with a Level I trauma center that provides care to more penetrating trauma victims than DallasCounty's tax-supported Parkland hospital. BUMC has the largest Neonatal ICU in the Southwest, and one of the five largest organ transplant programs in the Country. Baylor Health Care System is deeply committed to its mission as a non-profit hospital. Last year, we provided more than $240 million in Community Benefits, at cost and 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.

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.

Five of these 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. The IRS requires the tax-exempt entity to have certain governance controls with respect to the partnership and for the partners to agree that "charitable interests" will prevail over for-profit interests.

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.

Thus, our flagship hospital, BaylorUniversityMedicalCenter, owns 51% of the Baylor Jack and Jane Hamilton Heart and VascularHospital, located adjacent to and physically attached to BUMC. Cardiologists and vascular surgeons own the remaining 49% of the equity in the facility.

In north Dallas the BaylorRegionalMedicalCenter at Plano owns 51% of the TexasHeartHospital of the Southwest, LLP, and 83 cardiologists, cardio-thoracic surgeons and vascular surgeons own the 49% interest. The governing board of each partnership has a majority of Baylor appointed representatives (lay-volunteers from the community), and if ever a conflict arises between the for profit interests of the partners and Baylor's charitable mission, the board and partnership must defer to Baylor's charitable mission.

The three surgical hospitals have a similar ownership structure, and all five facilities have adopted the Baylor Charity Care/Financial Assistance Policy. They all participate in Medicare and Texas Medicaid and they all agree to take all patients regardless of their ability to pay. In our newest partnership, the TexasHeartHospital of the Southwest, the 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 it 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 downtown DallasHeartHospital open for almost three years. The results have far exceeded expectations. 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.

Baylor's Vision is to become the most trusted source of comprehensive health care services by 2010. We urge you to allow the Moratorium on physician ownership and development of specialty hospitals to end June 8. This moratorium has affected our ability to meet our Mission and Vision, due to the need to grow these services to meet the demands of the fast growing population of Dallas-Fort Worth.

Thank you.

Chairman JOHNSON. Is the physician ownership in your facilities public information? Both of you.

Mr. HARRIS. No. It is private.

Mr. BROCK. We are a Medicare participating hospital, and to the extent of what is consolidated, this controlled interest would be part of our Medicare cost report.

Chairman JOHNSON. But I do not think that the investors' names are included as part of your cost report.

Mr. BROCK. No.

Chairman JOHNSON. I am asking are the investors' names public information.

Mr. BROCK. No.

Chairman JOHNSON. Then you referred to the cardiologists and vascular surgeons who own the remaining 49 percent. Are any of the other doctors of your large medical complex or doctors in the greater Dallas area allowed to invest?

Mr. BROCK. We have, as I mentioned, surgical centers, and we have over 500 different investors in those facilities. So, we have surgeons of all types that invest.

Chairman JOHNSON. Are any of your investors doctors who do not practice at your facilities?

Mr. BROCK. Yes. Well, actually about half the cases done in the facilities are not physician investors.

Chairman JOHNSON. And are they doing the specialized cases? In other words, are they doing surgical cases, or you are such——

Mr. BROCK. Yes, they are doing——

Chairman JOHNSON.—a big organization you could be doing other kinds of cases, like some of the heart hospitals do a great va-

riety of cases. And in the heart hospital where you do a great variety of cases, have you offered physician ownership opportunities to all of the doctors in your organization or just the heart doctors?

Mr. HARRIS. Typically our ownership structure is primarily around cardiovascular-focused physicians because we feel that they have the most expertise to be able to set up the care model. Many of our cases that are done outside of cardiovascular are patients who are received through the emergency Department. Many of those specialists are not owners.

Chairman JOHNSON. So, the specialists that own and help operate get a return on their investment as well as their Medicare fee, correct?

Mr. HARRIS. If there is profitability in the facility, yes, ma'am.

Chairman JOHNSON. And the facility fee that Medicare pays, do you also split that with them? Or is there some broader use of that amongst all of the collaborative entities?

Mr. HARRIS. In our case, the money that would come to the hospital from Medicare would come in—obviously all the costs would be incurred, and then at the end of a year or any given period of time, if there were a profit, there might be a distribution that is made.

Chairman JOHNSON. I see. So, the facility fee would just go into the general pot, and if the costs of operating were less, then that would be distributed, along with any other profit.

Mr. HARRIS. Possibly, yes, ma'am.

Chairman JOHNSON. And do you know whether the opportunity was made available to the non-cardiac physicians to invest since they also practice there?

Mr. HARRIS. Typically that is not the case. Again, in our case, at MedCath we are focused on cardiovascular care. And the care model is structured around those type of patients with cath labs or operating rooms specifically designed for a cardiac patient. So, the ownership and the governance in the hospital is really focused on that type of care. So, typically the ownership is not distributed outside of the group who gives input.

Chairman JOHNSON. I appreciate the greater control that physicians have, but given all of the physician advantages to practicing in these circumstances, why wouldn't they just come without investing? I mean, if this is such a tremendous thing to do, why wouldn't they come without investing?

Mr. BROCK. In our case, they are. We have physicians—as I mentioned, about half of the cases being done in our surgical centers are being done by physicians who are not investors because we are able to accommodate their schedules better, give them better block time. We exceed the patient satisfaction scores that we have set up. And so, I mean, it is the service that is driving a lot of physicians to work with us.

Chairman JOHNSON. In this context, you know, the patient satisfaction surveys are a little difficult to evaluate in terms of their value to us in health care, because many patients would prefer to go to a brand-new facility. I mean, it is much nicer and they are often smaller, and you can drive up and park. So, you know, I am looking at—what interests me and what I am responsible for is access to care for everyone, and particularly for those facilities that

have to provide services that cannot pay for themselves. It is nice to say, if you are interested in competition, have everything carry its weight and pay its own way. But you know and I know that just does not work in the real world. And nobody would be able to afford certain kinds of coverage if there was not an ability to cross-subsidize. Of course, the ability to cross-subsidize is primarily because of the up and down demand of an OB or pediatric ward.

So, there is a bigger picture here that I am concerned about. I would like to have anyone else who wants to comment on this issue of what happens to a community hospital, and whether or not these hospitals are lifting a Department or whether they are attracting physicians from outside. Are you taking your physicians from the existing Baylor cardiac capability or from the existing hospitals? Or are you bringing in new physicians? And if you are not bringing in new physicians, if you are hiring local physicians who are already in practice, then is the hospital from which you attracted those physicians hiring new physicians to create ultimately a higher capacity?

Mr. FOSTER. Thank you, Madam Chairman.

Chairman JOHNSON. This is my last question, so say what you want.

Mr. FOSTER. I would be happy to address that. A lot of questions within the statement there that I would like to pick up on a little bit. Clearly, the model of physician ownership in specialty hospitals, if it were, in fact, that dynamic and that fantastic, you would see non-physician investors using the facility. Our experience in Austin is that, to the extent that there are physicians that are not investors that might use the facility, it is for outpatient surgery centers, not inpatient hospitals like we are discussing today.

You tend to see in outpatient surgery centers a little bit more use of maybe some non-investing physicians, but not, at least in Austin, Texas, non-investors using the specialty-owned hospitals. Also, you know, we think that it is important to point out that, again, if this model was so powerful, then we would see more of them in development even during the moratorium. Currently there is no moratorium on the development, of course, of specialty hospitals. There is a moratorium on the development of physician-owned specialty hospitals, which I think underscores further this notion that the entire economic architecture of physician-owned specialty hospitals it dependent upon the physician ownership position and the self-referral of cases to those hospitals.

And so we have seen in Austin, Texas, dramatically so, that as these specialty hospitals develop, there is a large transfer of patients from the full-service hospitals to the specialty hospitals. And the response typically is that we either have to cut our costs or we have to raise our prices to continue to cross-subsidize the unprofitable services. Obviously there is a fair amount of physician recruitment that occurs to try to back-fill for the physicians that left because we are obligated to provide 24/7 emergency Department services and have those specialists on call. And so there are a lot of unique variables that go on.

The other thing that we have seen in Austin is that of some non-investor physicians that might see patients on a very infrequent

basis in specialty-owned hospitals—physician-owned specialty hospitals, it might even be those specialists that really are available to consult in the hospital, that they have to chase after those patients to new venues or risk losing the business themselves. And so to the extent that there is practice that is occurring by non-owning physicians in hospitals, it is largely sometimes because they feel pressured to, either by the physicians that are investors that are in a position to refer to them, or consult them, or just because they feel that they have to chase the business all over town. These are some of the observations that are occurring in Austin, Texas, that I think touch on some of the issues that you raised, Madam Chairman.

Dr. PLESTED. In response to similar questions, Madam Chairman, it is interesting how semantics plays into some of the things that we are talking about. Most general hospitals are interested in this thing that they call centers of excellence, which is essentially a specialty service in the hospital. It is interesting that for a community hospital that is a center of excellence, if it outside the community hospital and a competitor, it is a boutique specialty hospital. But it is really the same thing trying to localize service and provide the service better to patients.

The other thing that we have a tendency to do here is to ascribe an awful lot of very complex problems to a very small portion of our whole health care milieu. All of these problems are not caused by specialty hospitals. The problems with emergency room care certainly aren't caused by specialty hospitals. I doubt if we could find an area where the closure of a community hospital or a community ER had anything to do with a specialty hospital. This has to do with community hospitals closing their services because they are not profitable. And I think the recurring theme that you mentioned that must be stressed is that we certainly must look at the payment of disproportional share hospitals and make sure that these payments go to the hospitals that are actually providing these services.

Dr. BRIEN. Madam Chairman, in Los Angeles we face in and around the area of Cedars-Sinai Medical Center a little bit different issue. We, in fact, have specialty hospitals developing now. I am sure they are—in fact, they are waiting to see what happens with this moratorium, whether it is extended or not.

The issue that we face is that the same doctors that are claiming they can provide better care at the specialty center are still practicing and on staff at our hospital. Also, as they move their practices over, they do not and they have refused to participate in our emergency room trauma panels. So, they have walked away from that, what I believe is a responsibility to the community in participation.

The only difference in terms of the quality that seems to arise between our institution and these new institutions that are developing, it is the fact that the location is different, that the payer mix is different. They are looking for the better-paying patients. They are not signing Medicaid contracts. They do not want to take care of the uninsured. And the only other difference is that they are physician-owned and physician-run, and it is the conflict of interest that exists with regard to the physician referrals that is at issue.

I do not think that we would be sitting here talking about physician ownership if they were not self-referring to the facilities that they own. And I think that that is really the crux of the issue. An example, although it is not a hospital, it was a surgery center, combined by two major Los Angeles hospitals, went in together, started a surgery center to serve the physicians' and the community's needs. It failed in a couple years. That facility then turned over and became a physician-owned, self-referred surgery center, and the profits from that simple—I think it was a $25,000 investment in 1995 produces $20,000 to $25,000 a month in profit for the physicians.

So, this is not about physician control or cost containment. This is about profiting, and the problem is it is at the expense of the major facilities, communities hospitals that have to provide the remaining care to those patients that do not have access to those facilities.

Chairman JOHNSON. Thank you. Mr. Stark?

Mr. STARK. Thank you, Madam Chair, and I thank all of you for taking the time to come and enlighten us. Mr. Harris, the Chair nibbled around the edge of this, but do your partnerships or joint ventures with physicians have an investment agreement the physician signs and you sign?

Mr. HARRIS. Yes.

Mr. STARK. Are they the same, basically the same for all your joint venture hospitals?

Mr. HARRIS. Roughly.

Mr. STARK. Okay. And you do not disclose who the physician owners are.

Mr. HARRIS. Correct.

Mr. STARK. Are the physician owners allowed to disclose to the public who they are?

Mr. HARRIS. At their own choice.

Mr. STARK. I beg your pardon?

Mr. HARRIS. At their own choice.

Mr. STARK. And are other individuals given an opportunity to invest in these joint ventures?

Mr. HARRIS. We have a couple situations where we do have other individuals who have invested, but it is not normal.

Mr. STARK. Is it allowed? Is it possible? Could I buy an interest in any one of your ventures?

Mr. HARRIS. In certain cases, yes.

Mr. STARK. What would be the——

Mr. HARRIS. Our focus of the partnership is on physicians, in our case cardiologists, who can bring a real expertise to the clinical care and the clinical protocol.

Mr. STARK. But they do not have anything to do with the clinical care. You say in your annual report that you run them. You are in substantive—the company exercises substantive control over the hospital. So, you guys are exercising control. What difference does it make who you sell the joint venture to?

Mr. HARRIS. It actually is very important because our boards at an individual hospital is shared governance between the MedCath representatives and physicians.

Mr. STARK. But you will not disclose who they are.

Mr. HARRIS. According to the partnership agreement, that is correct.

Mr. STARK. Okay. And they are at liberty to disclose it. Do you lend or cover the partners against loss over a certain amount?

Mr. HARRIS. No, economically, the way that works is they invest a certain amount of money, we invest a certain amount of money. It is invested pro rata. If they lose that money, they lose it. We provide working capital.

Mr. STARK. What if the loss exceeds their investment?

Mr. HARRIS. If the loss exceeds their investment——

Mr. STARK. You cover it?

Mr. HARRIS. That is correct.

Mr. STARK. That is a loan, isn't it?

Mr. HARRIS. We loan it——

Mr. STARK. You get it back, don't you?

Mr. HARRIS. We do get it back.

Mr. STARK. I just want to ask Dr. Plested, in your principles of medical ethics, just to cut to the chase here, you say that physicians should disclose their investment interest to their patients when making a referral. You also say that individuals not in a position to refer patients to a facility should be given bona fide opportunity to invest in the facility, which obviously Mr. Harris' facilities do not meet. So, therefore, a doctor ethically should not be investing. Is that correct? Did you say that?

Dr. PLESTED. That is correct, and I was trying to point that out.

Mr. STARK. So, we have got all these unethical guys in his facilities. You ought to punish them. I don't know what you could do to them. And then you also say the entity should not loan funds or guarantee a loan for physicians in a position to refer to the entity. That is them, isn't it? And I don't know what you and I would call a loan. I am not a chief financial officer. But what I am getting at is when you cut below zero—we just did a bankruptcy thing on this. If somebody covers your losses below zero and you are going to pay them back later, that kind of smells like a loan to me. Doesn't it to you? Wouldn't you call that—an advance, maybe?

Dr. PLESTED. Let me comment. You said that they are dealing with a bunch of unethical physicians. He said that he——

Mr. STARK. You said they are unethical. I didn't.

Dr. PLESTED. He said that he does not disclose their ownership interest. The AMA Code of Ethics suggests that the physician——

Mr. STARK. But nobody else——

Dr. PLESTED.—their patient.

Mr. STARK. It says here individuals not in a position to refer should be given a bona fide opportunity to invest in the facility.

Dr. PLESTED. That is our opinion, yes.

Mr. STARK. And they cannot. In his facilities they cannot. So, that makes them unethical, right. According to your——

Dr. PLESTED. They are not complying——

Mr. STARK. I would like to make your ethics a part of the record here. But I guess that we did this many years ago, and I am not unfamiliar with all these physician agreements. And as a practical matter, they do not work very well if you let the general public in because you brought the physicians there to refer patients and

make a lot of money from it. And whether or not your hospitals are any good and hurt the other hospitals, as Mr. Foster and Dr. Brien would suggest they do, there is a real problem, it seems to me, in physician ownership. And that is about as close as the AMA and I ever get to agreeing in over 30 years, but that is not bad. So, I guess that on those issue, Madam Chair, I think there are some problems of ownership and referral and separating them, and I think as our witnesses have presented to us today, there are some problems brought up. And I guess I would just conclude from that—and my time is up—that perhaps before we allow this to mushroom and become a problem that we or the Administration cannot change with regulation, we ought to come to a conclusion what our long-range plan should be. And I don't think we disadvantage anybody by waiting another 12 months to work this out, because I think there are some real problems that could arise, and I don't know if there are—certainly hospitals are not overcrowded these days, I don't believe. Mr. Foster, Dr. Brien, you guys are not running 110 percent occupancy.

Mr. FOSTER. There are seasons of time where we run high.

Mr. STARK. Okay. So, I thank the witnesses, and I think the case has been made for some further study, and I appreciate the Chair's having this hearing.

Chairman JOHNSON. Mr. McCrery?

Mr. MCCRERY. Mr. Brock, do you disagree with Mr. Stark's statement that another 12 months or so moratorium wouldn't hurt anybody?

Mr. BROCK. Well, we are actually moving forward with the development of a heart hospital today with the moratorium in place. So——

Mr. MCCRERY. You are doing that without physician ownership?

Mr. BROCK. No. Physicians will be an owner in that if the moratorium is lifted.

Mr. MCCRERY. Oh, if it is lifted. Well, my point is: Do you disagree with Mr. Stark's statement that no one will be hurt? Will you be hurt if the moratorium stays in place?

Mr. BROCK. We are asking that the moratorium be lifted, be done away with, yes.

Mr. MCCRERY. Okay.

Mr. BROCK. We are in a very growing market in the Dallas-Fort Worth region, so we are moving toward 9 million population in a 10-county area over the next 15 years. So, these are very cost-effective access models for us to use to serve a growing population. We did not get into this as a defensive measure. We got into it as an offensive strategy to give access, greater access to the public, and we bring additional capital partners to the table with us, with physicians bringing their dollars in, which reduces our capital burden, and it also puts—the physicians have upside but they also have downside risks. So, it really makes them get real focused around helping us operate these facilities and to pay attention to the costs that we are incurring within the facility, both in our operating supplies, our labor, as well as our capital costs. But Baylor and all of the competitors in the Dallas-Fort Worth area cannot generate

enough capital to provide access to the growing population that we have today.

Mr. MCCRERY. So, you are not asking physicians to be investors in your new facilities so that they will feed you patients through self-referral?

Mr. BROCK. No. I mean, we are looking for physicians to be there to be a partner with us, to develop quality, competitive programming for the community.

Mr. MCCRERY. Well, it does kind of make sense, doesn't it, that if a physician has an ownership in a facility, he is going to want to refer patients to that facility. That is human nature, isn't it?

Mr. BROCK. Well, definitely they would because they are going to have more involvement, more operating knowledge about that facility. All of these facilities that we operate in partnership with our physicians, they also retain active staff privileges on our other hospitals. So, they are extensions of their practice. They are extensions of our hospitals.

Mr. MCCRERY. Dr. Brien or Mr. Foster, what is wrong with that? What is wrong with physicians referring patients to a facility in which they have an ownership interest?

Mr. FOSTER. Well, I have seen situations with people I know where you might be a patient that needs surgery, you might even be in one of the St. David's hospitals. And a surgeon might be consulted to come see you to decide whether you need surgery or not. And what we have seen happen—and not just on one occasion—where a surgeon who is consulted is an investor in a hospital that they own will say to the patient, "You know, you need surgery, but I am just not completely comfortable with doing the surgery here. I am a little bit more comfortable with the staff and the equipment," you know, and all that at this other hospital. "So, what I work to do is discharge you and let's schedule that surgery for another time."

The problem with that is that it in essence leverages or plays upon the implicit relationship of trust that exists between the patient and the physician, because the patient cannot judge whether or not the facility has all the right technical equipment and all the right staff and all that. But they trust their physician. And you sure, if you are having surgery, do not want your physician uncomfortable. Right? So, what do you do? You, of course, go to where the physician is directing you to go. And we are seeing that happen. And we think it is an exploitation of the relationship that is implicit, that trust relationship between the patient and their physician. We have some big concerns about that. We really do.

Also, this whole issue of the unlevel playingfield, because I believe that we have physicians that can be fully aware of the services that we offer, fully familiar with the surgery centers and the operating rooms and all the things that we offer, without having to be an owner. At the St. David's Healthcare Partnership, our board is made up of 35 percent physicians. We have physician involvement and governance. And there are 2,000 doctors on our medical staff that are fully familiar and fully aware and participated in the process, you know, within our facilities, and do not have to be a physician owner to get that. So, you know, I think it is a little bit disingenuous to say that you have to be a physician

owner to be familiar with the facility or comfortable with it or anything like that. That would be my response.

Dr. BRIEN. I would agree. I think that the issue again, is physician ownership. I do not see an issue with physicians being partners in design of a complex, being partners in the development of a program, being partners in marketing the program, as long as they are not receiving money for referring their patients there. Because in the end, they do—I mean, the patients are coming from somewhere, and they are taking the healthy patients, they are taking the Medicare patient who needs a total hip replacement who doesn't have any co-morbidities, and taking them to their specialty facility.

Mr. MCCRERY. But the change in the DRG system, at least for Medicare, would solve that problem, wouldn't it?

Dr. BRIEN. To some degree for the inpatient. It obviously doesn't deal with the outpatient, which in orthopedics in particular and some of the surgical centers are also trying to bring in their outpatient patients because they actually get a better return from Medicare if they are doing them in a hospital-based facility than in an outpatient surgery center. So, those are still issues. The issue is the conflict of interest. The issue is the physician ownership and the self-referral.

And I just want to say, you know, it makes it sound like the existing community hospitals are not doing anything to improve the quality of patient care. And, in fact, compared—I mean, I look at this from my role in peer review, which is assessing quality and performance by the physicians. The focus truly is to educate physicians when errors have been made, to educate the system that we then try to fix to prevent those errors from occurring in the future, whether it is medication errors, wrong-side surgery errors. We work hard to fix those problems.

I look at a facility, though, where the physicians have ownership interests, and if I am now peer reviewing somebody who does more cases, brings in more volume, and more revenue for the hospital, for themselves, and for me, it makes it very hard for me to critically look at them on an independent basis and peer review them, and currently that peer review process does go on, at least in our facility at this point.

