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S. Hrg. 109–140

OVERVIEW OF THE COMPETITIVE EFFECTS OF SPECIALTY HOSPITALS

HEARING

BEFORE THE

FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION, AND INTERNATIONAL SECURITY

OF THE

COMMITTEE ON
HOMELAND SECURITY AND
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

FIRST SESSION

MAY 24, 2005

Printed for the use of the
Committee on Homeland Security and Governmental Affairs

U.S. GOVERNMENT PRINTING OFFICE

21–822 PDF WASHINGTON : 2005

For sale by the Superintendent of Documents, U.S. Government Printing Office
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OVERVIEW OF THE COMPETITIVE EFFECTS OF SPECIALTY HOSPITALS

TUESDAY, MAY 24, 2005

U.S. SENATE,
SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT,
GOVERNMENT INFORMATION, AND INTERNATIONAL SECURITY,
OF THE COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:15 p.m., in room SD–562, Dirksen Senate Office Building, Hon. Tom Coburn, Chairman of the Subcommittee, presiding.

Present: Senators Coburn and Carper.

OPENING STATEMENT OF SENATOR COBURN

Senator COBURN. The hearing will come to order. We attempted to delay to wait for Senator Carper. Hopefully, he will be here soon. I would like to welcome each of you here.

The subject of today's hearing is an important one. Congress will soon need to make a decision about continuing a moratorium to prohibit new specialty hospitals from opening. It is my belief that if our Nation is to continue having the world's best healthcare system, we must carefully consider how our actions will impact the healthcare marketplace in both the long and the short term.

This hearing will primarily focus on the effects of competition between and among hospitals in the delivery of medical and surgical services. We will examine a number of issues related to effectiveness and quality of care provided by specialty hospitals, including morbidity and mortality, operating time and time under anesthesia, nursing turnover, patient satisfaction, and efficiency.

Our first panel will include witnesses from the Federal Trade Commission and the Medicare Payment Advisory Commission. We are pleased to have these witnesses give the Subcommittee their views on competition between and among specialty hospitals and community hospitals.

In July 2004, the FTC and the Department of Justice issued a joint report on the role of competition in the healthcare delivery system, "Improving Health Care: A Dose of Competition." This report is the culmination of a 2-year review of our Nation's healthcare system. It discusses the balance that must be struck between competition and regulation in the healthcare marketplace, the impact of certificate of need policies on competition, and hospital subsidies of the uninsured and under-insured in non-profitable areas such as trauma centers.

In March 2005, MedPAC released its study of physician-owned specialty hospitals. The purpose of the study was to compare and contrast the differences between heart, orthopedic and surgical physician-owned specialty hospitals, and community hospitals.

Regrettably, the Federation of American Hospitals and the American Hospital Association declined our invitation to be here today. It is our intention to provide a balanced hearing, including all parties, prior to the June moratorium. The purpose of this hearing is to allow a record to be laid down in the Senate which can be used for future legislative development or to analyze current and future legislation.

This hearing is intended to allow the Senate to consider arguments explaining that specialty hospitals have a pro-competitive effect on the healthcare industry, and that their elimination will reduce competition, decrease quality of medical and surgical care, and eliminate efficiencies produced by these institutions.

I believe that unless we find a way to add a "true dose" of competition to the Nation's healthcare marketplace, the consumer will bear the brunt of our action or inaction. I also want our panelists and the Senate to know that I believe where we stand in healthcare in America today is at a crossroads. We spend 40 percent more per capita on healthcare than any Nation in the world. Yet, our healthcare is not better.

The question is not competition versus no competition. The question is how do we spend the money the best way to get the most people cared for in the most efficient way with the fewest errors and not have redundancy of service and inefficiency as we deliver that care.

Seven percent of the cost of healthcare today is because of the wrong incentives, the incentive of physicians ordering tests not because their patients need it, but because they feel a need to protect themselves from malpractice.

If you look at the cost of pharmaceuticals in our country and the lack of true competition among branded items and patented items that all do the same thing, what you find is there is no competition in those particular brand name drugs treating the same disease under different chemical modalities.

The fact is that competition is the very thing that has been lacking in healthcare. The idea that you can't rate a physician—consumers need to be able to rate their physicians. They need to know if they are a good physician or a bad physician. If they are a bad physician, they need to get better or get out. That is what American consumers deserve. That is what we ought to give them.

So the purpose of this hearing is to allow a good body of information on competition to come before the Senate as we start down the first track—this is not the last; this is the first time, and it is my goal that we will inform the Senate as to the information it needs to make good decisions on how we truly allocate this scarce resource. To not do so, means that for those people who don't have access today, who are under-treated and have minimal access or have lack of affordability, we will be letting down.

I would like to recognize Senator Carper for an opening statement.

Senator Carper, welcome. I am glad you made it.

OPENING STATEMENT OF SENATOR CARPER

Senator CARPER. Mr. Chairman, how are you doing? I apologize for running a few minutes late. We just finished our caucus luncheon and I came as quickly as I could. Thank you to our witnesses for being here.

Mr. Chairman, I am happy to be with you today and our witnesses and our guests to discuss the issue of specialty hospitals and their role and impact on our healthcare system. One of the great things about this job is you learn a lot literally everyday. Sometimes, we learn things we didn't want to know. I didn't know a whole lot about specialty hospitals, so one of the good things that has come out of this is I have learned a good deal. I have got a lot more to learn, I am sure.

We appreciate our witnesses being here and testifying. Just by looking at the expressions on their faces, I can tell they are delighted to be here. Our audience cannot see that, but these guys are happy campers. Particularly, I want to thank Mark Miller and all the folks at MedPAC for the hard work that they have done over the past year and a half since the MMA mandated that they study this issue. One of the things I learned is MedPAC is not a political action committee. My staff said, no, they are not; if they were they wouldn't be coming to this hearing.

We know we have a big task ahead of us to complete in just 15 months, but you have risen to the challenge and we appreciate all the work that you do not just for the Congress, but really for our country.

I am sure we all know that this has been a controversial issue. Over the past decade or so, we have seen the number of specialty hospitals, I think, triple. We don't have any in Delaware, but I understand they have a few in Oklahoma. Proponents of specialty hospitals tell us that they give doctors more say in the management of hospitals, that they provide better quality, more efficiency and higher patient satisfaction. They also say that they inject competition into the healthcare marketplace.

However, I think we ought to keep in mind that in 2003 there were a couple of GAO studies that lead to concerns about specialty hospitals' rapid growth, about the possible conflicts of interest that could exist when physicians have an ownership interest in the hospitals to which they refer, and whether specialty hospitals might represent an unfair kind of competition that could harm community hospitals, and in turn harm our communities by making it harder for hospitals to provide needed care.

These concerns led the Congress to include a provision—I think it was in the 2003 Medicare Modernization Act—which placed an 18-month moratorium on physician self-referral to new specialty hospitals. This provision was meant to serve as a sort of cooling-off period during which the Congress could further study the relevant issues.

The moratorium, I think, is set to expire next month, and I am pleased that we are continuing to examine the issue so that we can decide how best to proceed. The focus of today's hearing is the role that specialty hospitals play in healthcare competition and whether this is the type of competition that we want to foster.

We are going to hear today about whether specialty hospitals do, in fact, result in lower costs or better quality, as their proponents claim, and we are going to hear some different perspectives on that, which is good. MedPAC's work, for example, has shown that care provided by specialty hospitals, in their view, might actually cost more than care provided in community hospitals. Other recently published research has shown that specialty hospitals do not necessarily provide higher quality care.

I, myself, am all for competition as long as it is fair competition. I suspect I speak for most of the people in this room. When it comes to specialty hospitals, I have heard from some people that the competition may not be taking place on a level playing field because specialty hospitals can essentially select their patients, while community hospitals treat everyone in the community, and also have to provide many unprofitable services like emergency care and intensive care services.

However, I have also heard from physicians who believe that investment in specialty hospitals gives them an opportunity to play a larger role in making decisions about how best to provide care. Ultimately, I believe that a shared goal of all involved is to provide the best possible care for all patients, for all conditions, in all facilities. The question we must answer is are we doing just that.

In closing, Mr. Chairman, let me just say I think we would also agree that as a Nation we need to reduce healthcare costs and improve healthcare quality in all sectors of healthcare. We will spend over $1.5 trillion on healthcare in this country this year. Yet, despite this spending, 45 million Americans lack health insurance. For Americans who do have health insurance, premiums continue to rise. Rising healthcare costs are becoming an increasing burden on small businesses and big ones, too, making us less competitive around the world.

One of the things that I hear most, whether it is in Delaware or all around the country, is the need to control rising healthcare costs and improve outcomes. These increasing costs don't correspond to increased quality. Research has shown that the quality of healthcare in the United States varies widely, and as many as 98,000 deaths a year are caused by preventible medical errors.

Finally, I am interested to learn the role that specialty hospitals might have to play in this effort. However, I believe that any competition between specialty hospitals and our full-service hospitals must take place on a level playing field. I am interested to hear the perspectives of all of our witnesses regarding this important issue, and I thank you for coming and for this opportunity.

Thank you.

Senator COBURN. Thank you, Senator Carper.

I am going to ask our witnesses to limit their oral testimony to 5 minutes. Your complete statements will be made a part of the record, and we will hold our questions until our first two witnesses have finished their testimony.

I first would like to recognize John Graubert. He is the Principal Deputy General Counsel of the Federal Trade Commission. Mark Miller is the Executive Director of the Medicare Payment Advisory Commission.

Mr. Graubert.

TESTIMONY OF JOHN GRAUBERT,[1] PRINCIPAL DEPUTY GENERAL COUNSEL, FEDERAL TRADE COMMISSION

Mr. GRAUBERT. Thank you, Mr. Chairman, and I appreciate the opportunity to appear before you today to discuss new entry into hospital competition and related issues.

The Federal Trade Commission has gained familiarity with these issues through the hearings held together with the Antitrust Division of the Department of Justice which led to the report which the Chairman mentioned, "Improving Health Care: A Dose of Competition," issued jointly by the Commission and the Department of Justice in July 2004, as well as through the Commission's substantial experience in enforcing the antitrust laws in healthcare markets.

The joint hearings and the joint report broadly examined the state of the healthcare marketplace and the role of competition and consumer protection in satisfying the preferences of Americans for high-quality, cost-effective healthcare. The joint hearings took place over 27 days, from February through October 2003, following a Commission-sponsored workshop on healthcare issues in September 2002.

The Commission and the Department heard testimony from about 240 panelists, including representatives of various provider groups, insurers, employers, lawyers, patient advocates, and leading scholars on subjects ranging from antitrust and economics to healthcare quality and informed consent.

Together, the hearings and workshop elicited 62 written submissions from interested parties. Almost 6,000 pages of transcripts of the hearings, and all written submissions are available on the Commission's website. In addition, staff of the Federal Trade Commission and the Department of Justice undertook independent research for the report.

Our written statement for this hearing focuses specifically on a few of the issues addressed in this report that relate to new entry among hospitals, and I would emphasize three main points.

First, vigorous competition can have important benefits in the hospital arena just as it has in the multitude of markets in the U.S. economy that rely on competition to maximize the welfare of consumers. Competitive pressure can lead hospitals to lower costs, improve quality, and compete more efficiently. Competitive pressure also may spur innovation and new types of competition.

In hospital markets today, some new entrants specialize and provide only a limited portion of the in-patient and out-patient services that general hospitals tend to provide. Of course, specialty hospitals are not new. In recent years, however, an increasing number of single-specialty hospitals have entered or attempted to enter particular markets to compete with hospitals in providing certain types of hospital services such as cardiac or orthopedic surgery.

Ambulatory surgery centers have emerged to perform surgical procedures on patients who do not require an overnight stay in the hospital, thus providing additional competition to hospital services in this area. Testimony at our hearings reported that this entry has had a number of beneficial consequences for consumers who receive care from these providers.

[1] The prepared statement of Mr. Graubert appears in the Appendix on page 37.

Second, when new firms enter or threaten to enter a market, incumbent firms may seek to deter or prevent that new competition. Such conduct is by no means unique to healthcare markets. It is a typical reaction of incumbents to possible new competitors in any market. In certain circumstances, such conduct may violate the antitrust laws. Antitrust scrutiny, however, sometimes may not reach certain anti-competitive conduct.

For example, the *Noerr Pennington* doctrine immunizes from antitrust scrutiny conduct that constitutes petitioning of the government, even when such petitioning is done to restrain competition or to gain advantage over competitors. Moreover, the State action doctrine shields from antitrust scrutiny a State's activities when acting in its sovereign capacity.

In the context of hospital competition, the combination of these two doctrines can offer antitrust immunity to hospitals or other groups that wish to lobby State officials to deny a potential entrant, such as a single-specialty hospital, the Certificate of Need it may require to open its doors. State CON programs generally prevent firms from entering certain areas of the healthcare market unless they can demonstrate to State authorities an unmet need for their services. The FTC and DOJ report concluded that market incumbents can too easily use CON procedures to forestall competitors from entering an incumbent's market.

Not all States have CON requirements. Indeed, almost all of the recent entry by single-specialty hospitals has taken place in States that do not have CON requirements. Our report recommended that States with CON programs should reconsider whether these programs best serve their citizens' healthcare needs.

Finally, policymakers should consider the extent to which regulatory distortions may affect competition among hospitals and other firms. Although entry by single-specialty hospitals and ambulatory surgery centers has provided consumer benefits, Medicare's administered pricing system has driven in substantial part the emergence of such facilities. Medicare's administered pricing system, albeit inadvertently, can make some services very profitable and others unprofitable.

Several panelists at our hearings expressed concern that single-specialty hospitals and ambulatory surgery centers would siphon off the most profitable patients and procedures under Medicare reimbursement policies, leaving general hospitals with less money to cross subsidize other socially valuable, but less profitable, care.

The FTC/DOJ report pointed out that, generally speaking, competitive markets will eventually compete away the higher profits and super-competitive profits that are necessary to sustain such subsidies. And we concluded that, 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.

The FTC/DOJ report recommended that governments should reexamine the role of subsidies in healthcare markets in light of their inefficiencies and potential to distort competition. Indeed, I note that CMS has underway, as everyone knows, a study of Medicare payment rates that may address some of those issues.

I would like to thank the Subcommittee for inviting the FTC to participate and taking the time to consider our report, and we will be happy to answer any questions later.

Senator COBURN. Mr. Miller.

TESTIMONY OF MARK E. MILLER, PH.D.,[1] EXECUTIVE DIRECTOR, MEDICARE PAYMENT ADVISORY COMMISSION

Mr. MILLER. Chairman Coburn and Ranking Member Carper, I am Mark Miller, the Executive Director of the Medicare Payment Advisory Commission, which is called MedPAC. MedPAC is a small congressional support agency that advises Congress on a range of Medicare issues. The staff reports to 17 commissioners who use our work to make those recommendations to Congress.

The Commission is comprised of 17 members with rotating terms that are appointed by the Government Accountability Office. They come from various parts of the health delivery system and from the health policy sector. For example, there are five physicians, three managers of hospitals and home health agencies, two nurses, a former Senator, a former CMS administrator and two health economists. The Commission was mandated by the Congress in the MMA to report on cardiac, orthopedic and surgical physician-owned hospitals, and I would like to briefly review what we found for you.

The Commission found strong evidence, as did CMS, that specialty hospitals focus on less complicated patients than community hospitals. As you know, Medicare pays a fixed price for an admission at a hospital. In our analysis of the payment system, we found that Medicare systematically overpays for less complicated patients. And the reverse is also true; Medicare underpays for more complicated patients.

We found that physicians are investing in specialty hospitals that focus on the type of patient that Medicare overpays. Since Medicare overpays for these less complex patients, specialty hospitals have a greater ability to earn profit whether or not they develop efficiencies.

In the Commission's view, this is an unlevel playing field. Our report contains a set of payment recommendations that would create a more level playing field among all hospitals. A fair payment system would allow hospitals to profit through efficiency rather than simply through the patients that they focus on.

There were several other questions in the mandate, and to touch on those, the Commission found mixed results on whether specialty hospitals are more efficient than community hospitals. On the one hand, they did find that they had shorter lengths of stay, which is a measure of efficiency. However, we could not establish that they had lower costs per case. It is important to note that this is the kind of result that could change if one examined this market later in its development, the specialty hospital market.

The Commission report finds that the appearance of a specialty hospital in a market generally did not increase the number of services provided per beneficiary, which is one of the fears that people had. However, what this means is that specialty hospitals tend to

[1] The prepared statement of Mr. Miller appears in the Appendix on page 63.

get most of their business from community hospitals that are existing in the market.

Turning to another question that the Congress asked us, the impact on community hospitals, we found that they experience small reductions in their Medicare revenues, but they appear, so far, to be able to compensate for this loss. We reached that conclusion because their overall profitability appeared to be unaffected by the entrance of the specialty hospitals in their markets. Once again, it is important to note that this is the kind of result that could change, depending on how mature the market was.

The Commission found that specialty hospitals serve fewer Medicaid patients than community hospitals, although there is some variation depending on whether a specialty hospital runs a fully operating emergency room. The Commission found that cardiac hospitals get about two-thirds of their patients from Medicare and orthopedic and surgical hospitals get about two-thirds of their patients from private payers.

The Commission recommended that the current moratorium be extended another 18 months beyond the 18 months that were included in the MMA. The Commission reached this conclusion for several reasons: The evidence that I pointed out that specialty hospitals tend to focus on patients where Medicare overpays, and wanted to give the Congress and the Secretary time to make changes to the payment system because the evidence on specialty hospitals' efficiency was mixed.

At the time that we completed our report and turned it in, there were no results on quality. Neither the Cram study, nor CMS's work had been published. Our mandate did not include us looking at quality. It is important to point out that there is continued interest on the part of the Commission in examining the issue of physician investment and its impacts on efficiency in the delivery of care.

One final point about our report. The Commission recommended that the opportunities for gain-sharing be encouraged. Physicians and hospitals should be allowed to share in savings from improved efficiencies, and under current law physicians are often prevented from sharing in those gains.

The specialty hospital physicians we talked to on our site visits often noted that they wanted to work with community hospitals, but pointed out frustrations with the community hospitals and certain barriers. One of those barriers can be addressed by the Congress and the Secretary by expanding gain-sharing.

In summary, I want to be clear. Competition and specialization are not the problem, and specialty hospitals may be an important contribution to competition. However, the immediate problem is that there is an unlevel playing field in Medicare reimbursement that rewards focusing on patients where Medicare overpays and discourages efficiency.

I look forward to your questions.

Senator COBURN. Well, thank you for your testimony.

Let me go to you, Dr. Miller, first. Since there are no new specialty hospitals out there, how is 18 months more going to help you make a better decision? I know we have to do some payment changes, but how does 18 more months of no new competition in

healthcare make a difference in terms of the data that you are going to collect?

Mr. MILLER. Actually, there is additional data that would come in. We had to look at 2002 data for the purposes of doing our analysis because many of the questions that Congress asked us were empirical in nature. Between 2002 and 2003, there are more specialty hospitals that actually entered the market. I think our sample size could actually be significantly larger and would allow us to look at more hospitals.

Senator COBURN. What is "significantly" to you?

Mr. MILLER. We have 48 specialty hospitals in our sample. I think we could have that number again if we looked at an additional year.

Senator COBURN. And what would you expect to change in that year?

Mr. MILLER. There are two or three things that I think potentially could change. The finding on cost, for example, when I laid that out for you—it is actually more subtle than that. We found that costs in specialty hospitals were actually higher than community hospitals, which is completely counterintuitive. And as analysts, we entered this analysis expecting to find the opposite. It may very well be that in a more mature specialty hospital market, that result would be different.

To give you another side of the argument, we also found that there was no impact on community hospitals, and here again the results were trending in a direction showing that Medicare revenues, for example, were being affected. That may be the kind of thing that, over time, you saw a clearer impact of the specialty hospitals on community hospitals.

Senator COBURN. Let me ask you a question about level playing field. You are stating that maybe the payment rates are too high for certain procedures and that those tend to be moved to a specialty hospital. And therefore they have revenue with less costs associated with them, but yet they are not more efficient by your own testimony. That doesn't create an unlevel playing field.

If, in fact, their costs are higher, it is not an unlevel playing field if the margin between them is less for those that are going to a specialty hospital by your very testimony. So if, in fact, that is the case and we continue to study this for 18 months, how would you account for the fact that the community hospitals don't pay income taxes and don't pay property taxes? That is an unlevel playing field in the opposite direction.

So when you size it all up, how do you get 18 months more data that shows a significant level or unlevel playing field? It seems to me you can take that argument either way. It is unlevel in terms of the tax structure afforded to community hospitals in property tax and income tax versus supposedly a cost benefit in a private hospital, which your own study says wasn't the case. It is not more efficient, although their length of stay is significantly less, their complications are significantly less, their infection is less, but their cost isn't less. Explain that to me.

Mr. MILLER. You have a lot of questions in there, so let me just get this down. The first thing I want to address is the notion of the tax treatment. This is not an area that we have studied. In terms

of whether that is fair or unfair, there is nothing that the Commission has done that——

Senator COBURN. Well, let me interrupt you for a minute. If you are going to look at level playing fields and you are going to look at revenues versus costs, versus bottom line, because that is where capital comes from to reinvest in the healthcare field, how can you say that on one end we are going to look at an area that creates an unlevel field and in another area we are not going to look at an area that creates an unlevel playing field?

Mr. MILLER. Well, our mandate was to look at specialty hospitals and their role in Medicare, and I think the FTC is also pointing that out. A lot of people view the Medicare payment system as one of the stimuli in this marketplace that drives the development of these hospitals.

Senator COBURN. Is it your viewpoint that one of the main stimuli is Medicare payment rates?

Mr. MILLER. I think it plays a substantial role, yes. Now, to your point on cost, I think the concern is when we found this result that they had higher costs, we were a little perplexed by it and so we talked to people in the specialty hospital industry. They said there could be a lot of things going on. We have higher start-up costs. We may have more staff. We may be paying our staff more. We certainly have more amenities, those types of things.

I don't think those are bad things at all, but the point is that if two hospitals are competing and you are going to provide more amenities, it should be, in our view, on the basis of having a comparable payment for a comparable patient. And if you can produce efficiencies that allow you to provide those amenities, then you should prevail in the market and you should be able to do well. But what happens now is if the specialty hospitals focus on less complicated patients, their payments far exceed what their costs actually are even when they have higher costs.

Senator COBURN. Do you think that the heart hospitals focus on less complicated patients?

Mr. MILLER. Yes. I think there are two things that happen in the heart hospitals, and it is a little bit complicated. They pick DRGs, the payment categories, that are more profitable and then within that there is some patient selection. For orthopedic and surgical, the story is a little bit different. The payment categories they pick are about average, but they definitely have stronger selection where they pick less complex patients.

Senator COBURN. So if the payment changes were made, is it your feeling that we would see less incentive into specialty hospitals?

Mr. MILLER. That is our strong view, and the most important point that our report is trying to make is that a lot of this signal can be removed by re-torquing and re-balancing the payment system.

Senator COBURN. Well, my time is up. We will come back. Having been a practicing physician, I will tell you it doesn't have anything to do with it. The only thing a doctor has to sell is their time, and having that time scheduled efficiently and effectively to where you get time utilization is why doctors—where 6 may own a hos-

pital, but 60 go there to practice, it is because they are accommodating the physicians' efficient utilization of their time.

Senator Carper.

Senator CARPER. Dr. Miller, go back. What was the last thing you said about the most important finding? Say that again.

Mr. MILLER. I am not sure I remember. I am sorry. [Laughter.]

Senator CARPER. Neither do I, but I want to.

Mr. MILLER. In response to this, I think the last thing I said was our most important finding was that we felt that the payment system was distorted and sending an improper signal. Based on the type of patient that specialty hospitals focus on, Medicare tends to overpay. And we believe that through the series of recommendations that are included in our report, you can correct most of that.

Senator CARPER. Run through some of those recommendations in the report for me.

Mr. MILLER. There are three or four recommendations, and I won't get really detailed, but the first and foremost to track on is that you would have an adjustment for the severity of the patient that you see. So the way it stands right now, Medicare's DRG is based on an average, but within that average there is a range of patients. So there are systems that allow you to tailor your payment more precisely to the type of patient you pick up.

Second, these are pretty technical—in constructing the weights, the relative weights paying more for this surgery, less for that, you would use cost instead of charges. We believe there are distortions being entered into those weights because of hospital charging practices.

Third, and this is highly technical—you would derive the average first at the hospital level and aggregate up to the national level instead of starting at the national level. There are a whole bunch of reasons that you do that, but one is that it eliminates some of the differences in charging behavior among the hospitals.

Finally, we make a recommendation that you should adjust the outlier policy to have it tailored more precisely to the category of patient that experiences the outliers. And it is kind of complicated, but the way it currently——

Senator CARPER. Try to say this in a way that even I could understand it, OK?

Mr. MILLER. I will try. As it currently stands, it distorts some of the weights.

Senator CARPER. All right, thank you.

Mr. Graubert, a question, if I could, and I may ask Dr. Miller to respond to this as well. Mr. Graubert, I think your report cites testimony discussing specialty hospitals' better outcomes, and I think better clinical standards and their ability to produce services less expensively. Your testimony also mentions that the entry of specialty hospitals has had a number of beneficial consequences for consumers. However, I don't believe that you elaborate a great deal on what those beneficial consequences are.

Also, since the release of your report—I believe it was last year, 2004—there have been a number of studies that don't necessarily validate the claim that specialty hospitals have higher-quality outcomes or lower costs. MedPAC's work, for example, showed that

specialty hospitals actually had, in their view, higher costs, despite their shorter lengths of stay.

I think there was another study published by a Dr. named Peter Cram in the *New England Journal of Medicine* that reported that in hospitals with similar volumes, mortality for specialty hospitals and general hospitals were really about the same after adjusting for patient severity.

I just want to ask you, if I could, your reaction to some of these newer findings, especially maybe Dr. Cram's work that is published in the *New England Journal of Medicine,* and what do you believe the beneficial consequences of specialty hospitals are to consumers.

Mr. GRAUBERT. Although it is true, Senator——

Senator CARPER. That was a long question, wasn't it?

Mr. GRAUBERT. I will do my best, Senator.

Senator CARPER. Thank you.

Mr. GRAUBERT. It is true that it is difficult to analyze cost of service in this area because of the overlay of administered pricing. What our report did was collect comments of our panelists. We did not independently do a great deal of analysis, and have not since. Our interest is in any meaningful source of potential competition, and it was interesting, I think, that there was quite a bit of testimony that this competition actually was beneficial.

Most of the testimony—and this is cited on page 19 of Chapter 3 of our report; I believe it is Chapter 3, yes—does deal with patient satisfaction issues, quality of care issues. That was predominantly where most of our testimony came. There was not a lot of testimony, I don't believe I can recall offhand, on the actual economic efficiencies of the specialty services. But some of the points have already been mentioned, I think, in terms of patient satisfaction, and also more efficient use of physician services, more efficient scheduling of physician services, more control by physicians over their time.

There was testimony that the cost of care might eventually be lowered because hospital stays were shorter and there were fewer post-operative complications, which is a subject that Dr. Miller had addressed. So I would have to defer to agencies with more of a healthcare-specific mandate to determine, under an administered pricing scheme, how the costs should be reflected.

From a general antitrust enforcement point of view, obviously we believe that competition should solve these problems to the maximum extent possible, and it is intriguing to use that there is a potential here for such competition.

Senator CARPER. Mr. Chairman, if I could, I would like to ask Dr. Miller to comment on this Cram study, as well, whether you believe from the available research that specialty hospitals do provide better quality care.

Mr. MILLER. This was not part of our mandate, but here is what I know about what is out there. The *New England Journal of Medicine* article that you refer to by Peter Cram went through and compared Medicare patients in specialty and community hospitals. He controlled for severity of patient and volume of service. Actually starting off, he found that there was higher quality in specialty hospitals.

Then when he controlled for severity and volume, he found that those differences disappeared, and his conclusion is that there is nothing peculiar to specialization that produces the quality. It is the severity of the patient that you are dealing with and the volume of service that you are providing.