And just to go back on what we do at Cedars, we are reinvesting. We are reinvesting our moneys in building a brand-new, six-story critical care tower to bring in state-of-the-art critical care equipment and refurbish, all brand-new ICUs. We are refurbishing all of our operating rooms over the course of the next several years. We are building more operating rooms because our goal is not about the money that I make because I make it for my professional component only. It is about providing care for patients. These ICUs are for everybody, whether they are uninsured or they are Medicaid or they are insured or Medicare. We are providing the service to everyone, but there is a cost. And if we lose our best-paying patients, it makes it very difficult obviously to maintain and continue to refurbish and modernize our institutions to provide the best-quality care and access for everybody.

Mr. MCCRERY. Is your concern that physicians are referring patients to their hospital, so to speak, their physician-owned hospital,

and that takes a patient away from you? Or is your concern that physicians are referring patients to their hospitals that do not really need the treatment?

Dr. BRIEN. No, I don't think it is a matter of referring for unnecessary treatment.

Mr. MCCRERY. Okay.

Dr. BRIEN. I think it is a matter of cherry picking the patients that are best for them to make money and leaving the other patients that do not make money for their institution at the community hospital. If it does not make money for their institution, it is certainly not going to make money for the community hospital. And that jeopardizes all the other programs, including trauma services and community services that we provide for the community.

Mr. MCCRERY. I understand that argument.

Mr. Foster, I would like to get a copy, if you can provide us one, of that flyer that you saw from Austin Surgical Hospital saying if you invest $4 million, you can get $55 million in 6 years. That is very interesting.

Mr. FOSTER. I will follow up on that.

Mr. MCCRERY. If I had $4 million, I——

[Laughter.]

Mr. FOSTER. Again, I don't know whether it has actually done that or not, but that was the marketing pitch.

Mr. MCCRERY. Yes, I would like to see that, Madam Chair, so we can maybe follow up on that and see what the experience has been.

Chairman JOHNSON. I also think you need to clarify the answer to Mr. McCrery's question. You talked about the doctor who comes in and consults and then has a way of moving the patient. Does that doctor also perform operations at your hospital? And do you see evidence that the patients he chooses to move are more complex and so on?

Mr. FOSTER. Yes, I mean, we have situations where doctors practice——

Chairman JOHNSON. The same doctor.

Mr. FOSTER. The same doctor would practice at both locations, one he owns, one he does not, where there is a proactive attempt to steer the more profitable patients away from our hospital.

Chairman JOHNSON. Do you see that?

Dr. BRIEN. Yes, I do, and I think the other point, in fact, is that the hospitals that are opening, you have heard cardiac hospitals, orthopedic hospitals, surgical hospitals. We do not see AIDS hospitals opening, Medicaid hospitals opening, managed care hospitals opening, seniors with pneumonia hospitals opening. These are very specialized procedures that have the highest reimbursement.

Chairman JOHNSON. Thank you.

Mr. Doggett.

Mr. DOGGETT. Thank you, Madam Chairman.

Mr. Brock, I want to be sure I understand. I got interrupted during part of your testimony. You have the Baylor University Medical Center and then attached to it is the physician-invested Hamilton Heart and Vascular Hospital.

Mr. BROCK. That is correct.

Mr. DOGGETT. And your belief is that you can get better patient—I believe it is better, safer care at a lower cost in the physician-owned attachment.

Mr. BROCK. I know that to be the fact.

Mr. DOGGETT. Do you have data comparing the two?

Mr. BROCK. Yes.

Mr. DOGGETT. Do you treat any cardiac patients at the portion of the hospital that is the University Medical Center?

Mr. BROCK. When we opened this hospital, we moved all of our cardiac programming into this hospital.

Mr. DOGGETT. What portion of Medicaid patients do you have there?

Mr. BROCK. I mean, all cardiac is done in that hospital.

Mr. DOGGETT. Including Medicaid?

Mr. BROCK. Yes, Medicaid, Medicare, uncompensated.

Mr. DOGGETT. There has been no decline in the portion of Medicaid patients since you did that?

Mr. BROCK. No. Our payer mix reflects the payer mix of the main hospital. That facility has the highest quality scores. We follow the CMS core measures. They rank 92 to 100 percent in all of those measures. So, they are higher than any of our facilities. Their patient satisfaction scores are higher than in any of our facilities. The first year that facility was in operation, the physicians reduced the cost of care $12 million for that service over the way we were running it before they were involved with us. And the way they did that was through development of teams and councils that worked on standardization of equipment, supplies, and plannables, capital, purchases that were being made, care paths working with each other on how they can most effectively treat the patients that were going through there. We have data before and data after, so we can look at it. And we have shared that with CMS, and we would be glad to share it with this Committee as well.

Mr. DOGGETT. Mr. Foster, I hear a number of physicians saying we can get the very benefits that Mr. Brock just talked about, that Dr. Plested talked about, expressing concern about corporations that are not from the local area and do not understand it. Aren't there some benefits to be had by having physicians involved in this manner in the hospital?

Mr. FOSTER. I think very clearly, to the extent that you can involved physicians in helping you in trying to lower costs and other things, that is a very good thing to do. I think the question is what is the vehicle that he is to do that. And that is why we are intrigued with the notion of the gain-sharing idea that was mentioned earlier, where you can, in fact, share with physicians the benefits of their efforts to reduce costs, but not do so to the extent that you create a system that induces them to self-refer. And so that is where gain-sharing I think does good with respect to aligning some of the incentives between providers and physicians, but stops short of creating an inducement to self-refer to facilities that they own.

Mr. DOGGETT. And what effect do you believe it will have if the moratorium is allowed to expire in 3 months?

Mr. FOSTER. I would also echo what was said earlier. We know that there are many of them in the queue, and Texas is sort of

ground zero for these things, as you know. And there are many of them in the queue, and whether or not facilities decide to proceed or not will be dependent upon how they read the tea leaves about whether there might be some subsequent action or regulation that would outlaw those. And so it is hard to predict, but my guess is that there would be a fair number of them that would roll the dice and go ahead and build on the hopes that they would be grandfathered in any kind of future or subsequent legislation.

Mr. HARRIS. To that point, we have 12 heart hospitals, and I have heard this statement from Mr. Foster that there is a lot in the queue. We do not have any physician-owned heart hospitals in the queue. We are working with a number of community hospitals to do some joint ventures. That doesn't include physician ownership, but we don't see that queue being lined up that he is speaking of. And if I could comment just briefly on the physician ownership?

Mr. DOGGETT. Sure.

Mr. HARRIS. Because I think we actually have a hospital in your district. One of the things we believe strongly in physician ownership is that physicians, you know, care deeply about the community. The statistics that we gave in terms of a high number of the patients arriving at our hospital from the emergency Department, a high number of the patients coming from outlying central Texas, and if we go to South Dakota, we get folks from all over the eastern part of South Dakota. And those are areas that previously were underserved, and we have a program where a patient has a problem out 2 hours from the hospital in the middle of the night. They make one phone call, and they can be in our hospital immediately. And the physicians embrace the community aspect of that. And, Madam Chairman, to the point you asked me about disclosure, I want to make sure I clarify that correctly. Disclosure is not made publicly in terms of the physician as an investor like we would a public company. But we embrace very strongly disclosure to the patient that the physician is an owner in the facility. So, anytime there is a patient referral made, we embrace that very strongly. And we find that the patient likes that a lot because they feel that inside the hospital—we have probably all be in the hospital where we have complained to the doctor, and the doctor says, "Go talk to the administrator about it." The doctor is—he owns the hospital, he or she owns the hospital. They can do something about it immediately. So, the gain-sharing piece, while it has some advantages, it stops short of putting the physician at risk if things do not go right.

Chairman JOHNSON. Mr. Harris, we have a vote coming up, so I want to be sure that Mr. Hulshof has a chance to question.

Mr. HULSHOF. Thank you, Madam Chairman. You know, listening to the difference of opinion on this panel brings to mind the ancient conundrum where two women claim to be the mother of the same child. And, unfortunately, I don't think anybody, with all due respect to my colleagues, I don't think anybody on this side possesses the wisdom of Solomon.

I would say, Mr. Foster, that, you know, reading the tea leaves, I am not sure that I would want to be one out there trying to do that, because as you know, the moratorium was a compromise. Our

counterparts over in the Senate had a very different point of view about what should happen with specialty hospitals. That is my editorial comment. Let me use the couple of minutes I have.

Dr. Plested, let me ask you this, because I am going directly to your conclusion, the last paragraph of your testimony that says this: "Based on the MedPAC and [Federal Trade Commission/Department of Justice] recommendations and the limited data currently available"—the limited data, my emphasis, but your words—currently available on physician ownership of specialty hospitals, the AMA believes that patients would be better served if we allowed the moratorium to expire and then come back and review what impact, if any, this has on communities. In other words, let me just—with the limited data available, would we not be better served allowing the moratorium to continue rather than let the genie out of the bottle and then trying to come back afterward, if, in fact, there is a dramatic impact on community hospitals, and then trying to undo what has already occurred if we allow the moratorium to expire.

Dr. PLESTED. I believe that the testimony from CMS and MedPAC was that the moratorium went into effect on the 8th of December of 2003 and they have data through 2002, so that the amount of data that would be added to what they already have would be limited as well. So, we would still have limited data with a limited amount added to it, but the data that they do have doesn't support a lot of these conclusions.

Mr. HULSHOF. Well, let me ask you this, and again, just to kind of cut to the quick, as we have this vote pending, Mr. Hackbarth's written this—and I am just going to sort of summarize in his testimony what MedPAC found. Does the AMA agree or disagree with this following conclusion of MedPAC: Physician-owned specialty hospitals treat patients who are generally less severe cases and concentrate on particular diagnosis-related groups, some of which are relatively more profitable? Do you agree or does your organization agree or disagree with that conclusion?

Dr. PLESTED. I think that is the data that they had, and we would agree that that is what that data showed.

Mr. HULSHOF. Do you agree or disagree with MedPAC's conclusion that they, meaning specialty hospitals, tend to have lower shares of Medicaid patients than community hospitals?

Dr. PLESTED. Absolutely, yes, sir.

Mr. HULSHOF. And I presume you would most assuredly agree with the conclusion that the financial impact on community hospitals in the markets where physician-owned specialty hospitals—that that impact was limited in 2002?

Dr. PLESTED. Yes, but these relationships do not really prove anything. They are interesting observations, but they do not prove that there is a problem with physician ownership of a specialty hospital because there are many, many other reasons why MediCAL patients go someplace else, Medicaid, MediCAL in my instance, that do not have anything to do with ownership of the hospital.

Mr. HULSHOF. And I appreciate this hearing very much, and our vote is going on. Missouri is interesting in that we are a certificate-of-need State, and so we do not have specialty hospitals per

se. And yet the certificate of need is an interesting discussion to follow in our State legislature, as you know. But I do appreciate the diverse opinions that have been shared with us today. Madam Chairman, thank you very much.

Chairman JOHNSON. Thank you very much, and I appreciate your pointing out the certificate-of-need issue. It is an interesting one. I think it is Dr. Brien that mentioned in your testimony that poor patients covered by MediCAL and those without insurance are all not welcome. Is that your testimony? Because if you can give us any backup on that statement about what is going on in Los Angeles, that would be very helpful.

Dr. BRIEN. We will work to gather that information.

Chairman JOHNSON. And then I am just interested in a very quick response. Was there a waiting list in your hospital before the new hospital was built? Was it a response to under-capacity demonstrated by a waiting list?

Mr. FOSTER. There was no waiting list in Austin.

Chairman JOHNSON. Okay. I am very interested in the Baylor experience. I do consider it a little different since the hospital continues to benefit from the surgeries that are done there. If any of you can shed light on this facility fee issue, it is interesting to me. And in Baylor's sub-hospital, you would have the same facility fee as in your big hospital, but very many fewer costs. So, it seems to me it would add to the profitability of that sector and not be available to the bigger hospital to deal with, its responsibility to cross-subsidy and so on. So, I have only 3 minutes left until the vote, so now I do have to go. But the facility fee issue and how that works at all, this is important for us to understand better and also what the hospitals that are in the community, where boutique hospitals have been developed, what they are doing now in terms of recruiting. Because if they are recruiting, now you have an overall greater capacity in the town where there was not a waiting list, and capacity breeds usage. So, those are concerns that we did not get on the record earlier. Thank you very much for your testimony and your discussion of what is a difficult issue. Thank you. Members who have further questions may put them in the record.

[Whereupon, at 6:48 p.m., the Subcommittee was adjourned.]

[Submissions for the record follow:]

Texas Hospital Association
Austin, Texas 78761
March 8, 2005

The Honorable Nancy L. Johnson
Chair, Subcommittee on Health
House Committee on Ways and Means
U.S. House of Representatives
1136 Longworth House Office Building
Washington, DC 20515

Dear Congresswoman Johnson:

On behalf of its 421 member hospitals, the Texas Hospital Association (THA) welcomes this opportunity to provide information and comments on the dramatic growth of physician-owned specialty hospitals in Texas, and the impact these specialty hospitals have had on full-service hospitals in effected markets. THA appreciates the subcommittee's interest in this issue and urge you and your colleagues to take prompt action on the recommendations being presented by the Medicare Payment Advisory Commission (MedPAC).

Over the last year, THA has reviewed physician investment in specialty hospitals and other types of health care facilities in Texas and has assessed the impact this physician investment has had on the health care delivery system generally and on full-service hospitals specifically. Consistent with the reports previously issued by the General Accounting Office on specialty hospitals and confirmed by MedPAC in its review of this issue, the THA study found that physician-owned hospitals and other types of physician-owned facilities: (1) specialize in well-reimbursed services, such as cardiology, orthopedics and diagnostic imaging; (2) provide a lower acuity level of services; (3) serve relatively few uninsured and Medicaid patients; and (4) provide significantly less emergency care. THA's study also revealed that physician investment in hospitals in Texas has grown dramatically over a very short period of time. Since 2000, the number of physician-owned hospitals has more than doubled, and Texas leads the nation with 47 such facilities. With an additional 29 physician-owned hospitals under development in Texas, the potential long-term impact on full-service hospitals and the delivery of health care in the state could be significant.

While the long-term impact of physician investment and self-referral is uncertain, it is clear from the national studies as well as THA's report that the development of physician-owned limited service facilities has been very detrimental to full-service hospitals, particularly in smaller urban or rural markets. Across Texas, the ability of full-service hospitals to continue to provide high cost, lower margin services (trauma, more complex medical or surgical cases) is jeopardized by the loss of revenues to physician-owned hospitals and other facilities that do not provide these essential services. This loss of revenues also makes it more difficult for full-service hospitals to cross-subsidize the costs of care to uninsured patients and other non-profitable services. Key findings from the THA study are attached for your information and review.

THA supports the MedPAC recommendations being presented to the Subcommittee on Health at your hearing on March 8, 2005. The recommended changes to the Medicare hospital payment are appropriate and should help reduce the financial incentives that have prompted physician investment in hospitals and their referral of the more profitable cases to these facilities. THA also supports the recommendation that would allow the Secretary of Health and Human Services to regulate gain-sharing arrangements between physicians and hospitals. If properly structured, such arrangements can promote collaborative relationships between physicians and hospitals and can reduce health care costs without impacting the quality of care provided.

While THA supports the MedPAC recommendation to extend the moratorium on physician-owned specialty hospitals, THA urges the subcommittee to deal with this issue in a more substantive manner by eliminating the "whole hospital" exception. As you know, the legislative intent of this exception was to allow for physician ownership in general hospitals that offer a full spectrum of health care services, where a single referral would produce little personal economic gain. In contrast, most of the newly developed physician-owned hospitals are much smaller in size, provide a more limited scope of services and the potential for personal financial gain to influence physician referral is more likely. This exception also allows physician investors to refer patients to their hospital for the performance of outpatient services, such as laboratory and diagnostic imaging, without violating the prohibition on self-referral applied to these types of health care services.

THA also supports the elimination or narrowing of the "rural area" exception that allows self-referrals by physicians in a rural area if the physicians provide most of any designated services to patients who reside in such a rural area. This exception is extremely broad and provides little impediment to physician self-referrals in rural areas. There is a growing number of rural hospitals in Texas that have been negatively impacted by the establishment of a physician-owned ambulatory surgical center or outpatient imaging center in their community. Further, to address the ethical and financial issues associated with physician investment and referral of patients to ambulatory surgical centers, THA recommends that legislative action be undertaken to extend the prohibition on self-referral to ambulatory surgical centers.

Thank you for the opportunity to provide comments on this important issue. Should you or your staff have questions concerning these comments or the THA study on physician ownership and self-referral of patients, please contact me or Gregg Knaupe on the THA staff at 512/465–1000.

Sincerely,

Richard A. Bettis, CAE
President/CEO

Texas Hospital Association Report on Limited Service Providers

FEBRUARY 2005

Texas leads the nation in the number of physician-owned limited service hospitals with 47 such facilities, and there are an additional 29 limited service hospitals under development.[1] Texas has 300 ambulatory surgical centers in operation and an additional 59 facilities are under development.[2] Diagnostic testing facilities and other outpatient facilities are not required to be licensed or certified in Texas, and it is difficult to determine the actual number of these facilities. However, with changes in medical technology and the associated shift to outpatient settings, there is no question that there also has been a dramatic increase in the number of outpatient facilities in the state that provide diagnostic and therapeutic services.

The proliferation of physician-owned limited service facilities in Texas in the last several years is a result of a number of factors. As noted in the 2003 GAO report, all of the specialty hospitals under development and 96 percent of those that opened since 1990 are located in states without a certificate of need process that requires state review and approval of additional hospital beds or new facilities.[3] The Texas certificate of need review process was discontinued by action of the Legislature in 1985.

To assess the proliferation and impact of physician-owned specialty hospitals and other types of limited service providers on full-service hospitals, THA evaluated financial and utilization data that are available on these providers from the Texas Department of State Health Services and the Texas Health Care Information Council.[4] THA also conducted a series of meetings with hospital representatives in various cities across the state, including: Abilene, Amarillo, Austin, Brownsville, Bryan, El Paso, Huntsville, Lubbock, Midland, Odessa, Plano, San Angelo, and San Antonio.

An analysis of the health care facilities, utilization of services (admissions, births, emergency room visits, inpatient and outpatient surgeries), payer mix (percentage of Medicare, Medicaid, commercial and indigent patients) and amount of uncompensated care was compiled for those markets across the state for which data was available. This analysis also provides information on the financial and operational impact that physician-owned limited service hospitals have had on full-service hospitals. The following is a summary of the findings from the THA study:

- The proliferation of limited service providers has occurred more frequently in urban markets and primarily in more affluent, high population growth markets. The highest concentration of physician-owned limited service hospitals is in Austin, the Dallas-Fort Worth area (Collin, Dallas and Tarrant counties), Houston and San Antonio.
- In smaller urban markets and rural areas, limited service providers have focused on outpatient services, such as outpatient surgery and diagnostic imaging. Due to the high costs associated with the building of a hospital and the volume of services needed to make the hospital's operations financially viable, there has been fewer physician-owned limited service hospitals developed in smaller urban or rural areas. However, physician-owned hospitals have been built in Amarillo, Brownsville, Bryan, Edinburg, Harlingen, Lubbock, Midland, Odessa, Tyler and Wichita Falls.

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[1] Texas Department of State Health Services, Facility Licensing Group (2004)
[2] Texas Department of State Health Services, Facility Licensing Group (2004)
[3] GAO–04–167 (Oct. 22, 2003), pg. 4
[4] Publicly available financial and utilization data were obtained and reviewed on inpatient and outpatient hospital services; no public data are available on ambulatory surgical centers, diagnostic testing facilities or other types of outpatient health care facilities.

City	Existing Hospitals	Proposed Hospitals
Abilene		1
Amarillo	2	
Arlington	1	
Austin	3	1
Baytown		1
Beaumont		1
Bellaire		1
Bridgeport		1
Brownsville	1	
Bryan	1	
Clear Lake		1
Dallas	3	1
Denton		1
Edinburg	2	
El Paso	3	1
Fort Worth	1	1
Frisco	1	
Garland1	1	
Harlingen	1	
Houston	7	6
Humble		1
Hurst	1	
Irving	1	

City	Existing Hospitals	Proposed Hospitals
Jasper	1	
Keller		2
Kingwood	1	
Lubbock	2	
Midland	1	
Nederland	1	
Odessa	2	
Paris		1
Pasadena	1	
Pearlman		1
Plano		2
Port Author	1	
Red Rock		1
Richardson		1
Roanoke		1
San Antonio	3	
Southlake	1	
SugarLand	1	
The Woodlands	1	1
Trophy Club	1	
Tyler	1	
Webster		1
Wichita Falls	1	
Total Hospitals	47	29

- Physician-owned limited service providers tend to specialize in well-reimbursed services, such as cardiology, orthopedics and diagnostic imaging. While a limited service facility may specialize in cardiology or orthopedics, it typically does not provide the full range of cardiac services (e.g., heart transplant and pediatric cardiac procedures) or orthopedic services (e.g., bone marrow transplants, major joint replacements, trauma and patients requiring tracheotomy), but tend to provide services that do not require a longer length-of-stay or intensive care unit service.
- Physician-owned limited service hospitals tend to provide a lower acuity level of services.[5]An analysis of hospital discharge data indicates that statewide

[5]Texas Health Care Information Council, Hospital Inpaient Discharges Public Use Data File 2003, December 2004

across all DRGs and conditions, the physician-owned hospitals treat a smaller percentage of patients in the higher severity levels (15.7 percent for physician-owned as compared to 21.5 percent for non-physician-owned hospitals). An analysis of diseases of the musculoskeletal system reveals that only 5.3 percent of patients treated at physician-owned hospitals fall into the higher severity levels, whereas 15.9 percent of the patients treated at non-physician-owned hospitals fall into those same categories. The trend is less marked in treatment of circulatory diseases.

- Physician-owned limited service hospitals serve relatively few uninsured patients and, with the exception of a small number that provide a significant level of services to Medicaid recipients, physician-owned hospitals treat a lower percentage of Medicaid patients.An analysis of financial data submitted to the Texas Department of State Health Services by hospitals shows that full-service hospitals provide more than twice as much uncompensated care (charity and bad debt) as compared to physician-owned limited service hospitals.[6]
- Physician-owned limited service hospitals provide significantly less emergency care, and access to the emergency department and emergency personnel is more restrictive when compared to full-service hospitals. Full-service hospitals had 14,760 emergency room visits per year as compared to 480 emergency room visits per year for physician-owned limited service hospitals.[7] Heart hospitals typically provide more comprehensive emergency services and have 24/7 physician coverage of the emergency department. In contrast, limited service orthopedic or surgical hospitals tend to have very limited emergency capabilities and physician coverage of the emergency department is provided on an on-call basis.
- With the proliferation of limited service hospitals, full-service hospitals have experienced more difficulty in securing physician on-call coverage of their emergency departments and in some instances, physicians with an investment interest in a limited service facility have resigned their privileges at the full-service hospital or have reduced significantly their on-call coverage. Full-service hospitals have been required to recruit new physicians or increase the compensation paid on-call physicians to assure coverage of the emergency department.
- Physician investment in a health care facility poses a conflict of interest between physician investors and patients. Some patients are being strongly encouraged to use the facility in which the physician has an ownership interest, and it is uncertain whether the physicians are disclosing their ownership interest to patients. In some instances, these referrals to the physician-owned facility will result in a health insurer and patient paying more for the services rendered because the facility is not a participating provider in the health plan network.
- Some referrals of patients to a physician-owned limited service facility raise quality of care concerns:
  - o Patients stabilized at a full-service hospital and then transferred to a physician-owned limited service facility for surgical procedures;
  - o Patients with cardiac problems stabilized at a full-service hospital and then transferred to a physician-owned heart hospital for pacemaker insertion;
  - o Delays in treatment after patients have post-surgical complications or a limited service hospital does not have the appropriate medical staff, equipment or ICU beds available to meet patient needs and patients are transferred to full-service hospital; and
  - o Delays in treatment when patients are admitted to limited service facilities that do not provide the required care (a patient with suspected cardiac condition is transported to a heart hospital by EMS and is discovered to have suffered a stroke, or a woman presents to a limited service hospital in active labor).
- Physician investment in a limited service hospital often results in a significant and almost immediate movement of patients from the full-service hospital to which the physician previously admitted patients to the facility in which the physician has an ownership interest. For example, physician investors in the Lubbock Heart Hospital began moving patients to their facility as soon as it was opened and over a period of eight months reduced their performance of cardiac services at Covenant Health System hospitals by 71 percent.[8]

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[6] Texas Department of State Health Services, Center for Health Statistics, Annual Servey of Hospitals (2003)

[7] Texas Department of State Health Services, Center for Health Statistics, Annual Survey of Hospitals (2003)

[8] Covenant Health System Internal Utilization Data

A similar movement of patients occurred with the opening of the Austin Heart Hospital in late 1998. There were significant reductions in the number of cardiac services performed at the St. David's HealthCare Partnership hospitals by physician investors in the heart hospital after that hospital opened.[9]

Reductions in Inpatient/Outpatient Procedures at SDHC Partnership Hospitals

- This movement of patients to a physician-owned limited service hospital soon after it opens does not appear to be based on any quality of care concerns the physicians may have had with the full-service hospitals in the community because the physician investors continue to admit patients into those facilities. However, the patients admitted into the full-service hospitals by the physician investors tend to have more complex medical conditions or are Medicaid or uninsured patients.
- The financial impact of limited service providers has been detrimental to full-service hospitals, particularly in smaller urban or rural markets where there has not been much population growth. Full-service hospitals have experienced significant reductions in revenues for outpatient surgery and diagnostic services. The impact on revenues for inpatient surgeries and other inpatient services has been less because limited service providers tend to provide more outpatient services and inpatient services with a lower acuity level.
- The ability of full-service hospitals to continue to provide high cost, lower margin services (trauma, more complex medical or surgical cases) is jeopardized by the loss of revenues to limited service facilities. This loss of revenues also makes it more difficult for full-service hospitals to cross-subsidize the costs of care to uninsured patients and other non-profitable services.
- Full-service hospitals have lost key physicians and other professional staff to limited service providers and have had to recruit new physician specialists and other personnel to replace them.

Statement of D.J. Calkins, Guadalupe Valley Hospital Board of Managers, Seguin, Texas

My name is D.J. "Dave" Calkins, and I am a board member on the Guadalupe Valley Hospital, Board of Managers, in Seguin, Texas. Guadalupe Valley Hospital is a 117-bed full service medical facility and the sole full service medical facility in Guadalupe County, Texas with a population of approximately 90,000. The proliferation of physician-owned specialty hospitals and limited service facilities are having a devastating impact on the ability of full service hospitals, such as Guadalupe Valley Hospital, to remain fiscally-viable and to provide access to a broader range of services needed in the community, especially rural communities with limited full-service healthcare options.

The dramatic increase of physician-owned specialty hospitals and limited service medical facilities, coupled with the practice of physicians self-referring patients to their physician-owned facilities, raises serious public policy concerns. Left unchecked, the proliferation of these facilities will continue to drive up healthcare costs and will put many smaller, rural community hospitals at significant financial risk of closure and will undermine the ability of full-service urban hospitals to subsidize unprofitable, but essential services.

Physicians with ownership interests have the ability and the financial incentive to shift well-reimbursed services and patients to their facilities and are exercising this practice. This practice drains essential resources from full-service hospitals, which rely on a cross-section of patients to subsidize unprofitable, but essential services. The loss of patients, and associated revenues, from physician-owned facilities has a dramatic impact. In addition, reimbursement rate structures make it more favorable for insurance companies to direct beneficiaries to these facilities hindering the ability of full-service hospitals to obtain needed provider contracts to enhance patient access to hospital services.

In the case of Guadalupe Valley Hospital, a group of physicians with privileges at the hospital recently opened an Ambulatory Surgical Center (ASC) just down the street from the hospital. Since the ASC opened, the hospital's outpatient surgical

[9] Texas Hospital Association, Patient Data System and St. David's Medical Center Internal Data

revenues have declined approximately 40%. This is a substantial loss for a rural hospital with limited population to garner market share. The hospital's Chief Financial Officer projects an eventual loss of approximately $180,000 in revenue monthly due to patients being self-referred by physicians that own the ASC, yet practice out of the hospital. This is unfair competition and a blatant conflict of interest. In addition, a number of medical insurers recently restricted their beneficiaries from obtaining certain services at the hospital and began forcing the beneficiaries to travel to another community 15 miles away; in another county to obtain the same services they could receive in their own community. Insurers are doing this, because of the more favorable reimbursement rates received from stand alone facilities compared to full-service hospitals for the identical service; the only difference being location. This is absurd.

I urge legislation to close loopholes allowing physician self-referrals to physician-owned specialty hospitals and limited service facilities, such as Ambulatory Surgical Centers. While I understand the desire by physicians to enhance their income, this should not come at the expense of full service medical facilities and the communities, which so dearly depend on them for access to the full spectrum of medical services. Physicians should be working in collaboration with hospitals to maintain the community's health care infrastructure and to serve all patients, rather than contributing to the demise of the very institutions, which allow them privileges in which to practice medicine and only serving the well-insured few. Close the loopholes and adopt sound public policies, which allow physicians and hospitals to both benefit.

Sincerely,

D.J. Calkins

Ohio Hospital Association
Columbus, Ohio 43215
March 10, 2005

The Honorable Nancy Johnson
Chair, Subcommittee on Health
U.S. House Ways and Means Committee
Washington, DC 20515

Dear Congresswoman Johnson:

On behalf of the Ohio Hospital Association (OHA), we thank you for the opportunity to submit comments for the record regarding your hearing on limited-Service, Physician-Owned Hospitals, held on March 8, 2005.

The OHA is the oldest state hospital association in the nation, representing the more than 170 acute-care hospitals and health systems across Ohio. Our governing Board of Trustees is comprised of representatives from the whole gamut of providers in Ohio; from large, urban teaching facilities to small, rural hospitals, and from every corner of the State. Each of our members is dedicated to providing their communities the highest-quality health care service all day, every day. But the emergence of limited-service, physician-owned hospitals threatens their ability to remain successful.

According to a recent report by the Medicare Payment Advisory Commission (MedPAC)[1], limited-service, physician-owned hospitals (often nicknamed "specialty hospitals") harm their communities and local full-service, community hospitals by treating primarily cases that are relatively well-reimbursed by government and private insurance, and generally not treating patients with conditions that are poorly-reimbursed. Studies by the Centers for Medicare and Medicaid Services (CMS)[2] corroborate these findings. This anticompetitive cherry-picking allows limited-service facilities to make significant profits while expecting the community hospital to handle the most difficult and least profitable cases, as well as provide all of the community's graduate medical education, emergency care, and other ancillary services.

Under Section 507 of *the Medicare Modernization Act of 2003,* Congress enacted a moratorium that effectively froze the growth of new limited-service, physician-owned hospitals. The eighteen month moratorium, due to expire in early June of this year, was intended to give MedPAC and the Department of Health and Human Services time to study the practices and impact of limited-service hospitals. In re-

[1] MedPAC, Report to Congress: Physician-Owned Specialty Hospitals, March, 2005
[2] CMS, House Ways and Means Health Subcommittee Testimony of Tom Gustafson, Deputy Director, March 8, 2005

sponse, the subsequent report from MedPAC recommends various changes to the Medicare system.

The report also recommends Congress extend the current moratorium until January, 2007, to allow Congress and the administration time to gather additional information and make the necessary changes to the payment system. Conversations with CMS staff, however, prove beyond doubt the federal government will need far more time to implement the broad scope of regulatory and legislative changes necessary to thoroughly and properly address the situation. **Given the slow pace with which structural changes are made at the federal level, and rather than forcing the Congress in eighteen months to revisit the question of whether the needed policies have been implemented, it makes far more sense to continue the current moratorium permanently to allow adequate time to thoroughly address the issue. Therefore, OHA urges Congress to enact a permanent extension to the moratorium before it expires on June 8.**

We are not alone in our position. The American Hospital Association has been a leader in this effort, along with the Federation of American Hospitals and numerous other State hospital associations. The American Academy of Family Physicians (AAFP) recently voted[3] to extend the moratorium until "the AAFP is convinced by evidence of their benefit on the health and well-being of our communities." And in a February 16, 2005 editorial (attached), *The Columbus Dispatch* said:

". . . Specialty hospitals will sprout. If the moratorium expires, experts say, the current number of 100 nationwide could double in just a few years. With each of them taking a bite out of the market, full-service hospitals' bottom lines eventually will suffer; hospitals can do only so many things to become more efficient. And when a hospital goes under, the entire community suffers."

It is ironic that current federal law will sanction a physician for referring an inexpensive test to a laboratory in which she or he has a financial interest, but will allow another physician to refer a costly orthopedic surgical case to a "specialty" hospital. Beyond the enormous—but necessary—task of addressing the payment system as MedPAC recommends, Congress must take further action, such as revisiting the "whole hospital" exception to the physician self-referral law. Eighteen months will not likely be a sufficient span of time for all of the needed changes to happen.

The time for legislative action is now. While much needs to be done to address the dangers to the health care delivery system posed limited-service, physician-owned hospitals, the first step Congress must take should be to make permanent the current moratorium.

Sincerely,

James R. Castle
President and CEO

Extend the moratorium

Freeze on specialty hospitals necessary for further study of ill effects on communities

WEDNESDAY, FEBRUARY 16, 2005

The 18-month moratorium on the building of specialty hospitals is to expire in June, but the problems presented by such businesses are far from resolved.

Congress should extend the moratorium.

The Medicare Payment Advisory Commission was charged by Congress in 2003 to study specialty hospitals, and its preliminary report has reaffirmed what The Dispatch has contended all along: Specialty hospitals cherry-pick the most lucrative patients, while leaving the expensive-to-treat patients to nonprofit, full-service hospitals.

They do this through a loophole in the law that allows doctors to refer patients to hospitals in which they own an interest, even though they would be prohibited from referring patients to other facilities they own, such as labs, pharmacies and home health-care services.

This shady self-referral is good for specialty hospitals. It provides them a steady stream of the kind of patients that will ensure high profits. But it is a drain on full-service community hospitals, which are forced to take the complicated cases, the expensive cases and the uninsured and indigent cases, while at the same time losing an important source of revenue. That revenue from lucrative specialties, such as

[3] AAFP, "Extend Moratorium on Specialty Hospitals, Says Board," online news story, February 17, 2005

cardiac care and orthopedics, helps to finance a community hospital's money-losing services, such as emergency rooms, burn units and trauma re units.

But when that revenue goes to specialty hospitals, those vital services suffer. This allows a few doctors to unjustly enrich themselves at the expense of the community.

The commission found that the Medicare reimbursement system favors specialty hospitals. They get the same reimbursements as full-service community hospitals even though they have less overhead.

In return for this sweet deal, the commission found, specialty hospitals treat fewer poor people, handle fewer complicated cases and transfer patients to other hospitals more frequently than do full-service community hospitals. Those patients transferred by the specialty hospitals were more severely ill and more costly to care for than patients transferred by community hospitals.

And, in spite of handling less complicated cases for shorter stays, physician-owned specialty hospitals actually cost more per patient than full-service community hospitals and even other surgical hospitals.

The commission says that specialty hospitals do, indeed, take market share from full-service community hospitals. Community hospitals have, for the most part, been able to weather the storm financially by becoming more efficient and more competitive. But as specialty hospitals sprout, that will become more and more difficult.

And specialty hospitals will sprout. If the moratorium expires, experts say, the current number of 100 nationwide could double in just a few years. With each of them taking a bite out of the market, full-service hospitals' bottom lines eventually will suffer; hospitals can do only so many things to become more efficient.

And when a hospital goes under, the entire community suffers.

The commission recommends that the Department of Health and Human Services revise the method of payment for Medicare services.

It also recommends that full-service hospitals be allowed to share the savings from cost-cutting measures with doctors, to try to minimize doctors' referrals of patients to their own specialty hospitals.

Congress should go further. It should bar physicians from referring patients to hospitals in which the doctors own an interest.

As the commission itself noted, when physicians can earn income on a patient twice, as a doctor and as a hospital owner, the incentive to recommend surgery is great. Such a situation casts even good doctors in a bad light.

Next month, the commission will issue its final report to Congress. Unfortunately, a ban on self-referrals isn't likely to be part of its recommendations. It is, however, expected to recommend an extension of the moratorium for another 18 months. Congress should grant that extension.

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Statement of Carmela Coyle, American Hospital Association

On behalf of the American Hospital Association's (AHA) 4,700 member hospitals and health care systems and our 31,000 individual members, we are pleased to present our views on the critically important issue of physician-owned limited-service hospitals, which is having a serious impact on health care access, use and cost across the country.

Certain physicians are exploiting a loophole in federal law that allows doctors to own limited-service hospitals where they then refer their carefully selected patients to perform highly reimbursed procedures. This raises serious concerns about conflict of interest, fair competition, and whether the best interests of patients and communities are being served.

In order to preserve care in communities, prevent conflict of interest and promote fair competition, AHA strongly urges Congress to act quickly to close the loophole in federal law by permanently banning physicians from referring patients to new limited-service hospitals they own.

The History of Self-Referral

"Self-referral"—the practice of physicians referring patients to a facility they own—has been of concern to the Congress for many years. Laws to regulate these referrals grew out of a rapidly changing health care environment, in which new technologies made it possible for physicians to perform a variety of services and procedures in settings outside the traditional hospital. As a result, it became increas-

ingly common for physicians to invest in and own a health care facility—a clinical laboratory, for example—and also refer their patients to that facility.

Physicians' ability to refer patients to facilities they owned raised questions about the potential for conflict of interest. Were physicians' referral decisions in the best clinical interests of the patient, or the best economic interest of the physician-owner? Research in 1989 by the Department of Health and Human Services' Office of the Inspector General found that physicians, in fact, ordered more services when they owned the facility that provided the service.

- Medicare patients of physicians referring to entities in which they had an investment interest **received 34% more laboratory services** than the general Medicare population. (U.S. Department of Health and Human Services, Office of the Inspector General: Financial Arrangements Between Physicians and Health Care Businesses, 1989b.)

As a result, this practice was limited by a new law, the Ethics in Patient Referrals Act of 1989, which created a strict prohibition on physician conflicts of interest and self-referral to clinical laboratories—the area studied in 1989. Research continued looking at other services, and since that time additional findings show that self-referral increases the use and cost of health care services.

Patients of physicians referring to entities in which they had an investment interest:

- Got imaging exams **4.0 to 4.5 times more often** than patients of physicians referring to independent radiologists (Hillman et al, 1990)
- Received physical therapy at **rates 39% to 45% higher** than patients referred to independent practitioners (Mitchell and Scott, 1992)
- Had **higher overall costs** for medical care covered by workers' compensation (Swedlow et al, 1992)
- Were **substantially more likely to receive referrals** for imaging services (GAO, 1994).

These studies led to an expansion of the 1989 law to apply to many other services, including:

- inpatient and outpatient services;
- physical therapy services;
- occupational therapy services;
- radiology, including magnetic resonance imaging, computerized axial tomography scans and ultrasound services;
- radiation therapy services and supplies;
- durable medical equipment and supplies;
- parenteral and enteral nutrients, equipment and supplies;
- prosthetics, orthotics and prosthetic devices; home health services and supplies; and
- outpatient prescription drugs.

However, exceptions were created in the law to allow what Congress thought, at the time, to be a narrow set of arrangements that would be free from conflict of interest. One is the so-called "whole hospital" exception for self-referrals for inpatient and outpatient hospital services when a physician has an ownership stake in a "whole hospital." This exception was created based on the reasoning that a single physician's ownership in and referral to a whole hospital was diffused across so many different departments in the hospital that it would limit any financial gain that might result to the physician. And Congress expressly prohibited physician self-referral to individual departments or subdivisions within a hospital to protect against conflicts of interest.

But at the time the self-referral laws were passed, policy makers did not foresee that specific departments or specialties within a hospital (e.g., cardiac care, orthopedics, surgery) would become stand alone hospitals. Because of concerns with this practice, the Medicare Modernization Act of 2003 (MMA) imposed a temporary moratorium on physician self-referrals under Medicare to new limited-service providers. The moratorium is set to expire June 8, 2005.

This is Not About Competition

Some suggest that full service community hospitals are just afraid of competition from these limited-service hospitals. Some have also suggested that consumer choice might somehow be limited without these facilities. That is absolutely not the case.

Full service hospitals are more than willing to compete based on cost, quality and efficiency. They compete with other providers in their market areas every day. But when physician owners of limited-service hospitals can pick and choose the services

they provide, and when they can pick and choose the patients—often the healthier, well-insured patients—they refer to the facilities they own, they have unfair advantages. And that's anti-competitive.

As to patient choice, most patients rely almost exclusively on the advice of their physicians when deciding where to have a surgical procedure performed. Real choice means not having to worry that the motivation for referring a patient to a limited-service hospital is anything other than what is in the best interest of the patient.

Full service community hospitals welcome competition and patient choice—as long as it is free from the physician ownership and self-referral that create an un-level competitive playing field.

The Facts

According to the Centers for Medicare and Medicaid Services (CMS), 59 physician-owned, limited-service cardiac, orthopedic and surgical hospitals were open and operating at the end of 2003 as a result of this federal loophole. Many more have opened since then and many more are waiting to open their doors.

These physician-owned, limited-service hospitals raise concerns about conflict of interest and fair competition in the health care market place. In October of 2003, the Government Accountability Office found that, when compared to full service hospitals, physician-owned limited-service hospitals:

- treated patients that tended to be less sick;
- treated smaller percentages of Medicaid patients;
- are much less likely to have emergency departments;
- derive a smaller share of their revenue from inpatient services;
- have higher margins; and
- had physician ownership that averaged slightly more than 50 percent.

In March 2005, the Medicare Payment Advisory Commission (MedPAC) issued its report to Congress on the topic. They found, when compared to full service hospitals, physician-owned limited-service hospitals:

- Tend to treat lower shares of Medicaid patients;
- concentrate on certain diagnoses (diagnostic related groups (DRGs))
- treat relatively low-severity patients within those DRGs; and
- do not have lower Medicare costs per case.

In March 2005, CMS shared with the Congress preliminary findings from their research on this topic. Their work showed that, when compared to full service hospitals, physician-owned limited service hospitals:

- generally treat less severe cases; and
- provide less uncompensated care.

These findings, from all three sources, describe some of the ways in which physician ownership creates unfair competition in the health care market place. But all of these advantages accrue to physician-owned limited-service hospitals because of procedure, service and patient selection—all driven by self-referral.

Why Physician Conflict of Interest is a Serious Problem

Self-referral, and the conflict of interest it creates, is dangerous for patient care. When physicians own, even in part, the facilities to which they refer patients, their decisions are subject to competing interests—what's in the best clinical interest of the patient and what's in the best financial interest of the physician. Studies have shown that when physicians self-refer, these competing interests lead to increased use of services and higher spending.

Self-referral allows physician-owners to reward themselves in several ways.