There has been a longstanding point in the literature that says if you treat more heart patients, you have better outcomes. And his point was really those seem to be the drivers here, not so much the specialization. That is one point.

You are certainly aware of the CMS report. The CMS report found a couple of things on specialty hospitals. They found that in-hospital mortality is, in fact, lower among specialty hospitals when you control for severity. But they also found that readmission rates were higher, and that patients were more likely to have to go back into the hospital. So there was something of a mix there, and that is what I understand from CMS, but obviously they should speak for themselves.

Senator CARPER. Good. Thanks very much.

Senator COBURN. Dr. Miller, you talked about the laws that prevent physicians from sharing in cost savings that are in hospitals today and incentivizing physician participation in that. It strikes me as curious that we would say that would be alright, but we have concerns with physician ownership in terms of it might create some other obligation. In every other area in our country where we have markets allocating resources, we get pretty good efficiency.

If, in fact, CMS sends the signal that they are going to readjust rates so that the rates are truly up for those with higher severity of illness, more outliers, better payment for the more complicated patients, significantly lower payment for those with less complications, why in the world would we need to study it any longer? Why wouldn't we want the market to go on and just let it work?

If that is what is going to happen and we all know that is what is going to happen, is that not a signal to the market that people might pause and say if, in fact, I am only doing this so I can cherry-pick patients, I wouldn't come into this since I am not going to have any advantage from cherry-picking patients? Would that not be a signal that would allow the market to truly function as it should?

Mr. MILLER. I think that is a fair point and I think that in the Commission's deliberations, this point was made and discussed many times. There is definitely a view among commissioners that if you aggressively move on changing the payment system, that alone will be sending signals to the marketplace that say don't enter unless you are really here to play for a more efficient or a different kind of product.

However, the Commission is comprised of 17 people, and as I tried to lay out in my opening statement, there were still some remaining concerns. There was this somewhat surprising result that the costs were not lower. There was the surprising result that the effects on the community hospital that people expected to see didn't seem to materialize. So that left some commissioners uneasy. There are also commissioners who—and I tried to be direct about this—have concerns about physician investment and the potential impact

it has on delivery of care. So those issues still remain for some commissioners.

Senator COBURN. But doesn't that disregard the fact that the vast majority of volume done in most of the specialty hospitals is done not by the owners, but by other physicians who are utilizing those hospitals?

Mr. MILLER. I am not sure how to answer that question. I know from the CMS work that physician ownership is related to how much you refer to a specialty hospital. You may be correct that most of what goes on in specialty hospital is unrelated to the owners.

Senator COBURN. But carry that to an extreme. Say I am a cardiac surgeon and I am going to send this patient over there. By the time you get down to the bottom line at a specialty hospital, I might make $30 out of it, or $50 out of it or $70 out of it. What you are asking me to believe as a practicing physician is that $70 times two a day, times 7 days a week, is more important to me than my time efficiency and time utilization.

I didn't see anything in either report, neither yours nor CMS's or anybody else's, that has to do with one of the reasons I think specialty hospitals came into existence, and it doesn't have anything to do with money. It has to do with the ability of physicians to be able to practice.

Mr. MILLER. Can I say something about that? Because actually I think our report does say something about that. I think we were really on point on this. In addition to grinding through all the claims data and doing all the empirical analysis, we went out to specialty hospitals and community hospitals and talked to people, and there was a very clear message.

And I want to be clear about this, because I think you are correct on this point that physicians are very frustrated with community hospitals in certain circumstances and they do feel that it is hard to come in and operate on a set schedule and be efficient about moving that business through. And I think there is some truth to that and I think there are community hospitals, in our conversations with them, who acknowledged it and said we had a wake-up call and we needed to change how we were running our business in order to accommodate these physicians.

Senator COBURN. Isn't that exactly what we want competition to do?

Mr. MILLER. Absolutely, but I also want to make another point, which is you said that this was only worth a few dollars. I mean, that is potentially the case, but think about it this way. If we are talking about a payment rate that significantly overpays on costs, let's hypothesize a group of physicians. You have cleared your fixed costs in the hospitals. You start filling those beds. It is not just $10 and $20 and $30. It can really accumulate. And to be also direct on the other side of the conversation, there were physicians in our site visits who said point-blank, I am doing this in order to increase my income.

Senator COBURN. Well, there is no question about that, but that is why anybody does anything in a market economy. That is why they take risks.

Mr. MILLER. I am not taking issue with that.

Senator COBURN. Before the Hill-Burton Act, the vast majority of the hospitals in this country were owned by physicians.

Let me go back. I want to reinforce for the record that sending a signal by CMS that the rates are going to change—knowing that signal is out there, how will that change anything in terms of your next 18 months of study in terms of anybody coming into the market if there was not a moratorium?

If the rates are going to change, then people are going to make their decisions based on what they perceive the declining rate would be. Why would we want to study it longer when we can have the market allocate much better than CMS has ever been able to market healthcare? My contention is because we are trying to manage this, we are having trouble—you would have to admit we are having trouble managing healthcare costs because we can't find every hole.

Why would we not want the market to allocate that resource, since you are going to send the signal that the reimbursements for those less complicated cases are going to go down?

Mr. MILLER. The only answer that I can offer you is that we at MedPAC agree with that part of your statement that the most important thing to do is to aggressively move on changing the payment system, because we think that there is a clear distortion and we think it is the most important thing to do to reset the clock here and make this work better.

However, I also have to say there are parts of the Commission who remain concerned about the role of specialty hospitals, for some of the reasons that I went through earlier in my statement. That is about as direct as I can be with you on that.

Senator COBURN. Senator Carper.

Senator CARPER. Thanks, Mr. Chairman.

Mr. Miller, I think the MedPAC report recommended that the moratorium on physician self-referral be extended until January 2007, but it did not go so far as to recommend that the moratorium be extended permanently. I believe that the Chairman and Ranking Democrat on the Finance Committee might be looking at an approach that says let's extend the moratorium permanently. I don't know if they have introduced that or not.

The MedPAC report, though, noted "physician-owned providers could have a competitive advantage over other facilities because physicians influence where patients receive care."

Can you discuss with the Chairman, and me, MedPAC's concerns with physician self-referral? Can MedPAC's concerns be addressed solely through adjustments to the Medicare payment system or is there just a larger issue at play?

Mr. MILLER. Let me answer your questions.

Senator CARPER. Thank you. [Laughter.]

Witnesses don't always do that, so it is welcome. [Laughter.]

Mr. MILLER. In fact, when they say that, they probably are not going to.

Senator CARPER. Or sometimes they answer questions, just not the ones we ask.

Mr. MILLER. I think it is important to point out that it is correct that MedPAC did not say extend the moratorium indefinitely, or ban specialty hospitals. In fact, I think the quote is something

along the lines of that would be too severe of a remedy; there may be some promise here or there may be some value here. But nonetheless, the Commission did say extend the moratorium.

On self-referral, the best I could explain it to you, I think, works like this. There were some studies somewhere in the 1990's, I think, that looked at physician ownership of laboratory and imaging services.

Senator CARPER. I remember those.

Mr. MILLER. OK, and if you remember those studies, then you know that there were some eye-popping results there on how much services were generated by physicians who owned imaging services versus physicians who didn't for controlled populations, similar patients, that type of thing, and I mean eye-popping numbers—twice as many MRIs relative to physicians who didn't own MRI machines, 29 percent more CT scans relative to physicians who didn't own them.

Now, to be clear, the Commission also said we are not sure that same concern arises where specialty hospitals are concerned because surgery is often a different prospect than just let's run another MRI on somebody. So it was that kind of concern along with the uncertainty or the lack of clarity in some of our findings on cost, the impact on the marketplace, and the fact that no quality data existed at the time that we finished the report. I think that configuration of results left some of the commissioners concerned about it. But on self-referral, it is the notion that somebody may be generating or routing patients on less than completely clinical grounds.

There was one other thing. I think you said something about would solely——

Senator CARPER. What I said was could MedPAC's concerns be addressed solely through adjustments in the Medicare payment system or is there a larger issue at play.

Mr. MILLER. And here is the best way I think I can explain the situation on the Commission. It may be sufficient to fix the payment system, but at the point when we issued the report on the date it was due, some commissioners still had outstanding concerns. So the report says we need these changes to the payment system. The report even says the Congress could consider lifting the moratorium if the payment system changes and gain-sharing were in place, but also there are still these concerns on self-referral and the Commission might come back to that issue. So that was the best way I could explain how the Commission broke down on that issue.

Senator CARPER. Mr. Chairman, let me ask about just one last issue, if I could, and I am going to direct this again to you, Dr. Miller, and if time permits, I am going to ask Mr. Graubert to comment, too.

One of the concerns that I have heard over and over again about specialty hospitals is that they could be further segmenting our healthcare delivery system, treating well-insured, healthier patients at specialty hospitals, while treating few, if any, Medicaid and uninsured patients. I am concerned about this trend and I know some others are, too, and concerned about an overall trend

in our healthcare system of wide health disparities between the insured and the uninsured, and also minority patients.

It has been brought to my attention that MedPAC may have data that specialty hospitals are treating half as many uninsured minority patients as full-service hospitals. I understand that even in the same market, among patients who all have Medicare coverage, they are still treating half as many minority patients.

Dr. Miller, can you shed any light at all on this issue? Any idea why this is occurring, and should this be the subject of some further study?

Mr. MILLER. I am not sure I can shed light. Just to clarify a couple of things, it is very clear from our analysis when we look at discharge data that specialty hospitals are serving significantly fewer Medicaid patients. There are lots of reasons why that could be the case. We don't particularly have a definitive analysis that says it is the location of the hospital. It could be the contracts that they are involved in. It could be any number of things.

On the issue of the mix of the patients by race, I think my response is the same. Exactly what is generating that kind of pattern is not something that we looked directly at. You can observe it in the data. It is definitely there, as you said, but what generates that actual result I don't think I could say.

Senator CARPER. Mr. Glauber, any idea why we are seeing this kind of data?

Mr. GLAUBER. There is an interesting empirical question there, Senator, and the only data that I can recall that we dealt with in our report was the GAO data, which as I recall showed, in fact, only very modest differences in the Medicare rates of admissions. So as far as we were aware at the time we wrote the report, there was not a very noticeable difference.

There might be other data that we are not aware of and there might very well be a healthcare policy issue lurking here. But, again, from a competition point of view, I don't think that there is an independent problem in trying to encourage competition to the extent possible in the marketplace while simultaneously taking care of any other healthcare policy concerns.

Senator CARPER. Thank you. Thanks to both of you.

Senator COBURN. I just think for the record if you have that data, we ought to have it in the record, if you can substantiate that data. I believe that your report showed like an 8- and a 12-percent community hospital Medicaid rate, and I think there was a 2- or 3-percent difference in Medicare.

Do you have that number available?

Mr. GRAUBERT. I am looking at a table on page 21 of Chapter 3 again, and in the orthopedic hospitals there was a difference of between 8 and 10 percent, cardiac hospitals a difference between 3 and 6 percent, and Medicaid admissions for women's health was 37 to 28 percent.

Senator COBURN. But there is no data in your report or in your report that shows a difference in minority utilization?

Mr. GRAUBERT. I am not familiar with that.

Senator COBURN. And is there any published data that you know that to be factual?

Mr. MILLER. What Mr. Carper is referring to is that there was a data request from the Senate Finance Committee that we responded to, and I believe that is what he is referring to. That was not in the report.

Senator COBURN. But there is no reported data that would show that, in fact, is the case?

Mr. MILLER. At the request of the Senate Finance Committee, they asked us to review the admissions in a data set that is called MedPAR, which is where the admissions come from, and asked us to report it for them by race. The conclusions of that analysis were that there was something like—and these are using the categories that the MedPAR lists patients by. The percentage black was like 3 percent for specialty hospitals, compared to, if I am correct and remember correctly, about 9 percent for other hospitals.

Senator COBURN. And this is race-adjusted for the communities that they are in?

Mr. MILLER. Yes, and that is a really good question. It is looking at hospitals within the given marketplace to control for the fact that you have the mix within a——

Senator COBURN. Would you be so kind as to submit that to this Subcommittee?

Mr. MILLER. Absolutely.

Senator COBURN. Thank you very much.

Senator CARPER. That would be good. Thanks.

Senator COBURN. I just have one other question, if I might ask it, and this is for Mr. Graubert. In June, your report on healthcare competition recommended repealing certificate of need laws because of their anti-competitive effects. Have you been able to quantify the cost that certificate of need laws add to the healthcare system, and if not, are you aware of other studies that have tried to measure this?

Mr. GRAUBERT. I believe we do have some studies that address this question, Mr. Chairman. Now, of course, I should preface this by saying that it is very difficult to measure all of the cost from lost competition because it also includes not only higher prices, but lost innovation, product choice and quality, things that if they are prevented, they are gone.

In our study, we cite a number of studies in Chapter 8, particularly in footnote 37 which I would recommend to you. There is an older study from 1987 that estimated price increases between 4 and 5 percent resulting from the existence of CON laws. A later 1991 study indicated hospital costs approximately 10 percent higher in States that had had CON laws in place for at least 10 years. Then one of the witnesses at our hearings, Dr. Morrissey of the University of Alabama-Birmingham, testified that his research had found price increases up to 20 percent attributable to CON laws.

Senator COBURN. Thank you.

Dr. Miller, aren't all the sub-specialty hospitals or specialty hospitals that receive Medicare reimbursement JCAHO-approved?

Mr. MILLER. Not every hospital in Medicare has to be JCAHO-approved, but it does have to meet Medicare conditions of participation.

Senator COBURN. Is one of those conditions quality control in terms of surgical and medical procedures by the medical staff?

Mr. MILLER. I am not sure I could answer that.

Senator COBURN. I can answer it. Absolutely, if you don't have control on that. The fact is in terms of self-referral for cases that should not be done, in fact, you can't get accredited if, in fact, you don't have a quality control looking at that in terms of utilization review inside any hospital in this country today.

For my profession, I just want to defend it for a minute. Not everybody is a great actor in my profession. I understand that, but I also understand the institutions that are out there, and the physicians in this country are working hard everyday to make sure physicians who are not doing it right are held accountable for not doing it right. Procedures are rarely done on people that are not needed. And I am referring to hospitals; I am not referring to the others.

So I wanted to make the point for the record that the whole purpose for accreditation is to make sure you have the controls in place in a hospital setting to control behaviors that might be susceptible to economic advantage through the lack of a medical ethic that is proper for the care of that patient.

Mr. MILLER. There should be nothing from my comments or the Commission's comments that should be taken as an attack on the medical profession. I don't think anything was meant to imply that a patient in these hospitals was getting inappropriate care. It was just that the patients that were going to those hospitals were less complex and the payment system was missing them.

And if I could just say one other thing, I think it is important to point out that the Commission also looks at the issues much more broadly. I think in the FTC report they say something along the lines of you need to reward for quality. Physicians are rational animals like anyone else and if you can incent those types of things—and there were a series of recommendations that MedPAC made for inside the Medicare program to pay more on the basis of quality. So nothing should be taken as an attack on the medical profession here.

Senator COBURN. No, but I think it is important for us when we talk about self-referral in specialty hospitals. The people I know who have an interest in specialty hospitals—it is about giving their patient the best care and the most timely care and the most efficient care, and controlling their own schedules in doing that, rather than self-referral for their own advantage.

Now, there is no question that there is competitive advantage. That is why they put their investment into the hospital, but it goes back to the point I said earlier. In most of the specialty hospitals in Oklahoma, the number of doctors who are on staff who have no ownership far outweighs the number of doctors who are on staff that have an ownership.

And you have to ask the question, why are they there? Why are they coming? If they get nothing financially out of it, why are they utilizing those services? That is an important question that needs to be asked by you all as you look at this.

I have several questions I would like to submit for the record and ask that you return them with answers within 2 weeks, if there is no objection by my counterpart. And I want to thank you so much

for your forthright testimony and the hard work that you have done in this area.

Mr. MILLER. Sure. I appreciate it.

Senator COBURN. Thank you. Let me welcome our second panel, and I appreciate all of those of you who have traveled and made an effort to be here for this Subcommittee hearing. Senator Carper had to attend another hearing and will not be with us for this second panel. However, your complete testimony will be made a part of the record and I would ask you, if you would, to limit your oral testimony to 5 minutes.

On our second panel is Regina Herzlinger. She is the Nancy R. McPherson Professor of Business Administration, School of Business, Harvard University. Next is a well-known acquaintance of mine from Oklahoma, Dr. Stan Pelofsky, President, Neuroscience Specialists, and owner of Oklahoma Spine Hospital, and associated with a very good friend of mine, Dr. Jim Oder; John Thomas, Senior Vice President and General Counsel, Baylor Health Care System; Dr. James Cain, a practicing family physician from Lampasas, Texas; Ed Jungbluth, heart patient, Albuquerque, New Mexico—welcome; and Dr. Plested, Immediate Past Chair, Board of Trustees, American Medical Association.

I welcome each of you, and Dr. Herzlinger, if you would start, please.

TESTIMONY OF REGINA E. HERZLINGER, PH.D.,[1] NANCY R. McPHERSON PROFESSOR OF BUSINESS ADMINISTRATION, HARVARD BUSINESS SCHOOL, BOSTON, MASSACHUSETTS

Ms. HERZLINGER. Thank you, Dr. Coburn, ladies and gentlemen. It is a pleasure to be here. I am going to talk about healthcare competition from the perspective of healthcare in our economy.

We are very fortunate to live in the United States. We are fortunate in many ways, but we also have the highest GDP per capita among the countries in the world. The reason we have it is we have the highest rate of growth of productivity among developed countries in the world. Productivity comes from innovation.

It is unfortunate that this moratorium and the recommendations by MedPAC to extend it kill off one of the best chances for productivity in the healthcare system. It is unfortunate because, although we have such record high GDP per capita, our healthcare costs are killing national competitiveness.

General Motors' financial problems can be traced directly to its healthcare costs. It is difficult to compete with countries that have far lower healthcare costs. At 15 percent of GDP, one out of every seven dollars, our healthcare costs are the highest in the world and they rise at record rates.

Hospitals account for the most significant portion of our healthcare costs and they are the number one reason that they are rising. Innovation in hospitals would lead to productivity and productivity would increase our competitiveness when it comes to healthcare costs.

[1] The prepared statement of Ms. Herzlinger appears in the Appendix on page 74.

Now, my colleagues here will talk about why specialization in healthcare is so good, but generally, specialization in our economy does two things. It makes things cheaper. It makes things better.

When it comes to healthcare, specialization has another asset that nobody has addressed and that is the infrastructure of our nonprofit community hospitals is very old. It is going to have to be replaced and it will cost the taxpayers a great deal of money to do that. Specialty hospitals are investor-owned. It will be the private sector that provides that capital and not the public sector.

Now, what do we know about specialization from the rest of our economy? We know it is critical. For example, Nucor, which is a specialty steel company, almost singlehandedly revived the steel sector. Here are some of the results from Nucor. It takes one man-hour to make a ton of steel. The rest of the industry takes three man hours. Its workers earn $60,000 per year, mostly from bonuses based on productivity. They are treated like owners, whereas the unionized workers in the rest of the industry earn $50,000. Nucor made huge profits while the rest of the industry lost an enormous amount of money.

What is the Nucor story? It is "do good, do well." They did great for the customer, lowered the price of steel; great for their workers, higher wages; and great for their shareholders. That is the story of specialization.

Another part of specialization is it is typically started by people who know what they are doing. Thomas Edison was a very famous inventor. He started a little business that is now called General Electric. Bill Gates certainly knows a lot more about computing than I do or than most people do. He started a little business called Microsoft. Sam Walton, a fabulous retailer, started a company called Wal-Mart. Typically, specialization is led by people who own it, who know a great deal about it. Many people may not know that Jack Welch, the brilliant CEO of General Electric, had a doctorate in engineering.

Yet when the hospitals complain about specialized hospitals, they have valid points. It will hurt their profitability; there is the danger of over-referral; and who will care for the uninsured? Those complaints are quite valid. But the diagnosis that it is the specialty hospital that is causing these problems is not valid.

The profitability issue, as your two prior witnesses ably testified, is caused by mispricing by CMS. It is caused by a system in which a bunch of bureaucrats try to replace what the market normally does.

The problem of over-referral is not caused by the fact that physicians own facilities. Why don't people buy more steel than they need to? Why don't they buy more products than they need to? The answer is that the third-party system in healthcare insulates consumers from the costs of their care and they may buy more than they need to, and because it is a third-party system, consumers don't have the kind of information that would help them be very savvy in their buying.

Last, the issue of the uninsured. Is that an issue that should be solved by suppressing efficient innovations, or is that an issue that should be solved through another mechanism by addressing the financing needs of the uninsured? Surely, it should be the latter.

So what should the Congress do? It should lift the barrier to competition. The moratorium is a way of suppressing the competition that is so sorely needed in the hospital sector. It should encourage market-based provider pricing and stop the tinkering by a group of bureaucrats trying to emulate the market. And lastly, it should address the issue of how to make sure that the uninsured have as much access as anybody else.

Senator COBURN. Thank you, Dr. Herzlinger. Dr. Pelofsky.

TESTIMONY OF STAN PELOFSKY, M.D.,[1] PRESIDENT, NEUROSCIENCE SPECIALISTS, AND PHYSICIAN OWNER, OKLAHOMA SPINE HOSPITAL, OKLAHOMA CITY, OKLAHOMA

Dr. PELOFSKY. Dr. Coburn, my name is Dr. Stan Pelofsky. I have been a practicing neurosurgeon for 35 years. I am a physician owner of the Oklahoma Spine Hospital, and I truly appreciate the invitation to appear before you and your Subcommittee. I have submitted my written testimony and now would like to present my thoughts concerning the Oklahoma Spine Hospital.

I belong to a group of ten neurosurgeons, one of the largest and most reputable neurosurgical groups in the country. Ten years ago, my partners and I became extremely concerned with the quality of care our patients were receiving at all the large community hospitals in Oklahoma City. Staffing budgets were being drastically reduced. Agency nurses were being subcontracted to care for our patients not only on the floor, but in the operating room, as well. Trying to obtain new technology was like pulling teeth and often took 1 to 2 years. Endless and mindless committee meetings were zapping our time and our efficiency.

CEOs receiving high six-figure salaries were spending seven figures annually on blatant advertisement. Inefficiencies were built into the system. Surgeons were competing for operating room time. The infection rate and complication rate was unacceptable, and quality of care had deteriorated and costs were skyrocketing.

My partners and I knew there had to be a better way. We had a dream. We had a vision. We put together the Oklahoma Spine Hospital model and offered it to just about every community hospital in Oklahoma City. We were rejected and were told, what do doctors know about running a hospital? Well, Dr. Coburn, it turns out we knew a heck of a lot.

What is the Oklahoma Spine Hospital? It is a totally owned and operated physician specialty hospital. It is a hospital which specializes in the diagnosis and medical treatment of spine disease. It is a world-class facility. And it is for patients who have failed every effort at maximum aggressive medical treatment. Surgery is never the first, second, or third choice. We are a true hospital. We are not an ambulatory surgical unit. We are licensed by the Oklahoma Health Department and we belong to the Oklahoma Hospital Association.

Our patients stay 1 to 2 days in the hospital, some 3 to 4 days after complex surgery. When surgery becomes, and I must stress this point, the last and only other choice for patients who are suf-

[1] The prepared statement of Dr. Pelofsky appears in the Appendix on page 81.

fering from spine disease with disability and with pain, then expert surgeons with expert technology take care of them.

Since our opening in November 1999, we have performed over 12,000 spine and complex spine surgeries, including microsurgeries, fusion surgeries, and artificial disk replacements. We are an 18-bed, 5-operating room hospital that now employs over 200 Oklahomans. We are most proud of the fact that we have been able to save literally thousands of patients from surgical treatment by providing them a proper diagnosis and medical treatment plan.

Well, what have we accomplished? Length of stay after complex surgery, spine surgery, 1.6 days now on the average, a 0.11 percent infection rate, zero mortality rate, a nurse turnover rate of 3.2 percent, 98 percent patient satisfaction rate, 98 percent employee satisfaction rate, and I submit all these factors not only improve quality, but they cut the cost of healthcare to both Medicare as well as to the healthcare industry.

We outsource all administrative functions. We have no six-figure CEOs running the place. We spend nothing on advertisement or marketing except to give each patient who leaves our facility a pastel-colored T-shirt, their choice of color, their choice of size, with our logo on it. We have, as the physician owners, the ability to purchase state-of-the-art equipment at any cost, change policies, increase salaries, AND provide bonuses, literally overnight, without mindless, wasteful meetings.

We have a Level IV emergency room that is opened and staffed by an on-call physician owner of the hospital 24/7, 365. Plus, every one of the physician owners at the Oklahoma Spine Hospital participates in coverage in the emergency room of Mercy Hospital, a large community hospital across the street, 24/7, 365.

Last year, the Oklahoma Spine Hospital paid the following taxes: Federal tax, $4.5 million; State tax, $770,000; sales tax, $860,000; property tax, $225,000. And much of our taxes have helped fund numerous State and Federal healthcare problems.

The Oklahoma Spine Hospital brings value to our healthcare system and improves quality and is cutting costs. It has raised the bar. It has once again shown what American competition, invention, and freedom can do.

However, our critics are not applauding our accomplishments. Our critics, the American Hospital Association, the Oklahoma Hospital Association, HCA, the $100 billion Goliath in the industry, Integris in Oklahoma City, rather than embrace our model or compete against it, have decided quite simply to try to legislate us out of business. Here is our critics' spin versus the facts.

Spin number one, Oklahoma Spine Hospital physicians self-refer and are essentially knife-happy in order to reap personal financial rewards. This claim, based on our professional integrity and national reputation, is not only outrageous, it is insulting.

Spin number two of our critics, the Oklahoma Spine Hospital physicians cherry pick our patients. Dr. Coburn, the fact is, we cherry pick our doctors. We cherry pick our staff. We cherry pick our nurses. We cherry pick our scrub techs. We never cherry pick our patients. Here is the payer mix of Oklahoma Spine Hospital: Private health insurance, 42 percent; workmans' comp, 33 percent, Medicare and Medicaid, 17 percent; self-pay/no-pay, 8 percent.

Spin number three of our critics, the physicians at Oklahoma Spine Hospital don't cover the ERs. Fact: We cover our ER, we cover Mercy's ER, again, 24/7, 365.

Spin number four, we are sapping much-needed financial resources from our community hospitals and academic medical centers. Fact: HCA, which has a joint operating agreement with OU Medical Center, last year had a $47.5 million net profit, an 11.1 percent profit margin, probably the highest in the State. Integris, Oklahoma City, made tens of millions of dollars in profit and they are a nonprofit hospital. Fact: Every large community hospital in Oklahoma City did extraordinarily well financially last year and these Goliaths should not be threatened by our 18-bed specialty hospital.

In summary, Dr. Coburn, we are extremely proud of our accomplishments. We have created giant efficiencies with wonderful outcomes, patient and staff satisfaction rates that have been unheard of. Isn't that what being a doctor is all about? Isn't that what America is all about, the freedom to create, to compete, to raise the bar for everyone? What a country.

Finally, two last points. Without grandstanding or showboating, the physician-owners of the Oklahoma Spine Hospital challenge any hospital in this country, any for-profit, nonprofit, HCA, academic center, Integris, to go one-on-one with us on a scientific study, a study that is prospective, double-blinded, independently judged and analyzed, peer reviewed, and with matched cohorts of patients looking at just three parameters. What are these three parameters? The parameters are outcomes, patient satisfaction, and cost. I will tell you, if they go one-on-one with us, once again, David will slay Goliath. [Laughter.]

Last point, Dr. Coburn. The future viability of specialty hospitals rests largely within the control of the U.S. Congress and the Center for Medicare and Medicaid Services. The current moratorium is scheduled to end in just a few short weeks. On behalf of the Oklahoma Spine Hospital and its physician owners, I urge you to let this moratorium come to a permanent end. I also hope that you will express your support of specialty hospitals to CMS Administrator Mark McClellan and encourage the agency not to impose further regulations that will, by de facto, extend the moratorium beyond June 8.

Again, thank you for this opportunity to testify.

Senator COBURN. Dr. Pelofsky, thank you. I was somewhat lenient. I would hope the rest of us would stay within the 5 minutes, if we could.

Mr. Thomas.

TESTIMONY OF JOHN T. THOMAS,[1] SENIOR VICE PRESIDENT AND GENERAL COUNSEL, BAYLOR HEALTH CARE SYSTEM, DALLAS-FORT WORTH, TEXAS

Mr. THOMAS. Mr. Chairman, Members of the Subcommittee, my name is John Thomas. I am the General Counsel of Baylor Health Care System based in Dallas-Fort Worth, Texas.

[1] The prepared statement of Mr. Thomas appears in the Appendix on page 88.

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 Baylor and to ask you to resist efforts to extend the moratorium on the development and growth of physician-owned specialty hospitals that will expire June 8 and to resist efforts to repeal the whole hospital exception under the so-called Stark self-referral law.

Baylor is the corporate sponsor of 13 nonprofit hospitals. Our flagship, Baylor University Medical Center, is located in downtown Dallas, a 1,000-bed quadenary teaching hospital with a Level I trauma center that provides care to more penetrating trauma victims than Dallas County's tax-supported Parkland. Baylor has the largest neo-natal ICU in the Southwest and one of the five largest organ transplant programs in the country. Last year, we provided more than $240 million in community benefits at cost, not including bad debt. Charity care is provided under the most generous charity care financial assistance policy among all Dallas-Fort Worth hospitals.

At the same time, Baylor has a long history of innovation. In the early 1900's, Baylor developed the prepaid 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 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 surgical centers, surgical hospitals, and heart hospitals. Today, Baylor has an ownership interest in 25 facilities partnered with physicians. Over 2,000 physicians actively practice at these facilities, while only about 500 have an ownership interest.

Texas Health Resources, the other major nonprofit system in Dallas, also has a number of hospitals and facilities partnered with physicians.

Five of Baylor's facilities are affected by the moratorium. Three are surgical hospitals. Two are heart hospitals. Each is critically important to the mission, but more importantly, is critical to the advancement of healthcare competition and improvements in quality, safety, patient satisfaction, and access in Dallas-Fort Worth.

By 2020, the population of Dallas-Fort Worth is expected to exceed ten million people, more than double the population today. As Baylor projects the needs of our community to meet this population growth and demand for access to healthcare services, partnering with physicians not only brings capital to help finance the response to those needs. More importantly, economic investment motivates physicians to bring their time, energy, and talent to the design, operation, and governance and operation of more effective and efficient healthcare facilities.

No example proves this point better than our Baylor Heart and Vascular Hospital, a facility located on the inner-city campus of our flagship, Baylor University Medical Center. The quality of this facility is the highest in our healthcare system and is among the highest rated heart programs in the United States on CMS's website, hospitalcompare.hhs.gov. In my written testimony, you

will see a chart comparing that hospital to the national average and the teaching hospitals.

Month after month, the Baylor Heart Hospital scores at or near 100 percent on the CMS indicators for acute myocardial infarction, congestive heart failure, and surgical infection prevention standards. Emergency room Baylor Heart Hospital protocols consistently result in ER patients going from the door to the cath lab within 30 to 45 minutes of arrival, with vessel inflation under 90 minutes. Patient satisfaction, as measured by a national survey tool, exceeds the 96th percentile in that national database. When patients are asked, "Did you feel the staff were knowledgeable and provided safe care?" month after month, 100 percent of patients respond yes.

With physician alignment, the Baylor Heart Hospital has seen dramatic improvements in cost reduction and efficiency. In the first year of operation, over $12 million of costs were eliminated from the cost to provide these services before the heart hospital opened.

Dramatically, staff turnover is less than 11 percent per year, while the rest of our community exceeds 20 percent. This is an important indicator of both the quality of clinical environment—the staff enjoys working there—and cost containment. Baylor's cost to replace an R.N. approaches $60,000 per nurse for recruiting, training, and retention. With low turnover, these dollars are saved.

Finally, Baylor's specialty hospitals are the safest in the system, with the Baylor Heart Hospital leading the way with no medical liability claims ever in the history of that facility. Baylor's other specialty hospitals also have much lower liability claim rates.

Last, as the community focused on homeland security, the Nation's trauma system is the backbone of effective response to future incidents, if any. Baylor has used alignment of physicians through specialty hospitals and ambulatory surgery center joint ventures and other forms of effective alignment to keep physicians engaged in the trauma system. These physicians also commit to providing charity care under Baylor's charity care and financial assistance policy. Unfortunately, 30 percent of the Texas population is uninsured, with an even higher rate in downtown Dallas, where the heart hospital is located.

We urge you to allow the moratorium on physician ownership and development to end June 8. The moratorium has not been benign and a continuation will be even worse. This has affected our ability to expand our inner-city heart hospital to meet the needs of that community. The moratorium has prevented Baylor from bringing higher-quality heart and vascular care to Plano, where heart disease remains the number one killer. And the moratorium has prevented the Baylor-Frisco Medical Center from expanding to provide obstetrics and other women's services to one of the fastest-growing communities in the country.

Senator COBURN. Thank you, Mr. Thomas. Dr. Cain.

TESTIMONY OF JAMES E. CAIN, M.D.,[1] PRACTICE IN FAMILY MEDICINE, LAMPASAS COUNTY, TEXAS

Dr. CAIN. Dr. Coburn, thank you for having me here today.

Senator COBURN. I am glad you are here.

[1] The prepared statement of Dr. Cain appears in the Appendix on page 96.

Dr. CAIN. My name is James E. Cain. I am from Lampasas, Texas, and I practice rural medicine. The first 18 years of my life, I was raised in rural Arkansas, the next 18 years of my life in Houston, Texas. My education was at Houston Baptist University, Baylor College of Medicine, and University of Texas Health Science Center.

When I finished my education, I chose to go back to rural America and practice medicine. I live in Lampasas now, which is about an hour north of Austin, an hour West of Fort Hood, and about an hour South of a little town called Crawford, Texas. We have about 20,000 people in our county. Our average income per family there is about $30,000 per year.

My partners and I are about the only show in the county. We also help the surrounding counties. Primary sources of income are Medicare, Medicaid, Tricare, which is the military insurance, a handful of commercial insurances, and private pay insurances. We work on an average 12 hours a day and we don't turn away anyone for their ability or lack of ability to pay.

A few weeks ago, someone asked me how Austin Heart Hospital has affected my practice in Lampasas County, and the reasons I gave and the answers I gave to those questions are why I am here today.

I shared with them the scenario, and I share it with you today. It plays out in my life on a weekly basis. I get a call from the emergency room. A patient of mine is there and is not doing well. I get in my truck—yes, I am from Texas and I drive a pick-up truck, no hat—— [Laughter.]

Drive to the emergency room, and I call Austin Heart Hospital. Within a few minutes, I have a cardiologist on the line with me. They help me stabilize my patient, often stabilizing me, as well. You can relate to that, I am sure. We discuss transfer, ambulance, helicopter. The patient is transferred. I go back to work or back home.

Within a few hours, that cardiologist is generally calling me, letting me know what happened to the patient, what kind of care they received, and what kind of follow-up care they are going to need. Within a few weeks, few days, the patient is back in my office for follow-up, obviously very well cared for and very impressed with the care that they have received there.

The most important things about the scenario that I have laid out for you is that at no point in this conversation so far has anyone asked me about my patient's insurance or their ability to pay.

Second, the time with which they handle these cases is second to none, and when you are an hour-and-a-half away from a tertiary center, sometimes minutes do mean everything.

Compare that with what I get at most of the other hospitals that I transfer to. Right off the bat, I get an administrator. What is the first question she asks me? Who is paying? What is the insurance? Of course. Then I get a utilization nurse, and there is nothing wrong with that. I certainly can understand this. When they find out the patient has Medicaid, or for God's sake has no insurance, then the conversation turns to bed availability, is the patient actually stable enough to transfer to their facility, and are they actually the closest hospital for me to transfer my patient to? In the end,

if I get that patient transferred to their facility, it is usually to the emergency room department because the utilization review nurse feels like a second workup will probably be better and in the best interest of the patient, which means maybe we can find something different, keep the patient out of the hospital, not utilize resources that this patient obviously can't pay for.

It also frustrates me when I get a patient at another facility after hours on the weekend. In a few hours, I call, try to find someone. I usually get a nurse on the phone and I am told the patient can't get a procedure tonight because they don't do this after hours on the weekends. The patient is going to have to wait until Monday to figure out what is going on with them. They are stable, however. To me, that is two extra days in the hospital, a calculated but small increased risk to my patient, obviously an increased risk to the system.

My experiences with Austin Heart Hospital has been, like the neurosurgeon down the table, a 7-day workweek, 24 hours a day.

I am constantly seeing in the medical journals and in the medical economic journals now medical models that are being related to patient outcome. Then the insurance companies are now reimbursing us based on patient outcome. I have included in my written statement many of the studies and recognitions by the reputable organizations that speak favorably of Austin Heart Hospital, their length of stay, their patient outcome, quality of care, so on and so forth, but it is my personal experience and the experience of my patients that leave no doubt in my mind that they are receiving the best possible care that I can offer them at this institution.

In this day and age of frustrated physicians, skeptical patients, confused administrators and politicians, trying to figure out how to make these dollars cover expenses, it is very easy to become cynical. I assure you, I am no cynic. I still love what I do. I enjoy going to work every day. I am proud to be a country doctor.

I ask that you guys look at the information, look at the data that institutions such as the Heart Hospital of Austin are giving you. Look at the effective care that they are delivering. Look at their patient outcome data. I believe, as many of us in the business, that good patient outcome and effective care in the end is what is going to stretch these dollars.

I appreciate your time and thank you for your patience.

Senator COBURN. Thank you, Dr. Cain. Mr. Jungbluth.

TESTIMONY OF ED JUNGBLUTH,[1] HEART PATIENT, HEART HOSPITAL OF NEW MEXICO, ALBUQUERQUE, NEW MEXICO

Mr. JUNGBLUTH. Thank you, Mr. Chairman. My name is Ed Jungbluth and I am a 71-year-old heart patient and I think I am one of the patients that everybody is talking about today, actually, although you may be jumping around it. I have had a heart attack, angioplasty, and an AICD, automatic internal coronary defibrillator. I am sure you know what that is.

Senator COBURN. I do.

Mr. JUNGBLUTH. Make that three AICDs. I have always been an active person and enjoyed life to the very fullest, so needless to say,

[1] The prepared statement of Mr. Jungbluth appears in the Appendix on page 100.

the onset of my first heart attack was a bit discerning to both me and my wife, Mimi.

In 1988, I had a heart attack while living and working in the tourism industry in Estes Park, Colorado. After experiencing chest pains, we went to the local emergency department, where I was stabilized and transported to St. Luke's Hospital in Denver, Colorado, where I had an angioplasty. Though the care at the emergency room in Estes Park was good, the hospital was not equipped to do any interventional procedure. I have termed this as a "pack and ship" operation. That is what I got a lot of, pack and ship. Because I love life and because my wife took advice to heart, we modified our eating and exercise habits and took the steps necessary to give my heart the best chance for recovery.

It wasn't until 2000 that I began to experience other heart problems, though this time it was rhythm problems. While spending time in Phoenix for Major League Baseball spring training, I had my first bout with v-tach, ventricular tachycardia. It was a Sunday afternoon and I ended up at Mesa General in the Phoenix area and spent many days in intensive care while my condition was being diagnosed and I was stabilized. Again, I happened to land in a facility where there was not specialty care available for my heart problems.

Finally, I was transported to another facility in Phoenix where I received my first AICD. The care was adequate, but neither facility really had the extensive type of cardiac care that I required. I was released and I was able to travel back home to Gallup, New Mexico, on the next day after the implant.

Soon after arriving home, I had my first experience as a patient at Rehoboth McKinley Christian Hospital in Gallup. I had a tremendous pain in my left arm and went to the emergency room. The diagnosis was a blood clot in my arm. Unfortunately, I was told that they could not treat me—a higher level of cardiac care was necessary—-and was instructed to go to Albuquerque for treatment.

As you can imagine, these weeks were traumatic and I was concerned about my heart. I am a Medicare-insured patient and I knew that I could have access to any facility in Albuquerque. At that point, I heard about the Heart Hospital of New Mexico and that if I went there, I would have access to all heart specialists and decided to get myself there as quickly as possible. I was driven by a friend and arrived about 3 a.m. that morning. I spent 9 days at Heart Hospital of New Mexico and have never felt so safe and secure and confident that I was receiving the specialty treatment that my condition required. I was not sent by investor physicians, but rather chose to go because I had investigated and learned that they provide the highest quality heart care. It is important when you live in a rural area to educate yourself and be prepared to make life and death decisions in terms of healthcare.

The story continues. In 2002, while in Santa Fe on business, my AICD fired for the very first time. That is really a thrill. I went to St. Vincent's, the sole community hospital. Again, I was stabilized overnight and released with follow-up instructions to see a New Mexico Heart Institute electrophysiologist in Albuquerque.

My condition became more of a concern, and throughout the year of 2002, I experienced numerous firings of the AICD while living

in Gallup. On each occasion, I had to get to the emergency department at Rehoboth while I was being stabilized, and because they were unable to treat me, I was transferred, packed and shipped, by air to the Heart Hospital of New Mexico.

Fortunately, through the relationship of Dr. Swaminathan, a New Mexico Heart Institute cardiologist who practices in Gallup, and Heart Hospital of New Mexico's quick transfer initiative, I was able to arrive with specialists waiting as quickly as possible. In one instance, while in the ambulance en route to the airport in Gallup, my AICD fired four times and I had to return to the hospital to be stabilized again before I could be flown to the Heart Hospital of New Mexico (HHNM). Upon arrival at HHNM, it was determined that the unit installed in Phoenix had failed and I received a new AICD. Because my v-tach is severe, I have had numerous firings over the past few years and in each case was transferred.

Upon concern for my health and well-being, for the peace of mind for both my wife and I, we decided we wanted to move to Albuquerque to be close to Heart Hospital of New Mexico. We feel at home, safe, and secure. With the experience we have had as an inpatient, I know that care is always timely, with the most specialized staff.

As it has turned out, our decision was the right one. Since moving, I have had the fortune of being close to the Heart Hospital of New Mexico and have experienced treatment in their emergency department. They know that time means muscle, heart muscle, and life when it comes to heart patients. I have had more problems with v-tach and have been rushed twice over a 2-month period to the Heart Hospital emergency department. I know from experience that the timeliness of care and expertise of all physicians have allowed me to maintain an active and normal life. The emergency department physicians have deep experience and have immediate access to the specialized cardiologists. On both occasions, my treatment was quick, technically superb, and compassionate. In fact, my wife, who is an accomplished artist, was scheduled to participate in an art show in California, felt comfortable with me in HHNM that she went on to the art show.

Senator COBURN. Could you sum up for us?

Mr. JUNGBLUTH. I am going to do that. In April 2005, I received a replacement AICD from the Heart Hospital. They put patient care first. I am a chronic heart patient. I suffer from congestive heart failure. Am I concerned? Yes, but worried, no. Thank you.

Senator COBURN. Thank you. Dr. Plested.

TESTIMONY OF WILLIAM G. PLESTED, III, M.D.,[1] IMMEDIATE PAST CHAIR, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Dr. PLESTED. Thank you, Chairman Coburn. My name is Bill Plested. I am Immediate Past Chair of the Board of Trustees of the American Medical Association and a practicing thoracic and cardiovascular surgeon from Santa Monica, California.

First, I want to thank you for calling this important hearing. The AMA believes that competition is absolutely vital to ensuring high

[1] The prepared statement of Dr. Plested appears in the Appendix on page 103.

quality, cost effective healthcare for America's patients. And competition from physician-owned hospitals is key. Why? It means more choices for patients, improvements and innovations, increased quality of care, extremely high patient satisfaction, and healthcare decisions that are made by patients and their physicians.

Physicians who invest in specialty hospitals increase productivity and efficiency, improve scheduling of procedures, maintain desired staffing levels, purchase state-of-the-art lifesaving equipment. Competition from specialty hospitals has even been a self-admitted wake-up call for some general hospitals, forcing them to innovate in order for them to stay competitive.

Studies support the premise that focus on a specific area of service can lead to higher quality and lower costs 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 patients' needs, and modify care delivery, as necessary.

CMS found that quality measures at specialty heart hospitals were equal to or better than general hospitals. It also found lower rates of infection. Post-operative hip fracture, deep-vein thrombosis, and sepsis were also lower at specialty hospitals. In addition, mortality rates were significantly lower at specialty hospitals, even when adjusted for severity.

Numerous studies, including CMS and MedPAC studies, found that patient satisfaction at specialty hospitals is extremely high. Greater convenience and comfort, higher nurse-to-patient ratios, and knowledgeable specialized nurses all contribute to these extremely high levels of satisfaction reported by patients and their families.

Despite these benefits to patients, the continued existence of specialty hospitals is in jeopardy. The hospital associations and many general hospitals are vigorously attempting to eliminate competition. They attack physician ownership of specialty hospitals and engage in numerous practices to simply stifle competition.

For example, general hospitals revoke or refuse medical staff membership or clinical privileges to physician investors and they advance State laws to ban physician ownership of hospitals. General hospitals also force health plans to sign exclusive contracts that shut out competing specialty hospitals. They refuse to cooperate with specialty hospitals in ways such as declining transfer agreements for emergency care. These practices interfere with the patient-physician relationship and they adversely affect patients.

General hospitals claim that competition from specialty hospitals will hurt them financially by reducing some of their most profitable services which they use to subsidize unprofitable services. However, MedPAC found that general hospitals that compete with specialty hospitals have demonstrated financial performance that is comparable to other general hospitals.

But even assuming that a hospital could prove it incurred financial harm, the answer is not to eliminate competition and support cross-subsidization. The answer is exactly the opposite. It is to support competition and eliminate cross-subsidization. The Federal Trade Commission and the Department of Justice share this view.

MedPAC recommends that CMS change Medicare hospital DRG payments to more accurately reflect the relative costs of hospital care, thus eliminating cross-subsidization, and the AMA supports these changes.

The AMA strongly supports and encourages competition as a means of promoting high quality, cost effective healthcare. We believe that patients should continue to benefit from increased choice and competition that result from specialty hospitals.

Therefore, the AMA believes patients will be better served if neither Congress nor the Administration acts to extend the moratorium on physician referrals to specialty hospitals, and CMS makes payment and policy changes recommended by MedPAC, and finally, healthy competition is not stifled. Thank you, sir.

Senator COBURN. Thank you, Dr. Plested.

For any of you that want to answer this question, we heard today that the study from MedPAC says that it is not necessarily cheaper, even though the number of hospital days is less. In any of your experience, can you relate to that at all? Dr. Herzlinger.

Ms. HERZLINGER. I teach accounting as well as healthcare at the Harvard Business School. The MedPAC method that was used to calculate costs is archaic. It is no longer used by corporations. The cost techniques that corporations now used is called activity-based costing and many of the cost data that come about from this methodology differ substantially from the old way that companies used to allocate their costs, which is the technique that MedPAC used.

So, first of all, I question whether they accurately measured the costs of the general hospital. Of course, they measured accurately the costs of the specialty hospital because it does only one thing. But in a community hospital, in order to identify the costs of that one thing, you have to allocate a lot of joint costs and the methodology that was used is antiquated.

Second, the specialty hospitals have to spend a tremendous amount of money in order to get through the thicket of regulations that would justify their existence. In MedCath, which is a heart hospital, the average expenditure just to enable it to exist, just to satisfy the myriad regulations it must go through, is about $200,000 a year.

Third, depreciation, which is a major element of cost, is measured on the basis of historical cost, the plant and equipment, and community hospitals are often much older than the plant and equipment in specialty hospitals. So when specialty hospitals depreciate, those dollars are going to be much more expensive.

Fourth, specialty hospitals have a cost of capital. They borrow money at non-subsidized rates. They have equity costs. Nonprofit community hospitals have none of those costs.

The comparison is heavily flawed and until it is corrected, I don't think that it stands to support the allegation that one is more or less efficient than the other. Specifically, what MedPAC should do is adopt activity-based costing techniques in order to better understand what the costs of community hospitals are in providing the specific kind of care that special purpose specialty hospitals do.

Senator COBURN. Thank you, Dr. Herzlinger. Dr. Pelofsky.

Dr. PELOFSKY. It just doesn't compute, Dr. Coburn, for those of us in the trenches. When you can have a patient out of the hospital

in 1½ days after complex spine surgery with instrumentation, or the placement of an artificial disk, when you have an 0.11 percent infection rate compared to national 2 to 5 percent, every time there is an infection, that is 7 more days of hospitalization at a cost of, what, $1,000 a day with antibiotics? If you could cut your infections, your complications, your days in the hospital, your readmission rate, you have to be saving the system money. It just simply doesn't compute.

Senator COBURN. Mr. Thomas.

Mr. THOMAS. Mr. Chairman, the Baylor Heart Hospital experience was vastly different than MedPAC reported. As I testified, we reduced $12 million of cost directly out of the heart service that was once controlled and owned completely by our nonprofit hospital and then it was moved across the street. We have very accurate apples-to-apples comparisons.

And then, second, with MedPAC's conclusion about the full-day lower length of stay, on the managed care side, where you have per diem contracts and other forms of payment as opposed to a DRG fixed-base system, that is a 25 percent reduction in the cost to the payer and the individual patient.

So, again, with us, it doesn't compute, either. Our hospital was open the year after MedPAC's study was—they looked at 2002. Ours is 2003. So we think that is an inaccurate conclusion that they reached.

Senator COBURN. So maybe his comments about start-up costs and things like that may have been theirs, too?

Mr. THOMAS. Sure.

Senator COBURN. All right. Does anybody else want to answer on that, comment on it?

I want to make one observation and then I will ask a question. Dr. Cain, as a primary care doctor myself, dealing mainly in obstetrics but doing everything, my biggest frustration is the lack of accountability at the interface of where hospital employees interface with my patient. I don't know if you have experienced that. I know Dr. Pelofsky has. But there is no control by physicians anymore in terms of getting written orders done on their patients on a timely basis because the management in the hospital setting often does not compare to that of a specialty hospital.

Any comments about accountability of ancillary personnel, in your hospital or in the Baylor or in the Austin Heart Hospital in terms of efficiency, of responsibility?

Dr. PELOFSKY. Yes. I brought 500 patient surveys that will deal with that issue. We at the Oklahoma Spine Hospital have happy faces, efficient people working at the top of their level of accomplishment and knowledge. If they don't, they are gone. We fire people if they don't perform our orders in the appropriate manner, or in the appropriate way.

Senator COBURN. When all the hospitals are struggling to have nurses today, how is it that you can fire somebody and get a replacement?

Dr. PELOFSKY. Because we have a waiting list of nurses and——

Senator COBURN. And that is because?

Dr. PELOFSKY. Because we pay better, we have better benefits, they have a better job, they have a better quality of life, and they are part of a team. They are part of every decision we make.

I had a scrub tech tell me—we have a suggestion box. He tells me, Dr. Pelofsky, for your complex spine cases, you open up three packages of suture and you only usually use one. That was on my computer card. So we only open up one. We save two packages of suture, $15 each, $30 a case, 10 cases a week, $300 a week times 52 weeks. On just me, we saved $15,000 in cost.

So our people are part of the team. They are part of the creation of this model and it works. They are incentivized. It is America.

Senator COBURN. All right. Mr. Thomas, any comment?

Mr. THOMAS. I think the team approach is exactly what we experienced. There is a waiting list to move from our other hospitals to our heart hospital and our specialty hospitals and the turnover rate—and the treatment by the physicians, again, as part of that team approach, there is much more accountability and the accountability flows both ways. The staff like working there. And again, the turnover rate has been very low.

Senator COBURN. Let me ask those of you that are involved—did you want to answer, Dr. Plested?

Dr. PLESTED. Well, I just wanted to say that in my visits to the specialty hospitals, the thing that I am struck with and has been of interest to me my whole life is the level of esprit. I have always thought that people need to love what they do, and we heard that very well from Dr. Cain.

In the general hospital, we have a continuing problem. I have to continually meet with nurses to tell them how important they are. They don't feel like they belong. They are shuffled off here and there and they are short here today and they are short there the next day. In the specialty hospitals, they are where they want to be. They are important members of the team, and this esprit is there. It is palpable, and I think that is incredibly important, and the question you have about turnover.

Senator COBURN. Why is it there and not in the general hospital, in your opinion?

Dr. PLESTED. Well, my personal opinion is that is a matter of leadership, and I just think that—what Stan said about happy faces, I think it just goes all the way. If you walk into the general hospital today, nobody is happy. I mean, walk into the admissions thing. You are greeted by the most dour, unhappy people, who don't like their job, they don't want to be there. They wonder why you are there. I have spent my life working on this in my hospital and I wish I could say it was different, but it isn't.

Senator COBURN. All right. Dr. Pelofsky.

Dr. PELOFSKY. Dr. Coburn, I think the difference is that doctors get it. We are not administrators. We have no administration at our hospital. It is doctor-owned, doctor-run, and we know how valuable nurses are. They will make or break our case. They will get us sued or they will get us glorified. They are our left hand and our right hand and we treat them that way.

Senator COBURN. Which would say that maybe they are not treated that way in the other hospitals?

Dr. PELOFSKY. They all have left the other hospitals because——

Senator COBURN. OK. The question, what I want to get to is here is another advantage of specialty hospitals. What is the problem in the general hospitals with morale, turnover, training, competence, and efficiency?

Dr. PELOFSKY. The problem is that the CEO never goes up to the floor, never goes into the operating room, never goes into the doctor's lounge. I am thoroughly convinced it is so bureaucratic and it is such a dinosaur. The organization of today's community hospitals have got to change. They are 100 years behind the time.

Senator COBURN. Dr. Herzlinger.

Ms. HERZLINGER. I think there is analogy to other parts of the economy. For example, the department store is a failing economic entity and it has been supplanted by targeted, focused lifestyle stores.

For example, I go to a store that is called Talbot's, which is a store that specializes in career dressing. That means dark pantsuits with long jackets for women with hips. [Laughter.]

My daughter, who is a physician, she goes to Ann Taylor, which is a store that specializes in clothes for young career women. I don't know if you have Office Max or Office Depot or Staples in Oklahoma, but they are an example——

Dr. COBURN. We are not quite that backward. We do have them. [Laughter.]

Mr. HERZLINGER. I didn't mean it that way. I didn't say—it is very complicated. [Laughter.]

Senator COBURN. Markets work everywhere.

Ms. HERZLINGER. The point is, why did the department store fail? It failed to please its customers and it was because the scope was too big. It was beyond the ability of managers to manage it, and so the salespeople were unhappy. The merchandise was stale. It was just too much. These focused lifestyle-oriented stores are very successful. They are successful in any way you count it.

Now, McKensie did a study of why we have such great increases in productivity in our country. There were six industries that accounted for all the increases. Number one was the retailing industry, and the retailing industry is very surprising because it is a service industry and it is consumer-driven. Why retailing? Because it reorganized itself from being everything for everybody kind of department stores that nobody could manage to much more feasible entities that were focused on things from the consumers' point of view.

Senator COBURN. So higher unit sales per volume of work.

Ms. HERZLINGER. They do. They certainly do.

Mr. JUNGBLUTH. From the patient's perspective, Mr. Chairman, having been a very frequent visitor of the Heart Hospital, I see many of the same faces time and time again, not only the doctor staff, I also am talking about the nurses, I also am talking about the techs. I am talking about the people that sweep your floors and mop your floors every single day.

I can only guess the reason that they are still there is that they are happy, because the tendency in this country is if you are not happy, you move on. And they must be fairly well paid, again, because the tendency is to move on if you are not well paid.

I can't speak enough for at least this specialty hospital, and I know in talking with Dr. Cain about the Heart Hospital in Austin, the two are run by the same company. We both experienced the same thing in my conversation. It is the same feeling throughout each of these institutions—that there is just a different feeling there.