Patient selection. Physician owners have at least three ways in which they can financially reward themselves by selectively referring or "cherry picking" patients. First, physician-owners can simply avoid treating uninsured, Medicaid and other patients for whom reimbursement is low. They can do this by opening facilities that have no emergency departments, by locating in upper income areas, and by not treating patients with certain insurance coverage in their daily practices. All of these activities create barriers for uninsured, underinsured and other patients.

Second, physician-owners can selectively refer patients to different facilities. Because patients trust and follow the advice of their physician, most will seek care and treatment in the facility recommended by their physician. Physician-owners, through their referral practices, can refer well-insured patients to the facilities they own, and poorly insured or uninsured patients elsewhere, often to the local full service community hospital.

And third, as physician-owners selectively refer, they can refer healthier, lower cost, lower risk patients to facilities they own, leaving more severely ill patients to be treated by local full service community hospitals.

Service selection. Physician-owned limited-service hospitals, by definition, limit the care they provide to a select group of services. As MedPAC research has shown, physician-owners reward themselves by opening facilities that target only profitable diagnoses and procedures—cardiac care, orthopedic surgery, and other surgical procedures. There are no limited-service burn hospitals, limited-service neonatal care hospitals, or limited-service pneumonia hospitals.

Quality oversight concerns. Physician ownership and self-referral can also lead to serious conflict of interest in the area of quality oversight. Oversight for the quality of care in America is performed through a "peer review" process—groups of physicians who review, evaluate and oversee the quality of the care provided by their physician colleagues and specialists. Challenging as peer review is, quality oversight is fraught with conflict of interest when the physician doing the review is an owner/partner with the physician being reviewed. The arrangement raises concerns about whether quality could be compromised because of financial interests.

The Impact on Care

These conflicts of interest that create patient selection, service selection and quality oversight concerns are jeopardizing our health care safety net. Community hospitals are committed to serving all patients, regardless of their health status or ability to pay. But the conflict-of-interest practices of physician-owned limited-service hospitals are robbing community hospitals of their ability to serve their communities and placing health care services in many communities at risk.

As physician-owned limited-service hospitals pull out from the community hospitals profitable services and healthier elective patients, full service community hospitals are challenged to:

- Continue providing essential services that are seldom self-supporting, such as emergency departments, burn units, trauma care, and care for the uninsured.
- Maintain specialty "on-call" coverage in their emergency departments, as physician-owners of limited-service hospitals no longer want to participate in this broader community commitment. Lack of specialty coverage in our nation's emergency departments can jeopardize a hospital's trauma level status and cause emergency patients to be transported much farther to access needed specialty care.
- Overcome growing inefficiencies, such as more downtime and less predictable staffing needs, that result from a higher proportion of emergency admissions at full service hospitals. These result as physician-owners move more and more elective admissions to their own limited-service hospitals.
- Coordinate care for patients in their community when more and more are being treated for a single condition by a limited-service hospital. Also, complications unrelated to the condition being treated (for example, a heart attack or a blood clot during or following surgery) result in last-minute emergency transfers to full-service hospitals, increasing the risk to patients.

In a recent study by McManis Consulting, researchers went in to four communities to assess the impact of physician-owned limited-service hospitals on the full service hospitals and the communities they serve. The findings show that the self-referral that results from physician ownership creates an un-level competitive playing field for hospitals.

The study shows that when physician-owned limited-service hospitals open in an area, the financial health of the full service hospitals decline. Because the patient selection tactics of the physician-owned limited-service hospitals were not available to the full service hospitals, revenues from the "best" services, payers, and elective cases plummeted and costs increased. Operating rooms and staffing at the full service hospital were now less efficient, recruiting costs rose to replace departing physicians and staff, higher salaries and other incentives were required to retain staff in services targeted by limited-service hospitals and lower bond ratings increased borrowing costs for full service hospitals. The net income from Wesley Medical Center's Heart Program in Wichita, Kansas fell by $16 million after the opening of the limited-service Galichia Heart Hospital in 2001. In Rapid City, South Dakota, the Black Hills Surgery Center's net income grew and the full service Rapid City Regional Hospital's net income fell by the same amount—about $18 million.

At the same time, self-referral creates an un-level playing field for the services offered and access to care provided by full service hospitals. The McManis study documents that in two communities, patient access to emergency and trauma care was put at risk. In the Black Hills, South Dakota region and in Oklahoma City, a critical

mass of physician-owners in key specialties opted out of community emergency call obligations. The lead organizers of the Black Hills Surgery Center, who were the most active neurosurgeons in the region, no longer provide emergency coverage at the full service hospital. And no emergency service is offered at the surgical hospital.

Oklahoma faced a statewide crisis in trauma coverage as a result of so many physicians opting out of emergency call coverage. As neurosurgeons, anesthesiologists and other critical specialties removed themselves from call coverage, the Level II trauma hospitals could no longer meet state standards for coverage. And the withdrawal of specialists from on call coverage placed a greater burden on physicians at inner city hospitals with busy emergency departments. This has caused some of the surgeons remaining at the full service hospitals to leave, and has made it difficult to recruit replacements.

The loss of net income from key services forced cutbacks in under-reimbursed services such as behavioral health, trauma and subsidized services for the poor in all four areas of the study: the Black Hills region of South Dakota, Lincoln, Nebraska, Oklahoma City, Oklahoma, and Wichita, Kansas. And in each case, the total resources (physicians, staff, facilities and equipment) devoted to providing the procedures targeted by the limited-service hospitals increased in the community overall.

These are serious implications for all patients served—for everyone who relies on an emergency department when they are in need of urgent care or a hospital to be there to meet a wide range of health care community needs.

The Solution—Ban Physician Self-Referral to Limited Service Hospitals

This conflict of interest created by physician ownership and self-referral is easily addressed. To protect patients and the health care safety net in America, Congress should close the current loophole in federal law now—amend the Ethics in Patient Referrals Act of 1989 to permanently ban physician self-referral to new limited-service hospitals. Nothing short of banning self-referral will do.

Why is this a federal concern? Some have suggested that the growth in limited-service hospitals might be stemmed through state laws. But this approach misses the heart of the problem. The problem is not limited-service hospitals. There may be a role for "focused factories" within our health care system. The problem is not physician ownership. If a physician in California wants to invest in a limited-service hospital in Kentucky, conflict of interest wouldn't exist. The problem is self-referral—physician-owners who refer patients to facilities they own. Self-referral is a federal issue, and Congress has acted, beginning in 1989 and in years since, to limit self-referral at the federal level.

Payment changes alone are not enough. MedPAC has recommended a number of changes to the Medicare hospital inpatient payment system designed to rebalance payments and remove financial incentives for physicians to target certain, more-financially-rewarding Medicare services. While this may appear to be a viable option for addressing the issue, these changes alone won't solve the problem. Even if Medicare inpatient payments were revised, it would do nothing to address incentives for physician-owners of limited-service hospitals to increase use of outpatient care and ancillary services (e.g., lab and imaging services) for which self-referral under the whole hospital exception loophole is currently permitted. And changing Medicare inpatient payments does nothing to change physician-owners' incentives to select the most well-insured patients, avoid Medicaid patients, and avoid uninsured patients.

Many Others are Concerned

Full service community hospitals are concerned about the impact of physician ownership and self-referral on health care. But hospitals are not alone. The American Academy of Family Physicians, representing more than 94,000 physicians and medical students specializing in primary care, and the National Rural Health Association, representing practitioners and organizations that share a common interest in rural health, are among those supportive of continuing the moratorium on self-referral to limited-service hospitals.

And the U.S. Chamber of Commerce, also concerned about physician self-referral, supports extension of the current moratorium. In their recent letter to Congressman Bill Thomas, the U.S. Chamber stated that the "business community is concerned about the potential for physician owners to refer the most profitable patient cases to entities in which they have a financial interest, while referring more complicated and poorly reimbursed cases to general hospitals serving the community at large." Their letter goes on to say that the Chamber "believes further evaluation of this topic is warranted, and thus urges an extension of the current moratorium."

In conclusion, physician ownership and patient referral lead to very serious concerns about the health and economic interests of a community, including higher health care costs, duplication of services, patient and service selection, reduced emergency room coverage, inappropriate use of procedures, and more. We strongly urge Congress to close the loophole in federal law by permanently banning physician self-referral to new limited service hospitals. By doing so, Congress can help to prevent conflict of interest between physicians and patients, preserve care for everyone's emergent and urgent health care needs, and promote fair competition in today's market place.

North Texas Hospital
Lewisville, Texas 75067
March 7, 2005

Ways and Means Committee

My name is Dr. Damien Dauphiné. I am a reconstructive foot and ankle surgeon with **North Texas Hospital** which is a surgical hospital in Denton, Texas. I am writing in reference to the Ways & Means Committee meeting tomorrow. As you know, the percentage of the national budget devoted to healthcare continues to rise. We believe that increasing competition in the healthcare arena while providing superb patient care is a win-win situation for Americans.

I'm sure you have heard from the American Hospital Association and their stance on specialty or surgical hospitals. The fact remains, that the AHA is determined to squelch competition to preserve their monopolies all over America. The bureaucratic corporate hospital companies are the reason physicians like me have created these new facilities for healthcare delivery.

The surgical hospital industry must continue to exist. Employees of nearly 100 facilities would be in danger of losing jobs. Whole communities are at risk. But most importantly, the citizens of our communities are at risk. **Please do not allow the moratorium on specialty hospitals to continue.** *Patients must be allowed to have a choice in health care.* We feel our opponents have misrepresented our industry. The facts are:

- The so-called "cherry picking" of profitable patients can be eliminated more appropriately by DRG reform
- The American Surgical Hospital Association (ASHA) is not aware of any facilities that are planning to open within a year of the expiration of the moratorium this June
- Surgical hospitals serve both Medicare and Medicaid patients
- **Truth!** There are currently 40 specialty hospitals that do not have ER's. **Also True!** There are 400 general hospitals that do not have ER's
- Physician investment averages 2% in specialty hospitals, according to the Government Accounting Office—hardly a conflict of interest
- Studies done in the 80's show no inappropriate referrals by surgeons and over 85% of our cases are outpatient Take a look at the general hospitals in your area, more than likely they are expanding, not closing departments or closing their doors altogether
- *The Wall Street Journal and The Washington Times* have both supported the industry with opinion pieces.

To further the argument that competition is a necessary component of price control, the Federal Trade Commission and the Department of Justice have examined the "Certificate of Need" programs in various states. The FTC and the DOJ's aim was to determine if they (state's CON's) were effective in protecting the healthcare needs of their citizens. The following is a brief synopsis of their conclusions regarding certificate of need programs:

"States should consider the following steps to decrease barriers to entry into provider markets:

a. **Reconsider whether Certificate of Need Programs best serve their citizens' health-care needs. On balance, the FTC and DOJ believe that such programs are not successful in containing health care costs, and they pose serious anticompetitive risks that usually outweigh their purported economic benefits."**

At North Texas Hospital we offer expertise in emergency medicine, hyperbaric medicine, general surgery, vascular surgery, podiatric surgery and peripheral nerve reconstruction, orthopedic surgery, plastic surgery, gastroenterology, eye surgery, pain management, ear-nose-throat surgery, spine surgery, breast reconstruction,

and gynecologic surgery. We can compete in the Denton marketplace because we provide efficient and high quality care and our patient satisfaction response has been overwhelmingly positive. We offer services and procedures that many of the surrounding hospitals do not offer. We treat patients regardless of ability to pay and will be treating Medicare and Medicaid patients for many years to come.

Please consider these factors as you debate the issues before you.

Sincerely,

Damien M. Dauphiné, DPM
Fellow

Statement of Trevor Fetter, Tenet Healthcare Corporation, Dallas, Texas

I am Trevor Fetter, CEO of Tenet Healthcare Corporation. Through its subsidiaries, the company owns and operates acute care hospitals and related health care services. Tenet's 83,259 employees proudly provide high quality, compassionate care at 74 full-service acute-care hospitals in 13 states. Recognizing the importance of our role in the community, not only do we provide a vital charity care program through our industry-leading *Compact With Uninsured Patients,* but we also make significant investments in essential state-of-the-art health care services, such as transplant, open heart, neurosurgery, pediatrics, and neonatal intensive care. In addition, as an investor-owned health care company, our hospitals contribute to the economic development of each of the communities in which they operate through payment of state and local taxes.

I am pleased to offer comments to the House Ways and Means Subcommittee on Health about 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. Physician-owned specialty hospitals, sometimes called limited service providers, undermine and complicate the delivery of responsible, effective health care decisions by injecting self-referral into the clinical process.

Within the past several years, physician-owned specialty hospitals have emerged to capitalize on an unintended loophole in the anti-referral laws. The success of a physician-owned specialty hospital depends upon referrals by its physician owners. Succinctly, these arrangements tilt the competitive playing field by providing 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 the local community hospitals.

Physicians owning a financial interest in a specialty hospital tend to direct to their facilities only the most attractive patients—those with private health insurance and those who are less sick. However, those same specialists tend to refer underinsured or uninsured patients, as well as those with higher acuity, to full-service community hospitals for treatment, which is administered with little to no reimbursement of costs. Full-service hospitals then are left with inadequate resources to treat the sickest of patients. The practice of patient selection does not serve the American health care system, it does not serve community hospitals, and most importantly, it does not serve the best interests of the patients in our care.

The only way to solve this problem is to close the loophole in federal law to permanently ban physician ownership of and self-referral to specialty hospitals. The relationships required by such ownership/referral patterns are exactly what the anti-referral laws are designed to prevent.

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 insurance premiums, pressures of managed care, demanding regulatory burdens, and on-call requirements, just to name a few. Within this demanding environment, it is understandable that some physician specialists would be intrigued by a specialty hospital's promise of incomparable personal financial gain. However, I believe that each of these challenges requires a comprehensive solution aiming to reform 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.

As the CEO of multi-state hospital operating company, I support free and fair competition. True competition, however, requires a level playing field. Tenet hospitals, 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 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 service—often cardiac, orthopedic, or surgical care—which guarantees high profit margins, while avoiding essential but unprofitable community services, such as emergency services.

Ownership interest in these facilities is typically granted only to physicians who are able to refer patients, not to any investors from the general public. Referring physicians are often given sweetheart equity arrangements at bargain basement rates. By contrast, full-service hospitals, like those owned and operated by Tenet Healthcare, are prohibited by federal laws from offering physicians an ownership interest in the specialty wings or subdivisions of our hospitals. In fact, offering a physician any "inducement" for referrals is expressly against federal laws. These laws prohibit Tenet from giving specialists at our hospitals more than $300 in gifts per year, none of which can be given in exchange for a referral. Fair competition under the interpretation of existing rules simply would be impossible.

The "whole hospital" loophole in the anti-referral laws permits specialty hospitals to cherry pick only the most profitable patients, leaving high-cost patients, individuals on Medicaid, and the uninsured to community hospitals. The Government Accountability Office ("GAO") and the Medicare Payment Advisory Commission ("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.

Commitment to Community

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

As the Members of this Committee are well aware, America's hospital emergency rooms are quickly becoming the *de facto* public health care system, the primary point of access to quality health care services for the nation's uninsured. Hospitals equipped with emergency rooms must provide medical evaluation and required treatment to everyone, regardless of their ability to pay, as required by federal law. Since the advent in recent years of these physician-owned specialty hospitals, which skim profitable service areas for low-risk patients, this burden has grown even heavier. 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.

A 2003 study by the GAO 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, 24-hour emergency rooms. The GAO study reveals that while nine in 10 of all full-service community hospitals maintain an emergency department to address any medical concern that comes through its doors, half of 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.

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 24-hour emergency services.

Full-service community hospitals long have used funds generated by profitable services to subsidize the losses suffered by unprofitable services. Only by maintaining the successful product lines are full-service hospitals able to subsidize other critical but less profitable services, such as trauma and burn centers, as well as fund special programs for delivering care to uninsured and underinsured patients. By removing the most profitable 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.

In Slidell, Louisiana, Tenet operates North Shore Regional Medical Center. In 2002 North Shore had 723 cardiac admissions. After a physician-owned limited access facility specializing in cardiac care opened in 2003, the North Shore cardiac admissions had dropped to 359 in 2004. However, North Shore continues its community service of providing a full complement of critical emergency department services to all patients in need. In 2003, NorthShore received 23,570 visits to its emergency department, and 30 percent of those patients were self-pay and Medicaid. From what Tenet has witnessed in Slidell, and from what we have seen nationwide, physician-owned specialty hospitals simply do not share in the full complement of critical ED services to all patients, which full-service hospitals consider as a responsibility and commitment to their communities.

Solution: Self-Referral Loophole Closure

Allowing for the continuation of these 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 policy response, which focused on refinements of Medicare's DRG payment system, is inadequate. As an operator of acute care hospitals, Tenet operators can assure the Committee that simply adjusting the DRG's will only marginally reduce the profitability of self-referral. It is the owner and referral relationship that creates patient selection. The underlying economics of these facilities, which relies upon referrals from physician owners, would not change materially. Furthermore, while some modifications 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 is an amendment to the anti-referral laws. These laws generally prohibit physician referrals for 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 inpatient hospital, but not a subdivision of a hospital. 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.

The "whole hospital" exception was intended to allow physician ownership in a comprehensive health facility, as long as that ownership interest is in the entire facility, not merely a subdivision. Congress never contemplated the emergence of specialty hospitals, which essentially have turned the entire concept of the "whole hospital" exception on its head. Specialty hospitals are not whole hospitals; rather they are subdivisions of hospitals—essentially cardiac, surgical, or orthopedic wings—that have been removed from the full-service hospital. As such, physician referral to specialty hospitals in which they have an ownership interest is as clear a violation of the anti-referral laws 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 the hospital industry's hope that Congress will close the loophole in anti-referral legislation that allows for self-referral to these facilities. The whole hospital exception loophole is not in the best interest of patients, and it will continue to undermine the vital health care services communities expect from their full-service community hospitals.

Thank you for your attention to this critical issue negatively impacting access to care of all services to patients across the country.

Statement of Shawn Friesen, American College of Surgeons

The American College of Surgeons is pleased to submit a statement for the record of the Subcommittee on Health's hearing on physician ownership of 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

[1] Herzlinger RE. MedCath Corporation. Harvard Business School case 9–303–041. Cambridge, Mass.: Harvard University, 2003

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 1 report to Congress and repeated today in its report on specialty hospitals.

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 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

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[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.

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 call 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 College of Surgeons. Questions and comments may be directed to the College's Washington Office.

Statement of James Grant, American Surgical Hospital Association, San Diego, California

The American Surgical Hospital Association (ASHA) is pleased to have the opportunity to submit this statement for the record of the Subcommittee's hearing on specialty hospitals and the reports and recommendations of the Medicare Payment Advisory Commission and the Centers for Medicare and Medicaid Services. ASHA is the national trade organization representing 75 physician owned hospitals that specialize in surgical care, the vast majority of such hospitals in the United States.

THE VALUE OF SPECIALTY HOSPITALS

ASHA members 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. The fact that patients have the option of choosing where their surgery is to be performed gives them a much greater sense of control, which is very important to maintaining patient well-being. Choice is a fundamental attribute of our society, and there is no reason it should not be an equal part of our healthcare system. The preliminary information from the report of the Centers for Medicare and Medicaid Services bears out both the quality of our services and the satisfaction of our patients.

ASHA particularly wants to emphasize the excellent patient outcomes our members achieve. The average nurse to patient ratio in our hospitals 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 is being challenged by California general hospitals. On all measures of quality, surgical hospitals excel, including lower infection rates, few medically related 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 and its functions. The second is the very fact of specialization that allows physicians and staff to develop a high level of skill 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 important point 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. In addition to the information that CMS will provide to Congress on quality of care, ASHA also encourages the Committee to look at HealthGrades.com, an independent service that evaluates hospital quality for specific procedures. Using Medicare data and other resources, this service calculates an expected complication rate for each hospital. Actual performance is then measured and compared to the projected rates. Physician owned surgical hospitals score very well.

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.

MEDPAC'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 complete reports from the Government Accountability Office (GAO) and the Medicare Payment Advisory Commission (MedPAC) that shed more light on the issues in the debate. The preliminary report of the Centers for Medicare and Medicaid Services (CMS) provides important information on quality of care, patient satisfaction and physician referral patterns.

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 bottom line is 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 the experience of our members throughout the country. 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.

ASHA wants to make an important observation about the current moratorium. 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 false 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 and our physicians has been eroded. Another moratorium would only exacerbate this situation.

ASHA also believes that none of MedPAC's findings would justify any change to the current law governing physician ownership of hospitals. We are pleased that MedPAC decided against including any recommendations on the whole hospital exemption to the Stark law. CMS' analysis of referral patterns supports this conclusion, finding "no difference in referral patterns for physician owners and non-owners." This finding indicates that financial gain is not the basis for a physician's decision on where a patient will have surgery.

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 Congress and CMS to act on them this year. The Administration's budget also supports these payment changes. We also urge adoption of MedPAC's recommendations on gainsharing to encourage hospitals and physicians to work in concert to improve the quality and efficiency of healthcare. Finally, ASHA encourages the Committee to act on MedPAC's recent proposals on pay for performance measures in the hospital setting.

ASHA also supports full disclosure of ownership, consistent with the ethical standards of the American Medical Association.

THE WHOLE HOSPITAL OWNERSHIP EXEMPTION IN STARK II

The Federation of American Hospitals has called 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 general-based hospitals." As previously noted, ASHA believes that no evidence exists that should cause Congress or the Department to modify the current hospital ownership exemption.

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. It is important to note that 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, if you examine the variation in services provided by general hospitals across the country, you quickly see that there are many differences among those facilities that we might think are "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?

As previously noted, 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. It is obvious that there is no clear line that easily distinguishes physician ownership of one hospital versus another. HHS should not accept the recommendations of the FAH.