It is not a "pack and ship" operation, and I say that with somewhat affection. It is not that type of operation at all. You are welcomed. The emergency rooms are great. I see the same people in the emergency rooms, because that is the only way I get in, is through the emergency room because I am an emergency case every time I go.

Senator COBURN. Thank you. Let me thank each of you for being here. You will be submitted some questions for most of you and we would hope that you would respond to those within 2 weeks.

I would also make note that this country's economic model was based on the concept of competition, fair and open competition, and it is very concerning to me that the very thing that I think we need the most to control the cost in healthcare is the very thing that is probably going to be limited, at least over the next 6 months, through bureaucratic fiat associated with CMS. That costs us a lot. And if you are wondering how that can happen, all you have to do is look around at the power of lobbying and bureaucracies in Washington rather than the power of true competition and an honest and forthright discussion.

My hope is that we see much more competition in healthcare, and I do not mean just at the hospital level, I mean at every level of healthcare—putting the consumer in the game. I know they know how to buy, and I know that we can compete. Good competition produces better quality, better price allocation, and better outcomes.

I thank each of you for being here.

[Whereupon, at 4:12 p.m., the Subcommittee was adjourned.]

APPENDIX

PREPARED STATEMENT OF THE
FEDERAL TRADE COMMISSION

Before the

SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT,
GOVERNMENT INFORMATION, AND INTERNATIONAL SECURITY

of the

COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS

U.S. SENATE

on

NEW ENTRY INTO HOSPITAL COMPETITION

MAY 24, 2005

I. INTRODUCTION

Mr. Chairman, I am John Graubert, Principal Deputy General Counsel of the Federal Trade Commission.[1] I appreciate the opportunity to appear before you today to discuss new entry into hospital competition and related issues.

The Federal Trade Commission has familiarity with these issues through Hearings held together with the Department of Justice, Antitrust Division, and the resulting Report, *Improving Health Care: A Dose of Competition,* issued jointly by the Commission and the Department of Justice, Antitrust Division, in July 2004, as well as through the Commission's substantial experience in enforcing the antitrust laws in health care markets. The Joint Hearings and Joint Report broadly examined the state of the health care marketplace and the role of competition, antitrust, and consumer protection in satisfying the preferences of Americans for high-quality, cost-effective health care. The Joint Hearings took place over 27 days from February through October 2003, following a Commission-sponsored Workshop on health care issues in September 2002. The Commission, along with the Department of Justice, heard testimony from about 240 panelists, including representatives of various provider groups, insurers, employers, lawyers, patient advocates, and leading scholars on subjects ranging from antitrust and economics to health care quality and informed consent. Together, the Hearings and Workshop elicited 62 written submissions from interested parties. Almost 6,000 pages of transcripts of the Hearings and Workshop and all written submissions are available on the Commission website, www.ftc.gov. In addition, staff of the Federal Trade Commission and the Department of Justice,

[1] This written statement reflects the views of the Federal Trade Commission. My oral statements and responses to any questions you may have represent my own views, and do not necessarily reflect the views of the Commission or any individual Commissioner.

Antitrust Division, undertook independent research for the Report.

Today, the Commission focuses specifically on a few of the issues addressed in the Report that relate to new entry into competition among hospitals and other entities. Three main points require attention. First, vigorous competition can have important benefits in the hospital arena, just as it has in the multitude of markets in the U.S. economy that rely on competition to maximize the welfare of consumers. Competitive pressures can lead hospitals to lower costs, improve quality, and compete more efficiently. Competitive pressure also may spur new types of competition. In hospital markets, some new entrants specialize and provide only a limited portion of the in-patient and out-patient services that general hospitals tend to provide.

Specialty hospitals (*e.g.*, pediatric) are not new. In recent years, however, an increasing number of single-specialty hospitals have entered, or attempted to enter, particular markets to compete with hospitals in providing certain types of hospital services, such as cardiac or orthopedic surgery. Ambulatory surgery centers have emerged to perform surgical procedures on patients who do not require an overnight stay in the hospital, thus providing additional competition to hospitals' services in this area. Testimony at the Hearings reported that this entry has had a number of beneficial consequences for consumers who receive care from these providers.

Second, when new firms threaten to enter a market, incumbent firms may seek to deter or prevent that new competition. Such conduct is by no means unique to health care markets; it is a typical reaction of incumbents to possible new competitors. In certain circumstances, such

conduct may violate the antitrust laws.[2] Antitrust scrutiny, however, sometimes may not reach certain anticompetitive conduct. The *Noerr-Pennington* doctrine immunizes from antitrust scrutiny conduct that represents petitioning the government, even when such petitioning is done "to restrain competition or gain advantage over competitors."[3] Moreover, the state action doctrine shields from antitrust scrutiny a state's activities when acting in its sovereign capacity.[4]

In the context of hospital competition, the combination of these two doctrines can offer antitrust immunity to hospitals that wish to lobby state officials to deny a potential entrant, such as a single-specialty hospital, the Certificate of Need (CON) it may require to open its doors. State CON programs generally prevent firms from entering certain areas of the health care market unless they can demonstrate to state authorities an unmet need for their services. The FTC and DOJ Report concluded that "[m]arket incumbents can too easily use CON procedures to forestall competitors from entering an incumbent's market."[5]

Not all states have CON requirements. Indeed, almost all of the recent entry by single-specialty hospitals has taken place in states that do not have CON requirements. The Report recommended that "States with Certificate of Need programs should reconsider whether these programs best serve their citizens' health care needs."[6]

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[2] Federal Trade Commission & the Department of Justice, *Improving Health Care: A Dose of Competition,* Exec. Summ., at 15-16, ch.1, at 31-33, ch.3, at 22-27 (July, 2004) [hereinafter "*Improving Health Care*"].

[3] *Id.*, ch.8, at 10, n.70.

[4] The state action doctrine also immunizes from antitrust scrutiny the actions of most other entities and individuals if they are acting in furtherance of a clearly articulated state policy and are actively supervised by the state.

[5] *Improving Health Care, supra* note 2, Exec. Summ., at 22.

[6] *Id.*

Finally, policymakers must consider the extent to which regulatory distortions may affect competition among hospitals and other firms. Although entry by single-specialty hospitals and ambulatory surgery centers has provided consumer benefits, Medicare's administered pricing system has substantially driven the emergence of single-specialty hospitals and ambulatory surgery centers. Medicare's administered pricing system, albeit inadvertently, can make some services extraordinarily lucrative, and others unprofitable.

Several panelists at the FTC/DOJ Hearings expressed concern that single-specialty hospitals and ambulatory surgery centers would siphon off the most profitable patients and procedures under Medicare reimbursement policies, leaving general hospitals with less money to cross subsidize other socially valuable, but less profitable, care.[7] The FTC/DOJ Report pointed out that "[c]ompetitive markets compete away the higher prices and supra-competitive profits necessary to sustain such subsidies,"[8] and concluded that "[i]n 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."[9] The FTC/DOJ Report recommended that "[g]overnments should reexamine the role of subsidies in health care markets in light of their inefficiencies and potential to distort competition."[10]

In testimony before the House Committee on Energy and Commerce on May 12, 2005, Mark McClellan, Administrator of the Centers for Medicare and Medicaid Services (CMS),

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[7] *Id.*, ch.3, at 21 & n.106, and 27 & n.138.

[8] *Id.*, Exec. Summ., at 23.

[9] *Id.*

[10] *Id.*

reported that CMS, following its own study of specialty hospitals pursuant to congressional direction,[11] will analyze and reform its payment rates "to help reduce the possibility that specialty hospitals may take advantage of imprecise payment rates in the inpatient hospital prospective payment system" and "to diminish the divergences in payment levels [for ambulatory surgical centers] that create artificial incentives for the creation of small orthopedic or surgical hospitals."[12]

II. NEW TYPES OF FIRMS TO COMPETE WITH HOSPITALS.

One topic of great interest at the FTC/DOJ hearings involved entry by single-specialty hospitals and ambulatory surgery centers to compete with general hospitals in the provision of certain types of services. Although the types of services offered by such firms differ, they raise similar competitive issues. We discuss each in turn.

A. Single-Specialty Hospitals.

Single-specialty hospitals (SSHs) provide care for a specific specialty (*e.g.*, cardiac, orthopedic, or psychiatric) or type of patient (*e.g.*, children, women),[13] tailoring their care and

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[11] Section 507(b)(2) and (b)(3) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires the Department for Health and Human Services, of which CMS is a part, to study a set of quality and cost issues related to specialty hospitals and to report to Congress on their findings. Pub. L. No. 108-173, § 507, 117 Stat. 2066 (2003). Dr. McClellan's testimony presented the results and recommendations from the CMS report.

[12] Testimony of Mark B. McClellan, M.D., Ph.D., Administrator, Centers for Medicare & Medicaid Services, Before the House Committee on Energy and Commerce Hearing, "Specialty Hospitals: Assessing Their Role in the Delivery of Quality Health Care," May 12, 2005, *available at* http://www.cms.hhs.gov/media/press/testimony.asp?Counter=1459 [hereinafter McClellan Testimony].

[13] George Lynn, Remarks at the Federal Trade Commission and Department of Justice Hearings on Health Care and Competition Law and Policy (Mar. 27, 2003) at page 27 ("Historically, they were children's hospitals or psych. hospitals; now they include heart hospitals, cancer hospitals, ambulatory surgery centers, dialysis clinics, pain centers, imaging centers, mammography centers and a host of other narrowly focused providers generally owned, at least in part, by the physicians who refer patients to them.") [hereinafter, citations to transcripts of these Hearings state the speaker's last name, the date of testimony, and relevant page(s).] Transcripts of the Hearings are *available at* http://www.ftc.gov/ogc/healthcarehearings/index.htm#Materials.

facilities to fit the chosen type of condition, patient, or procedure on which they focus. Specialty hospitals are not new to the hospital industry; pediatric and psychiatric hospitals have existed for decades. Nonetheless, more recently, new cardiac and orthopedic surgery hospitals have opened or are under construction. Such SSHs may compete with both inpatient and outpatient general hospital surgery departments, as well as with ambulatory surgery centers.

Panelists at the FTC/DOJ Hearings identified a number of market developments that encouraged the emergence of SSHs, including less tightly managed care;[14] the willingness of providers to invest in an SSH;[15] physicians' desire to "provide better, more timely patient care";[16] physicians looking for ways to supplement declining professional fees;[17] and the growth of entrepreneurial firms.[18] Panelists also stated that some providers desire greater control over management decisions that affect their incomes and productivity.[19] Several panelists suggested efficiency was an important consideration for many providers, asserting that specialty hospitals allow "surgeons to start on time, do more cases in a given amount of time, and get back to their

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[14] Lesser 3/27 at 10-11.

[15] *Id.*

[16] Alexander 3/27 at 34. *See also* Nat'l Surgical Hospitals, *Single Specialty Hospitals* (Mar. 27, 2003) (Public Comment) [hereinafter links to FTC/DOJ Health Care Hearings Public Comments are *available at* http://www.ftc.gov/os/comments/healthcarecomments2/index.htm].

[17] J. Wilson 4/11 at 66 (as doctors make less money from insurance companies, they will "get into surgery centers, ... [W]e're getting into ancillary activities in order to maintain our standard of income and living.").

[18] Lesser 3/27 at 10-11.

[19] *See, e.g.*, D. Kelly 3/27 at 70 ("[I]t's because of the care, the control we have over the care provided for their patients in the in-patient setting;"); Kane 4/11 at 74 (many physicians starting specialty hospitals because they are dissatisfied with general hospitals "because of the inability to manage their day-to-day patient interactions and their inability to provide high-quality medical care"); Dan Caldwell, *Health Care Competition Law and Policy Hearings* 2 (Public Comment) (listing physicians participation in the governance of a facility and physician efficiency as influencing the development of SSHs).

office on time."[20] According to one panelist, physicians view SSHs as an "opportunity to make improvements" by "redesign[ing] the care delivery process in a way to be more effective and efficient."[21] Several panelists contended that SSHs achieve better outcomes through increased volume, better disease management, and better clinical standards.[22] They attribute these positive outcomes to their focus on a single specialty. Indeed, numerous empirical studies indicate a relationship between the number of particular procedures performed and the probability of a good outcome.[23]

Overall, testimony at the FTC/DOJ Hearings identified a number of benefits that SSHs may offer to consumers, with no significant controversy about the potential for SSHs to provide those benefits. Rather, as discussed in more detail below, debate about SSHs generally centered

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[20] Rex-Waller 3/27 at 51. *See also* Rex-Waller 3/27 at 50 (specialty hospitals are responding to a "demand born out of frustration with local acute care hospital management that is unresponsive" to surgeon and patient requirements). *See also* D. Kelly 3/27 at 70 (describing "the productivity enhancement it provides to them because all of them are getting busier and they need to find ways to be more productive"); D. Kelly 3/27 at 81 (noting the savings on expenses: "instead of spending 40 to 60 percent of your total operating expense on labor, which is typical in the United States in a fully integrated health system, we do that at around 30 percent on a fully allocated basis"); Alexander 3/27 at 35 (stating that operating rooms in some markets "are at capacity" and it is very difficult for physicians to schedule elective surgeries at general hospitals).

[21] Lesser 3/27 at 14. *See also* Alexander 3/27 at 33 ("Specialized facilities are a natural progression and are a recognition that the system needs to be tweaked, perhaps overhauled, to achieve lower costs, higher patient satisfaction, and improved outcomes.").

[22] Lesser 3/27 at 14-15 (noting that specialty hospitals across the country have stated that by "concentrating more cases in a particular facility, specialty hospitals may help to lower per-case costs and boost quality"). *See also* NEWT GINGRICH ET AL., SAVING LIVES AND SAVING MONEY (2003); REGINA HERZLINGER, MARKET DRIVEN HEALTH CARE: WHO WINS, WHO LOSES IN THE TRANSFORMATION OF AMERICA'S LARGEST SERVICE INDUSTRY (1997).

[23] Hal S. Luft et al., *Should Operations Be Regionalized? The Empirical Relation Between Surgical Volume and Mortality*, 301 N. ENG. J. MED. 1364 (1979); John D. Birkmeyer, *Hospital Volume and Surgical Mortality in the United States*, 346 N. ENG. J. MED. 1128 (2002); Colin B. Begg, *Impact of Hospital Volume on Operative Mortality for Major Cancer Surgery*, 280 JAMA 1747 (1998). Some panelists argued, however, that SSHs and ambulatory surgery centers are inherently risky for patients with multiple conditions. They argued that chronic disease management, rather than fragmented specialty services, will serve those patients better. *See, e.g.*, Andrew 3/26 at 12 (Hospitals believe that SSHs do not take the more difficult cases with comorbidities.).

on how they may affect the functioning of general hospitals.[24]

B. Ambulatory Surgery Centers

Ambulatory surgery centers (ASCs) perform surgical procedures on patients who do not require an overnight stay in the hospital. Approximately half of the ASCs are single-specialty.[25] Single-specialty ASCs generally specialize in either gastroenterology, orthopedics, or ophthalmology.[26] Most ASCs are small (two to four operating rooms). ASCs' ownership structures vary: some are completely physician-owned; some joint ventures between physicians and private or publicly traded companies own them; some physician/hospital joint ventures own them; and some hospitals and hospital networks own ASCs.[27] Innovations in technology have made it possible to offer a broad range of services in ASCs.[28]

ASCs require less capital than SSHs and are generally less complex to develop, because they do not require the facilities needed to offer care twenty-four hours a day, seven days a week. In addition, ASCs generally do not have emergency rooms. Originally, ASCs were intended to compete with hospital inpatient units, but they now compete more against hospital outpatient surgery units.[29] Panelists indicated that many of the same factors spurring the growth of specialty

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[24] Some debate also focused on the fact that many of the physicians who refer patients to an SSH have an ownership interest in that facility. While noting the existence of that issue, the FTC/DOJ Report did not examine it in depth. *Improving Health Care*, *supra* note 2, ch.3, at 20 n.98, at 22 nn.109, 113.

[25] Beeler 3/26 at 59.

[26] Lawrence P. Casalino et al., *Focused Factories? Physician-Owned Specialty Facilities*, 22 HEALTH AFFAIRS 56, 59 (Nov./Dec. 2003).

[27] Beeler 3/26 at 60.

[28] Rex-Waller 3/27 at 50 (stating that the growth of ASCs "has been driven by technology, technological advances, particularly in endoscopic surgery . . . in surgical techniques, and in advanced anesthetic agents").

[29] Casalino et al., *supra* note 26, at 59. *See also* Beeler 3/26 at 63; Sacks 3/26 at 40.

hospitals influenced ASC development. One panelist noted that ASCs were "a common-sense, intelligent response to a mature health care delivery system and industry gripped by inefficiencies and to health care spending being out of control."[30] Other reasons for ASC growth listed by panelists included improved technology,[31] physician demand for efficient surgical facilities,[32] control and specialized staff, as well as "patient demand for a non-institutional, friendly, convenient setting for their surgical care, and payor demand for cost efficiencies as evidenced by the ambulatory surgery center industry."[33] One study also noted that ASCs offer patients more "convenient locations, shorter wait times, and lower coinsurance than a hospital department."[34] This testimony suggests that ASCs, like SSHs, can provide significant benefits to consumers.[35]

III. Certificates of Need: Responses by Incumbent Hospitals to Proposed Entry by Single-Specialty Hospitals.

Some general hospitals have planned for possible competition from SSHs by competing

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[30] Alexander 3/27 at 32.

[31] Technological changes include the development of flexible fiberoptic scopes used for colon cancer screening and upper GI procedures as well as advancements in microsurgery and ultrasound techniques used in cataract lens replacement. *See* MEDICARE PAYMENT ADVISORY COMM'N (MEDPAC), REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY § 2F, at 140 (2003), *at* http://www.medpac.gov/publications/congressional_reports/Mar03_Entire_report.pdf [hereinafter MEDPAC] .

[32] *See, e.g., id.*, § 2F, at 140 (noting that the specialized settings may have allowed physicians to perform procedures more efficiently than in an outpatient setting and allowed physicians to reserve surgical time).

[33] Rex-Waller 3/27 at 50. *See also* Beeler 3/26 at 62 (noting the "development of new technology and techniques for both the surgery itself and anesthesia" have allowed providers to discharge patients more quickly after surgery).

[34] MEDPAC, *supra* note 31, § 2F, at 140 (assessing coinsurance is 20 percent lower in an ASC).

[35] According to the testimony of the Administrator of CMS on May 12, 2005, the CMS congressionally mandated study of specialty hospitals also found that "specialty hospitals provide high patient satisfaction, high quality of care and patient outcomes in some important dimensions, [and] greater predictability in scheduling and services, ..." McClellan Testimony, *supra* note 12.

more vigorously – establishing their own single-specialty wing, for example, or partnering with physicians on their medical staff to open an SSH.[36] Panelists at the FTC/DOJ Hearings also alleged, however, that some general hospitals have attempted to deter or prevent entry by single-specialty hospitals through a variety of means, some of which may be anticompetitive. Generally speaking, antitrust law does not limit individual hospitals from unilaterally responding to competition.[37] If there is specific evidence of hospitals colluding against efforts to open an SSH or ASC, however, the Agencies will aggressively pursue those activities.[38]

Among other things, it appears that some general hospitals have used CON laws to encumber specialty hospital entry.[39] As explained above, such conduct may escape antitrust scrutiny under the state action and *Noerr Pennington* doctrines. Nonetheless, such conduct raises significant competition policy issues.

The Commission believes that CON programs can pose serious competitive concerns that

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[36] Lesser 3/27 at 12 (describing some hospitals as taking a "kind of preemptive strike strategy where the hospital establishes its own specialty facility in an effort to ward off the establishment of the competing facility in the market"). *See, e.g.*, The Wisconsin Heart Hospital's partnership with Covenant Healthcare, *at* http://www.twhh.org.

[37] Of course, under some circumstances, a unilateral response can still constitute a violation of Section 2 of the Sherman Act, and there are sham and misrepresentation exceptions to the *Noerr-Pennington* doctrine. *See Improving Health Care, supra* note 2, ch.8.

[38] *Id.*, ch.3, at 27.

[39] Rex-Waller 3/27 at 53-54; Alexander 3/27 at 38. A new Florida law that bars licensure of any specialty hospital provides an example of this allegation. The law bans specialty hospitals that treat a single condition, and it eliminates its CON requirement for new adult open-heart surgery and angioplasty programs at general hospitals. The law also exempts from CON the addition of beds to existing structures, but new structures will still be required to file a CON. Fla. Bill SJ 01740 (effective July 1, 2004), *amending* FLA STAT. ch. 408.036, .0361 (2003). On CON laws, *see Improving Health Care, supra* note 2, ch.8.

Although one panelist alleged that some general hospitals have used state certificate of need laws to inhibit ASC entry, certificate of need regulations often are not as rigorous for ASCs, if they apply at all. *Id.*, ch.3, at 24, 27. Entry by ASCs appears to have been easier than for SSHs. For example, the number of ASCs has doubled in the past decade, currently totaling 3,371, while the number of SSHs remains around 100. *Id.* at 17, 24.

generally outweigh CON programs' purported economic benefits. Although CON programs originally were intended to control health care costs, considerable evidence reveals that they actually can drive up prices by fostering anticompetitive barriers to entry. Other means of cost control appear to be more effective and pose less significant competitive concerns. We analyze each point in turn.

A. Background on the History and Purpose of State CON Programs.

State CON programs generally prevent firms from entering certain areas of the health care market unless they can demonstrate to state authorities an unmet need for their services. Upon making such a showing, prospective entrants receive from the state a CON allowing them to proceed.[40]

Many CON programs trace their origin to a repealed federal mandate. The National Health Planning and Resources Development Act of 1974[41] offered states powerful incentives to enact state laws implementing CON programs.[42] By 1980, all states except Louisiana had enacted CON programs.[43] Congress repealed the federal law in 1986, but a substantial number of

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[40] *See* JOHN MILES, 2 HEALTH CARE & ANTITRUST LAWS: PRINCIPLES AND PRACTICE § 16:1, at 16-2, 16-5 to 16-6 (2003) (noting that CONs under the federal Health Planning Act required providers to "obtain state approval – a 'certificate of need' – before spending set amounts on capital investments or adding new health care services"); James F. Blumstein & Frank A. Sloan, *Health Planning and Regulation Through Certificate of Need: An Overview*, 1978 UTAH L. REV. 3; Randall Bovbjerg, *The Importance of Incentives, Standards, and Procedures in Certificate of Need*, 1978 UTAH L. REV. 83; Clark C. Havighurst, *Regulation of Health Facilities and Services by "Certificate of Need"*, 59 VA. L. REV. 1143 (1973).

[41] Pub. L. No. 93-641, 88 Stat. 2225 (1975) (codified at 42 U.S.C. §§ 300k-300n-5), *repealed*, Pub. L. No. 99-660, § 701, 100 Stat. 3799 (1986).

[42] MILES, *supra* note 40, § 16:1, at 16-2.

[43] *See, e.g.*, Morrisey 6/10 at 146; *On Certificate of Need Regulation: Hearing on H.B. 332 Before the Senate Comm. On Health and Human Services* (Ohio 1989) (Statement of Mark D. Kindt, FTC Regional Director) [hereinafter Kindt].

states continue to maintain CON programs,[44] "although often in a loosened form compared to their predecessors."[45]

CON programs had the major goal of controlling costs by restricting provider capital expenditures.[46] The forces of competition ordinarily limit excess supply, but, according to a panelist representing the American Health Planning Association, "[c]ompetition in health care is ... very different" than in other markets.[47] Congress appears to have shared this view in 1974; the passage of the Health Planning Act reflected a congressional belief that market failure plagued the health care market, resulting in "excess supply and needless duplication of some services."[48]

The system of cost-based reimbursement may have driven the problem that Congress sought to solve.[49] When many CON programs were established, government or private insurance

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[44] *See* Davenport-Ennis 5/29 at 113-14; Morrisey 6/10 at 146 (noting that by 2002, about 36 states and the District of Columbia retained CON programs in some form); MILES, *supra* note 40, § 16:2, at 16-9 (stating that "CON laws remain in many states and the District of Columbia"). Quite recently, Florida exempted from CON new adult open-heart surgery and angioplasty programs at general hospitals and the addition of beds to existing hospital structures. Fla. Bill SJ 01740 (effective July 1, 2004), *amending* FLA STAT. ch. 408.036, .0361 (2003).

[45] MILES, *supra* note 40, § 16:1, at 16-2 to 16-3. *See also* Len M. Nichols et al., *Are Market Forces Strong Enough to Deliver Efficient Health Care Systems? Confidence is Waning*, 23 HEALTH AFFAIRS 1, 11 (Mar./Apr. 2004) (noting that CON programs "eroded through the 1990s").

[46] *See* Piper 6/10 at 53; Morrisey 6/10 at 146 (noting that CON programs "were established in the '70s to help control health care costs"). *See also* MILES, *supra* note 40, § 16:1, at 16-4 ("[The primary role of the Health Planning Act was to regulate the supply of health care resources, particularly institutional services, by requiring a CON from the state before certain levels of capital expenditures could be made or new services introduced."); Kindt, *supra* note 43, at 2-3 (noting that a "key justification" for CON programs has been "the belief that health care providers, particularly hospitals, would undertake excessive investment in unregulated health care markets," driving up health care costs); PUBLIC HEALTH RESOURCE GROUP, CERTIFICATE OF NEED PROJECT REPORT 17-18 (2001).

[47] Piper 6/10 at 53-54 (observing that the main aim of CON programs is to limit "excess supply generating excess demand"). *See also* PUBLIC HEALTH RESOURCE GROUP, *supra* note 46, at 18.

[48] MILES, *supra* note 40, § 16:1, at 16-4.

[49] *See id.*

paid health care expenses "on a retrospective cost reimbursement basis."[50] This, coupled with the general concern that patients would not be sufficiently price sensitive and would demand the perceived highest quality services, led to the fear that health care providers would expand their services to the point of offering unnecessarily duplicative services, because they competed largely on non-price grounds.[51]

Cost-based reimbursement is much less common today, but some contend that CON programs still have a role to play. Indeed, one panelist argued that in health care markets, "providers control the supply of services. Medical practitioners direct the flow of patients and therefore the demand for services."[52] Moreover, consumers lack the information to compare prices, he said.[53] Such problems can lead to an inefficient allocation of health care resources and higher health care costs, absent CON programs, some state.[54] Some commentators also suggest

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[50] Keith B. Anderson, Certificate of Need Regulation of Health Care Facilities, FTC Staff Prepared Statement Before North Carolina State Goals and Policy Board 6 (Mar. 6, 1989). *See also* Davenport-Ennis 5/29 at 114 (noting that at the time, the federal government reimbursed health care expenses on a "cost-plus basis, which did not provide the cost control capability of today's prospective payment system").

[51] Morrisey 6/10 at 147; *see also* Davenport-Ennis 5/29 at 114 (noting that government officials intended CON to "retain rising health care costs, to prevent unnecessary duplication of resources and services, and [to] expand consumer access to quality health care services").

[52] Piper 6/10 at 55.

[53] *Id.* at 55 (noting, however, that consumers do "suffer under the ultimate increased costs in premiums and their taxes"). The same panelist also cited empirical studies suggesting that CON programs reduce health care costs, studies that another panelist questioned. *Compare* Piper 6/10 at 57-61, *and* Thomas R. Piper, *Comments Regarding Hearings on Health Care and Competition Law and Policy* 5-13 (Public Comment) (discussing these and other studies) [hereinafter Piper (public cmt)], *with* Loeffler 6/10 at 127 (questioning those studies), *and with* Piper 6/10 at 127-28 (responding to such questions).