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, ASHA has 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, we are 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. We 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. The emergency services offered by most general hospitals are not of that caliber. 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. ASHA is 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 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 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 StanislausSurgicalHospital 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. Stanislaus arose out of this unresolved conflict.

Fresno Surgery Center is a similar case. Physicians in Fresno believed that they could provide a better model for elective surgical care. They could not persuade the hospitals to go along with their ideas, so they built their own facility. They continue to care for patients at the other hospitals in Fresno, as do their colleagues in Modesto. In fact, they require their physicians to maintain privileges at one of the other general hospitals in town. That means, of course, that they 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, the physicians all must have privileges at multiple facilities if they are to meet the medical and financial needs of their 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.

One of the most interesting facets of the national debate over physician owned specialty hospitals is the fact that the distribution of specialty hospitals varies widely according to state law and regulation. States historically have determined what kinds of facilities can be licensed as hospitals and have established various kinds of 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 in 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 for itself 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

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 Medical Center 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. In Fresno there is a specialty heart hospital, the Fresno Heart Hospital, that is a joint venture between the largest not for profit hospital and local physicians.

RESPONSES TO CRITICS OF PHYSICIAN OWNED SPECIALTY HOSPITALS

ASHA would like to turn to the main criticisms of physician owned specialty hospitals and address them. Fundamentally these are allegations 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.

We will 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 general 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 that experience confirms the MedPAC conclusions. All Fresno hospitals have expanded since the debut of Fresno Surgery Center. This pattern is repeated in other communities where specialty hospitals operate.

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.

The Subcommittee needs only to look at the level of hospital expansion and construction in this country to determine that most general hospitals are financially healthy, with good access to capital. These are not the signs of an industry in distress. 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 surgical schedule. 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.

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. 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 higher Medicare rates, while hospitals specializing in other kinds of surgery have lower levels of Medicare. In addition the average specialty hospital paid nearly $2 million in federal, state and local taxes. CMS has reported that the total of specialty hospital charity care and taxes exceeds the average amount of charity care provided by not for profit general hospitals.

According to MedPAC, there was wide variation in Medicaid admissions among specialty hospitals, although on average the rate of Medicaid was lower in such facilities when compared to general hospitals. Several factors may 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.

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. 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.

ASHA will 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 take market share from other hospitals and 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. No information has been provided that would contradict that finding. This outcome is exactly what one would expect in a competitive environment

ASHA 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. ASHA believes 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 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 ASHA urges the Subcommittee to look at as it considers 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. Virtually 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. Specialty hospitals are the next logical step and 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.

In summary, after thorough study the allegations against specialty hospitals have not been proven. Therefore, ASHA urges the Committee to allow the moratorium to expire as scheduled in June. The reforms to Medicare's inpatient payment system and the hospital pay for performance recommendations 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 or any other operational limitation during the period these needed changes are implemented.

ASHA appreciates the opportunity to submit this statement for the record and looks forward to working with Congress as it addresses this issue.

2004 MEMBERSHIP SURVEY RESULTS

During the summer of 2004 the American Surgical Hospital Association (ASHA) distributed a questionnaire to the entire hospital membership. The purpose of the survey was twofold—to gather basic descriptive information about the nation's surgical hospitals and to test the accuracy of some of the allegations made against surgical hospitals by their opponents.

All 71 member hospitals received the questionnaire, distributed by email from ASHA headquarters. Forty four facilities provided usable data, for a response rate of 62%. Since a number of surgical hospitals are new, they had not completed the full year of operations needed to respond to all of the questions. The data are self reported, but are readily available in any hospital, so response accuracy should not be a factor.

According to the survey results, the average ASHA member hospital had the following characteristics in 2003. The facility had 21 inpatient beds, with 8 operating and procedure rooms. Six surgical specialties (orthopedics, urology, ENT, plastic surgery and general surgery were frequently identified) were offered at the hospital and 5343 procedures were performed. Of these, outpatient procedures accounted for 90 percent of the total, with the balance being inpatient surgical services. Hospitals also provide necessary ancillary services, like imaging and lab. Forty three percent of facilities reported having an emergency department. The balance did not, reflecting the fact that they only performed elective surgical procedures and were located in states that do not require hospitals to have emergency departments.

While only a few ASHA members are cardiovascular hospitals, they are a breed apart from the typical surgical hospital. They focus on heart care and do not provide other surgical specialties. In addition, they tend to be much larger, usually over 50 beds, and provide ICU and CCU services consistent with the needs of their patient population. These facilities are much more likely to have emergency departments, again a reflection of the type of patients they treat.

All ASHA member hospitals have physician investors. The average number is 31. However, the business arrangements varied greatly, with joint ventures being the most common model at 68 percent. Thirty two percent of surgical hospitals are owned exclusively by physicians.

The type of joint venture varied widely, with 46 percent of hospitals reporting that they had a corporate partner. One third of joint ventures were with local com-

munity not for profit hospitals, and 20 percent were a hybrid with both hospital and corporate partners.

However, investors are not the only physicians to use ASHA member hospitals. The typical member has 92 physicians with admitting privileges, far in excess of the number of investors. This is consistent with the findings of the Government Accountability Office in its 2003 reports on surgical hospitals.

The average ASHA member employs 119 full and part time staff. The nurse to patient ratio is 1:3.5, far better than the requirement of 1:6 mandated by California. It is well established that the ratio of nurses to patients is not only an indicator of hospital quality, but also a driver of high quality patient care. Other quality indicators were the low post operative infection rates, 0.57 percent; a low rate of emergency transfers to other facilities, 0.22 percent; and a low medication error rate of 0.56 percent.

One consistent accusation has been that surgical hospitals do not accept Medicare or Medicaid patients and fail to provide charity care. The ASHA survey refutes this allegation. Medicare revenue averaged 29 percent, with Medicaid making up 6.5 percent of earnings. The level of charity and uncompensated care was reported as 5.3 percent. According to the Medicare Payment Advisory Commission (MedPAC), in 2002 for all U.S. hospitals, Medicare was 32 percent of revenue. Medicaid accounted for 12 percent. MedPAC and other studies found that charity/uncompensated care averaged slightly more than 5 percent for all hospitals. Both the level of Medicaid and charity care depends largely on the location of the hospital. Inner city facilities usually have higher levels of both, while many suburban hospitals do not. Also, most Medicaid programs are based on managed care that limits the number of hospitals involved in the program. Unless a specialty hospital has a contract with Medicaid, it will not see those patients.

The ASHA membership survey presents a very different view of surgical hospitals than the one popularized by their opponents. It establishes that surgical hospitals provide high quality care in a variety of specialties, not just a select few. They treat all kinds of patients, regardless of the type of health insurance they may, or may not, have. It also demonstrates that the surgical hospital model appeals to physicians, whether or not they have an investment interest.

Economic and Policy Analysis of Specialty Hospitals*

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Economic and Policy Analysis

EXCUTIVE SUMMARY

This study examines the economic theory and published evidence related to specialty hospitals, including a review of evidence on efficiency, demand, case mix, and quality. We conduct a statistical analysis of profit margins of acute care general hospitals in markets with and without specialty hospitals. We also analyze the merits of two policy options: limiting specialty hospital entry and physician self-referral. The major findings of the study can be summarized as follows:

Demand

Demand for services provided at specialized inpatient and outpatient facilities has been growing rapidly in the past decade due to a combination of factors, including increased incidence of specific diseases, new treatment processes and technologies,

and changes in consumer preferences. An important factor contributing to the growth of specialty hospitals is that some procedures or specialized services are more profitable than others, given existing Medicare and private payment rates. Not surprisingly, there has been little or no entry by specialty hospitals targeted at unprofitable services.

Efficiency

There appear to be economic advantages associated with specialization, due mainly to process redesign, learning, avoidance of diseconomies of scope, and focus on core competencies. However, the literature does not consistently suggest that either form—specialized or diversified—is superior in terms of economic efficiency. In addition, specialty hospitals appear to have equal or better patient outcomes compared to their general hospital counterparts. Hence, there is no direct evidence to suggest that specialty hospitals should be barred from entering acute inpatient care markets on the basis of economic efficiency or quality of care.

Quality

There is comparatively little evidence on the quality of care delivered in specialty hospitals. The literature we have reviewed indicates that the care provided by specialty hospitals is, at the very least, equivalent to that provided by general hospitals. However, since specialty hospitals tend to exhibit high volumes of specific procedures usually performed by high volume surgeons, to the extent there is a relationship between higher volume and superior clinical outcomes, one might expect better outcomes at high volume specialty hospitals compared to lower volume general hospitals. More generally, our review of scores from HealthGrades data indicate that there are no significant differences in mortality rates between specialty hospitals and general hospitals in the same geographic area. Finally, our survey results suggest that the intensity and quality of services are likely to be higher in specialty hospitals.

Effects on General Hospital's Finanical Stability

Specialty hospitals, like their ambulatory surgery center predecessors, compete with general hospitals in some product line markets, particularly in states without certificate of need (CON) regulation. There is no evidence, other than anecdotal, to suggest that general hospitals have been financially harmed by such competition, or that such competition is undesirable from a societal perspective.

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. General hospitals in less competitive markets (*i.e.,* those with fewer competitors) had higher profit rates than general hospitals in more competitive markets. 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. These findings are also consistent with economic theory, which suggests that firms will enter markets in which extant profit margins are comparatively higher.

Effects on Access to Care

One potential result of an increase in competition between specialty and general hospitals is the alleged attenuation of a general hospital's ability to provide indigent care by internally cross-subsidizing loses from indigent care with profits from "high margin" procedures. Rather than limit market competition, the economically optimal public policy approach for reimbursing indigent care would be to directly subsidize any hospital for providing such care, to the extent that current subsidies (tax-exempt status, disproportionate share payments, etc.) are inadequate. Nonetheless, even in the absence of such reform in the financing of indigent care in the U.S. health care system, our analysis of Medicare cost reports fails to find any indication that entry by specialty hospitals has adversely affected the overall profitability of general hospitals in the same market area. Thus, some combination of current subsidies and profits on other "high margin" product lines appears to be sufficient to offset any possible adverse effect of specialty hospital competition on the ability of general hospitals to offer indigent care or other specific unprofitable services.

Physicians Self Referral

There is no evidence to support the contention that physician self-referral to specialty hospitals has any adverse effect on patient or societal welfare. The literature

on self-referral generally shows higher rates of service utilization associated with physician ownership of ancillary services. However, any inference of causality in this association is problematic at best, because those physicians most likely to use such ancillary services most intensively also have the most to gain from increased control over the availability of such services, independent of any incentive associated with a return on investment in the facility itself. Thus, it is extremely difficult to quantify the impact of the financial incentive associated with physician ownership *per se* on the volume of self-referrals.

More importantly, the existence of an association between physician ownership of self-referral for *ancillary* services provides no evidence that ownership of acute care facilities would result in similar differences in utilization. The direct financial incentive for physician self-referral associated with physician investment in specialty hospitals is unlikely to play a major role in a physician's use of a specialty hospital, for four reasons: (1) the extent of investment for the vast majority of physicians with ownership interests in specialty hospitals is small compared to the extent on physician ownership of *ancillary* services; (2) there is no direct evidence that physician self-referral is motivated primarily or disproportionately by financial incentives associated with physician ownership; (3) there is no evidence that self-referrals result in worse outcomes than other types of referral; and (4) in the case of physician ownership of acute care facilities, it is likely that the magnitude of financial incentives is small relative to the more direct financial incentive associated with fee-for-service payment for physician services.

Economic and Policy Analysis of Specialty Hospitals

1. INTRUCTION

Hospital specialization has become a controversial topic in recent years, culminating in a moratorium issued in 2003 by Congress directing the Center for Medicare and Medicaid Services (CMS) to cease reimbursements to new physician-owned specialty hospitals for those Medicare and Medicaid patients referred by physicians with a financial interest in the facility.[1]The moratorium, which comes in addition to existing laws in many states prohibiting the operation of some types of specialty hospitals, is in part a response to the concern among incumbent general hospitals that specialized facilities may harm the community by undermining the ability of general hospitals to internally cross-subsidize unprofitable services, many of which may be considered essential to the community.

This report focuses on two interesting and important economic questions raised by the moratorium. First, are there meaningful economic advantages associated with hospital specialization, such as lower costs or higher quality? Second, does the presence of specialty hospitals reduce the ability of general hospitals to provide necessary but unprofitable services, such as emergency care and other services disproportionately provided to low-income groups? Each of these questions has policy implications. If specialty hospitals are more efficient or higher quality or both, economic theory and prevailing competition policy in the U.S. generally support allowing free market entry. That is the argument made recently by a Federal Trade Commission report and an opinion essay in the *Wall Street Journal* (Federal Trade Commission and U.S. Department of Justice 2004; Wall Street Journal 2005). On the other hand, if specialty hospitals interfere with the ability of general hospitals to provide unprofitable services, separate policy concerns arise.

This report is divided into five sections. Section 2.0 provides a brief overview of the structure of the specialty hospital industry. Section 3.0 examines the first question—whether there are meaningful economic advantages associated with hospital specialization, such as lower costs or higher quality. The primary methodologies for the analysis presented in Section 3.0 are (a) published studies and reports and (b) observations from our case studies of five surgical hospitals, two in central California and three in South Dakota.[2] Section 4.0 reviews the evidence on the quality of care and case mix severity at specialty hospitals. The analysis presented in Sec-

[1] The moratorium was enacted by Congress as part of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). It became effective when the law was signed on December 8, 2003, and will expire June 8, 2005. However, the Medicare Payment Assessment Commission (MedPAC) recently recommended that the moratorium be extended to December 2006 in order to allow for more time to study the effects of specialty hospitals on general community hospitals.

[2] These states were chosen due to the relatively high proportion and maturity of specialty hospitals. Site visits generally involved question and answer sessions with all levels of the management team (including physician owners) at each facility, followed by tours. Also provided were documents on management strategy, quality assurance, consumer satisfaction, physician ownership, and cost management.

tion 4.0 relies on published studies, reports, and our own analysis of published quality data from HealthGrades®. Section 5.0 offers guidance from economic theory on assessing the pros and cons of the current policy debates over specialty hospitals. Section 5.0 includes an in-depth statistical analysis of the effect of specialty hospital market entry on the average profit margins of general hospitals. The analysis combines data from several sources, including Medicare Cost Reports and the Bureau of Health Profession's Area Resource File. Rather than make explicit policy recommendations, we discuss some of the salient economic issues relevant to the debate. Concluding remarks follow in Section 6.0.

1.1 Methodology

This report is based on data from four different sources. All sections rely on data drawn from published studies and reports. For some of the arguments and analyses we undertake, there is limited relevant published literature and reports, primarily because the debates over pros and cons of specialty hospitals are a relatively new occurrence. In cases where there is an insufficient supply of published data and analyses, we conducted analyses based on data collected from (1) site visits, (2) secondary data sources, and (3) our own survey of specialty hospitals. The secondary data sources used for this analysis include Medicare Cost Reports (HCRIS), quality data from Health Grades, and market area data from the Bureau of Health Profession's Area Resource File (ARF). These datasets are described in greater detail in Section 5.1.1.

Throughout the report, we describe some of the findings from case studies of five surgical hospitals, two in central California and three in South Dakota. These states were chosen due to the relatively high proportion and maturity of specialty hospitals. Site visits generally involved question and answer sessions with all levels of the management team (including physician owners) at each facility, followed by tours. Also provided were documents on management strategy, quality assurance, consumer satisfaction, physician ownership, and cost management. The main goal of the site visits was to improve our understanding of the layout and functioning of specialty hospitals. Thus, rather than focus this report on the findings from the site visits, we report the main findings relevant to each section of the report. For some of the discussions, the site visits did not directly provide any relevant insights.

In addition to secondary data and site visits, we conducted a survey of the 70 specialty hospitals belonging to the American Surgical Hospital Association. The survey achieved a 50 percent response rate, but incorporating existing data from ASHA resulted in item-level response rates ranging from 50 to 90 percent. Descriptive statistics from the survey are provided in Table 2 and the survey instrument is provided in Appendix A.

Table 2

Survey of ASHA Member Hospitals:[1] Means for Selected Survey Items

Variable	Mean
Q6–8: Accreditation (%)	67.0
Q11: Bed capacity	24.6
Q12: Staffed inpatient beds	19.3
Q13: Operating rooms	5.2
Q14: Intensive care beds	4.0
Q15: Recovery beds	17.2
Q16: Percent with ER (%)	42.1
Q18: Number of owners	32.7
Q19: MD owners	31.6
Q20: MD owners admit • 5 patients/year	20.6
Q21: Q20 with 0–1% ownership stake	13.0
Q22: Q20 with 2–5% ownership stake	11.7
Q23: Q20 with 6–9% ownership stake	1.4
Q24: Q20 with • 10% ownership stake	0.8
Q25: Inpatient discharges	835.1
Q26: Inpatient days (overnight stay)	2,269.6
Q27: Inpatient days (observation days)	884.2
Q28: Surgeries (overnight stay)	717.7
Q29: Outpatient surgeries (no overnight stay)	3,105.5
Q30: Total gross patient care revenue[2]	$39,300,000
Q32: Percent Medicare revenue (%)	32.4
Q33: Percent Medicaid revenue (%)	3.7
Q34: Percent Commercial revenue (%)	46.4
Q35: Percent other revenue (%)	18.1
Q38: Percent revenue as charity care (%)	2.1
Q39: State income tax paid, previous tax year	$830,661
Q40: Federal income tax paid, previous tax year	$994,082
Q41: Property tax paid, previous tax year	$221,463
Q44: Full-time equivalent (FTE) RNs	52.1
Q45: Patient to RN ratio	3.4
Q48: Percent collect patient satisfaction data (%)	92.1
Q50: Annual number of inpatients transferred	7.6
Q51: Percent with transfer arrangement (%)	92.1

2 Sources: Survey of ASHA membership; see section 1.1 for description and Appendix A for survey instrument. Notes: (1) based on responses from 35 specialty hospitals supplemented with data from the American Surgical Hospital Association; item-level response rates range from 50 to 90 percent; (2) includes inpatient and outpatient.

2. OVERVIEW OF HOSPITAL MARKET

During the latter half of the twentieth century, industries began exploring new ways to organize production. One of the most prominent of these changes was the adoption of lean production, flexible specialization, and focused factories (Skinner 1974; Womack, Jones, and Roos 1990; Essletzbichler 2003), which resulted in many business establishments becoming less diverse and more focused (Gollop 1991). The hospital industry appears to be following a similar path with the growth of free-standing specialty hospitals and specialized units within general hospitals (Myers 1998; Eastaugh 2001; Robinson 2005).

Demand for specialized inpatient and outpatient services has been growing rapidly in the past decade (General Accounting Office 2003a). The increase in demand is most likely due to a combination of factors, including increased incidence of specific diseases, new treatment processes and technologies, and changes in consumer preferences. Analogous to non-health care industries, the hospital industry has been the subject of renewed emphasis on quality of care and customer satisfaction. In response, general and specialty hospitals alike have developed consumer-oriented centers of care focused on providing a limited range of services tailored to the specific needs of patients (Baum 1999; Romano and Kirchheimer 2001; Eastaugh 2001; Smith 2002; Urquhart and O'Dell 2004; Herzlinger 2004a; Lo Sasso et al. 2004).

Specialty hospitals are typically defined as those that treat patients with specific medical conditions or are in need of specific medical or surgical procedures.[3] The former describes hospitals specializing in psychiatric care, cancer care, rehabilitation, women's care, children's care, and certain chronic diseases; the latter describes hospitals specializing in cardiac, orthopedic, and general surgery. As of 2002, there were a total of more than 1,000 specialty hospitals in the U.S. (Table 1). These estimates exclude specialized "distinct part" units of general hospitals, a large segment of the specialized facility market. For example, Schneider, Cromwell, and McGuire (1993) reported that there are more than 900 distinct psychiatric units and more than 500 distinct rehabilitation units within general acute care hospitals.

The recent political controversies surrounding specialty hospitals have focused primarily on facilities specializing in cardiac, orthopedic surgery and general surgery, and to a lesser extent obstetrics and gynecology. There are approximately 100 to 120 of these hospitals currently operating in the U.S. Growth in surgical hospitals ranged from 33 percent (orthopedic and general surgery) to 70 percent (cardiac surgery) during the seven-year period from 1995 to 2002. Most of these facilities are located in states without Certificate-of-Need (CON) programs, which regulate the construction and augmentation of health care facilities. States with the highest concentrations of surgical specialty hospitals are South Dakota, Kansas, Oklahoma, Texas, Louisiana, Arizona, and California.

Table 1

Trends in Numbers of Specialty Hospitals, 1990–2003

Facility Type	1995	2002	% Change, 1995–2002
Psychiatric [1,2]	675	488	−27.7%
Rehabilitation [1,2]	NA	216	——
Extended Stay [1,2]	NA	270	——
Obstetrics and Gynecology [1,5]	12	18	+41.7%
Orthopedic and General Surgery[3,5]	60	80	+33.3%
Cardiac Surgery [4,5]	10	17	+70.0%
Other [6]	96	100	+4.2%

Notes and sources: (1) American Hospital Association *Hospital Statistics* (1996/97 and 2004 editions); (2) Centers for Medicare and Medicaid Services; (3) American Surgical Hospital Association; (4) MedCath Corporation; (5) General Accounting Office (2003a); (6) includes hospitals specializing in children, cancer, respiratory diseases, and ear/nose/throat.