[54] *See, e.g.*, MILES, *supra* note 40, § 16:1, at 16-4 (describing Congress' concerns); Piper 6/10 at 62 (asserting that "[a]reas with more hospitals and doctors spend more on health care services per person"); PUBLIC HEALTH RESOURCE GROUP, *supra* note 46, at 11 ("Adding providers usually mean increases in costs."); *see also* Piper 6/10 at 126 (noting that the fact that the public fisc is at stake adds importance to the concern).

that CON programs can enhance health care quality and access.[55] One panelist, for example, stated that there are "few mechanisms" other than the CON process that promote "minimum patient volumes" that contribute to better quality care.[56] According to that panelist, CON regulation also can address cherry picking, preventing firms from, for example, converting "[cancer] medical practices to medical care facilities [that] divert well-insured patients [from] local hospital cancer programs" and "undermine[] the ability of essential community hospitals to provide a full array of oncology services to the entire community."[57]

However, as one commentator noted, "[t]he regulation of supply through mechanisms such as CON may have made sense when most reimbursement was cost-based and thus there was incentive to expand regardless of demand[,] but they make much less sense today when hospitals are paid a fixed amount for services and managed care forces them to compete both to participate in managed-care networks and then for the plans' patients."[58] This policy justification of CON programs is particularly questionable given the new strategies that have evolved to control

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[55] PUBLIC HEALTH RESOURCE GROUP, *supra* note 46, at 5.

[56] Piper (public cmt), *supra* note 53, at 12 (noting, for example, that in CON-free states, "the percentage of patients that had surgery in low volume programs was three times higher than in states with CON regulation").

[57] *Id.*, at 13-14; *see also* Piper 6/10 at 54 (noting that CON programs aim to overcome "market gaps and excesses like the avoidance of low-income populations and concentration of services in … affluent areas"); Nichols et al., *supra* note 45, at 11 (stating that today "some states are considering reinstituting or reinvigorating [CON programs] in response to construction of physician-owned specialty facilities, which has posed a competitive threat to community hospitals"). *But see* Price 6/10 at 108 (would-be entrant denying allegation of "cherry picking"); Davenport-Ennis 5/29 at 115-16 (stating that CON programs restrict the supply of cancer treatment services such that "low-income, seriously ill, and rural patients" who do not live near a hospital or major medical center lose access to care).

[58] MILES, *supra* note 40, § 16:1, at 16-3.

costs.[59]

Moreover, it appears that CON programs generally fail to control costs.[60] One panelist surveyed the empirical literature on the economic effects of CON programs and reported that the "literature tends to conclude ... that CON has been ineffective in controlling hospital costs," and that, to the contrary, "[i]t may have raised costs and restricted entry."[61] Commentators stated the reason that CON has been ineffective in controlling costs is that CON programs do not put a stop to "supposedly unnecessary expenditures[,]" but "merely redirect[] any such expenditures into other areas."[62] Thus, a CON rule that restricts capital investment in new beds does nothing to

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[59] *See, e.g.*, Kindt, *supra* note 43, at 8-11; Anderson, *supra* note 50, at 9-13 (same); Davenport-Ennis 5/29 at 121 (citing means other than CON programs "to regulate over-usage and over-referral"). *But see* PUBLIC HEALTH RESOURCE GROUP, *supra* note 46, at 11 (stating that "[m]anaged care companies have not created the competition and lower cost solutions originally expected of them").

[60] *See* Hennessy 6/10 at 93-94 (stating that "CON is a failure as a cost containment tool" and that the premiums in Kansas and Missouri are generally the same, in spite of the fact that one state has a CON program and the other does not); Anderson, *supra* note 50, at 2-6 (summarizing empirical evidence and finding that CON fails to regulate costs); Kindt, *supra* note 43, at 3-5 (summarizing empirical studies on the economic effects of CON programs and concluding that "[t]here is near universal agreement among the authors [of studies on the economic effects of CON programs] and other health economists that CON has been unsuccessful in containing health care costs"); DANIEL SHERMAN, FEDERAL TRADE COMM'N, THE EFFECT OF STATE CERTIFICATE-OF-NEED LAWS ON HOSPITAL COSTS: AN ECONOMIC POLICY ANALYSIS (1988) (concluding, after empirical study of CON programs' effects on hospital costs using 1983-84 data, that strong CON programs do not lead to lower costs but may actually increase costs); MONICA NOETHER, FEDERAL TRADE COMM'N, COMPETITION AMONG HOSPITALS 82 (1987) (empirical study concluding that CON regulation led to higher prices and expenditures); KEITH B. ANDERSON & DAVID I. KASS, FEDERAL TRADE COMM'N, CERTIFICATE OF NEED REGULATION OF ENTRY INTO HOME HEALTH CARE: A MULTI-PRODUCT COST FUNCTION ANALYSIS (1986) (economic study finding that CON regulation led to higher costs, and that CON regulation did little to further economies of scale); *cf.* PUBLIC HEALTH RESOURCE GROUP, *supra* note 46, at 4 (noting that the "track record of the cost effectiveness of state CON programs is decidedly mixed," and that "[i]n some states, the effectiveness is at least partially attributable to deficiencies in program operations and to political environments in which legislative or high-level executive branch intervention alters or affects CON decision-making"). *See also* David S. Salkever, *Regulation of Prices and Investment in Hospitals in the United States*, *in* 1B HANDBOOK OF HEALTH ECONOMICS, 1489-90 (A.J. Culyer & J.P. Newhouse eds., 2000) (concluding that "there is little evidence that [1970s-era] investment controls reduced the rate of cost growth," even though "inconsistent reports of constraining effects on numbers of beds and diffusion of some specialized services did appear").

[61] Morrisey 6/10 at 148-49, 152-53.

[62] Kindt, *supra* note 43, at 5.

prevent hospitals from "add[ing] other kinds of fancy equipment" and using that to compete for consumers.[63]

B. Competitive Concerns that CON Programs Raise

Many have criticized CON programs for creating barriers to entry in the health care market.[64] As noted previously, CON regimes prevent new health care entrants from competing without a state-issued certificate of need, which is often difficult to obtain. This process has the effect of shielding incumbent health care providers from new entrants. As a result, CON programs actually can increase health care costs, as supply is depressed below competitive levels.[65]

CON programs also can retard the entry of firms that could provide higher quality services than the incumbents.[66] By protecting incumbents, CON programs can "delay[] the introduction and acceptance of innovative alternatives to costly treatment methods."[67] Similarly, CON programs' "[c]urtailing [of] services or facilities may force some consumers to resort to more expensive or less-desirable substitutes, thus increasing costs for patients or third-party

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[63] *Id.*

[64] *See* Anderson, *supra* note 50, at 7; Hennessy 6/10 at 95, 99-100 ("CON protects incumbent providers . . . from competition" and is an "impediment to innovation [and] quality improvement" in health care); Blumstein & Sloan, *supra* note 40; Bovbjerg, *supra* note 40; Havighurst, *supra* note 40. The Commission has also noted the impact of CON programs on entry and firm behavior. *See In re Hosp. Corp. of Am.*, 106 F.T.C. 361, 489-501 (1985).

[65] *See* Anderson, *supra* note 50, at 7-8; Kindt, *supra* note 43, at 6-7.

[66] *See, e.g.*, Anderson, *supra* note 50, at 7-9; Kindt, *supra* note 43, at 6; *Hosp. Corp. of Am.*, 106 F.T.C. at 495 (opinion of the Commission) (stating that "CON laws pose a very substantial obstacle to both new entry and expansion of bed capacity in the Chattanooga market" and that "the very purpose of the CON laws is to restrict entry").

[67] Anderson, *supra* note 50, at 9; Kindt, *supra* note 43, at 6.

payers. For example, if nursing home beds are not available, the discharge of patients from more expensive hospital beds may be delayed or patients may be forced to use nursing homes far from home."[68]

The experience of SSHs is revealing. There are relatively few SSHs. In October 2003, the General Accounting Office identified 100 existing SSHs, with an additional 26 under development. SSHs are located in 28 states, but two-thirds are located in only seven states.[69] The GAO concluded that "the location of specialty hospitals is strongly correlated to whether states allow hospitals to add beds or build new facilities without first obtaining state approval for such health care capacity increases."[70] Ninety-six percent of the SSHs that opened from 1990 to 2003, and all 26 SSHs under development in 2003 were located in states without CON programs.[71]

C. Conclusion

The Commission believes that CON programs generally are not successful in containing health care costs, and that they can pose anticompetitive risks. As noted above, CON programs

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[68] Kindt, *supra* note 43, at 7.

[69] U. S. GENERAL ACCOUNTING OFFICE, GAO-04-167, SPECIALTY HOSPITALS: GEOGRAPHIC LOCATIONS, SERVICES PROVIDED AND FINANCIAL PERFORMANCE 3-4 (2003) (Report to Congressional Requesters) [hereinafter GAO, SPECIALTY HOSPITALS], *at* http://www.gao.gov/new.items /d04167.pdf. The seven states are Arizona, California, Texas, Oklahoma, South Dakota, Louisiana, and Kansas. Of those seven states, only three (Texas, Oklahoma and Arizona) require all hospitals to have an emergency room. *Id.*

[70] *Id.*, at 15. *See also Improving Health Care, supra* note 2, ch.8 (discussing CON programs).

[71] GAO, SPECIALTY HOSPITALS, *supra* note 69, at 15. According to the GAO report, as of 2002, "37 states maintained certificate of need (CON) requirements to varying degrees. Overall, 83 percent of all specialty hospitals (including, among other things, pediatric, cardiac, and psychiatric), 55 percent of general hospitals, and 50 percent of the U.S. population are located in states without CON requirements." *Id. See also* Casalino et al., *supra* note 26, at 58-59.

In the MMA, Congress included a moratorium on payments for single specialty hospitals. The moratorium continues until June 8, 2005. Pub. L. No. 108-173, § 507, 117 Stat. 2066 (2003).

risk entrenching oligopolists and eroding consumer welfare. The aim of controlling costs is laudable, but there appear to be other, more effective means of achieving this goal that do not pose anticompetitive risks. Indeed, competition itself is often the most effective method of controlling costs. A similar analysis applies to the use of CON programs to enhance health care quality and access. For these reasons, the FTC/DOJ Report recommended that states with CON programs reconsider whether those programs are best serving their citizens' health care needs.

IV. Cross-Subsidization and The Influence of Government Purchasing on the Development of Competition in the Hospital Arena.

Medicare's administered pricing system has substantially driven the emergence of SSHs and ASCs. Medicare's administered pricing system, generally inadvertently, can make some services extraordinarily lucrative, and others unprofitable. This problem is by no means unique to Medicare; it is virtually impossible for any administered pricing system to specify prices identical to those that a fully competitive marketplace would have produced.

The result of such pricing distortions is that some services are more or less available than they would be based on the demand for the services – which in turn triggers adaptive responses by providers.[72] New entrants formed to profit from distortions in Medicare's administered pricing can take such profits away from general hospitals. General hospitals, however, report that they have used, and continue to need, those profits to cross subsidize unprofitable services, such as the care they must provide to indigent and other patients.

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[72] *See, e.g.*, Hammer 2/27 at 52 (noting that when CMS "has a misalignment of the regulatory pricing system, . . . it creates competition gaming the regulatory system); Scully 2/26 at 28, 46 ("So, when the government, either Federal or State, is fixing prices, the rest of the market's flexibility to respond to that is kind of muted . . . I can tell you when I drive around the country and see where ASCs are popping up, I can tell who we're overpaying.").

Cross subsidization and competition are at odds with one another. Competition competes away cross subsidies. Thus, policymakers may wish to replace indirect cross subsidies with direct subsidies for services that are socially desirable.

A. Medicare's Administered Pricing Program Has Encouraged the Entry of SSHs and ASCs.

Some SSHs have entered in response to government reimbursement for cardiac care that makes cardiac care generally more profitable than many other types of inpatient care. Commentators and panelists suggested that CMS never made a deliberate decision to provide for greater profits for such services relative to the amounts paid for other inpatient services, but that the administered pricing schedule does so.[73] This pricing distortion creates a direct economic incentive for SSHs to enter the market. Absent the distortions created by the excess profits for cardiac services in Medicare's administered pricing system, the incentive for SSH entry would be less.

Medicare reimbursement also has had a profound impact on the number of ASCs and the amount of surgery performed in them.[74] Congress first approved coverage of ASCs by Medicare in 1980, as part of an effort to control health care spending by providing low-risk surgeries in a

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[73] *See, e.g.*, Ginsburg 2/26 at 65 ("Medicare sets the DRG rates, ... but their productivity gains are much faster in cardiovascular services so that, in a sense, the rates become obsolete fairly quickly ...."); KELLY DEVERS ET AL., SPECIALTY HOSPITALS: FOCUSED FACTORIES OR CREAM SKIMMERS? (Ctr. for Studying Health Sys. Change, Issue Brief No. 62, 2003), *available at* http://www.hschange.com/CONTENT/552/ (reporting statements of hospital executives that certain surgical procedures (*e.g.*, cardiovascular and orthopedic) are among the most profitable surgeries, and that it is unlikely that payors intended to create these distortions in payment rates).

[74] The anti-kickback statute, described in detail in *Improving Health Care*, *supra* note 2, Chapter 1, has also had an effect on the rise of ASCs. The anti-kickback statute generally discourages physicians from investing in facilities to which they refer patients, but a regulatory safe harbor explicitly excludes ASCs from this prohibition. Office of the Inspector General, *Programs: Fraud and Abuse; Clarification of the Initial OIG Safe Harbor Provisions and Establishment of Additional Safe Harbor Provisions Under the Anti-Kickback Statute; Final Rule*, 64 Fed. Reg. 63,517 (Nov. 19, 1999).

less-expensive ambulatory setting.[75] Between 1982 and 1988, Medicare paid 100 percent of the reasonable charges for approved ambulatory procedures, and waived the deductible and copayment that would apply if the procedure were provided in an inpatient setting.[76] From 1988 to 2003, the fee schedule has been based on an inflation-adjusted 1986 cost survey for ambulatory surgery. The ASC payment schedule has not been adjusted for advances in technology and productivity over the last 16 years; some procedures that were once labor-and-resource intensive are now much less costly for ASCs to perform. In recognition of this, among the other things, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003[77] (MMA) freezes Medicare payment rates for ASCs from 2005 through 2009 and directs the Department of Health and Human Services to implement a new payment system by 2008.[78]

In addition, although ASCs and hospital outpatient departments perform some of the same procedures, payment varies depending on where the services are provided. Higher reimbursement for services performed in a hospital outpatient department may make sense when a patient has multiple complicating factors, making the surgery more complex. One panelist also asserted that hospitals should receive higher payments for outpatient services because they have higher overhead costs.[79] Yet, payment may be higher, lower, or the same at ASCs and hospital

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[75] Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, § 934, 94 Stat. 2599 (1980). *See also* Shelah Leader & Marilyn Moon, *Medicare Trends in Ambulatory Surgery*, 8 HEALTH AFFAIRS 158, 158-59 (Spring 1989).

[76] *Id.*, at 158-59.

[77] Pub. L. No. 108-173, 117 Stat. 2066 (2003).

[78] MMA § 626(d).

[79] Andrew 3/26 at 118.

outpatient departments.[80] These differences create predictable incentives for providers. As former CMS administrator Tom Scully noted, when the ASC rate is high, "all of a sudden you start seeing ASCs pop up all over the place to do colonoscopies or to do outpatient surgery .... If the hospitals get paid a little more, they're going to have more outpatient centers."[81]

B. SSHs and ASCs Will Tend to Compete Away the Profits that Hospitals Use to Cross Subsidize Unprofitable Care.

Several panelists were concerned that SSHs would siphon off the most profitable procedures and patients, leaving general hospitals with less money to cross subsidize other socially valuable, but less profitable, care.[82] As one panelist stated, "it is the profitable services they are taking away that jeopardizes a hospital's capability of providing unprofitable services."[83] Panelists expressed concern that "the community [will] lose[] access to specific services or ultimately to all hospital services as the general hospital deteriorates or closes."[84] One panelist

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[80] The MMA also directs the GAO to conduct a study comparing the costs of procedures in ASCs to the cost of procedures furnished in hospital outpatient departments, and make recommendations about the appropriateness of using the outpatient prospective payment system as a basis for paying ASCs. MMA § 626(d).

[81] Scully 2/26 at 46.

[82] Lesser 3/27 at 14-21; Cara Lesser, *Specialty Hospitals: Market Impact and Policy Implications* 14-15 (3/27) (slides) (considerable variation in scope of emergency services provided) at http://www.ftc.gov/ogc/healthcarehearings/docs/lesser.pdf; Ginsburg 2/26 at 66 (stating the "threat for specialized services does have the potential to erode some of the traditional cross subsidies that the health system is run on"); Lesser 9/9/02 at 92. *See also* G. Lynn 3/27 at 31 (arguing that the Agencies must take into account the effect specialty hospitals have on "the medical safety net" of the community hospital).

[83] Morehead 3/27 at 42. *See also* Harrington 4/11 at 76-77 ("We can't afford to continue to lose a percentage of our volume and thus our revenue, and be able to provide the same quality level of service that we provide ... if we continue to be niched away."); G. Lynn 3/27 at 28 (specialty hospitals "threaten[] community access to basic health services and jeopardizes patient safety and quality of care"); Dan Mulholland, *Competition Between Single-Specialty Hospitals and Full-Service Hospitals: Level Playing Field or Unfair Competition?* 7 (3/27) (slides) at http://www.ftc.gov/ogc/healthcarehearings/docs/mulholland.pdf (community hospitals may be victims of patient dumping and revenue loss threatens community services).

[84] G. Lynn 3/27 at 29.

noted that the balance of the population relies for its health care services on an infrastructure built in response to the excesses and inadequacies of Medicare's administered pricing system.[85]

Many of the concerns expressed by panelists about SSHs were also expressed about ASCs. Panelists asserted that ASCs are eroding the outpatient market share of hospitals that hospitals depend upon, that ASCs do not care for Medicaid beneficiaries, and that ASCs "skim and cherry-pick on the front end regarding [] the finances of the patient."[86]

Hospital panelists see cross subsidies not as a theory, but as a fact of life:

> [If we] take away those profitable services and leave the hospital, the community hospital, with just the unprofitable services, one of two things is going to happen. Either services will be diminished to the community in a way that is not transparent, in a way that they cannot see that happening, or costs will be shifted back to other payors, and business and labor and consumers end up absorbing them, once again, not in a transparent way where they can see what's happening.[87]

C. Cross Subsidization and Competition Are At Odds.

Cross subsidizing is the practice of charging supracompetitive prices to some payors for some services and using the surpluses to subsidize other payors or other clinical services. Cross-subsidies can occur if there are barriers to entry in a market and a non-profit-maximizing firm

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[85] Sage 5/29 at 148 ("Public purchasing distorts prices, overbuilds capacity, and skews the development and dissemination of technology.").

[86] Andrew 3/26 at 12; Sacks 3/26 at 41 ("It is the profitable business, and that continues to be picked away by this type of competition.").

[87] G. Lynn 3/27 at 86. *See also* Opelka 2/27 at 180 ("Cost shifting was once the remedy to ensure a stable practice, but this [is] no longer a solution for surgeons."); Mansfield 4/25 at 88-89 ("[A]cute care hospitals, ... [are] very dependent upon being able to cross subsidize the losses we have for patients who have medical DRGs by treating those who are surgically or procedurally oriented."); Joyce Mann et al., *Uncompensated Care: Hospitals' Responses To Fiscal Pressures*, 14 HEALTH AFFAIRS 263, 263 (Spring 1995) ("Hospitals historically have taken it upon themselves to fill some of the gaps in the U.S. health insurance system by treating uninsured patients and then charging more to those who can pay to offset the costs. This practice, known as cost shifting, distinguishes the hospital sector from nearly all other sectors of the economy.").

receives greater profits on some services (*e.g.*, from Medicare for cardiac services)[88] that it uses to underwrite the provision of other services.[89]

Reliance on cross-subsidies, instead of direct subsidies, to ensure access to health care makes the availability of such care contingent on the location in which care is provided, the wealth and insurance status of those receiving care at any given hospital, and the un-competitiveness of the market for hospital services. Several panelists noted that in some communities, hospitals make substantial profits on one group and use those funds to provide charity care to the balance of the community.[90]

In other locations, this approach is not viable – particularly if those paying the bills identify alternative locations to provide care that choose not to engage in cross subsidization. Cross subsidies distort relative prices, resulting in inefficient decisions by payors and patients. Cross subsidies also complicate attempts to provide consumers with better price information. For governments, it is generally more efficient to subsidize directly, than to pay higher prices elsewhere and for hospitals to use those profits to cross subsidize the socially valuable services that the government desires in transactions that are not transparent.

As noted previously, cross subsidies require a non-profit-maximizing firm to receive

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[88] Cross subsidies may also occur if a non-profit-maximizing firm has market power and exercises that power to obtain supra-competitive profits on certain services, but not on other services.

[89] Commentators state that for-profit hospitals are less likely to offer non-remunerative services. *See* Jill R. Horwitz, *Why We Need the Independent Sector: The Behavior, Law, and Ethics of Not-for-Profit Hospitals*, 50 UCLA L. REV. 1345, 1367-76 (2003) (finding increased probability of non-remunerative services offered by nonprofit hospitals); Linda B. Miller, *The Conversion Game: High Stakes, Few Rules*, 16 HEALTH AFFAIRS 112, 116 (Mar./Apr. 1997) ("These services – such as burn units, perinatal intensive care units, transplantations, and other sophisticated medical interventions – exist overwhelmingly in the nonprofit sector and represent an investment in a social good, not potential financial returns.").

[90] G. Lynn 3/27 at 29.

supra-competitive profits on some services in a market with barriers to entry. As competition becomes more effective in hospital markets, competition will erode these cross subsidies.[91]

D. Conclusion.

Competition can help make health care more affordable, but it cannot transfer resources to those who do not have them. SSHs and ASCs may well enhance quality of care, lower prices, and improve access. From the perspective of those receiving care at an SSH or ASC, that is a desirable outcome. From the perspective of the general hospital that relied on specialty care to cross subsidize unprofitable patients and services, and from the perspective of such patients and perhaps others that the hospital serves, the same outcome is undesirable.[92]

Competition has a number of effects on hospitals, including the potential to improve quality and lower costs. Competition will also undermine the ability of hospitals to engage in cross-subsidization, however.[93] The FTC/DOJ Report recommended that "[g]overnments should reexamine the role of subsidies in health care markets in light of their inefficiencies and potential to distort competition."[94] In testimony before the House Committee on Energy and Commerce on May 12, 2005, Mark McClellan, Administrator of CMS, reported that CMS, following its own

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[91] Blumstein 2/27 at 30-31 (noting that "substantively, antitrust evaluates conduct on grounds of a competition and efficiency. It encourages competing away excess profits and cross subsidization. This is something that the health system has lived on for many years, but it is hard to do when super-competitive profits are being competed away and that many monopolies are being targeted.").

[92] *See, e.g.*, Lesser 3/27 at 17-18 ("While specialty facilities may lead to improved access for certain services … there may be a cost from the broader system and societal perspective [] in terms of the ability of general hospitals to maintain the cross-subsidies necessary to fund other less profitable services.").

[93] *See* COUNCIL OF ECONOMIC ADVISORS, ECONOMIC REPORT OF THE PRESIDENT, at ch.4 (2002) ("Competition need not threaten the quality of care received by those with the least ability to pay; rather, government support and oversight can be better directed to ensure that all Americans are able to participate effectively in a competitive health care system.").

[94] *Improving Health Care, supra* note 2, Exec. Summ., at 23.

study of specialty hospitals pursuant to congressional direction,[95] will analyze and reform its payment rates "to help reduce the possibility that specialty hospitals may take advantage of imprecise payment rates in the inpatient hospital prospective payment system" and "to diminish the divergences in payment levels [for ambulatory surgical centers] that create artificial incentives for the creation of small orthopedic or surgical hospitals."[96]

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[95] Section 507(b)(2) and (b)(3) of the MMA requires the Department for Health and Human Services, of which CMS is a part, to study a set of quality and cost issues related to specialty hospitals and to report to Congress on their findings. Dr. McClellan's testimony presented the results and recommendations from the CMS report. McClellan Testimony, *supra* note 12.

[96] *Id.*

TESTIMONY

Physician-owned specialty hospitals

May 24, 2005

Statement of
Mark E. Miller, Ph.D.

Executive Director
Medicare Payment Advisory Commission

Before the
Subcommittee on Federal Financial Management,
Government Information, and International Security
Committee on Homeland Security and Governmental Affairs
U.S. Senate

Chairman Coburn, Senator Carper, distinguished Subcommittee members. I am Mark Miller, executive director of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss physician-owned specialty hospitals.

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

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

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

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

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

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

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

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

How many and where

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

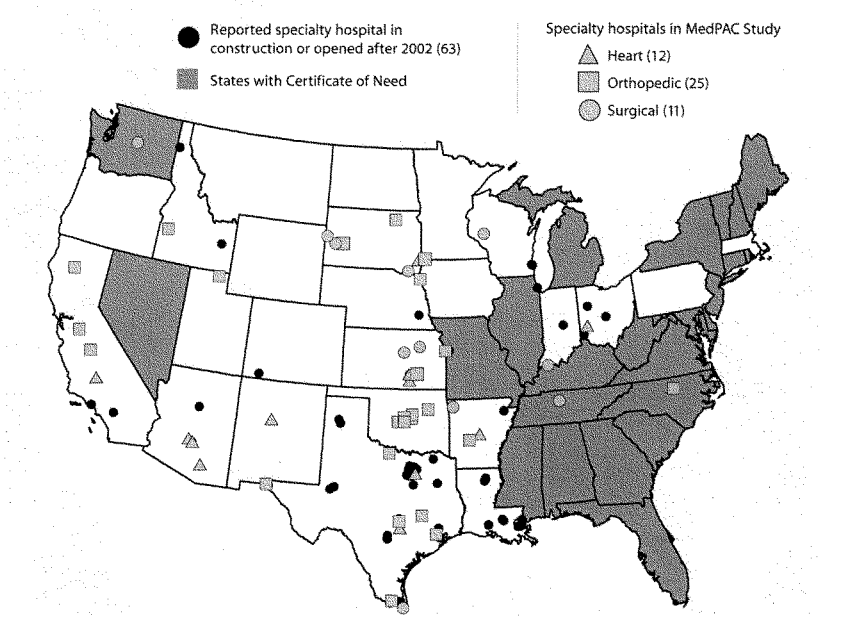
Many specialty hospitals do not have emergency departments (EDs), in contrast to community hospitals where the large majority (93 percent) do. Those that have EDs differ in how they are used, and that may influence how much control the hospital has over its schedule and patient mix. For example, 8 of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

Specialty hospitals are not evenly distributed across the country (Figure 1). Almost 60

percent of the specialty hospitals we studied are located in four states: South Dakota, Kansas, Oklahoma, and Texas. Many of the specialty hospitals that are under construction or have opened since 2002 are located in the same states and markets as the specialty hospitals we studied. As the map shows, specialty hospitals are concentrated in states without certificate-of-need (CON) programs.

FIGURE 1

Specialty hospitals are geographically concentrated



Motivations for forming physician–owned specialty hospitals and critics objections

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

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

The other motivation to form specialty hospitals is enhanced income. In addition to increased productivity resulting in more professional fees, physician investors also could augment their income by retaining a portion of the facility profits for their own and others' work. Although some specialty hospitals have not made distributions, the annual distributions at others frequently have exceeded 20 percent of the physicians' initial investment, and the specialty hospitals in our study had an average all-payer margin of 13 percent in 2002, well above the 3 to 6 percent average for community hospitals in their markets.

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

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

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

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

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

Who goes to physician-owned specialty hospitals, and what happens to community hospitals in their markets?

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

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

- Physician-owned heart, orthopedic, and surgical hospitals that did not focus on obstetrics tended to treat fewer Medicaid patients than peer hospitals and 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 $p<.05$ criterion.

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

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

Payment recommendations

The Congress asked the Commission to recommend changes to the IPPS to better reflect the cost of delivering care. We found changes are needed to improve the accuracy of the

payment system and thus reduce opportunities for hospitals to benefit from selection. We recommend several changes to improve the IPPS.