The distinction between surgical specialty hospitals and all other specialty hospitals is an important one because the current debates and controversies refer exclusively to surgical hospitals. There are two likely reasons for the concentration on surgical hospitals. First, although reliable evidence is lacking, it is possible that the average operating margins associated with surgical procedures are higher than those associated with, for example, psychiatric and rehabilitation care. Second, 70 percent of surgical hospitals have at least some level of physician ownership (General Accounting Office 2003a), which is a concern to some policy makers. Some additional discussion of these issues is provided in Section 5.0.

Another important aspect of the specialty hospital industry is the motivation for market entry. Site visits and published literature identify several important motivating factors (Walker 1998; MedPAC 2003; Casalino, Pham, and Bazzoli 2004; Casey 2004; Rohack 2004; Iglehart 2005). Motivations include the ability of physicians to (1) directly control quality of care; (2) optimally schedule operating room time (e.g., allow more choice in operating room block time and minimize schedule disruptions caused by emergent cases); (3) select patients that are clinically appropriate for the specialized setting; (4) maintain greater decision-making authority over equipment and supply purchases; and (5) capture a portion of the facility fee as additional entrepreneurial earnings. An additional motivation for market entry is likely to be the existence of above-average profit margins on certain procedures. As is the case in any industry, it is the exception to observe market entry into products and services for which profit margins are unusually low or negative.

[3] For example, focusing on core competencies has been associated with improved supply chain management (primarily through standardization), simplified human resource management, and streamlined production scheduling.

Some of the other factors identified relate to physicians freeing themselves from contract restrictions and other bureaucratic apparatus common to larger general hospitals. Interestingly, many of the comments recorded during the site visits mirror those expressed by physicians in single-specialty medical groups. Casalino, Pham, and Bazzoli (2004) report that one of the motivating factors for single-specialty groups was to "avoid the complicated governance and operational issues engendered by having primary care and specialty physicians in the same organization" (p.86).

3 EFFICIENCY

An important question concerning the efficiency of specialty hospitals is whether there are distinct economic advantages or disadvantages to specialization. Embedded in this question is whether there are advantages or disadvantages associated with the dominant hospital organizational structure, which consists primarily of full-service diversified general hospitals. This section reviews the theory and evidence on four aspects of efficiency that are relevant to specialization: (1) economies of scale, (2) economies of scope, (3) competencies and learning, and (4) volume-outcome effects.

3.1 Economic of Scale

Economies of scale exist if the average costs of producing a product or service decline as the volume of production increases. The evidence on economies of scale in the production of hospital services, while highly variable, indicates that U.S. general hospitals typically experience scale economies up to approximately 10,000 discharges per year (Cowing 1983; Vita 1990; Gaynor and Anderson 1995; Keeler and Ying 1996; Dranove 1998; Li and Rosenman 2001). However, the same evidence suggests that scale economies vary significantly by product and service line. In order to asses the potential role of scale economies in specialty hospital efficiency, scale economies for specific services (e.g., total knee replacement) in specialty hospitals versus general hospitals would need to be compared. We are not aware of any study that does so. However, for many specific surgical procedures, the volume of these specific services performed at specialty hospitals typically exceeds that performed at general hospitals within the same market area (Cram, Rosenthal, and Sarrazin 2004). Thus, to the extent economies of scale exist in these specific procedures, they are likely to be realized to a greater degree in specialty hospitals compared to general hospitals.

3.2 Economic of Scope

In some cases the joint production of two or more products or services can be accomplished at lower cost than the combined costs of producing each individually. This is often the case when production relies on common resources, such as technology, workers, inputs, and general overhead. Cases where the costs of joint production are lower than the costs of separate production are said to exhibit economies of scope (Panzar and Willig 1981). The decision to specialize will depend in part on the extent to which firms' existing scope of products and services exhibit diseconomies of scope (*i.e.,* where joint production is more costly than separate production). Conversely, the decision to diversify will in part be based on the extent to which joint production costs are less than separate production costs.

Evidence on economies of scope in the U.S. hospital industry is inconclusive. Menke (1997) found limited evidence of inpatient-outpatient scope economies in chain and non-chain hospitals. Similarly, Fournier and Mitchell (1992) found significant scope economies among select outpatient services and surgery services, but their study is based on 20-year old data from one state. Sinay and Campbell (1995) examined 262 merging acute care hospitals in the U.S. during the period 1987 to 1990. Of the service pairings studied, evidence of economies of scope was found between acute care and sub-acute care (in merging hospitals) and between intensive care and outpatient visits (in control hospitals); all other pairings showed either diseconomies of scope (e.g., acute care and outpatient care; intensive care and sub-acute care) or were statistically insignificant. Rozek (1988) failed to observe scope economies in general hospital diversification into psychiatric services, and Li and Rosenman's (2001) study of hospitals in the state of Washington reached inconclusive findings on scope economies. The lack of consistent findings on economies of scope suggests that it is probably not a significant source of production economies for general hospitals. Thus, it would be difficult to argue that specialty hospitals are less efficient than general hospitals due to the absence of scope economies.

3.3 Learning and Competencies

Skinner (1974) stressed that "simplicity, repetition, experience, and homogeneity of tasks breed competence." Learning occurs as the experience of production in one time period influences the production in a later time period; that is, the production

process is assumed to have some degree of flexibility and can change over the relevant range of output (March 1996; Nooteboom 2000; Greve 2003). The implication is that the costs of producing the first batch of output are greater than the costs of the producing a subsequent batch due to the learning that occurred during the production of the first batch. Assuming that experiences of producing the first batch can be applied to the second batch (and other subsequent batches), the average costs of production are expected to decline as output cumulates over time. The learning effect will depend on the ability of the firm to process information during the production process and then apply that information appropriately.

The learning process is critical to the formation and adaptation of organizational routines, which include rules of thumb, guidelines, templates, and protocols (Nelson and Winter 1982). Specialized routines are the subcomponents of organizational "know how" and "core competencies," and are often sources of comparative advantage and production economies (Chandler 1992; Wruck and Jensen 1994; Greve 2003). Core competencies refer to firms' existing stock of knowledge assets (including tacit knowledge and know-how), skills, and resources. By diversifying and expanding into activities that are related to core competencies, firms are typically able to take better advantage of the learning process and improve managerial efficiency (Teece et al. 1994; Teece and Pisano 1994; Hill 1994; Danneels 2002).[4] In addition, limiting expansion into related business lines is likely to minimize some of the negative tradeoffs associated with growth in firm size, such as influence costs and other forms of incentive attenuation (Milgrom and Roberts 1990). Consistent with Skinner's emphasis on the value of repetition, concentrating on core competencies is believed to enhance the learning process by assuring that decision-making situations are repeated in sufficiently large numbers. According to Teece et al. (1994, p.17), "If too many parameters are changed simultaneously, the ability of firms to conduct meaningful quasi experiments is attenuated." Given the complexities of the learning process, the costs of learning in some cases may be lower for smaller specialized firms. Smaller firms may have the advantage of being able to allocate the majority of the resources available for learning and adaptation to a relatively small set of related production process (Almeida, Dokko, and Rosenkopf 2003).

Learning and core competencies have been shown to be important determinants of the performance of health care organizations. In health care setting the learning process is to some extent evident in the positive association between procedure volume and outcomes (discussed in greater detail in the next section). During our site visits, we consistently observed a culture supportive of coordination and cooperation aimed at achieving ongoing improvements in efficiency and quality. Specialty hospital managers generally attributed their success in process adaptation to three factors: (1) relatively small size, which enables more rapid and efficient decision making; (2) flat hierarchical structures, which allow decision making and process improvement to migrate to the most appropriate level; and (3) focused and consistent management goals, which make it easier for team members to learn and their roles. Managers also emphasized the importance of performance feedback, mainly through surveys of customer satisfaction. Again, managers indicated that their relatively small size allowed them to spend more time collecting, analyzing and acting on customer feedback. While it is possible that diversified general hospitals are able to achieve similar learning effects, the smaller scale of specialty hospitals may lower the costs associated with learning.

In health care settings, there also appear to be distinct advantages to focusing production within core competencies.[5] Shortell, Morrison, and Hughes (1989), in their three-year case study of eight large hospital systems, found that the best performing systems and hospitals were the ones that avoided diversification into unrelated activities, thereby minimizing diseconomies of scope and maximizing efficiencies associated with learning. Eastaugh (2001) examined a panel of 219 U.S. acute care hospitals from 1991 to 2000, finding that a 31 percent increase in specialization over the time period was associated with an eight percent decline in costs per admission. Douglas and Nyman (2003) review the theory of core competencies in hospitals and test the theory using data from the 32 largest hospital markets in

[4] For example, focusing on core competencies has been associated with improved supply chain management (primarily through standardization), simplified human resource management, and streamlined production scheduling.

[5] The relationship between core competencies and hospital efficiency is relatively under-studied. General discussions are provided by Eastaugh (2001; 1992); Snail and Robinson (1998); Douglas and Ryman (2003); Coddington, Palmquist, and Trollinger (1985), Porter and Teisberg (2004), Herzlinger (2004c), Moore (1990), and Walker and Rosko (1988).

the U.S. They found that the degree to which hospitals focused on core competencies was positively related to hospital financial performance.

In terms of core competencies, our site visits reached similar conclusions. When asked why their facility performed one set of procedures or services and not another, managers consistently indicated that they had a strong desire to not venture too far from the core of their collective knowledge. Managers and owners emphasized that the key decision makers are typically physician owners, most of whom are likely to feel most comfortable focusing on the delivery of services in their specialty field. One chief executive officer and physician owner stressed that specialty hospitals often attract the most highly trained and skilled physicians in the community by allowing them to essentially redesign the care process based on the state of the art in their field. We found corroborating anecdotal evidence in the trade press (Walker 1998; Baum 1999; Daus 2000; Casey 2004; Wolski 2004; Zuckerman 2004).[6]

3.4 Volume-Outcome Effect

Several studies have found a positive association between the volume of services a hospital performs and the quality of the outcomes (Hillner, Smith, and Desch 2000; Halm, Lee, and Chassin 2002; Shahian and Normand 2003). One potential criticism of specialty hospitals is that the volume of cases may be too low to capture the positive effects of volume on patient outcomes. There are, however, five important limitations to these findings. First, the magnitude of the relationship is highly sensitive to case mix adjustment (Halm, Lee, and Chassin 2002). Second, there is considerable debate over how much volume is necessary to improve outcomes. For example, a common belief is that outcomes for percutaneous coronary interventions are better in hospitals that perform more than 400 such procedures per year. However, Epstein et al. (2004) found that there were no significant mortality differences between hospitals with medium volume (200–399 cases per year) and high volume (400–999 cases per year). Third, many studies do not differentiate between individual physician effects and hospital effects. It is possible that the volume-outcome relationship reflects differences in experience levels of individual physicians, most of whom maintain admitting privileges at multiple institutions (Robinson et al. 2001). Fourth, volume-outcome relationships are likely to be procedure specific. Again, on average specialty hospitals have higher procedure-specific volumes than their general hospital counterparts (Cram, Rosenthal, and Sarrazin 2004).

The fifth limitation is that the causal relationship between volume and outcome is unclear: do patients treated at high-volume hospitals achieve better outcomes because of learning and practice (the "practice makes perfect" hypothesis), or do hospitals with better quality reputations attract higher volumes of patients (the "selective referral" hypothesis) (Hughes et al. 1988)? Some recent studies have used instrumental variable techniques to disentangle these effects; one such paper found strong evidence of the "practice makes perfect" hypothesis for coronary artery bypass graft surgery.[7] There is some evidence that both hypotheses explain differences in outcomes but, nonetheless, taken together these two hypotheses explain a relatively small proportion of the overall variation in patient outcomes (Luft 1980; Luft, Hunt, and Maerki 1987).

3.5 Summary

The preceding discussion suggests that there are several areas in which specialty hospitals achieve production economies. First, specialty hospitals are able to take advantage of economies of scale and scope by producing relatively high volumes of a limited scope of services, and by lowering fixed costs by reengineering the care delivery process. Second, the site visits consistently found evidence of learning and core competencies. Managerial and clinical staff indicated a strong desire to focus on a relatively narrow array of tasks, and indicated a commitment to perfecting those tasks. The evidence on scale and scope economies and core competencies suggests that there are efficiency reasons for some degree of diversification, but that expansion into unrelated activities can result in diminished financial performance.

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[6] MedCath's description of their facilities is apposite: "Externally, MedCath's heart hospitals appear typical; however, a step inside reveals important differences: Physicians empowered to make decisions about hospital operations; state-of-the-art operating rooms; cutting-edge equipment and technology; centrally located services such as radiology, pharmacy and laboratories; nursing stations strategically positioned to allow better patient monitoring; and large, single-patient, fully equipped rooms that avoid unnecessary patient moves and permit family members to remain overnight. Above all, physicians and nurses freed from bureaucratic and administrative chores so they can devote a majority of their time and energy directly to caring for their patients." (MedCath Corporation 2001)

[7] Unpublished working paper: Seider H, M Gaynor, and WB Vogt (2004) "Volume-Outcome and Antitrust in U.S. Health Care Markets" Carnegie-Mellon University.

Specialty hospitals also may in some cases possess a technological advantage or resource that is unique in the market. This is likely to be the case for many entering specialty hospitals, as most have had the opportunity to redesign care delivery processes from the ground up.

Perhaps as a result of these efficiencies, specialty hospitals appear to be capable of offering more intensive services for the same price. Specialty hospitals tend to have substantially higher nurse-patient ratios[8] and tend to place greater emphasis on ancillary services identified by patients as important, such as comfortable family-friendly rooms, more attention from administrative and clinical staff, and the mitigation of common inconveniences (e.g., appropriately located elevators and convenient parking). Specialty hospitals also appeal to physicians by offering newer equipment, more staff assistance, and more flexible operating room scheduling. These are costly services, yet specialty hospitals must compete for contracts with the same managed care organizations that general hospitals do; similar to general hospitals, they must also accept the Medicare fee schedule as payment in full.

4. CASE MIX AND QUALITY

4.1 Case Mix

There is some evidence that, on average, specialty hospitals treat patients with lower acuity compared to general hospitals (General Accounting Office 2003a, 2003b; Cram, Rosenthal, and Sarrazin 2004).[9] These findings are consistent with the observed case mix differences between ambulatory surgery centers and general hospitals (Winter 2003). The focused nature of specialty facilities may be better suited to patients whose care involves relatively little uncertainty, or whose condition is reasonably well defined. General hospitals may be more efficient in treating complex cases, particularly cases that allow them to exploit scope economies across service lines. In sum, it is possible that the apparent cost advantage of specialty hospitals is in part attributable to a healthier average case mix.

It should also be noted that prospective administered pricing mechanisms create incentives for general and specialty hospitals alike to focus on diagnosis categories and procedures where the administered price exceeds facilities' average costs. Medicare's administered pricing system (PPS) has been shown to affect the scope of services offered by acute care hospitals. The PPS system employs a fee schedule based on approximately 500 diagnosis related groups (DRGs); each DRG is mapped to a price, with some hospital-specific adjustments. Payment by DRG provides strong incentives to hospitals to specialize in those DRGs for which they have relatively low production costs (Dranove 1987). In the context of specialty hospitals, Robinson (2005) posits that "The success enjoyed by the specialized firms reflect astute selection of services and markets as much as efficiency in delivering care."

4.2 Quality

Empirical evidence on the quality of care provided by specialty hospitals is limited to two studies, one by the Lewin Group (2004) and another by Cram et al. (2004) from the University of Iowa. The Lewin study used Medicare Part A (MedPAR) data to compare eight MedCath heart hospitals to 1,056 peer general hospitals that perform open-heart surgery in the U.S. After adjusting for risk of mortality, MedCath heart hospitals on average exhibited a 16 percent lower in-hospital mortality rate for Medicare cardiac cases compared to peer general hospitals.

Cram, Rosenthal, and Vaughan-Sarrazin (2004) found no significant differences in mortality for cardiac patients treated at specialty hospitals and general hospitals, after adjusting for lower severity and higher procedure volume at specialty hos-

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[8] Kovner et al. (2002) found that the median number of RN hours per adjusted patient day was 6.43 for the study's 534 general hospitals. For the five specialty hospitals we visited, RN hours per adjusted patient day ranged from 10 to 15 hours per patient day. Ideally, however, the appropriate comparison would be between cardiac and orthopedic units of specialty hospitals and cardiac and orthopedic units of general hospitals. We know of no such studies, and we were not able to identify a source of data on nurse staffing ratios within specific units of general hospitals.

[9] Dobson (2004), in a study conducted by Lewin Group for the MedCath Corporation, found case-mix results counter to the GAO study and Cram et al. (2004). The Lewin Group found that MedCath cardiac hospitals have a 21 percent higher case mix severity for cardiac patients compared to their community general hospital peers. The differences in findings are likely attributable to differences in the sample and the measurement of severity or complexity. For example, the Lewin Group study used DRG weights to measure severity, whereas Cram et al. used a predicted mortality model based on age and presence of seven comorbid conditions. However, the Lewin Group findings are consistent with anecdotal and empirical evidence that admitting physicians may perceive specialized facilities as being more appropriate for complicated cases, due in part to the positive volume-outcome relationship (Baum 1999; Magid et al. 2000).

pitals.[10] Similar results have been found when comparing ambulatory surgery centers and general hospitals (e.g., Warner, Shields, and Chute 1993; Mezei and Chung 1999). Data gathered from our site visits mirror these findings. Managers of specialty hospitals consistently reported two factors they believed to have been critical to achieving high quality patient outcomes: high volume and high nursing intensity. Consistent with the Cram et al. findings of higher procedure volume, managers of specialty strongly believed that they were improving care through ongoing learning and improvement. Specialty hospitals also reported nurse-patient ratios higher than the national average,[11] which suggests that they may be able to capture some of the positive quality and outcome effects associated with richer nurse staffing (Kovner et al. 2002; Lang et al. 2004; Stanton and Rutherford 2004; Mark et al. 2004).

Limited scope is also likely to increase accountability associated with the smaller set of procedures. For example, a specialty hospital leader at one of the visited hospitals remarked that "four procedures account for seventy percent of our business; if we develop any kind of quality problem in one or more of those procedures it's a huge problem for our organization." In addition, specialty hospitals typically engage in extensive collection of data on quality and patient satisfaction, and use these data to modify care processes (Walker 1998; Fine 2004; Iqbal and Taylor 2001). Among the ASHA member hospitals surveyed, 92 percent reported that they engage in regular assessments of customer satisfaction. Finally, there is consistent anecdotal evidence that the kind of care delivered by the typical specialty hospital is consistent with the general trend toward "consumer-driven" health care (e.g., O'Donnell 1993; Baum 1999; Leung 2000; Urquhart and O'Dell 2004; Hoffer Gittell 2004; Herzlinger 2004b).

4.2.1 HealthGrades Analysis

HealthGrades is a national organization that produces hospital quality reports for over 5,000 U.S. acute care hospitals.[12] We merged membership data from ASHA and MedCath to publicly available quality data published on the HealthGrades website. There were 22 matched hospitals, representing approximately 31 percent of the ASHA hospital sample. For those hospitals, we examined the mean quality score (based on a 1–5 Likert scale) for the most common sets of procedures performed by the 22 hospitals. Consistent with the Lewin Group study and Cram et al., the results show that specialty hospitals typically performed at least as well as general hospitals in the same geographic region. Based on measures of in-hospital mortality (including 1 and 6 month post-discharge mortality rates), the mean score for the 22 specialty hospitals was a 3.86 out of 5, which was not statistically different from the mean scores for general hospitals in the same market areas.

5. POLICY ISSUES

The debate over specialty hospitals has raised several policy questions, two of which have received a high level of attention. First, do specialty hospitals harm the ability of general hospitals to provide indigent care? Some argue that specialty hospitals take profitable business away from general hospitals, and as general hospitals lose market share, particularly in high-margin product lines, they are hampered in their ability to provide low-margin services and meet their implied obligations to serve the community. Second, does having an ownership stake in the facility create financial incentives for physicians to provide inappropriate and unnecessary treatment? What are the optimal policy options to address these questions? Rather than make explicit policy recommendations, we discuss some of the salient economic issues concerning these two policy problems.

In this section policies are discussed in terms of their effectiveness in accomplishing intended objectives. In order to assess the net effect of a policy, ideally it is necessary to take into account all direct and indirect effects attributable to the policy. The sum of these effects is analogous to what economists refer to as change

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[10] In this respect the Cram et al. study and the Lewin Group study found similar results, although the Lewin study found that risk-adjusted in-hospital mortality rates in cardiac hospitals were 16 percent *lower* on average than the mortality rates of community hospital peers.

[11] Kovner et al. (2002) found that the median number of RN hours per adjusted patient day was 6.43 for the 534 hospitals studied. For the five specialty hospitals we visited, RN hours per adjusted patient day ranged from 10 to 15 hours per patient day. However, these data comparisons are limited; ideally, nurse staffing ratios should be compared only within particular product and service lines (e.g., orthopedic).

[12] Health Grades quality measures are based on data from Medicare Part A (hospital) discharge abstracts for the time period 2001–2003. For more information on methodology and analysis, refer to www.HealthGrades.com and the Health Grades report entitled "The Seventh Annual Health Grades Hospital Quality in America Study" Health Grades Inc. 2004)

in net social welfare; that is, the extent to which the policy effects aggregate well-being. For example, the Federal Trade Commission recently emphasized that health care policies intended to mitigate some of the less desirable side effects of competition must be weighed against the losses normally resulting from restrictions on market entry and competition (Federal Trade Commission and U.S. Department of Justice 2003, 2004).