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

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

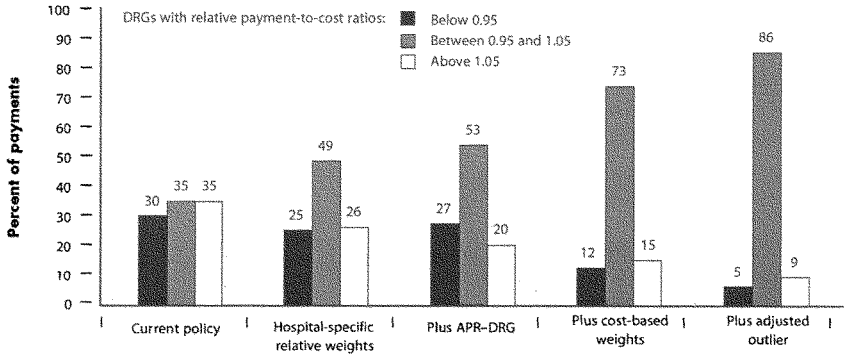
All of these actions are within the Secretary's current authority.

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

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

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

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

Recommendations on the moratorium and gainsharing

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

Aligning financial incentives for physicians and hospitals could lead to efficiencies. Physician ownership fully aligns incentives; it makes the hospital owner and the physician one in the same, but raises concerns about self-referral. Similar efficiencies might be achieved by allowing the physician to share in savings that would accrue to the hospital from reengineering clinical care. Such arrangements have been stymied by

provisions of law that prevent hospitals from giving physicians financial incentive to reduce or limit care to patients because of concerns about possible stinting on care and quality. Recently, the Office of Inspector General has approved some narrow gainsharing arrangements, although they have been advisory opinions that apply only to the parties who request them.

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

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

Committee on Homeland Security and Government Affairs

Subcommittee on Federal Financial Management, Government Information and International Security
SD-562

May 24, 2005

Testimony by

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Ladies and Gentlemen, I am honored to be here to testify on an issue that is central to the future welfare of the U.S. economy.

Americans owe their prosperity to the country's productivity. We have the world's highest per capita GDP among large nations mainly because we have the highest rate of productivity gains[1]. From 1995 – 2003, the differential between U.S. and European growth rates reached a record high[2]. But, when it comes to health care, the U.S. Congress has inadvertently strangled an innovation that holds great promise for productivity gains, with the moratorium it imposed on specialty hospitals in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

The Congress could not have picked a worse area. As evidenced by General Motors' financial woes, our health care costs, at 14.9% of GDP, far higher than those of any other country, create major competitiveness problems, as does their rate of growth[3]. Hospitals not only are the primary component of our health care costs but are also the major reason for their growth[4]. The hospital sector sorely needs managerial innovations

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[1] Central Intelligence Agency, *The World Factbook* (2004), www.odci.gov/cia/publications/factbook/rankorder/2004rank.html, accessed May 23, 2005.
[2] *OECD Economic Outlook*, Table 1, Growth Rate and Level of GDP per Hour Worked, U.S. vs. Europe, 1990-2003, December 2003.
[3] Davis, Karen and Barbara S. Cooper, "American Health Care: Why So Costly?" New York, NY: The Commonwealth Fund, 2004.
[4] Cowan, Cathy, Aaron Catlin, Cynthia Smith, and Arthur Sensenig, "National Health Expenditures, 2002," *Health Care Financing Review*, 25:4, Summer 2004.

like specialty hospitals. Further, the aging facilities of nonprofit hospitals[5] will soon require massive capital funds from U.S. taxpayers, a source of which investor-owned specialty hospitals will not require.

The moratorium is based on faulty diagnoses: specialty hospitals *do not* cause hospitals to lose their most profitable areas and physician ownership *does not* induce overuse of hospital services. Rather, these real problems are caused by the third-party payers for U.S. health care, the insurers and governments. They distort prices, so that some services are artificially profitable and others artificially low, and insulate users from costs, so they have no financial incentive to curb over-consumption.

The solution is to permit health service providers to quote the prices they want to charge in a consumer-driven insurance system. Consumers will choose those providers who give them the best value for the money. The resulting competition between all types of hospitals, including specialty hospitals, cannot help but control our health care costs.

Specialization in the U.S. Economy

Specialty hospitals may well help to control both the magnitude and the growth of the hospital sector's costs. After all, specialization is key for productivity growth elsewhere in the economy.

Consider the steel industry, for example, which Ken Iverson, a technology entrepreneur, almost single-handedly revived. His success contains important lessons for health care. Nucor, the steel-focused factory Iverson managed, differed from the everything-for-everybody steel behemoths of yore, like Bethlehem Steel, with its specialty steel products and relatively small mini-mills, as did his egalitarian, productivity-based management practices. Nucor paid its nonunionized workers like owners, primarily with productivity-based incentives. In contrast, Bethlehem Steel's unionized workforce was paid wages, largely regardless of their productivity.

The results of this revolution in focus and ownership? Nucor required 1 man-hour per ton of steel and Bethlehem 2.7; Nucor's workers earned $60,000 ($40,000 from bonuses), and Bethlehem's $50,000; and Nucor was highly profitable, earning $100 million in recessionary 2002, whereas Bethlehem lost $2 billion.[6]

Nucor did good for its customers, employees, and the U.S. economy, and it did well for its shareholders, including Ken Iverson, hailed as the second Andrew Carnegie of the industry.

Sadly, were Iverson a doctor, he could not create the "do good—do well" health care-focused factory equivalent of Nucor.[7] Rival everything-for-everybody hospitals

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[5] Harrison, Jeffrey P. and Christopher Sexton, "The Paradox of the Non-for-profit Hospital," *The Health Care Manager*, 23:3: 192 – 200.
[6] Henry, K. Nucor sets pace for steelmakers. *The Hamilton Spectator*. May 13, 2002: D10.
[7] Herzlinger, Regina E., *Market-Driven Health Care*. Cambridge, MA: Perseus Books: 2000: 173-182.

would allege that he was robbing them of their most profitable business, leaving them with the money-losing dregs, while federal government regulations would inhibit its growth. The combination of negative press and legislative prohibitions creates daunting obstacles for productivity-minded entrepreneurial physicians. For example, MedCath, a partially physician-owned heart hospital firm, spends up to $200,000 to counter hospital complaints per project per year.[8]

Specialization in Health Care

As elsewhere in our economy, specialized health care facilities, partially owned by entrepreneurial physicians, present hope for a higher-quality and higher-productivity health care system. The specialization integrates care that consumers must now struggle to obtain from a system organized by separate providers and typically reduces costs. And ownership provides an important additional incentive for physicians to provide the best value for the money.

Indeed, when it comes to specialization, the question is not whether to specialize but rather how to do it. There is widespread agreement that the health care system should provide focused, integrated care—especially for the victims of chronic diseases and disability who account for the bulk of costs.[9] Where it does, the results are impressive. For example, when Duke Medical Center offered an integrated, supportive program for congestive heart failure, annual treatment costs declined by $9,000, nearly 40%. Duke's new model achieved these cost reductions by improving participants' health status—their hospital admission and lengths of stay dropped—and not by restricting access to needed care or reducing providers' payments—visits to cardiologists increased nearly 6-fold.[10,11] (From 1995 to 1999, physicians' inflation-adjusted net income dropped, in part because of such strategies.[12]) In these ways, specialization helps both patients and physicians.

But the paradigm for specialization currently favored—top-down disease and/or care management, typically initiated by insurers—has demonstrated scant evidence of efficacy.[13,14] In contrast, the evidence of specialist-initiated and/or specialist-owned programs is compelling, although sparse. For example, Dr. Denton Cooley's price for coronary artery bypass surgery at his focused Texas Heart Institute center was approximately 40% lower than the national average with a case mix whose severity was at least equal to the average. [15,16]

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[8] Herzlinger, Regina E., *MedCath Corporation*. Boston, MA: Harvard Business School Publishing; 2003:4.
[9] Robert Wood Johnson Foundation and FAACT. "A Portrait of the Chronically Ill in America." Princeton, NJ, and Portland, OR: Robert Wood Johnson Foundation and FAACT; 2002.
[10] Snyderman, R. and Williams, R. W. "The new prevention," *Modern Healthcare*, 33:19 (2003).
[11] ------, "Congestive heart failure: comprehensive heart failure teams reduce health care costs," *Health & Medicine Week* (2000).
[12] "Behind the time: physician income 1995-99," *Medical Benefits*. 20:4 (2003).
[13] Ferguson, J. A. and Weinberger, M. "Case management programs in primary care," *Journal of General Internal Medicine*, 13 (1998): 123-126.
[14] Boult, C., Kane, R. L., Pacala, J. T., et al., "Innovative healthcare for chronically ill older persons: results of a national survey," *American Journal of Managed Care*, 5 (1999): 1162-1172.
[15] Edmonds, C. and Hallman, G. L. "CardioVascular Care Providers: a pioneer in hundled services, shared risk, and single payment," *Texas Heart Institute Journal*, 22 (1995): 72-76.

The reason is clear-cut: specialist physicians are in the best position to understand the needs of other physicians. Notes the CEO of an orthopaedic surgery practice: "Orthopaedists . . . in a hospital . . . work in the same operating room [as] general surgery and obstetrics. Orthopaedics is nuts-and-bolts equipment intensive. It drives them crazy to have a staff that's not familiar with a tray of multisize screws and nuts and bolts."[17]

Physician Ownership of Specialized Facilities

The positive connection between corporate ownership and performance is a bulwark of our economy. As Adam Smith noted in 1776,

> "The directors of . . . [joint-stock] companies, . . . being the managers rather of other people's money than of their own, it cannot well be expected, that they should watch over it with the same anxious vigilance with which the partners in a private copartnery frequently watch over their own. Like the stewards of a rich man, they are apt to consider attention to small matters as not for their master's honour, and very easily give themselves a dispensation for having it. Negligence and profusion, therefore, must always prevail, more or less, in the management of the affairs of such a company."[18]

The robust U.S. economy provides compelling evidence of the positive relationship between ownership and productivity. The economy's productivity growth bests that of all but smaller, newly developing economies, such as Ireland and Hungary—a result akin to a mature elephant's outrunning a young cheetah.[19] Small businesses, created by owner-entrepreneurs, are key: they are highly productive—some becoming titans such as Microsoft, Wal*Mart, or General Electric (founded by Thomas Edison)—because owners are motivated to create the balance between quality and efficiency that will increase their market share and profits through satisfied repeat customers.

Free markets create appropriate ownership structures[20], while government meddling hampers them. This occurred in late 19th century France when the government forced the stock exchange to become essentially a government agency[21] and in "continental European social democracies [that] press managers to stabilize employment, to forego some profit-maximizing risks with the firm, and to use up capital in place rather

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[16] Herzlinger, Regina E. "MedCath claims to have saved Medicare $800 per discharge in 2000," *MedCath Corporation*. Boston, MA: Harvard Business School Publishing (2003): 22.
[17] Hawryluk, M. "Congress eyes boutique hospital backers," *American Medical News*, May 12, 2003: 6.
[18] As cited by Jensen, Michael C. and Meckling, William H. "Theory of the Firm: Managerial Behavior, Agency Costs and Ownership Structure," *Journal of Financial Economics*, 3:4 (October 1976): 305-360.
[19] Central Intelligence Agency, *The World Factbook* (2004), op. cit.
[20] Demsetz, Harold and Vilalonga, Belen. "Ownership Structure and Corporate Performance," Social Science Review Network.
[21] Coffee, John C., Jr. "The Rise of Dispersed Ownership: The Role of Law in the Separation of Ownership and Control," Columbia Law and Economics, Working Paper No. 182, December 2000.

than to downsize when markets no longer are aligned with the firm's production capabilities."[22]

Ownership incentives appear to work in health care. The ambulatory surgery center (ASC) sector illustrates the importance of physician ownership. First, it stimulates entrepreneurial ventures. Two Phoenix, Arizona, physicians opened the first ASC in 1970. Although no outside entity would insure it, they persisted. The Office of Inspector General noted: "Physician investment of ASCs was . . . important . . . since many hospitals were reluctant to open or invest in ASCs that competed with their own outpatient and inpatient surgery departments. Accordingly, many of the early ASCs were financed and owned by surgeons and other physicians who worked in them."[23]

Currently, approximately 90% of ASCs are owned and operated by physicians.[24] Most companies active in the development and operation of ASCs seek at least 49% physician ownership. They want not only the physicians' capital but also their entrepreneurial ideas about how to improve health care quality and costs. One analysis found that when physician compensation was based on net revenues it was associated with lower costs, whereas salary-based compensation was linked to higher costs.[25]

Health Care Specialization and Its Discontents

Nevertheless, despite the clear theoretical and practical benefits of specialized, physician-owned systems of care, the objections raised to them are valid. For example, because cardiology accounts for 35% or more of a community hospital's revenues, its absence will likely significantly damage the hospital's financial status.[26] Similarly, the overuse that characterized physician-owned imaging laboratories and physical therapy facilities appears genuine and persuasive.[27]

Yet, although the complaints are valid, the diagnoses of the causes and the resultant cures are misplaced. These problems in hospital profitability and referral abuse occur because of the way our third-party health care system is structured and not because of the existence of physician-owned specialty hospitals.

To sharpen these points, let us return to the steel industry analogy to examine why integrated steel manufacturers did not complain that Nucor was cherry-picking or act to restrict Iverson's ownership interests.

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[22] Roe, Mark J. "Political Foundations for Separating Ownership from Corporate Control," *Stanford Law Review*, 53 (December 2000).
[23] 64 Federal Regulation 63537 (November 19, 1999).
[24] Federated Ambulatory Surgery Association (FASA), "Physician-Led Ambulatory Surgical Centers Vital to Meeting the Surgical Needs of Tomorrow," FASA: Alexandria, VA (January 2005): 5.
[25] Kralewski, J. E., Rich, E. C., Feldman, R., et al. "The effects of medical group practice and physician payment methods on costs of care," *Health Services Research*, 53 (2000): 591-613.
[26] Devers, K. J., Brewster, L. R., Ginsberg, P. B. "Specialty Hospitals: Focused Factories or Cream Skimmers?" Washington, DC: Center for Studying Health System Change, 62, April 2003.
[27] O'Sullivan, J. *Health Care: Physician Self-Referrals, "Stark I and II."* Washington, DC: Congressional Research Services 7-5EPW; December 6, 1996.

They did not complain that Nucor was stripping out their most profitable products because steel prices were set by the market. Free-market pricing makes it impossible for firms to succeed simply because the price is excessively high: if the price is so high that existing firms earn excessive profits, new entrants will cut prices to gain market share and thus reduce prices. In a free market, suppliers succeed because they are productive, not because a third party technocrat has mistakenly set their prices too high. Similarly, steel buyers do not complain that manufacturers are foisting off unneeded steel on them. Because they pay directly for the product, they buy only what they need.

In contrast, in health care, some services are highly profitable primarily because the third-party payers that unilaterally set prices have reimbursed them at wrongly generous rates while other services lose money because they set prices too low. Further, because third-party payers insulate users from the costs of their care, they are susceptible to over-utilization. Users who pay are more sensitive to the value for the money. One careful analysis revealed a 16% decrease in volume for a 10% price increase in consumers' payment for health insurance. (Patients were also sensitive to quality measures, however. Providers who appeared to skimp on quality to control costs lost patients.[28])

One way to solve both the hospitals' and economy's problems is to allow the *market* to set prices and to strip insurance and government bureaucrats of this power. It is not that they are incompetent or venal but rather that they are incapable of simulating market prices. As a result, they make costly errors. For example, a 2003 analysis showed that overly generous prices for procedures in hospital-based outpatient departments cost $1 billion more than the prices for the same procedures in free-standing surgery centers.[29] Similarly, the best way to achieve user sensitivity to the cost of services is to switch to a consumer-driven system in which users select from a wide array of insurance products offered at different prices. (Currently, in the United States, most large employers offer a limited number of policies with nearly identical features except for the cost and ease of reaching providers.) The competition will also reward cost-effective health service providers. The consumer-driven Swiss health care system features many novel insurance policies.[30] (The Swiss have universal insurance. The government either gives citizens who cannot afford health insurance funds or buys it for them.) The resulting competition reduces the costs of the excellent Swiss health care system, as a percentage of GDP, to 10%, versus 15% for the United States.[31]

Some worry that health care consumers lack the expertise and clout of steel buyers. They should consider the consumer-driven markets for complicated products such as cars and computers. Despite consumers' lack of expertise and group-purchasing

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[28] Harris, K., Feldman, R., and Schultz, J. "The buyers health care action group: consumer perceptions of quality differences," in Herzlinger, Regina E. *Consumer-Driven Health Care*, San Francisco, CA: Jossey-Bass (2004).

[29] Office of Inspector General (OIG). *Payment for Procedures in Outpatient Departments and Ambulatory Surgical Centers*, Washington, DC: OIG Report OEI-05-00-00340, January 2003.

[30] Herzlinger, Regina E., Parsa-Parsi, R. "Consumer-Driven Health Care: Lessons from Switzerland," *Journal of the American Medical Association*, 292:10 (September 8, 2004): 1231-1220.

[31] Ibid.

clout, both products have steadily improved in quality and decreased in costs. Consumers are assisted by readily-available, user friendly, excellent information. Thus, buyers who do not know a piston from a valve can be excellent buyers because of sources such as *Consumer Reports'* automobile buying guide and J. D. Power consumer quality rating.

Conclusions

The solution for controlling the monumental costs of our health care system is to encourage entrepreneurial innovators, not to bind them in regulatory straightjackets.

The level competitive playing field that would reward or punish them requires market-based pricing of services and a consumer-driven insurance system. Fortunately, consumer-driven health care is becoming a reality. More than three million American already are enrolled in consumer-driven insurance products.[32] Yet, although insurers such as United and Aetna offer panels of providers selected for their excellence and competitive price,[33] third-party buyers continue to inhibit innovation with their stranglehold on pricing.

Let us cure our health care woes the good, old-fashioned American way, not with a thicket of regulations, but, instead with a market of competitive suppliers—entrepreneurial physicians and other providers—and empowered consumers. The U.S. Congress can lead the way by lifting this moratorium and supporting consumer-driven health insurance and market-based pricing for provider services in the Medicare and Medicaid programs.

This testimony is partially based on "Specialization and Its Discontents: The Pernicious Impact of Regulations Against Specialization and Physician Ownership on the U.S. Health Care System," *Circulation*, 109 (2004): 2376-2378.

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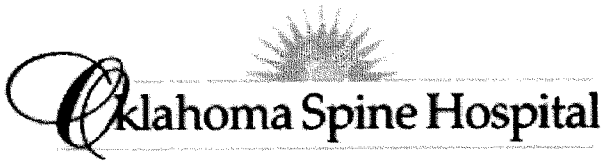
[32] *Inside Consumer-Driven Health Care*, February 4, 2005.
[33] Innovative Products Offer Narrow Provider Networks Targeted to High Cost Diseases," *Managed Care Week*, 13:4 (2003).



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Statement of

Stan Pelofsky, MD

Oklahoma Spine Hospital

Before the

Subcommittee on Federal Financial Management, Government Information, and International Security

Committee on Homeland Security and Government Affairs
United States Senate

RE: An Overview of the Competitive Effects of Specialty Hospitals

May 24, 2005, 2:00 pm
Dirksen Senate Office Building, Room 562

Dr. Coburn and Members of the subcommittee, my name is Dr. Stan Pelofsky. I am a practicing neurosurgeon in Oklahoma City and a physician-owner of the Oklahoma Spine Hospital. On behalf of our community, our spine hospital and the patients that we serve, I appreciate the invitation to appear before your subcommittee to set the record straight about specialty hospitals.

Why Specialty Hospitals?

Specialty hospitals developed for many reasons. As community hospitals became larger and more cumbersome, many physicians found it increasingly difficult to navigate the complex governance structures, budgetary processes, and operating room scheduling systems, which often created intra-hospital conflicts between the different specialties and hospital administrators. In an effort to put themselves in the healthcare delivery driver's seat, physicians turned to the concept of specialty hospitals so they, themselves, could make all the decisions involved in providing the best and most technologically advanced care for their patients. By focusing on targeted specialty care areas, such hospitals can provide superior services, with lower costs, fewer complications, and greater economy and efficiency of scale -- all of which lead to higher quality and excellent patient satisfaction.

Specialty hospitals are therefore clearly an important marketplace innovation, providing high-quality healthcare and presenting patients with additional choices for meeting their healthcare needs. Beyond their own walls, specialty hospitals also inject competition into the marketplace, forcing all the hospitals in a given community to become more efficient, while at the same time raising the quality bar. Such healthy competition benefits not only consumers and patients, but also employers, states and the federal government. When healthcare is delivered in an efficient, high-quality manner, consumers, payers and purchasers of healthcare all come out winners.

The Oklahoma Spine Hospital is clearly doing its part to meet all of these objectives, and we are doing so in an exemplary fashion.

What is the Oklahoma Spine Hospital?

Let me take this opportunity to tell you about our specialty spine hospital. Oklahoma Spine Hospital is the nation's first physician-owned and operated specialty surgical spine hospital. It is a world class facility owned by 21 doctors who had a dream, had a mission and had the courage of their conviction to take the risk and establish a facility that focused on quality of care, access to care, efficiency, patient and patient family satisfaction and employee happiness. There are over 200 employees serving the needs of our patients. A totally licensed Medicare-approved facility, the hospital meets and/or exceeds all of the requirements for a hospital in the state of Oklahoma. Every physician at our facility is board certified and many are fellowship trained in the diagnosis and treatment of spine disease. Our facility owners are neurosurgeons, orthopedic surgeons, pain management experts, anesthesiologists and neuroradiologists. To ensure quality, the physician owners direct the administration and the daily operations of the hospital and oversee all aspects of patient care.

Our 62,000 square foot facility is state-of-the-art. The hospital features five large operating rooms; four major pain management procedure rooms; eighteen in-patient beds; fourteen pre-op and post-op outpatient beds; category IV emergency service; seven recovery room beds; MRI, X-ray, myelography and CT suites; laboratory services; respiratory therapy services; and a pharmacy. The hospital also owns and operates a 7,500 square foot off-site physical therapy

service. Patients suffering from diseases of the spine, and those with chronic pain conditions, are able to receive full-service advanced medical and surgical treatment at a single "one-stop shop" facility.

Why are Critics of Specialty Hospitals Wrong?

At the Oklahoma Spine Hospital, we have created a home where brilliantly trained surgeons and the most innovative new technologies have come together for the betterment of our patients. We are very proud of the value that we have brought to the healthcare market place, not only in Oklahoma, but also throughout the country. We have created a model that raises the bar of excellence in the treatment of the very devastating spine diseases that we see. This a model for the 21st century, although it is a model rejected by just about every large community hospital – nationwide and in Oklahoma City. Faced with this unwanted competition, and in an effort to maintain their dominance in the healthcare delivery marketplace, these so-called "full service" hospitals, and their professional associations, are seeking to put specialty hospitals out of business through federal and state legislation and regulation (and in some reported cases, by intimidation).

The hospital lobby justifies the need to thwart the ongoing development of specialty hospitals by spinning a fantastic tale that simply belies the facts. Our experience in Oklahoma City clearly demonstrates that the critics of specialty hospitals are just dead wrong. Both our own findings, and those of numerous governmental and other studies, have confirmed the beneficial effects of specialty hospitals.

Oklahoma Spine Hospital Does Not "Cherry-pick" its Patients. The hospitals have argued that specialty hospitals cherry-pick the most profitable patients by avoiding low-income populations, offering the most profitable services and serving less sick patients within case types. At the Oklahoma Spine Hospital we absolutely do not cherry-pick our patients, although we do cherry-pick our doctors, nurses, scrub techs and employees to ensure that we have the best and most qualified team of medical professionals to treat our patients. At our hospital we have our own "Patients' Bill of Rights" and the first "right" on the list states that "individuals shall be accorded impartial access to treatment or accommodations that are available or medically indicated, regardless of race, creed, sex, national origin, or *source of payment*" [emphasis added]. Our payer mix breaks down as follows: private health insurance 42%; workers compensation 33%, Medicare/Medicaid 17%; and self-pay/charity/other 8%.

Oklahoma Spine Hospital Has Level IV Emergency Medical Facilities and Provides Full ED Coverage at a Tertiary Care Community Hospital. Critics of specialty hospitals argue that patients have less access to emergency and trauma care because physicians practicing at specialty hospitals no longer cover community hospital emergency departments and/or the specialty hospitals provide only limited or no emergency services. Contrary to these assertions, the Oklahoma Spine Hospital is a Level IV emergency medical facility that is open at all times. From November 1999 through April 2005, our specialty hospital served 144 patients with emergency medical conditions. In addition, the physicians in my practice cover the emergency department of one of the largest community hospitals in Oklahoma City, Mercy Hospital, twenty-four hours a day, seven days a week, three hundred and sixty-five days a year. Our practice is absolutely committed to meeting this obligation, and we have been leaders in working with the city and state to develop a local and state-wide trauma system, of which we are a part.

Oklahoma Spine Hospital is a True Hospital. Some have suggested that specialty hospitals are not "real" hospitals because they do not treat a full array of diseases and disorders. While it is true that our hospital focuses primarily on treating spine disease, this does not in any way mean that we are not a hospital. On the contrary, the Oklahoma Spine Hospital is indeed a true hospital. It is not an ambulatory surgical care center. It is officially certified by the state's health department and we are a dues paying member of the Oklahoma Hospital Association and the American Specialty Hospital Association. Over 95% of our patients stay over night (from November 1999 through April 2005 our average length of stay was 1.64 days) and many stay two, three and four days following complex spine surgery. Our hospital also provides a variety of outpatient services, similar to most community hospitals. And as mentioned above, we have a fully staffed 24-7-365 emergency room.

General Hospitals Have a Healthy Bottom-Line. The hospital lobby would have policymakers believe that they are financially devastated because specialty hospitals are zapping needed and essential financial resources away from community hospitals. Hospital financial statements, however, tell a very different story. Let me give you a few examples. HCA has a joint operating agreement with the Oklahoma University Medical Center. It was reported that last year HCA had a $47.3 million bottom line net profit from that arrangement. Its profit margin was reported to be 11.1%, which might be the highest in the state for any large community hospital. This is from our so-called "safety net" hospital, where most of our indigent patients are taken. Interestingly, little of this $47 million seems to flow back to the medical center, and in fact HCA threatened to close down the Level I Trauma Center because of loss of money. Despite these huge profits, the state continues to subsidize the trauma center to the tune of about $5.7 million each year. The for-profit hospitals are not alone in reaping huge profits. It is my understanding, based on their IRS Form 990 filing, that in 2003 non-profit Integris generated over $50 million in profit. It is therefore absolutely disingenuous for these community hospitals to assert that an 18-bed facility in the heartland is leading them to the brink of financial ruin. Unlike HCA and Integris, which are subsidized in one way or another by the state and federal governments through tax breaks and other financial assistance, the Oklahoma Spine Hospital contributes a significant amount of its income to the state, local and federal governments. Last year we paid the following taxes: federal income tax $4,495,000; state income tax $770,000; sales tax $860,000; and property tax $225,000 and these monies, in part, go to fund numerous state and federal healthcare programs.

Oklahoma Spine Hospital is Efficiently Operated. General hospitals argue that specialty hospitals are not more efficiently run. These hospitals obviously haven't visited the Oklahoma Spine Hospital. Every aspect of our hospital's operations and design is a paradigm of efficiency. Our physicians designed the layout of the hospital, its operating rooms, pre- and post-op areas, nursing stations, etc. to ensure that care is rendered in an efficient and high quality fashion. For example, each operating room is self-contained and fully outfitted with state-of-the-art equipment, eliminating the need to share equipment between operating rooms. This means there are no delays while one surgeon waits for another to complete an operation so he or she can use necessary surgical equipment. We also outsource many of our administrative functions. We do not employ hospital administrators or CEOs with their six or seven figure salaries. We do not spend any money on marketing or advertisements (other than to give each patient that leaves the hospital a pastel-colored tee-shirt of his or her color choice with our hospital logo on it). Our bottom-line profit is spent on developing and purchasing cutting edge technology, increasing employee salaries and benefits and staying way ahead of the technology and healthcare

curve. At the Oklahoma Spine Hospital, the physician owners can make major decisions concerning the purchase of new technology, new instruments, and change any hospital policy, literally overnight, without sitting through hours and hours of mindless hospital committee meetings. Our model of operations, administration and patient care delivery has allowed our physicians to be much more efficient and effective in their daily work. In fact, I have been able to increase my own personal productivity 33% and get home one hour earlier each day.

Oklahoma Spine Hospital Provides Higher Quality Care. Critics of specialty hospitals suggest that they do not provide higher quality of care than community hospitals. Once again, the data demonstrate just the opposite. Whether quality of care is based on measures such as mortality and infection rates, nurse to patient ratios or patient satisfaction indicators, Oklahoma Spine Hospital excels across all quality measures. Since we opened in 1999, we have had no deaths, the lowest infection rate in the city and the lowest re-admission rate for complex spine surgeries in the city. Out of the 12,383 surgical cases performed from November 1999 to April 2005, we have an infection rate of less than one percent (0.11%). According to the Centers for Disease Control and Prevention's (CDC) National Nosocomial Infections Surveillance (NNIS) system, which monitors reported trends in nonsocomial infections in participating U.S. acute care hospitals, 2 to 5% of operated patients will develop surgical site infections. These infections increase hospital length of stay by an average of 7.5 days, generating additional hospital costs in excess of one billion dollars. Our low infection rate record is clearly superior to the national average, saving the federal government and others significant money through reduced length of stay and low readmission rates.

Independent organizations have also confirmed the superiority of our hospital over others in Oklahoma City. For example, according to HealthGrades, a national organization that produces hospital quality reports for over 5,000 U.S. acute care hospitals, this year the Oklahoma Spine Hospital received the highest ratings for spine and neck surgery as compared with other rated Oklahoma City hospitals:

Rating System = *** Best *** As Expected * Poor**

Back and Neck Surgery (spinal fusion):

Oklahoma Spine Hospital	*****
Integris Baptist Medical Center	***
Oklahoma University Medical Center	***
Bone and Joint Hospital	***
Mercy Health Center Inc.	*

Back and Neck Surgery (except spinal fusion):

Oklahoma Spine Hospital	*****
Bone and Joint Hospital	*****
Mercy Health Center Inc.	***
Integris Baptist Medical Center	***
Oklahoma University Medical Center	***

Our excellent nurse to patient ratio also enhances our quality of care. At the Oklahoma Spine Hospital we have one nurse for every four patients, far exceeding national standards. And our nurses are highly trained and specialized in taking care of patients with spine disease and chronic pain. They are happy and love their jobs, so turnover is extremely low, saving us thousands of dollars in training costs each year, which we can spend on patient care.

Finally, patients love our hospitals. Our overall patient satisfaction rate is over 98%. Our January 2005 Inpatient Satisfaction survey found the following positive responses:

Would you return for other procedures?	99%
How was your overall experience at Oklahoma Spine Hospital?	99%
Were your questions answered?	99%
Were your discharge instructions easily understood?	99%
Was the seating comfortable?	97%
Did we meet your expectations?	96%
Was your room cleaned every day?	93%
Was the housekeeper courteous and friendly?	93%
Did the nursing staff keep you informed of your doctor's orders and what to expect following surgery?	99%
Were discharge instructions easily understood and questions answered?	99%
Responsiveness of the nurses to your needs.	99%
Was the nursing staff attentive to pain control needs?	99%
Waiting time (not having to wait over 15 minutes checking in and signing registration forms)	95%
Was our admission staff friendly and helpful?	100%

Physician Ownership in the Oklahoma Spine Hospital Does Not Influence Our Treatment Decisions or Treatment Location. Our critics have intimated in no uncertain terms that our prime interest is self-referral to our facility so we can perform complex surgical spine procedures and reap the financial benefits. I am here to tell this committee that nothing could be farther from the truth. It is an insult to me and my partners to suggest that economic motives dictate how we treat our patients. At the Oklahoma Spine Hospital our major emphasis is to exactly diagnose and pinpoint the source of trouble that is producing spine pain and disabling our patients. Once we accurately diagnose the disease state, our first, second and third goal is to treat the disease with aggressive medical management, including physical therapies, epidural steroid injections, selective nerve root blocks, pain management, exercise and weight-reduction programs, etc. Surgery is never the first, second or third choice. Let me say this again, at the Oklahoma Spine Hospital the physician owners perform surgery only as a last resort when our patients have failed aggressive medical management over an extended period of time and simply cannot continue to suffer in pain and agony. We are not "knife happy" and our surgical utilization rates are consistent with national rates of other neurosurgeons and orthopaedic surgeons, most of whom practice at general hospitals.

In addition, we do not perform all of our spine surgery at our specialty hospital and continue to treat patients with spine disease at Mercy Hospital as well. Although we perform between

five and ten cases per day at the spine hospital, we also perform between ten and twelve spine surgeries at our community hospital each week.

Physicians at the Oklahoma Spine Hospital Provide the Full Range of Neurosurgical Services at the Community Hospital. Contrary to some assertions, my partners and I provide the full range of neurosurgical services at our community hospital. In addition to spine surgery, we also treat patients with brain tumors, epilepsy, brain aneurysms, carotid artery disease, Parkinson's disease and many more neurologic conditions. We have established a Neuroscience Center in Oklahoma City and we have been involved in the training and teaching of medical students, interns and residents. Most recently, due to the collapse of Oklahoma University's department of neurosurgery (which is not attributed in any way to the existence of our specialty hospital), our practice has also been working collaboratively with OU to help take care of many of the university medical center's level II and level III trauma patients who are suffering from neurologic problems.

What Does the Future Hold for Specialty Hospitals?

Dr. Coburn and Members of the Subcommittee, the future viability of specialty hospitals rests largely within the control of the U.S. Congress and the Centers for Medicare and Medicaid Services. The current moratorium is scheduled to end in just a few short weeks, and on behalf of the Oklahoma Specialty Hospital and all other specialty hospitals now existing, and those yet to be developed, I strongly urge you to let this moratorium come to a permanent end. I also hope you will express your support of specialty hospitals to CMS Administrator, Mark McClellan, and encourage the agency not to impose further regulations that will, de facto, extend the moratorium beyond its current June 8, 2005 date and make it more difficult for outstanding facilities such as ours to maintain our Medicare hospital designation. Congress should support competition and innovation in healthcare and encourage new entities, like specialty hospitals, to enter and thrive in the marketplace.

Ultimately, the Oklahoma Spine Hospital is about the American dream; about entrepreneurship, where 21 doctors knew a better way to diagnose and treat patients with chronic spine disease. We spent our time, we risked our money, and with blood, sweat and tears, we made it happen. We conceived this baby, we birthed it, we grew it and we matured it and we will fight to protect it. Our community, our state and ultimately the healthcare of our country will be much better off. Do we want to go back to the status quo, and, in particular, have a few powerful hospital administrators controlling the fate of our healthcare needs, or do we want to continue with innovative and entrepreneurial ways to expand the horizons of medicine for the benefit of all patients?

Thank you for this opportunity to testify today. I would be pleased to answer any questions the Members of the Subcommittee may have.

TESTIMONY OF

JOHN T. THOMAS

SENIOR VICE PRESIDENT – GENERAL COUNSEL
BAYLOR HEALTH CARE SYSTEM

BEFORE THE

UNITED STATES SENATE

COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENT AFFAIRS

FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION
AND INTERNATIONAL SECURITY SUBCOMMITTEE

HEARING ON

AN OVERVIEW OF THE COMPETITVE EFFECTS
OF
SPECIALTY HOSPITALS

May 24, 2005, 2:00 pm
Dirksen Senate Office Building
Room 562

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

It is an honor for me to address you today on behalf of the Baylor Health Care System and to ask you to resist efforts to extend the current moratorium on the development and growth of physician-owned specialty hospitals that will expire June 8, and to resist efforts to repeal the whole hospital exception under the so called Stark Self-Referral Law.

Baylor Health Care System is the corporate sponsor of 13 non-profit hospitals. Our flagship —Baylor University Medical Center (BUMC) is 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 Dallas County'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. Over 2000 physicians actively practice at these facilities, while only about 500 have an ownership interest. Texas Health Resources, the other major non-profit hospital system in Dallas-Fort Worth also has a number of hospitals and facilities partnered with physicians.

Five of Baylor's facilities are affected by the Moratorium. Three are surgical hospitals. Two are heart hospitals. Each is critically important to the mission of Baylor Health Care System, but more importantly is critical to the advancement of health care competition and improvements in quality, safety, patient satisfaction, and access in Dallas-Fort Worth.

By 2020, the population of Dallas-Fort Worth is expected to exceed 10 million people, more than double the population today. As Baylor Health Care System projects the needs of our community to meet this population growth and demand for access to health care services, partnering with physicians not only brings capital to help finance the response to these needs, more importantly, economic investment motivates physicians to bring their time, energy and talent to the design, operation and governance of more effective and efficient health care facilities.

No example proves this point better than our Baylor Heart and Vascular Hospital, a facility located on the inner city campus of our flagship, Baylor University Medical Center. The Quality of this facility is the highest in our health care system, and is among the highest rated heart programs in the United States on CMS' website HospitalCompare.hhs.gov.

Data Shot			
Hospital Compare			
	National Average	AAMC Teaching Hospitals Average	BHVH
Heart Attack Care ACE Inhibitor for LVSD	75%	84%	99%
Heart Attack Care Aspirin at Discharge	86%	96%	100%
Heart Attack Care Beta Blocker at Discharge	84%	94%	100%
Heart Failure Care ACE Inhibitor for LVSD	74%	81%	99%
Source: AAMC Review of Hospital Compare.HHS.Gov Data			

Month after month, the Baylor Heart Hospital scores at or near 100% on the CMS indicators for Acute Myocardial Infarction, Congestive Heart Failure, and Surgical Infection Prevention standards. Emergency Room-Baylor Heart Hospital protocols consistently result in ER patients going from the door to the cath lab within 30-45 minutes of arrival, with vessel inflation under 90 minutes. Patient satisfaction, as measured by the NRC Survey tool exceeds the 96th percentile of their hospital database. When patients are asked "Did you feel the staff were knowledgeable and provided safe care?," month after month, 100% of the patients respond YES.

With physician alignment, the Baylor Heart Hospital has also seen dramatic improvements in cost reduction and efficiency. In the first year of operation, over $12 millions of cost were eliminated from the cost to provide these services before the heart

hospital was opened---these costs reductions resulted from better physician alignment with the selection and purchase of supplies and more efficient utilization of supplies, including less waste. Dramatically, staff turnover is less than 11% per year, while the rest of our system exceeds 20%. This is an important indicator of both the quality of the clinical environment (the staff enjoys working there) and cost containment. Baylor's cost to replace an RN approaches $60,000 per nurse for recruiting, training, and retention, with low turn-over, those dollars are saved.

Finally, Baylor's specialty hospitals are the safest in the system, with the Baylor Heart Hospital leading the way with NO medical liability claims filed against the facility or alleged in the 3 year history of the hospital. Baylor's other specialty hospitals also have much lower liability claim rates than our general hospitals.

Almost all of the hospitals in Dallas-Fort Worth have major heart programs. With the introduction of the Baylor Heart Hospital, other hospitals will either improve their quality to match the results, or more and more patients will expect access to the Baylor Heart Hospital. CMS, Payors, Leapfrog, and other organizations are posting more and more "quality scorecards" on the Internet and providing more access to this information to consumers. As more and more employers move to "consumer driven plans" and "health savings account" methods to finance health care, hospitals will feel greater pressure to improve their quality to be competitive with the hospitals producing the highest quality and safety scores. Physician alignment, we believe, will be necessary in many practice areas to achieve the best performance.

Lastly, as a committee focused on Homeland Security, the nation's trauma system is the backbone of effective response to future incidents, if any. There are less than 200 Level

1 and 2 designated trauma hospitals in the United States. Baylor has used alignment of physicians, through specialty hospital and ambulatory surgery center joint ventures, and other forms of effective alignment, to keep physicians engaged in the trauma system. These physicians also commit to providing charity care under Baylor's Charity Care and Financial Assistance Policy in these facilities, another important tool in Baylor's response to the growing uninsured population. Unfortunately, 30% of the Texas population is uninsured---with an even higher rate in downtown Dallas where the Baylor Heart Hospital is located.

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

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

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

Thank you.

Executive Summary
Testimony of Baylor Health Care System by John T. Thomas, Sr. VP-General Counsel

1. Baylor Health Care System is a large, Baptist faith based institution located in Dallas-Fort Worth, Texas, that is asking Congress NOT to renew the moratorium or pass legislation affecting the ability of physicians to own hospitals or other facilities.

2. Baylor provided over $240 Million in Charity Care and other Community Benefits in 2004

3. Baylor has large network of non-profit hospitals, including large, Level 1 Trauma, Inner-City Academic Medical Center, Baylor University Medical Center, located in Downtown Dallas.

4. Baylor has over 25 additional facilities, operated through limited partnerships with physician investors. Most are ambulatory surgery centers, but this strategy includes 2 Heart Hospitals and 3 Surgical Hospitals---all affected by the Moratorium.

5. Over 2000 physicians actively practice at these "joint ventured", with only about 500 who have an ownership interest.

6. Baylor Heart and Vascular Hospital (the inner city heart hospital adjacent to BUMC in downtown Dallas) is among the highest rated heart programs in the Country on the new CMS website, HospitalCompare.gov

7. Baylor's Mission is furthered by the "partnering" with physicians to build and operate "specialty" facilities which provide high quality, safe care, with very high patient satisfaction, at a lower cost.

8. Baylor's specialty hospitals are more efficient, have lower RN turnover, and are reducing the cost to provide health care services.

9. Baylor's model of partnering with physicians keeps physicians engaged in the delicate Trauma System, and more prepared to respond to Homeland Security "events."

10. The Moratorium has not been benign, and extensions of the moratorium will further affect Baylor's ability to provide heart, surgical and obstetrical care in three communities served by Baylor, including the heart services provided with the inner-city Level 1 Trauma Center. DFW communities are rapidly expanding in population and health care access is becoming more and more difficult to provide, without expansion of existing and development of new, more efficient, better models of care. Partnering with physicians, and using their financial and intellectual capital to build, manage and operate these facilities has proven to be a very effective, and innovative way to meet that need, including providing access to the uninsured and Medicare/Medicaid population.

Statement
Of

James E. Cain, MD
Practice in Family Medicine
Lampasas County, Texas

To

Subcommittee on Federal Financial Management,
Government Information, and International Security
Of the
Committee on Homeland Security and Government Affairs
United States Senate

Overview of the Competitive Effects of Specialty Hospitals

May 24, 2005

My name is Dr. James E. Cain and I practice family medicine in rural Texas. I spent the first eighteen years of my life growing up in rural Arkansas in a town called Eudora on the banks of the Mississippi river. The next eighteen years were spent in Houston, Texas where I received my education at Houston Baptist University, Baylor College of Medicine, and the University of Texas Health Science Center. At the end of my education I chose to return to a rural setting and practice primary medicine.

I live and practice in Lampasas County, which is about 1.5 hours north of Austin, forty-five minutes west of Fort Hood, and about one hour south of Crawford, Texas. The county population is approximately 20,000 with a median household income of a little over $30,000 dollars per year. My clinic has four doctors and we are essentially the only group that serves Lampasas County. Our clinic also serves patients from surrounding counties. Rollins Brook Community Hospital and Metroplex Hospital are the primary facilities serving our community. It is important to understand that while providing excellent care to our patients, specialty services including cardiovascular services are not available in our community hospitals. Our patients must be transported to facilities providing a higher level of care.

Our primary sources of reimbursement are Medicare, Medicaid, Champus Tricare (which is the military's insurance), a handful of commercial insurances, and private paying patients. We work an average twelve-hour days and see patients regardless of their ability to pay. We see any patient that presents at our office.

A colleague recently asked me what I thought about Heart Hospital of Austin, and how their services affected my practice. My answer to those questions is the reason I am here with you today. What I shared with this colleague and with you today is a scenario that plays out in my life on an almost weekly basis.

- I get a call from the Emergency Department of Rollins Brook Community Hospital.
- A patient of mine is having chest pain and it doesn't look good.
- I get in my truck (Yes, I am from Texas and I drive a truck-no hat!) and drive to the hospital.
- I call Heart Hospital of Austin CV Stat line and within minutes I am speaking with a cardiologist.
- We discuss the case; he or she helps me to stabilize my patient.
- Together we decide - ambulance or helicopter.
- The patient is transferred and I return to work or home.

Within a few hours of transport, I receive a call back from the cardiologist who provides an update of my patient's condition – including whether that patient received a stent, surgery, or other therapeutic treatment. Within a few days, my patient has returned home and visits my practice for a follow-up. My patient has been returned to me and is obviously well cared for. In addition, the patient is very impressed with the care that they have received. The most significant point here is that at no point during this scenario has any one asked me about my patient's insurance or their ability to pay. During the past twelve months, 136 patients from Lampasas have been treated as inpatients at Heart Hospital of Austin. Of those – 67 were transported directly from Rollins Brook Community Hospital and 14 came from Metroplex. 74% of those patients were Medicare insured. Additionally, 54 patients from Lampasas County were treated at Heart Hospital of Austin as Outpatients (Emergency Department or Observation). 37% of those patients were self-pay (uninsured) and 35% Medicare.

The above scenario also demonstrates the effective use of time that HHA incorporates into their management. The time line with which this case is managed is as good as it gets. When you live and hour or more from a tertiary center, often minutes are everything. When I compare the service I receive from Austin Heart Physicians and Heart Hospital of Austin to the standard process I get at the

other hospitals I use, and I do use several others, there truly is no comparison. What I typically get right off the bat is an administrator and what is the first question asked?

- What is the patient's insurance?
- Next I am told I will need to speak to a utilization review nurse.
- When they hear my patient has Medicaid or, God forbid, no insurance then the conversation usually turns towards lack of bed availability.
- I am asked where my county hospital is located or if the patient is stable enough to transfer.
- In the end, if they accept transfer, it is usually through their Emergency Department because they feel a second workup in their Emergency Department might lead to different results -- in other words, the patient will not have to be admitted and therefore utilize resources that they cannot pay for.

It also frustrates me to see a patient go to another facility on a Friday. When I call to follow-up after the transfer to find out what is being done for my patient, I am told that the patient is stable and since they can't do caths after hours or on the weekends my patient will have to sit in the hospital until Monday to figure out what is going on with them. This means two extra hospital days and a calculated but small increase in risk to my patient. And of course, this adds cost to the system. The Lewin data points out the following: HHA takes care of sicker patients, discharges more patients to their homes and has a shorter length of stay when compared to their central Texas peers. The fact is that I have done this long enough in rural practice to generally know what my patient is going to require without a lot of additional tests or procedures. But what do I know. I am just a country doctor.

My experience with Heart Hospital of Austin demonstrates a seven-day a week operation - and they take the good with the bad. I am also keenly aware that the cardiologist accepting my patient to Heart Hospital of Austin has the best interest of my patient at heart – and that is what is most important here. In addition my patients can receive follow up care from HHA cardiologists who work and live in our local communities. There are just no comparisons to the quality and efficiency of the care my patients receive at Heart Hospital of Austin. I consistently see data in medical journals confirming that good patient outcomes are becoming the focus for medical models. Good patient outcomes not only have a positive impact on the cost effectiveness of managed care health dollars, but also lead to higher patient satisfaction, fewer complications and fewer lawsuits. In the end this correlates with one thing…saving money. Many insurance companies now reward physicians based on patient outcomes. In terms of my sickest patients there is no one that comes close to matching what Heart Hospital of Austin does for me in this regard. There are many studies and recognitions by reputable organizations that speak favorably about the outcomes, length of hospital stay, and quality of care my patients receive at Heart Hospital of Austin. The following are some of the organizations that provide such information:

Solucient Top 100 Hospitals: Heart Hospital of Austin was named as a 2004 Solucient Top 100 Hospital. This Cardiovascular Benchmark for Success study identifies hospitals that are setting benchmark levels of performance for cardiovascular services throughout the nation. HHA is acknowledged for its high-performing cardiovascular clinical and management teams.

Texas Business Group on Health: TBGH believes that "hospitals aren't all the same—some have better results than others for the surgeries and procedures they do." The Texas Hospital Checkup for Heart Care was developed to enable consumers to compare outcomes and cost for abdominal aortic aneurysm repair, balloon angioplasty, carotid artery surgery, and heart bypass surgery.

- HHA meets or exceeds mortality expectations for high volume hospitals.
- HHA averages the lowest length of stay and lowest average charge when compared to all hospitals serving the Central area.

United Health Group Center of Excellence: United Health Group lists Heart Hospital of Austin as one of its Premium Cardiac Centers. The well-recognized Centers of Excellence program, organized around scientific evidence, expert physician input and robust clinical data, has continued to demonstrate sharp improvements in patient survival as well as significant cost savings for individuals and payers.

Lewin Group: A comparative study was done to determine how cardiac care services provided in MedCath heart hospitals compare on measures of patient severity, quality of care and community impact to cardiac services provided in peer hospitals across the country that perform open heart surgery. Following are the 2005 study findings based on 2003 data comparing Heart Hospital of Austin to its peer Central Texas community hospitals.

- HHA discharges 12.7% more patients to their homes as compared to peer community hospitals.
- HHA has a 6% higher case mix severity for cardiac patients than the peer community hospitals.
- After adjusting for risk of mortality, HHA exhibits a 31.9% lower in-hospital mortality rate for Medicare cardiac cases compared to the peer community hospitals.
- HHA has a shorter average length of stay (ALOS) for cardiac case (3.39 days) than the peer community hospitals (4.47 days) after adjusting for severity.
- An analysis of fiscal year 2003 data found that in comparison to the peer group of community hospitals, MedCath heart hospitals had relatively higher severity-adjusted cardiac case mix, lower mortality rates and lower average length of stay. We further found that MedCath heart hospitals discharged a higher proportion of their Medicare cardiac patients to their homes and transferred fewer discharged cardiac patients to other facilities. These conclusions are consistent with the results found in similar studies covering fiscal years 2000, 2001 and 2002. And because MedCath heart hospitals discharged a higher percentage of cardiac patients to their homes, that may have resulted in reduced Medicare expenditures.

It is my personal experience and that of my patients that leave no doubt in my mind about the quality of care we receive at Heart Hospital of Austin. If you told me tomorrow that I would lose Heart Hospital of Austin, I would seriously have to rethink how I practice medicine in rural America. In this day and age of frustrated doctors, skeptical patients, confused administrators and politicians trying to figure out how to make the dollar cover expenses it is easy to become cynical. I can tell you I am no cynic. I love what I do, I still enjoy going to work every day, and I am proud to be a country doctor. Heart Hospital of Austin and services like theirs help me practice medicine in rural Texas like no others have. The designated facility for patients from our area without payment abilities is in Galveston, Texas, which is a six to seven hours trip by ground transportation. Sending patients there or spending hours finagling others to take my uninsured is impractical. If I were to lose Heart Hospital of Austin as a referral destination for my non-resource patients, it would be very difficult to continue practicing rural medicine in Central Texas. I ask that you look closely at facilities such as Heart Hospital of Austin that are doing such effective work, model them and learn from them. In the end the organizations taking the best care of patients enable the most cost effective care. Thank you.

Statement
Of

Ed Jungbluth
Heart Hospital of New Mexico Patient
Albuquerque, New Mexico

To

Subcommittee on Federal Financial Management,
Government Information, and International Security
Of the
Committee on Homeland Security and Government Affairs
United States Senate

Overview of the Competitive Effects of Specialty Hospitals

May 24, 2005

My name is Ed Jungbluth and I'm a 70-year-old heart patient. I've had a heart attack, angioplasty and an AICD (automatic internal coronary defibrillator) – make that (2) AICD's. I've always been an active person and enjoyed life to the fullest – so needless to say, the onset of my first heart event was a bit discerning for both me and my wife, Mimi.

In 1988 I had a heart attack while living and working in the tourism industry in Estes Park, Colorado. After experiencing chest pain, we went to the local emergency department where I was stabilized and transported to St. Lukes in Denver, Colorado where I had angioplasty. Though the care at the emergency room in Estes Park was good – the hospital was not equipped to do any interventional procedure. I have termed this as a "pack and ship" operation. Because I love life (and because my wife took advice to heart), we modified our eating and exercise habits and took the steps necessary to give my heart the best chance for recovery.

It wasn't until 2000 that I began to experience other heart problems – though this time it was rhythm problems. While spending time in Phoenix for Major League Baseball spring training – I had my first bout with v-tach (ventricular tachycardia). Is was a Sunday afternoon and I ended up at Mesa General in the Phoenix area – and spent many days in intensive care while my condition was being diagnosed and I was being stabilized. Again, I happened to land in a facility where there was not specialty care available for my heart problems. Finally, I was transported to another facility in Phoenix where I received my first AICD. The care was adequate – but neither facility really had the extensive type of cardiac care that I required. I was released and was able to travel back home to Gallup, New Mexico the next day after the implant. Soon after arriving home, I had my first experience as a patient at Rehoboth McKinley Christian Hospital. I had a tremendous pain in my right arm and went to the emergency room. The diagnosis was a blood clot in my right arm related to the recent AICD implant. Unfortunately, I was told that they could not treat me (a higher level of cardiac care was necessary) – and was instructed to go to Albuquerque for treatment.

As you can imagine, these few weeks were traumatic and I was concerned about my heart. I am a Medicare insured patient – and knew that I could have access to any facility in Albuquerque. At that point – I had heard of the Heart Hospital of New Mexico and knew that I would have access to all heart specialists – and decided to get myself there as quickly as possible. I was driven by a friend and arrived about 3 a.m. that morning. I spent 9 days at Heart Hospital of New Mexico and have never felt so safe and secure – and confident that I was receiving the specialty treatment that my condition required. I was not sent by investor physicians – but rather chose to go because I felt they provided the highest quality heart care. It is important when you live in a rural area to educate yourself and be prepared to make life and death decisions in terms of healthcare.

The story continues. In 2002, while in Santa Fe on business, my AICD fired for the first time. I went to St. Vincent's – the sole community hospital. Again, I was stabilized overnight and was released with follow-up instructions to see a New Mexico Heart Institute electrophysiologist in Albuquerque. My condition became more of a concern. Throughout the year (2002) I experienced numerous firings of the ICD while living in

Gallup. On each occasion, I had to get to the emergency department at Rehoboth McKinley where I was stabilized and because they were unable to treat me, I was transferred (packed and shipped) by air to Heart Hospital of New Mexico. Fortunately, because of the relationship of Dr. Swaminathan, a New Mexico Heart Institute cardiologist who practices in Gallup, and Heart Hospital of New Mexico's quick transfer initiative, I was able to arrive with a specialist waiting, as quickly as possible. In one instance while in the ambulance in route to the airport in Gallup, my AICD fired four times and I had to be returned to Rehoboth McKinley to be stabilized again before I could be flown to Heart Hospital of New Mexico.
Upon arrival at HHNM, it was determined that the unit installed in Phoenix had failed and I received a new AICD. Because my v-tach is severe, I have had numerous firings over the past few years and in each case was transferred.

Upon concern for my health and well-being and for the peace of mind for both my wife and I, we decided we wanted to move to Albuquerque to be close to Heart Hospital of New Mexico. We feel at home – safe and secure. With the experience we have had as an inpatient – I know that care was always timely, with the most specialized staff. As it has turned out – our decision was the right one. Since moving, I have had the fortune of being close to the Heart Hospital of New Mexico and have now experienced treatment in their emergency department. They know that time means muscle (and life) when it comes to heart patients. I have had more problems with v-tach and have been rushed twice over a 2-month period to the Heart Hospital Emergency Department. I know from experience that the timeliness of care and expertise of all physicians has allowed me to maintain an active and normal life. The emergency department physicians have deep experience and have immediate access to the specialized cardiologists. On both occasions, my treatment was quick, technically superb and compassionate. In fact, my wife, who is an accomplished artist, was scheduled to participate in a show in California, shortly after my discharge from the October 2004 admission. The only reason she did not cancel the trip – is because she feels that the Heart Hospital of New Mexico is our second home. She knew that I would receive the specialized care that I must have. Coincidently, I had another v-tach episode while she was on her trip.