5.1 Indigent Care and Cross-Subsidization

The indigent care issue has several components. The first issue has to do with the practice on the part of general hospitals to meet their implicit obligation to serve the community[13] by cross-subsidizing low-margin services with high-margin services combined with other government subsidies. Many of the former state rate regulation programs were explicitly designed to help acute care hospitals meet these obligations (Fournier and Campbell 1997; Schneider 2003); however, all but one of the state rate regulation programs were dismantled during the 1990s. In the absence of state rate regulation, hospitals have relied on six other mechanisms to pay for unprofitable services: (1) tax-deductible donations, (2) tax-exempt bond financing, (3) exemption from income and property taxes, (4) internal cross-subsidization, (5) Medicaid disproportionate share payments (additional payment for treating a disproportionate share of Medicaid patients), and (6) state-administered charity care risk pools[14] (Figure 1).

Figure 1

Non-Profit General Hospital Methods for Funding Indigent Care

Tax exemption is perhaps the most widespread subsidy provided to non-profit general hospitals. non-profit tax status allows hospitals to avoid property and income tax in exchange for an obligation to serve the community. However, Kane and Wubbenhorst (2000) found that the amount of charity care provided by hospitals is significantly less than the amount of tax benefit accrued through non-profit status.[15] Thus, even if tax exemption were the only means for hospitals to fund indigent care, the amount of the benefit on average appears to be more than sufficient to fund prevailing levels of indigent care. Although specialty hospitals generally provide less charity care (approximately 2.1 percent of gross patient care revenues; Table 2), per facility they contribute on average approximately $2 million annually in state and federal taxes. This represents an additional 5.1 percent of gross patient care revenues. The combined 7.2 percent of gross patient care revenues exceeds the average charity care provision of tax-exempt general hospitals, which is approximately 5 to 6 percent of revenues (American Hospital Association 2005).

Hospital internal cross-subsidization is to be distinguished from the popular notion that hospitals shift costs between third-party payers; that is, "one group pays more because another pays less" (Morrisey 1994). In this case, hospitals cross-subsidize low-margin indigent services with the proceeds from high-margin services. Under normal circumstances, hospital internal cross-subsidization would not be sustainable, mainly because sustained high margins on some services would encourage market entry, and as firms entered the excess profits would be competed away.[16] In order for cross-subsidization to work, government must restrict market entry, either through certificate of need (CON) or some other means. Indeed, that is how many states currently approach the problem, and an important reason why Congress has resorted to the specialty hospital moratorium.

There at least two problems with policies encouraging cross-subsidization of this kind. First, the policy relies on CON to limit market entry, and there is a large vol-

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[13] Acute care hospitals' implicit obligation to serve the community is based on two policies: the Hospital Survey and Construction Act of 1946 and non-profit tax exemption. The nominal intent of the Hospital Survey and Construction Act of 1946 (commonly known as the Hill-Burton Act) was to bolster the relatively under-developed postwar hospital industry by requiring states "to develop programs for the construction of such public and other non-profit hospitals as will, in conjunction with existing facilities, afford the necessary physical facilities for furnishing adequate hospital, clinic, and similar services to all their people" (*Hospital Survey and Construction Act* 1946).

[14] See generally Lewin and Altman (2000).

[15] A summary of these issues can also be found in Nancy Kane's recent testimony to the Subcommittee on Oversight of the U.S. House Committee on Ways and Means (Kane 2004).

[16] This is a common occurrence in most industries. In the language of the current debate, this would be considered cream skimming. An important question is whether it is optimal policy to discourage triaging of care across settings according to intensity, given the extensive literature on the cost and quality benefits associated with moving patients from inpatient to outpatient settings following the implementation of Medicare's PPS.

ume of research critical of CON.[17] Studies of the impact of CON programs have consistently found the programs to be ineffective at controlling costs and enhancing access. Sloan and Steinwald (1980) found that mature CON programs had an insignificant effect on hospital costs, and immature CON programs actually increased hospital costs. Lanning, Morrisey and Ohsfeldt (1991) and Antel, Ohsfeldt, and Becker (1995) also conclude that CON is associated with higher inpatient costs and expenditures per capita. A possible explanation is that the CON constraint prevents hospitals from employing the least-cost combination of inputs to produce inpatient services, resulting in allocative inefficiency.[18] Further, there is no evidence that the repeal of CON was associated with an increase in hospital expenditures (Conover and Sloan 1998).[19] As a result of the apparent failure of CON to achieve its stated goals, many state CON programs have been either terminated or significantly reformed since the repeal of the Health Planning Act in 1986 (Conover and Sloan 1998). It would be more difficult in theory for hospitals located in competitive markets in non-CON states to engage in internal cross-subsidization; instead, such hospitals would have to rely on tax exemption, disproportionate share payments, and charity care risk pools to fund indigent care.

Second, it is not clear whether the losses in net social welfare associated with restricting market entry exceed the costs of alternative means of assuring the provision of indigent care, such as direct subsidies. The Federal Trade Commission's recent report on health care competition integrated this point into one of their policy recommendations, emphasizing that "[competition] does not work well when certain facilities are expected to cross-subsidize uncompensated care. In general, it is more efficient to provide subsidies directly to those who should receive them, rather than to obscure cross subsidies and indirect subsidies in transactions that are not transparent" (Federal Trade Commission and U.S. Department of Justice 2004 p.23).

The U.S. experience with airline regulation provides an excellent example. In order to develop air travel infrastructure, airline regulation required carriers to cross-subsidize unprofitable routes with profitable ones. Cross-subsidization appeared to contribute to infrastructure development in the early years of regulation, but eventually led to extraordinarily high costs (Morrison and Winston 1986). Consumer welfare and producer surplus improved markedly following deregulation (Winston 1998; Peltzman and Winston 2000). If subsidizing indigent care is a policy objective, the economically optimal public policy would be to directly subsidize any hospital for providing indigent care.[20] Protecting incumbent hospitals from competitive entry may be just as likely to allow incumbent firms to maintain higher prices and facilitate slack in organizational processes, rather than permit them to fund additional indigent care.

A related concern is that specialty hospitals engage in unfair competition with general hospitals by treating only less severe and more profitable patients (*i.e.,* cream skimming). As noted, there is some evidence that specialty hospitals, like their ambulatory surgery center predecessors, treat healthier patients with fewer comorbid conditions. However, from a policy perspective, treating healthier patients in less intensive settings is likely to improve patient welfare, given the extensive literature on the cost and quality benefits associated with triaging patients from inpatient to outpatient settings following the implementation of Medicare's PPS. Thus, the cream skimming issue, as others have observed, is predominantly a function of (1) variation in operating margins within DRG and (2) crude case-mix adjustments in current reimbursement rates. Case-mix adjustment methodology has improved dramatically in recent years, and CMS maintains the administrative data necessary for such adjustments (FitzHenry and Shultz 2000; Iezzoni 2003). Again, according to economic theory, establishing administered prices that are more closely aligned

[17] Currently, 14 states have no CON program and another six states maintain CON programs only for long-term care (Conover and Sloan 2003).

[18] The poor performance of CON is attributed to four factors: the administrative burden associated with determining appropriateness of new investments, the potential for CON laws to create and maintain hospital cartels by erecting barriers to new hospital entrants, the susceptibility of the CON process to industry influence (e.g., Payton and Powsner 1980), and the potentially sub-optimal input allocation induced by the CON constraint on the use of capital inputs.

[19] Some studies have found that CON programs can be used to enhance patient outcomes by concentrating services in high-volume facilities (e.g., Vaughan-Sarrazin et al. 2002). However, these studies are limited by the causality problem described in Section 3.4, and the lack of analysis of whether improvement in outcomes compensates for the net social welfare losses associated with barriers to market entry (Federal Trade Commission and U.S. Department of Justice 2004).

[20] One of the criticisms of specialty hospitals is that many do not provide 24-hour emergency services. But it is not clear whether any current means of funding emergency room services are optimal. From a societal perspective, it may be more economically efficient to fund and operate emergency rooms no differently than police and fire departments.

with average costs together with improvements in case-mix adjustment would be superior policy mechanisms compared to restrictions on market entry.

In sum, there are significant drawbacks to the current four-part strategy to encourage the provision of indigent care. Tax exemption should in theory be sufficient compensation for indigent care, particularly when combined with disproportionate share payments and charity care risk pools. However, there are no explicit mechanisms in place to control how hospitals allocate the proceeds from tax exemption.[21] Internal cross-subsidization would not be sustainable in competitive markets; therefore, costly entry-barrier regulations must accompany cross-subsidization. Both of these policies are sub-optimal insofar as they result in net losses in social welfare. Losses in net social welfare are likely to exceed the value of indigent care delivered. Policies such as direct subsidies for indigent care and more accurate case mix adjustment of payments would likely result in overall gains in net social welfare.

5.1.1 Effects on General Hospital Profit Margins

Were it the case that specialty hospitals erode profits of general hospitals in the same market, we should observe lower or at least declining profit margins among general hospitals in markets where there is at least one specialty hospital. In order to further examine this issue, we statistically analyzed the extent to which profit margins of general hospitals are affected by the presence of one or more specialty hospitals in the market. We obtained Medicare Hospital Cost Report Data for 1997 through 2003 for all U.S. acute care hospitals. For each hospital in the dataset, county and metropolitan statistical area (MSA) market areas were identified and additional market-level data from the Bureau of Health Profession's Area Resource File were merged. Mean general hospital profit rates[22] were calculated for all county and MSA market areas in the U.S.

The analytic approach was to estimate what economists refer to as a profit function—a mathematical expression of the likely relationship between profit margin, the dependent variable, and the factors expected to affect profit margin, referred to as covariates. We estimate a standard "ad hoc" profit function of the following basic linear form: $MARGIN_{it} = \alpha_0 + \alpha_1 D_{it} + \alpha_2 S_{it} + \alpha_3 P_{it} + \alpha_4 Z_{it} + \varepsilon_{it}$. In this expression, $MARGIN_{it}$ refers to the mean of the operating margins (profit rates) of general hospitals within the ith county (or MSA) in year t. It is hypothesized that the mean area-level general hospital profit rate is a function of demand factors (D_{it}), supply factors (S_{it}), input prices (P_{it}), a vector of market area characteristics (Z_{it}), and an error term (ε_{it}) representing unexplained or unmeasured factors. The demand factors included in this model are per capita income, population density, the percent of the population at or below the poverty level, and the area unemployment rate. The latter two measures are included to capture the likely indigent care burden faced by general hospitals. Supply factors include output measures (inpatient days per population and outpatient visits per population) and the number of physicians per capita. Price measures include the mean area wage for hospital workers (from the U.S. Bureau of Labor Statistics) and the Medicare Part A (hospital) average adjusted price per capita (AAPCC).

The main variables of interest are the specialty hospital indicator variables and the measure of market competition. We constructed two variables to measure the presence of specialty hospitals, each of which was based on our survey of ASHA membership. The first is a simple indicator variable (SCP) that equals 1 if the market area has one or more specialty hospital (most markets have only one). For example, if specialty hospital X opened in 1999, than SCP equals zero in 1997 and 1998 and equals one thereafter. The second specialty hospital indicator is the total number of physicians admitting patients to the specialty care provider in the market area.

The other main variable of interest is a measure of market concentration. Although not an ideal measure of market concentration, a standard method of measuring market concentration is the Herfindahl-Hirschman Index (HHI). The HHI is calculated by summing the squares of each firm's market share in the county; that

[21] Two recent law suits filed against large hospital chains have challenged the extent to which hospitals have been operating in accordance with the implicit contracts (Taylor 2004; Davies 2004). The suits allege that acute care hospitals, particularly those granted non-profit status, have been failing in their implicit obligation to serve mostly through aggressive bad-debt collection processes and turning away consumers with outstanding balances due.

[22] Profit rates were calculated as the difference between gross patient care revenue and total patient care costs (*i.e.,* net income from patient care activities), divided by gross patient care revenue. Mean profit margins reported here are somewhat lower than those reported elsewhere, for two reasons: (1) for the purposes of this study profit margins are based on patient care revenue rather than total revenue; and (2) profit margins are aggregated to the county or MSA level.

is, HHI = $\Sigma^i 100 * s_i^2$, where s denotes the market share of firm i. This method allows for firms with relatively large market share (e.g., 60 percent) to be more heavily weighted in the index. The HHI index equals 10,000 when an industry or market consists of a single seller. For the multivariate models of mean area profit rates, we assume the county or the MSA to be the relevant geographic market. In addition, since we are primarily interested in the effects of competition, we excluded from the analysis any county or MSA with only one acute care hospital (*i.e.,* counties or MSAs with HHI = 10,000).

The model is specified as a fixed effects panel data regression, which is designed to estimate the impact of the covariates on profit rates both cross-sectionally (county or MSA) and over time (year). This allows for the effects of specialty hospital entry to accrue over time, effects that may not be observable looking only at a cross-sectional snapshot. The regression models are based on 933 counties and 299 MSAs.

Descriptive trend comparisons of mean general hospital profit rates for counties and MSAs are shown in Figure 2 (counties) and Figure 3 (MSAs). The results for counties and MSAs are similar. Mean general hospital profit margins in counties with at least one specialty hospital were greater in all years of analysis. In the county-level analysis, the year 2001 and 2003 differences were statistically significant ($p \leq 0.05$). In the MSA-level analysis, the year 2001, 2002, and 2003 differences were statistically significant ($p \leq 0.05$).[23]

The regression results are consistent with the descriptive findings. The results of the regression model are shown on Table 3 (counties) and Table 4 (MSAs). For each geographic level of analysis, three models are reported: (1) specialty hospital variables are limited to the indicator variable SCP; (2) specialty hospital variables are limited to the total number of physicians admitting patients to the specialty care provider in the market area; and (3) including both specialty hospital indicator variables.

The estimated coefficients of the key variables have the anticipated sign.[24] The key variables of interest are (1) the HHI market concentration measure, (2) an indicator variable for the presence of a SCP, and (3) the number of MDs admitting patients to the specialty care provider. Consistent with economic theory, the models consistently showed that market concentration had a positive effect on profits; that is, as markets become more concentrated, profits increase. Interestingly, we also found that both of the specialty hospital variables were positive and significant in four of the six models, without regard to the geographic unit of analysis. This relationship was remarkably stable, evident in all model specifications tested.[25]

The interpretation of this finding is that, 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. These findings are also consistent with economic theory, which suggests that firms will enter markets in which extant profit margins are comparatively higher.

Table 3

Multivariable Profit Function Regression Models, Dependent Variable is Market Area (County) General Hospital Profit Margin, 1997–2003

[23] In addition, MSA-level year 2000 differences were significant at $p \leq 0.10$.

[24] Note that it is not uncommon in profit models for only a relatively small proportion of the variation in profit rates to be explained by the covariates; the best models often explain between 5 and 20 percent of the variance in profit rates. Our models explain less of the variation because the unit of analysis is the market area rather than the hospital.

[25] The analysis included several variants of the linear equation. For each model tested, the coefficients did not differ significantly from what is reported here.

Independent variable [1]	County		
	(1)	(2)	(3)
	-	-	-
Per capita income	−0.00000143**	−0.00000137**	−0.00000143**
Population density	0.00000218	0.00000203	0.00000219
Inpatient beds per capita	3.47753300**	3.55058200**	3.46631100**
MDs per 1000 pop.	−0.00400460	−0.00421430	−0.00401000
Inpatient days per 1000 pop.	−0.00000524	−0.00000545	−0.00000522
Outpatient visit per capita	−0.00126660	−0.00136540	−0.00126630
Medicare Part A AAPCC	0.00024970**	0.00024770**	0.00024970**
Unemployment rate	−0.00065720	−0.00067840	−0.00065280
Poverty rate	0.00194070**	0.00193060**	0.00194040**
Annual wage (hospital staff)	0.00000017	0.00000023	0.00000017
HHI	0.00000336**	0.00000329**	0.00000338**
1= SCP present	0.03676190**	—	0.03464330**
MDs admitting to SCP	—	0.00032730**	0.00006750
Constant	−0.09486860	−0.09659210	−0.09488130
Number of observations	6424	6424	6424
F	5.34	4.64	4.94
Prob. >F	0.0000	0.0000	0.0000
Overall R-squared	0.0111	0.0125	0.0110

Sources: Survey of ASHA membership, Medicare HCRIS Cost reports,

Area Resource File, and Bureau of Labor Statistics; see section 5.1.1 for description.

Notes: *Significant at p ≤ 0.10 (t-test); **Significant at p ≤ 0.05 (t-test)

5.2 Physician Self Referral

Multivariable Profit Function Regression Models, Dependent Variable is

Market Area (MSA) General Hospital Profit Margin, 1997–2003

Independent variable [1]	MSA		
	(4)	(5)	(6)
Per capita income	−0.00000073	−0.00000057	−0.00000072
Population density	−0.00002250	−0.00002380	−0.00002260
Inpatient beds per capita	7.56830900*	7.51012900*	7.52111000*
MDs per 1000 pop.	−0.01176980	−0.01183570	−0.01174600
Inpatient days per 1000 pop.	0.00000699	0.00000783	0.00000686
Outpatient visit per capita	−0.00283480	−0.00287550	−0.00286490
Medicare Part A AAPCC	0.0003083**	0.00031420**	0.00030700**
Unemployment rate	−0.00269240	−0.00274240	−0.00261580
Poverty rate	−0.00127800	−0.00156110	−0.00131490
Annual wage (hospital staff)	−0.00000064	−0.00000061	−0.00000064
HHI	0.00000395*	0.00000360	0.00000399*
1= SCP present	0.0323107**	—	0.02809040**
MDs admitting to SCP	—	0.00032330**	0.00013120
Constant	−0.01532120	−0.01553810	−0.01475440
Number of observations	1465	1465	1465
F	4.00	3.39	3.75
Prob. >F	0.0000	0.0001	0.0000
Overall R-squared	0.0454	0.0415	0.0462

Sources: Survey of ASHA membership, Medicare HCRIS Cost reports,

Area Resource File, and Bureau of Labor Statistics; see section 5.1.1 for description.

Notes: *Significant at p ≤ 0.10 (t-test); **Significant at p 5≤ 0.05 (t-test)

5.2 Physician Self Referral

The remaining policy issue is the potential effects of physician self-referral. The costs and benefits of physician self-referral has been debated for many years, mainly

because the dominant physician payment mechanism in the U.S. has been and continues to be fee-for-service, which creates financial incentives for self-referral. In the case of specialty hospitals, the general argument against physician self-referral is that physician ownership may result in financial incentives to admit patients to the facilities in which they have an ownership stake. These arguments are to some extent based on research that has found that utilization of ancillary services is higher when an ownership relationship exists between referring physicians and ancillary services (Mitchell and Sass 1995; Lynk and Longley 2002; Kouri, Parsons, and Alpert 2002; Zientek 2003; O'Sullivan 2004). However, there are at least four important limitations to applying these arguments to acute care hospitals.

First, the vast majority of studies of higher utilization resulting from self-referral are based on physician ownership of *ancillary* services, rather than acute care hospitals. Mitchell and Sass (1995), in their frequently cited study of physician referral, failed to find higher utilization rates associated with self-referral to acute care hospitals. This lack of association has been one of the main reasons that the two phases of Stark anti-kickback legislation have exempted physician ownership of acute care hospitals (Stout and Warner 2003; Rohack 2004; O'Sullivan 2004). In addition, there is no direct evidence that the observed higher utilization rates resulting from self-referral to ancillary services represent inappropriate or unnecessary care (Kouri, Parsons, and Alpert 2002; Zientek 2003).

Second, there is no direct evidence that physician self-referral is motivated disproportionately by financial incentives. Physician self-referral is motivated by four factors: appropriateness, quality, efficiency, and financial returns. The relative magnitude of each of these incentives has been the subject of debate, but there is no direct evidence to suggest how, on average, physicians assign weights to each factor. Consistent with the empirical findings, anecdotal evidence suggests that physicians may disproportionately weight financial incentives when the referral is for standardized products or services (e.g., lab or pharmacy), and disproportionately weight appropriateness and quality when the referral is for more intensive procedures, such as surgery (Moore 2003).

Third, there is no evidence that self-referrals result in worse outcomes than other types of referral (Kouri, Parsons, and Alpert 2002; Zientek 2003). A likely reason for these findings is the endogeneity of three factors: physician quality, the likelihood of self-referral, and the quality of patient outcomes. In the case of specialty hospitals, site visits and trade press literature indicate that physician investors in specialty hospitals tend to be those who highly value efficiency in quality and cost dimensions. Thus, for many physician investors, self-referral is likely to represent the most optimal referral in terms of quality and cost.

Fourth, in the case of physician ownership of acute care facilities, it is likely that the magnitude of financial incentives is limited. The General Accounting Office (2003a) found that 30 percent of specialty hospitals surveyed had no physician investors. For half of the facilities with physician investors, the average individual physician ownership share was less than two percent. In the ASHA survey, virtually all physician investors owned only five percent or less (Table 2). Moreover, the entrepreneurial returns (*i.e.,* the fraction of the facility fee considered operating margin) for any single case are likely to be substantially less than the professional fee charged by physicians. Given the order of magnitude difference between these two revenue streams, physician incentives are likely to be driven more by professional fees, which do not vary significantly by practice setting.[26] Indeed, in this context the potential for a surgeon to enhance his or her own productivity is a more likely source of financial incentive for self-referral to a specialty hospital. In other words, the primary financial motivation may be to enhance the return on investment for the surgeon's investment in "human capital" (associated with the number of procedures performed)[27] rather than any effort to assure a return on investment in the form of financial assets (associated with the overall financial performance of the hospital).

In terms of policy options, even if we were to assume that these limitations were not important, a more central question is whether creating barriers to market entry are the most appropriate means of addressing the issue. The net social welfare losses associated with barriers to market entry are likely to be greater than those

[26] It should also be noted that high variation in utilization and referral patterns exist without respect to physician ownership. For example, Weinstein et al. (2004) recently observed significant variation in utilization patterns for major surgery for degenerative diseases of the hip, knee, and spine in several South Florida hospital referral regions where there are no physician-owned specialty hospitals.

[27] Refer to section 3.4

attributable to physician referral incentives, particularly in light of the weakness of these incentives.

6. CONCLUDING REMARKS

In this study we have reviewed the theory and evidence on some of the key characteristics of specialty hospitals, including efficiency, demand, case mix, and quality. These findings were supported by observations from five specialty hospital site visits. We also conducted statistical analyses of the effects of specialty hospitals on the profit margins of general hospitals. The main findings of the study can be briefly summarized in the following three points.

First, there are economic advantages associated with specialization, due mainly to process redesign, learning, avoidance of diseconomies of scope, and focus on core competencies. Specialty hospitals appear to have equal or better patient outcomes compared to their general hospital counterparts. Hence, there is no evidence to suggest that specialty hospitals should be barred from entering acute inpatient care markets on the basis of efficiency or quality of care.

Second, there is no evidence, other than anecdotal, to suggest that general hospitals have been financially harmed by competition from specialty hospitals, or that such competition is undesirable from a societal perspective. Specialty hospitals compete with general hospitals in the same manner in which general hospitals compete with each other. 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. General hospitals in less competitive markets (*i.e.,* those with fewer competitors) had higher profits than general hospitals in less competitive markets. 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. These findings are also consistent with economic theory, which suggests that firms will enter markets in which extant profit margins are comparatively higher.

Third, though often cited as a significant policy concern, there is no evidence that physician self-referral is a problem in specialty hospitals. Physician self-referral is likely to play a relatively minor role in specialty hospitals, for four reasons: (1) the vast majority of studies of higher utilization resulting from self-referral are based on physician ownership of *ancillary* services, rather than acute care hospitals; (2) there is no direct evidence that physician self-referral is motivated disproportionately by financial incentives; (3) there is no evidence that self-referrals result in worse outcomes than other types of referral; and (4) in the case of physician ownership of acute care facilities, it is likely that the magnitude of financial incentives is limited.

APPENDIX A

2004 Survey of Specialty Hospital

Instruction:

1. These results will be kept strictly confidential. Under no circumstances will the data leave the control of ASHA and its principal contracted researcher, John Schneider. *Only aggregate data will be presented publicly* (e.g., means and standard errors).

2. All responses, unless otherwise noted, should refer to your *previous full fiscal year*. If your facility has not been open for an entire fiscal year, indicate so at the beginning of the questionnaire. Also, unless otherwise specified, responses should refer to the *main patient care facility*.

3. Please answer each question as accurately as possible. In the event that it is not possible to answer a question, use the following codes: Unknown = **DK**, Refused = **RF**, Not applicable = **NA**. Before resorting to these codes try to at least provide a reasonable estimate.

4. For technical questions contact John Schneider at john-schneider@uiowa.edu or 319–331–2122.

Question	Response
1. Name of facility:	
2. Zip code (main patient care facility)	
3. Has your facility been open for at least one whole fiscal year? (1=Yes; 0=No)	
4. Beginning date of most recent full fiscal year (MM/DD/YYYY)	
Licensing & Accreditation	
5. Is your facility licensed in your state as an inpatient hospital? (1=Yes; 0=No)	
6. Accredited by Accreditation Association for Ambulatory Health Care? (1=Yes; 0=No)	
7. Accredited by Joint Commission on Accreditation of Health Care Organizations (JCAHO)? (1=Yes; 0=No)	
8. Other accrediting organizations (1=Yes; 0=No) Specify:	
History	
9. First calendar year in which facility was licensed as inpatient hospital	
10. First calendar year in which beds were added, if different from Q9	
Beds and Capacity	
11. Total bed capacity	
12. Number of staffed inpatient beds	
13. Number of operating rooms	
14. Number of intensive care beds	
15. Number of recovery beds (all stages)	
16. Do you maintain & staff an urgent/emergent care center? (1=Yes; 0=No)	
17. If Q16 = yes, how many hours per day is the care center staffed?	
Ownership Structure (Q21–Q24 sum to Q20)	
18. Total number of owners	
19. Total number of physician owners	
20. Total number of physician owners who admit[28] at least 5 patients per year	
21. Number of physicians in Q20 with 0–1% ownership stake	
22. Number of physicians in Q20 with 2–5% ownership stake	
23. Number of physicians in Q20 with 6–9% ownership stake	

Question	Response
24. Number of physicians in Q20 with 10% or more ownership stake	
Volume and Case Load	
25. Number of inpatient discharges	
26. Number of inpatient days (overnight stay)	
27. Number of inpatient days (observation days)	
28. Number of surgeries (overnight stay)	
29. Number of outpatient surgeries (no overnight stay)	
Patient Care Revenue	
30. Total gross patient care revenue (inpatient + outpatient)	$
31. Outpatient revenue as percent of total gross patient revenue (Q30)	%
Sources of Patient Revenue (Q32–Q35 sum to 100%)	
32. Medicare revenue as percent of gross patient revenue	%
33. Medicaid revenue as percent of gross patient revenue	%
34. Commercial (private health plan) insurance revenue as percent of gross patient revenue	%
35. Other revenue as percent of gross patient revenue	%
Charity Care	
36. If your state has a charity care risk pool, do you pay into it? (1=Yes; 0=No)	
37. If the answer to Q29 was yes, indicate annual amount paid into risk pool	$
38. Charity careas a percentage of gross patient care revenue	%
Taxes Paid [29]	
39. State income tax paid previous tax year	$
40. Federal income tax paid previous tax year	$
41. Property tax paid previous tax year	$
Expenses and Income	
42. Total operating expenses	$
43. Net income after all expenses but before taxes	$
Nurse Staffing	
44. Total number of full-time equivalent (FTE) RNs	
45. Average patient to RN ratio (e.g., for 3:1 write “3;” for 5:1 write “5”) [30]	

Question	Response
Quality	
46. Do you employ a computerized physician order entry (CPOE) system? (1=Yes; 0=No)	
47. Do you employ an electronic medical record (EMR) system? (1=Yes; 0=No)	
48. Do you attempt to collect patient satisfaction data on all patients post-discharge? (1=Yes; 0=No)	
49. Percent of admitting physicians with admitting privileges at community / general hospitals in market area	%
50. Number of admitted inpatients transferred to community / general hospitals in market area	
51. Do you have a transfer arrangement with one or more community / general hospitals in market area? (1=Yes; 0=No)	
Competitors	
52. Number of inpatient hospitals in market area which you consider to be competitors	
53. Number of outpatient surgery centers and clinics in market area which you consider to be competitors	

[28] Admitted for inpatient care

[29] All tax information should refer to the most recent full tax year. Facilities organized as partnerships typically allocate taxes to owners. In these cases please provide and estimate of the total tax liability for the entity for all owners combined.

[30] Patient to nurse ratios are expected to vary by stage of care (*i.e.,* first and second stage recovery) and by shift. For this question, estimate an overall facility average; *i.e.,* report the average number of patients per RN across all stages of care.

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Focus On Therapeutic Outcomes, Inc.
Knoxville, Tennessee 37909
March 18, 2005

The Honorable Nancy Johnson, Chairman
Subcommittee on Health
House Ways and Means Committee
U. S House of Representatives
Washington, DC 20515

Dear Chairman Johnson:

Focus On Therapeutic Outcomes, Inc., (FOTO), a national medical rehabilitation outcomes database designed for providers, patients and payers of rehabilitation care, is pleased to submit this statement for the record in conjunction with a hearing conducted under your leadership by the Subcommittee on Health of the House Ways

and Means Committee on March 15, 2005. The hearing provided the Subcommittee an opportunity to hear what CMS is doing to relate physician payment to quality and to learn what some physician groups are able to achieve with their systems of quality improvement.

Due to a paucity of outcomes measures at this time, considerable discussion revolves around the use of process measures and claims data and perhaps a combination of the two. As was mentioned by two of the witnesses who testified at the hearing, valid and reliable outcomes measures are needed and in order to use such measures as a basis forreimbursement, precise risk-adjustment is essential.

Perhaps no other area offers such a unique and ripe opportunity for paying on the basis of outcomes than the rehabilitation therapies. Valid and reliable functional outcomes measures currently exist in rehabilitation and precise risk-adjustment is available to facilitate the development of a pay-for-performance process in the outpatient rehabilitation therapies. Moreover, given the impending expiration of the moratorium on the therapy cap, it could not be more timely to explore pay-for-performance as an alternative payment method required by the Balanced Budget Act of 1997.

FOTO, the leading purveyor of valid and reliable outcomes measures for outpatient rehabilitation therapy has amassed records from over 1.6 million patients treated by more than 13,000 clinicians in twelve years using scientifically-based, valid and reliable assessment instruments, which determine a patient's level of function prior to intervention, periodically during intervention and at the conclusion of rehabilitation intervention. These data reflect changes in functional health during the rehabilitation experience. The data are used to assess and predict resources necessary for specific patient interventions including the appropriate number of visits, time and amount of improvement to be expected. In addition, the data reflect patient satisfaction resulting from the rehabilitation experience. Results are tabulated and reports are benchmarked to the national database, which is privately owned, confidential and independent of all providers and payer-related organizations. The robust FOTO database has been compiled from more than 13,000 clinicians in over 1500 outpatient rehabilitation customers who are primarily hospital outpatient departments, therapy clinics and physician offices. The data collection process is independent of the type of provider, and therefore it is applicable to patients treated by chiropractors and many physicians who treat patients with physical function deficits.

The FOTO Experience

FOTO uses instruments that have been proven scientifically valid and reliable and have their origin in widely known and accepted instruments, such as the SF–36, SF–12, Lysholm Knee Inventory, Oswestry Low Back Pain Questionnaire, Neck Disability Index, Lower Extremity Functional Scale, Shoulder Flexi-Scale, and Back Pain Functional Scale. Through extensive research, much of which is published in peer-reviews journals, FOTO has used these instruments to develop a patient-friendly survey instrument that provides highly accurate information describing physical function and patient satisfaction.

The database is robust with valuable rehabilitation and patient information, so all FOTO reports are risk-adjusted. Risk-adjustment allows appropriate case-mix adjustment, which improves appropriate patient comparisons. FOTO uses risk-adjusted data to predict the number of visits necessary and degree of benefit derived from rehabilitation. No other acute rehabilitation outcome system combines outcomes and efficiency to allow payers to utilize outcomes data as a basis for provider reimbursement. The ability to accurately predict resources necessary to accomplish successful rehabilitation is of profound value to providers and payers as continued strides are taken to improve quality, enhance patient satisfaction and contain health care costs.

Implications

Retrospective analysis of the database has allowed FOTO to develop predictive models. Such information enables clinicians to practice evidence-based rehabilitation, payers to determine appropriate use of resources, employers to save money, and patients to feel confidence and express satisfaction knowing their rehabilitation is based on the most accurate, up-to-date, scientific information. Moreover, the data and methodology can be used as the basis of a pay-for-performance system for the outpatient therapies, thus aligning the incentives in rehabilitation therapy.

Aligning Incentives

For nearly two decades employers have been concerned about the rising cost of health care. Business owners have expressed a desire to pay for health care in the same manner used to purchase any commodity; contracting with vendors to provide a service delivered on time, at a known price and quality; and rewarding better-than-standard performance. In 2001, the Institute of Medicine published a land-

mark report, which essentially embraced such a philosophy. Crossing the Quality Chasm: A New Health System for the 21st Century, outlined a strategy that included broad themes to make healthcare safer and more accountable and called for an alignment of incentives in health care delivery. That is, incentivizing health providers for the delivery of high-quality care.

The March to Pay-for-Performance

In recent years numerous public and private sector developments have demonstrated a growing interest in value purchasing in health care delivery.

- The Medicare Modernization Act (MMA) of 2003 included a number of health care quality provisions and demonstrations including theHospital Quality Initiative and a pilot program with members of the Premier alliance of not-for-profit hospitals.
- In their 2004 publication Pay for Performance's Small Steps of Progress,

PriceWaterhouseCoopers reported that as many as one-third of health plans indicate they have a pay-for-performance program in place.

- In testimony before this subcommittee on February 10, 2005, Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC), stated that a good pay-for-performance program would reward absolute high levels of quality and those showing significant improvement. In addition, risk-adjustment is needed because providers treating the sickest patients should not be penalized for failing to show enough improvement on quality measures. Hackbarth went on to suggest that providers should be held accountable on measures that are within their control and that patient experience should be introduced as soon as means are available to collect such data. For example, rehabilitation providers should be judged on patient functional improvement.

With the availability of FOTO's robust, risk-adjusted database, which precisely quantifies functional improvement, it is indeed possible to judge and reimburse rehabilitation providers and suppliers on the basis of their patient's functional improvement.

The National Quality Forum (NQF) has identified various components that will make introduction of value purchasing acceptable and even appealing to all health system stakeholders:

1. Choosing and using quality measures that:
   - have a clear and compelling application,
   - do not impose an undue burden on those who provide data,
   - help providers improve quality of care, and
   - help consumers select plans, providers and/or treatments.

These quality measures should be held constant over time to permit benchmarking and measurement improvement and be open to improvement based on the scientific approach to care. The process should use risk adjusting for more accurate benchmarking and have audit standards for assessing implementation.

2. Voluntary approaches to quality measurement and reporting have failed to engage the entire health system. On the contrary, mandating participation and reporting increases compliance, bolsters data accuracy and value, and has potential to create a system that is more equitable for all stakeholders. Once captured, data must be routinely and publicly reported in a common set of measures.

3. Quality measures should possess the integrity that allows benchmarking individual patients to a national standard as well as measuring results of care on a patient-by-patient basis. Thus, information can be used to guide and accurately assess benefits of treatment. Data can be used as the basis for determining payment predicated on a comparison of results of intervention to the time, cost and quality parameters revealed by the database.

FOTO, Inc., has developed a Value Purchasing Payment Algorithm©, a methodology for the rehabilitation therapies that is consistent with the above NQF criteria, with the recommendations of MedPAC and of the Institute of Medicine. The Focus On Therapeutic Outcomes, Inc. value purchasing process for outpatient rehabilitation services rewards higher quality of care (*i.e.,* better functional outcomes) and more efficient rehabilitation services (*i.e.,* fewest possible visits).

The process is based on risk-adjusted patient self-report of functional abilities and an established number of rehabilitation visits provided per episode as determined by the robust FOTO database. Clinician/patient episodes are classified according to whether the number of visits for a patient was less than, the same as, or exceeded the predicted (established) number and whether the patient's change in functional health status was below, equal to, or greater than predicted by the database. The

number of visits required and the change in functional health status expected, are risk-adjusted by diagnosis, severity of functional ability, age and acuity of symptoms. Clinicians are reimbursed in accordance with their performance compared to the risk-adjusted data provided by FOTO. Clinicians with patient experiences that are more efficient (fewer visits) and more effective (better outcomes) are paid a bonus. Clinicians who are less efficient (more visits) and less effective (worse outcomes) are penalized. The patient interface is an attractive, user-friendly computer program that provides valuable functional information to the clinician for timely patient treatment. Once the necessary data are submitted, visit and functional outcomes data are matched to the risk-adjusted payment algorithm. In short, it is clinically relevant, easily collected data that creates a system change that empowers and incentivizes clinicians to deliver the most effective care in the most efficient manner.

FOTO joins other organizations who have submitted statements on this topic in supporting continuation of demonstration projects and studies on pay-for-performance. Such activities should be extended to the rehab therapies in an effort to develop and refine suitable alternatives to the therapy caps. Paying for results allocates resources to what is effective in caring for patients while shifting away from care that is ineffective, costly and possibly fraudulent. The FOTO value purchasing process for outpatient rehabilitation services results in: *Care Based on Need—Payment Based on Results.*

Business and industry have been paying for performance for decades and leaders in the business community have difficulty understanding why all health providers are paid the same irrespective of the end result. "What can be more American than pay-for-performance," they ask. Progressive businesses, the ones recognized with awards for high-quality, are pleased to see the "American way" coming to health care.

Health care quality has long been talked about, but progressive organizations who are now "walking the walk" are considered leaders in the field. These leaders are discovering that using data with valid and reliable quality indicators is the most efficient, clinically-relevant and administrative friendly way of aligning the incentives described in *Crossing the Quality Chasm.* Focus On Therapeutic Outcomes, Inc., is one of these leaders and is eager to share its vast experience, robust database and valid and reliable methods with the committee, the Congress and CMS in an effort to hasten the alignment of incentives in the delivery of outpatient rehabilitation services.

Thank you for the opportunity to submit comments on this important and timely issue and, more importantly, thank you for the leadership in pursuit of efforts to obtain better value for the Medicare dollar.

Sincerely,

Ben Johnston, Jr.
Chief Executive Officer

Based on Need—Payment Based on Results

Value Purchasing in Rehabilitation

Focus On Therapeutic Outcomes, Inc

Knoxville, TN

Focus on Therapeutic Outcomes

F O T O

FOTO

- A national outcomes database
- In existence for thirteen years
- Over 1500 providers
- Over 1.6 million patients
- Over 13,000 clinicians

Designed for providers, patients and payers of outpatient rehabilitation care

- Uses scientifically-based, valid and reliable assessment instruments, which determine the:
  - Severity of a patient's condition.
  - Patient's response during treatment.
  - Effectiveness of intervention.
    - Patient's level of function
      - Prior to intervention
      - Periodically during intervention
      - At the conclusion of rehabilitation intervention
  - Patient's satisfaction with the rehabilitation experience.
  - Appropriate resource utilization.
    - Predict the expected duration (# of visits) of treatment
    - Predict expected outcome

Risk Adjustment

- The ability to accurately predict the resources necessary to accomplish successful rehabilitation.
  - Robust database
  - Valuable rehabilitation and patient information
  - Able to predict
    - Number of visits
    - Satisfactory outcome

Analysis

- Results and reports are risk-adjusted and benchmarked to the national database.
- Analyses are independent of provider, payer or national association
- Amount of improvement per visit.
- Amount of improvement per dollar spent
- Wide variety of patient conditions, payer types and treatment settings.
- Results used to predict and manage care.
- Patient satisfaction with the rehabilitation experience.

Implications

- Clinicians enabled to practice evidence-based rehabilitation using benchmarked reports to direct and validate treatment choices.
- Payers obtain the reliability to determine the appropriate use of resources.
- Patients get the confidence and satisfaction associated with the knowledge that their rehabilitation is based on the most accurate, up-to-date, scientific information.
- A positive effect on access due to efficient use of patient and staff time.

Conclusion

- This methodology, available now, represents the future—evidence-based rehabilitation.
- Through retrospective analysis FOTO has developed predictive models, which are based on scientifically valid and reliable data-gathering instruments.
- This results in improved quality of rehabilitation intervention at the lowest cost.
- Allows payers to "pay-for-results."

Care Based on Need—Payment Based on Results

Statement of Steven Jones, Little Rock, Arkansas

Ladies and Gentlemen:

My name is Steven Jones, D.O. I am an orthopedic surgeon in Little Rock, AR. I am writing in reference to the Ways & Means Committee meeting on Tuesday. Specialty hospitals must continue to exist. Employees of nearly 100 facilities would be in danger of losing jobs. Whole communities are at risk. **But most importantly, the citizens deserve the right to make their own healthcare decisions and**

the opportunity to access the high quality of care that single specialty hospitals provide. Please do not allow the moratorium on specialty hospitals to continue. Patients must be allowed to have a choice in health care.

I feel opponents of specialty hospitals have misrepresented the industry. Here are the facts:

- Concerns over the so-called cherry picking of profitable patients are eliminated by DRG reform
- The American Surgical Hospital Association is not aware of any facilities that will open within a year of the expiration of the moratorium
- Surgical hospitals serve Medicare and Medicaid patients
- True! 40 specialty hospitals don't have ERs. Also True! 400 general hospitals don't have ERs
- Physician investment averages 2% in specialty hospitals, according to the Government Accounting Office—hardly a conflict of interest
- Studies done in the 1980s show no inappropriate referrals by surgeons and over 85% of specialty hospital cases are outpatient
- Take a look at the general hospitals in your area, more than likely they are expanding, not closing departments or closing their doors altogether
- *The Wall Street Journal* and *The Washington Times* have both supported the industry with opinion pieces.

Statement of Karen Kerrigan, Small Business & Entrepreneurship Council

Chairman Johnson, Ranking Member Stark and Members of the House Ways and Means 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) will soon be presenting 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 is expected to make positive recommendations, including changes to the diagnostic related group (DRG) payment system, they are also expected to 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

[1] Dr. John C. Nelson, "Competition works", *The Washington Times*, 2/10/05

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 them high marks. Specialty hospitals have a very high rate of successful procedures; higher nurse-to-patient ratios; with their innovative care and extra attention to customer service a positive 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 Johnson 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 to oppose the extension of the moratorium on specialty hospital development.

Please do not hesitate to contact me if you have questions about the SBE Council's position on this issue.

Statement of Jane Orient, Association of American Physicians and Surgeons, Tucson, Arizona

Madam 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 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, phy-

[2] Editorial, "In the (Specialty) Hospital", *Wall Street Journal*, 1/3/05.
[3] Editorial, "Bolstering specialty hospitals", *The Washington Times,* 1/24/05

sicians 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.

Statement of John W. Strayer III, National Center for Policy Analysis

Madam 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 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) conducted a study of MedCath Hospitals, a group of 12 heart hospitals across the country, and their impact on neighboring general and community hospitals. The GAO's conclusions found that their cost effectiveness and rate of high positive outcomes outweighs any perceived disadvantages experienced by general and community hospitals.

A study by the Lewin Group compared MedCath facilities 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 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.