In April of 2005 I received a replacement AICD at Heart Hospital of New Mexico at the encouragement of my electrophysiologist because of a vendor (Medtronic) recall. As I stated – I am a Medicare patient. I know that Heart Hospital of New Mexico does not receive adequate payment to cover the cost of the implant – however, not once, has there been any discussion about costs. They put patient care first. And accusations that HHNM selects less sick patients – Hey, I am a chronic heart patient, who on top of all other heart problems, has now been diagnosed with Congestive Heart Failure. Am I concerned – yes, but worried - no. I know that I have and will continue to receive the very best heart care available in New Mexico. Thanks for listening.

Statement

of the

American Medical Association

to the

Subcommittee on Federal Financial Management,
Government Information, and International Security
of the
Committee on Homeland Security and Governmental Affairs,
United States Senate

Overview of the Competitive Effects of Specialty Hospitals

Presented by: William G. Plested III, MD

May 24, 2005

Chairman Coburn, Ranking Member Carper, and Members of the Subcommittee, the American Medical Association (AMA) appreciates the opportunity to provide our views regarding specialty hospitals and their role in a competitive marketplace.

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. Specialty hospitals are key to that goal. They increase competition for hospital services by providing patients with more choices and by forcing general hospitals to innovate in order to stay competitive. Some general hospitals have even admitted that the entry of a specialty hospital in their area has been akin to a "wake-up" call. Specialty hospitals have improved care for Medicare beneficiaries and other patients, and patient and physician satisfaction with these hospitals is extremely high.

Hospitals that provide care for a specific type of patient or a defined set of services are not new. Specialty hospitals have been in existence for decades. For example, Delaware's Alfred I. DuPont Hospital for Children has provided specialty hospital care to thousands of children from across the country since its founding in 1940. Numerous market dynamics have led to the increase in physicians' desire to own and operate these hospitals in recent years. Since 1995, the number of hospitals that focus on cardiac, orthopedic and surgical services has

grown. This growth has led to concern among general hospitals who must compete with these facilities. The hospital associations and many general hospitals are vigorously attempting to eliminate this competition, employing anticompetitive practices to stifle competition.

Consistent with medical ethics, the AMA supports physician ownership of health facilities, and referrals by physician owners, if they directly provide care or services at the facility. The growth in specialty hospitals is an appropriate market-based response to a mature health care delivery system, as well as a logical response to incentives in the payment structure for certain services and the increasing medical needs of elderly patients.

Although general hospitals have not been harmed financially as a result of physician owned specialty hospitals, they claim that the playing field is not competitive because specialty hospitals take away lucrative services that general hospitals use to subsidize other community services. The Federal Trade Commission (FTC), the Department of Justice (DOJ), and many others, believe that cross-subsidization of services by general hospitals is a market distortion that must be eliminated to preserve competition. The AMA agrees.

Changes are needed in the inpatient and outpatient Medicare prospective payment systems to more accurately reflect the relative costs of hospital care, thus eliminating the need for cross-subsidization of services by general hospitals. The Medicare Payment Advisory Commission (MedPAC) has recommended specific changes to the Medicare hospital payment system to accomplish this end, and the AMA supports those recommendations. In addition, we support policy changes that would help ensure the financial viability of "safety-net" hospitals so they can continue to provide access to health care for indigent patients. Combined, these changes would ensure the continued financial stability of general and safety net hospitals, further enhancing competition in the market for hospital services.

For these reasons, the AMA urges this subcommittee to support competition, not an extension of the moratorium on physician referrals to specialty hospitals.

THE MORATORIUM ON SPECIALTY HOSPITALS SHOULD EXPIRE AND NOT BE REINSTATED

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.

[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.

According to the GAO,[2] there are 100 existing specialty hospitals that focus on cardiac, orthopedic, women's medicine, or on surgical procedures.[3] Of the 100 specialty hospitals identified by the GAO and 26 others under development in 2003, there were various owners/investors, including both hospitals and physicians. Seventy percent had some degree of physician ownership. One-third of these specialty hospitals were joint ventures with corporate partners, one-third were joint ventures with hospitals, and one-third were wholly owned by physicians.

The moratorium is due to expire on June 8, 2005. As of May 12, 2005, the GAO, HHS and MedPAC had all completed their MMA-required reports. Because these studies are complete and they demonstrate that specialty hospitals do not harm general hospitals—in fact, they show that specialty hospitals improve patient care—the AMA believes the moratorium should expire. There is no need for an extension of the moratorium, nor for imposition of a de facto moratorium as the Centers for Medicare and Medicaid Services (CMS) has indicated by its announcement to delay approval of applications for new specialty hospitals until 2006.

THE RECENT GROWTH OF SPECIALTY HOSPITALS IS A RESULT OF PATIENT AND PHYSICIAN NEED

There are numerous 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.

- 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.

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[2] *See* U.S. General Accounting Office, *Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served*, GAO-03-683R (April 18, 2003); and U.S. General Accounting Office, *Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance*, GAO-04-167 (October 22, 2003).

[3] This number excludes numerous other specialty hospitals that have been in existence for some time, such as eye and ear hospitals, children's hospitals, and those that specialize in psychiatric care, cancer, rehabilitation, and respiratory diseases.

- Business partners willing to provide capital and management expertise are more readily available.

SPECIALTY HOSPITALS DEMONSTRATE HIGH EFFICIENCY, QUALITY AND PATIENT SATISFACTION

For various reasons, specialty hospitals have achieved better quality, greater efficiency, and higher patient satisfaction than general hospitals. Specialty hospitals are able to achieve production economies by taking advantage of high volumes of a narrow scope of services, and by lowering fixed costs by reengineering the care delivery process. Managerial and clinical staff at specialty hospitals focus on a relatively narrow set of tasks, thus providing the capability to perfect those tasks and benefit from increased accountability for the quality of care provided to patients. **According to the Center for Studying Health System Change, the health services literature supports the premise that "focused factories" can lead to higher quality and lower costs as a result of more expert and efficient care.**[4]

Managers of specialty hospitals consistently report the factors they perceive as critical to achieving high quality patient outcomes: high volume and high nursing intensity.[5] Specialty hospitals tend to have higher nurse-patient ratios despite the fact that physicians at specialty hospitals contend that they spend about 30% of their operating expenses on labor, compared to 40 to 60% for general acute-care hospitals.

Physician control and facility design also increase productivity and quality. Specialty hospitals improve patient access to specialty care by providing additional operating rooms, cardiac-monitored beds, and diagnostic facilities. Specialty hospitals offer newer equipment, more staff assistance and more flexible operating room scheduling, thereby increasing productivity and physician autonomy over their schedules. Patients are therefore able to benefit from the higher productivity and increased flexibility in scheduling their procedures.

The 2005 HHS/CMS study suggests that measures of quality care at specialty heart hospitals were at least as good and in some cases better than general hospitals.[6] In addition, complication rates and mortality rates were lower at specialty hospitals, even when adjusted for severity. There were lower rates of readmission for moderately ill patients in orthopedic hospitals, and lower rates of infection due to medical care, post operative hip fracture, post operative deep vein thrombosis, and post operative sepsis in all specialty hospitals.[7] Furthermore, CMS found that patient satisfaction was extremely high in the specialty hospitals studied, and patients had very favorable perceptions of the clinical quality

[4] Kelly J. Devers, Linda R. Brewster and Paul B. Ginsburg, *Specialty Hospitals: Focused Factories or Cream Skimmers?* HSC Issue Brief Number 62, April 2003.
[5] John E. Schneider, PhD, et al., *Economic Policy Analysis of Specialty Hospitals*, February 20, 2005.
[6] Study of Physician-owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Department of Health and Human Services, Centers for Medicare and Medicaid Services, (2005).
[7] *Id.*

of care they received.[8] Significantly higher nurse-to-patient ratios and very knowledgeable nurses contributed to the positive experiences noted by patients and their families.

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 these services. In 2002, for example, 500,000 patients were diagnosed with congestive heart failure. With the estimated number of Americans at risk of cardiovascular disease projected to mushroom over the next decade, cardiovascular surgeons and cardiologists will need to see twice as many patients in ten years as they see today. Aging of the population, population growth, higher functioning and higher quality of life expectations associated with the baby boom generation are driving increased demand for cardiac, orthopedic, and surgical services. The greater efficiency of specialty hospitals will better enable physicians to care for these patients. Furthermore, the GAO found that 85 percent of specialty hospitals are located in urban areas and tend to locate in counties where the population growth rate far exceeds the national average.[9]

Patient satisfaction with specialty hospitals is extremely high. They enjoy relatively greater convenience and comfort, such as lack of waiting time for scheduled procedures, readily available parking, 24-hour visiting for family members, private rooms, more nursing stations that are closer to patient rooms, decentralized ancillary and support services located on patient floors, and minimized patient transport. Specialty hospitals have engaged in extensive collection of data on quality and patient satisfaction, and use the data to modify care processes. Because of the smaller size and narrow focus of specialty hospitals, they are more nimble and flexible to quickly respond to modify care processes as perceived necessary.

GENERAL HOSPITALS EMPLOY ANTICOMPETITIVE TACTICS IN RESPONSE TO INCREASED COMPETITION

As physicians began seeking greater involvement in the governance and management of patient services provided at hospitals, many who ultimately became investors in specialty hospitals tried initially to form joint ventures with hospitals to expand the availability of cardiology and orthopedic services. In many cases, the hospitals declined to enter into joint ventures with physicians. In other cases, the hospitals opened units or specialty hospitals of their own. By and large, however, general hospitals have become staunch opponents of physician owned specialty hospitals.

According to the GAO, the financial performance of specialty hospitals tended to equal or exceed that of general hospitals in fiscal year 2001.[10] 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.[11]

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[8] *Id.*
[9] GAO, *supra* note 2.
[10] *Id.*
[11] *Id.*

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" (e.g., ambulatory surgery centers, GI labs, imaging facilities, radiation oncology centers). The hospital industry has engaged in numerous focused strategies to prohibit physicians from opening a competing facility. Three core strategies the hospital industry is employing to address physician ownership of specialty hospitals are:

- Preemptive strike strategy—The hospital establishes its own specialty hospital and addresses some of the physician concerns, but does not offer physicians an opportunity for investment. Some hospitals also implement this strategy when a competing hospital or health system decides to build its own specialty hospital.

- Joint venture strategy with local physicians—The hospital recognizes a competitive threat from members of its medical staff or other local physicians and decides to engage in a joint venture with them rather than facing a reduction in the services.

- Roadblock strategy—Hospitals fights physicians that try to open a competing facility by building barriers and aggressively limiting 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 who have an indirect or direct financial investment in a competing entity).

At the state level, hospitals have initiated several different types of anti-competitive strategies to limit physician-owned specialty hospitals. These initiatives include, but are not limited to, the following:

- Adopting legislation banning the creation of any facility that focuses on cardiac care, orthopedic services or cancer treatment (Florida).

- Proposing legislation prohibiting physicians from having a financial ownership in specialty hospitals (Ohio and Washington).

- Proposing legislation to expand Certificate of Need (CON) requirements to include other physician-owned facilities such as ambulatory surgery centers and diagnostic imaging facilities (Minnesota).

- Resisting efforts to repeal CON legislation (Iowa).

- Proposing legislation and/or regulations requiring specialty hospitals (but not other hospitals) to provide emergency departments and/or accept Medicare, Medicaid, and uninsured patients (Washington).

Individual general hospitals have also implemented a variety of anti-competitive strategies and tactics to discourage their medical staff from investing in competing specialty hospitals or to harm the medical practice of those who do make such investments. These initiatives include, but are not limited, to the following (See also Exhibit A attached to this statement):

- Adopting economic/exclusive credentialing/conflict of interest policies and medical staff development plans that revoke or refuse to grant medical staff membership or clinical privileges to any physicians or other licensed independent practitioner that has an indirect or direct financial investment in a competing entity.
- Hospital-owned managed care plans denying patient admissions to competing specialty hospitals.
- Requiring health plans to sign an exclusive managed care contract or otherwise discouraging them from contracting with competing facilities.
- Removing physicians that have a financial interest in a competing facility from their referral and on-call panels.
- Refusing to cooperate with specialty hospitals (i.e., refusing to sign transfer agreements).
- Requiring primary care physicians employed by the hospital or vertically integrated delivery system to refer patients to their facilities or those specialists that are closely affiliated with the hospital/health care delivery system regardless of the needs of the patient.
- Limiting access to operating rooms and cardiac catheterization labs of those physicians who have a financial interest in a competing entity.
- Removing competing physicians from extra assignments at the hospital, such as serving as department directors or reading EKGs, ultrasounds, echocardiography, and x-rays.

ETHICAL AND LEGAL SUPPORT FOR SPECIALTY HOSPITALS

The hospital industry's overarching message is that physicians who invest in a specialty hospital have a conflict of interest. They use this to justify their strategies to eliminate legitimate competition. **However, it is both ethical and legal for physicians to invest in and refer patients to health facilities.**

AMA ethical opinion E-8.032, "Conflicts of Interest: Health Facility Ownership by a Physician," delineates two scenarios where physicians may appropriately make patient referrals to health facilities in which they have an ownership interest. First, it sets forth a general rule that physicians may appropriately make such referrals if they directly provide care or services at the facility in which they have an ownership interest. Second, it describes a separate situation where physicians may appropriately make such referrals, which arises when

a needed facility would not be built if referring physicians were prohibited from investing in the facility. In the latter case, the appropriateness of the referrals would not depend upon whether the physicians have personal involvement with the provision of care at the facility, but whether there is a demonstrated need for the facility. Physician ownership of specialty hospitals and referral of patients for treatment at such facilities fits squarely within this ethical opinion.[12]

In addition, physicians are legally permitted to own health care facilities and refer patients to them. The physician self-referral law and the federal anti-kickback statute both set forth very broad prohibitions that generally prevent physicians from receiving any form of remuneration in exchange for referrals. Because the laws contain such broad prohibitions that effectively prevent many legitimate forms of remuneration, they also contain exceptions or safe harbors that define permissible forms of remuneration. Both laws permit physician ownership of treatment facilities and referrals to such facilities under various circumstances.[13] The physician self-referral law, the "Stark law," explicitly permits physician ownership of a hospital, and referral of patients to the hospital, if the physician is authorized to perform services at that hospital and the ownership interest is in the "hospital itself" and "not merely in a subdivision of the hospital."

The hospital associations, however, claim that physicians who own specialty hospitals should not be permitted to make referrals to those hospitals under that exception because they claim a specialty hospital is equivalent to a subdivision of a hospital. They call the use of this exception a "loophole" to bolster their efforts to eliminate competition from physician owned facilities.

This claim is simply unfounded. **Specialty hospitals are entire hospitals, not subdivisions of a hospital. They are independent legally-organized operating entities that provide a wide range of services for patients, from "beginning-to-end" of a course of treatment including specialty and sub-specialty physician services, and a full range of ancillary services.** A significant number of specialty hospitals also provide primary care, intensive care and emergency services.

The protection of referrals to an entire hospital, and not just a "subdivision of a hospital," was intended to prevent circumvention of the ban on referrals of laboratory services. As originally enacted, "Stark I," only prohibited referrals for laboratory services to facilities physician owned.[14] It would be counter-intuitive to prohibit ownership of and referral to a laboratory, but permit ownership of and referral to a hospital subdivision that provided only laboratory

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[12] 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.

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

[14] Public Law 101-239, December 19, 1989.

services. The Centers for Medicare and Medicaid Services (CMS) (then HCFA) confirmed this intent in its 1992 proposed regulations interpreting the original Stark law. CMS explained that the exception protected referrals when the physician's ownership interest is in the entire hospital and "not merely a distinct part or department of the hospital, such as the laboratory."[15]

In the 1995 Final Rule, there is a protracted discussion of what constitutes a hospital and a distinct part or department of a hospital.[16] CMS defined "hospital" for purposes of the Stark law as "any separate legally-organized operating entity plus any subsidiary, related, or other entities that perform services for the hospital's patients and for which the hospital bills..."[17] A specialty hospital fits squarely within this definition.

In 1993, Congress enacted legislation, referred to as "Stark II," expanding the ban on physician referrals from just clinical laboratory services to an entire list of ancillary services referred to as "designated health services."[18] The hospital ownership exception was appropriately retained in Stark II, permitting physicians to refer patients to a hospital they own and where they practice medicine, but prohibiting referrals to a hospital "subdivision" they own. Thus, the referring physician could still refer patients to a hospital he or she owns for a course of treatment, but not circumvent the intent of the prohibition by referring patients to a subdivision of a hospital that only provides one or more of the designated ancillary services.

As noted, designated health services are ancillary services, not physician services.[19] **The Stark laws prevent referrals for ancillary services, not professional services performed by a physician.** Furthermore, the Stark laws specifically prohibit referrals of these services at locations where the referring physician is <u>not directly involved in the care of the patient</u>. Under the Stark laws, no referral restriction is imposed if the referring physician personally performs a service, even if it is an ancillary service that would otherwise be prohibited by the law. There is also an exception for referrals of ancillary services rendered by another physician in the referring physician's group practice, or supervised by that physician, as long as it is in the same building where the referring physician regularly practices or a centralized building used by the referring physician for some or all of the designated health services performed by the group practice. Thus, the Stark laws prohibit physicians from making referrals for ancillary services at facilities where they do not practice and that provide only ancillary services.

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[15] 57 Fed. Reg. 8588, 8598 (March 11, 1992).
[16] 60 Fed. Reg. 41913, 41956 (August 14, 1995).
[17] 60 Fed. Reg. at 41956-41957.
[18] Public Law 103-66, August 10, 1993. These ancillary services include clinical laboratory services, physical and occupational therapy, radiology services (including MRI, axial tomography, and ultrasound), radiation therapy services and supplies, durable medical equipment supplies (DME), parenteral/enteral nutrients, prosthetics/orthotics supplies, home health services, outpatient prescription drugs, and inpatient and outpatient hospital services.
[19] Radiation therapy and certain radiology services often encompass a professional component as well as a technical component, but there is no carve out for the professional service. CMS notes, however, that in most cases these services will fall under the exceptions for physician service or will not be a referral because they are personally performed by the physician.

A specialty hospital is an entire hospital that provides a wide range of services for patients. In addition, physicians who invest in these hospitals and refer patients to them also treat patients at the hospital. Moreover, specialty hospitals do not provide only ancillary services. As stated previously, specialty hospitals provide a spectrum of care, from "beginning-to-end" of a course of treatment, including specialty and sub-specialty physician services, a full range of ancillary services, and often including primary care, intensive care, and emergency services. Therefore, **a specialty hospital is not equivalent to a hospital subdivision.**

There is no credible evidence that physicians are inappropriately referring their patients to specialty hospitals. Physicians have an ethical and legal obligation to refer patients to the facility that best meets the needs of the individual patient. The HHS study did not conclude that physicians who have an investment interest in a specialty hospital inappropriately refer patients.[20]

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."[21] 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, 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 the hospital owned primary care practices and other 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. Why? It is clear that they only maintain these revenue-losing groups to control referrals and avoid competition.

The AMA is very concerned about efforts by hospitals and health systems to control physician referrals as they pose a number of significant concerns. **By dictating to whom physicians may refer, the hospital governing body or administration takes medical decision-making away from physicians. This introduces financial concerns into the patient-physician relationship and can run counter to what the physician believes is in the best interest of the patient. These hospital self-referral practices also limit patient choice.**

To reduce this interference in the patient-physician relationship, the AMA believes that disclosure requirements for physician self-referral, where applicable, should also apply to hospitals and integrated delivery systems that own medical practices, contract with group

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[20] CMS, *supra* note 6.
[21] Charles N. Kahn III, *A Health-Care Loophole*, Washington Times, February 3, 2005.

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. MedPAC found that overall utilization rates in communities with specialty hospitals were similar to utilization rates in other communities. In addition, of the specialty hospitals identified by the GAO with some degree of physician ownership, the average share owned by an individual physician was less than two percent. Of particular significance, the GAO found that the majority of physicians who provided services at specialty hospitals had no ownership interest in the facilities. Overall, approximately 73 percent of physicians with admitting privileges at specialty hospitals were not investors in those hospitals.[22] Therefore, the majority of physicians who admit patients to specialty hospitals receive no financial incentives to do so. Further, of those physicians who do have an ownership interest in the hospital, there is no evidence that their referrals are inappropriate or have increased utilization.

COMPETITION SHOULD BE PROMOTED AND MARKET DISTORTIONS SHOULD BE ELIMINATED

The AMA continues to have serious concerns about the tactics being employed by hospitals in their attempts to eliminate competition by prohibiting physician referrals to specialty hospitals in which they have an ownership interest. The AMA believes that the growth in specialty hospitals is an appropriate market-based response to a mature health care delivery system and a logical response to incentives in the payment structure for certain services. This type of market response will create an incentive for general hospitals to increase efficiencies to compete. In fact, it already has. Specialty hospitals have admittedly been a "wake-up" call for general hospitals in certain communities.[23]

General hospitals are not suffering financially as a result of the growth of physician owned specialty hospitals. **MedPAC found that the financial impact on community hospitals in the markets where physician owned specialty hospitals are located has been limited.** These hospitals have demonstrated financial performance comparable to other community hospitals.[24] 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.[25]

The cross-subsidies that hospitals use from profitable services to provide unprofitable services should be eliminated by making payments adequate for all services. The FTC, the DOJ, the Center for Studying Health System Change, and others believe there are inherent problems in using higher profits in certain areas of care to cross-subsidize uncompensated care and essential community services. In the July 2004 FTC/DOJ Report on Competition and Health Care, Recommendation 3 states:

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[22] GAO, *supra* note 2.
[23] MedPAC, "MedPAC Report to the Congress: Physician-Owned Specialty Hospitals," March 2005.
[24] *Id.*
[25] Schneider, et al., *supra* note 5.

> Governments should reexamine the role of subsidies in health-care markets in light of their inefficiencies and the potential to distort competition. Health-care markets have numerous cross subsidies and indirect subsidies. Competitive markets compete away the higher prices and profits needed to sustain such subsidies. Competition cannot provide resources to those who lack them, and it does not work well when providers are expected to use higher profits in certain areas to cross-subsidize uncompensated care. In general, it is more efficient to provide subsidies directly to those who should receive them to ensure transparency.[26]

Paul Ginsburg, president of the Center for Studying Health System Change offered the following theory at a recent conference on the topic of specialty hospitals:

> In a perfect world, competition might be the best system. But if you have a lot of market distortions, competition may not make you better off, and you have to decide either not to have the competition, or work on fixing the distortions.[27]

The AMA agrees and believes that pricing distortions that force hospitals to cross-subsidize should be eliminated so that competition can thrive. Cross-subsidization is not the appropriate method to fund community health and medical services. 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. **To ensure that hospital payments better compensate for these services so that safety-net hospitals receive proper funding, HHS should make changes to the Medicare hospital prospective payment system to minimize the need for cross-subsidization and accurately reflect relative costs of hospital care.**

MedPAC recommends that CMS improve payment accuracy in the hospital inpatient prospective payment system (PPS) by refining the hospital Diagnosis Related Group (DRG) payments to more fully capture differences in severity of illness among patients, basing the DRG relative weights on the estimated cost of providing care rather than on charges, and basing the weights on the national average of hospitals' relative values in each DRG. MedPAC also recommends that DRG relative weights be adjusted to account for differences in the prevalence of high cost outlier cases.[28] The AMA supports such recommendations and believes that such payment changes will ensure full and fair competition in the market for hospital services.

The AMA also believes that further policy changes are necessary to ensure continued provision of uncompensated care and to protect America's public safety net hospitals. Nonprofit hospitals are exempt from federal and state income taxes and local property taxes and have access to tax-exempt financing to help support their provision of uncompensated

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[26] Federal Trade Commission and Department of Justice, *Improving Health Care: A Dose of Competition*, July 23, 2004.
[27] *Update Conference Report: Specialty Hospitals , Ambulatory Surgical Centers, and General Hospitals, Charting a Wise Public Policy Course*, Health Affairs (May/June 2005).
[28] See MedPAC, supra, note 23.

care to patients. Most nonprofit hospitals also receive Medicare and Medicaid Disproportionate Share Hospital (DSH) payments to help defray the costs of uncompensated care. Specialty hospitals, most of which are for-profit entities, provide support to the community in various other ways. In fact, according to findings from the CMS study, the total proportion of net revenue that specialty hospitals devote to both uncompensated care and taxes "significantly exceeds" the proportion of net revenues general hospitals devote to uncompensated care.[29]

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. Safety-net hospitals provide a significant level of care to low-income, uninsured, and/or vulnerable populations. 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 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 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. **CMS should correct the flawed methodology for allocating DSH payments to help ensure the financial viability of safety-net hospitals so they can continue to provide access to health care for indigent patients.** In addition, the current reporting mechanism should be modified to accurately monitor the provision of care by hospitals to economically disadvantaged patients so that policies and programs targeted to support the safety net and the populations these hospitals serve can be reviewed for effectiveness. Medicare and Medicaid subsidies and contracts related to the care of economically disadvantaged patients should be sufficiently allocated to hospitals on the basis of their service to this population in order to prevent the loss of services provided by these facilities.

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

[29] CMS, *supra* note 6.

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, CMS and FTC/DOJ findings and recommendations, the AMA recommends the following:

- **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.**
- **CMS should make payment and policy changes outlined above to eliminate pricing distortions in the market for hospital services.**
- **While these payment and policy changes take effect, MedPAC, HHS and others should continue to monitor specialty hospitals and the impact on general hospitals and patient care, not stifle healthy competition.**

We appreciate the opportunity to testify on this important issue. We urge the Subcommittee and the Senate to consider the recommendations we have discussed today. We are happy to work with Congress as it considers these important matters.

Exhibit A

American Medical Association
March 8, 2005

Aurora Medical Group

Aurora Health Center-Mayfair
10400 West North Avenue
Wauwatosa, WI 53226-2425

T (414) 479-2300
F (414) 479-2340

www.AuroraHealthCa

January 30, 2004

Aurora Medical Group has been using you and your group as a referral source for our patients with , for some time now. To date, we have been very pleased with the care you give our patients.

As Aurora Medical Group physicians, we are dedicated to Aurora Health Care and its efforts in Care Management and continuity of care. The employers we contract with have come to expect excellence in both of these areas. We have installed an extensive infrastructure so that we can deliver on our promise.

For these reasons, we expect you and your group to use Aurora facilities for all of our referrals. This includes, but is not limited to: outpatient surgery and procedures, all imaging and laboratory work, therapy, and inpatient admissions.

We would like our current relationship to continue, and we anticipate your full cooperation.

Sincerely,

Daniel J. Miota, D.O.
Metro Region Director of Medical Operations

February 3, 2004

Dear Member of the West Allis Memorial Hospital Medical Staff:

As you know, the WAMH Board of Directors recently voided the results of my election to be Chief of Internal Medicine at our hospital. I accepted the nomination for this office primarily to work with my colleagues to improve the care of our patients at our hospital. I wanted to let you know that my motivation and intentions have not changed. I will support our new department chief and remain committed to the physicians and patients at our hospital.

It is unfortunate that the WAMH administration has chosen to punish me because of my limited association with another hospital system. Aurora has not only dismissed me from leadership in the Medical Staff but has also removed me from all cardiology panels, directed my referrals to other cardiologists, interfered with long established professional relationships and has cancelled my lease for the office space, ending a relationship that has existed since my partner Gerry McInerney opened an office at our hospital in 1964.

Some of you may own your own offices, share in imaging centers, GI labs or outpatient surgical centers or have other financial interests which are independent of Aurora. These are legitimate business decisions. American Medical Association policy opposes economic credentialing by hospitals, which punishes members of a hospital staff for owning their own businesses or having independent financial interests.

I truly appreciate the support you have given. I have no intention of leaving our hospital and will continue to be available to see your patients at West Allis Memorial Hospital. As physicians, it is important that we not lose sight of our primary commitment to our patients.

Sincerely,

Lisa L. Armaganian, MD

Wisconsin Heart and Vascular Clinics, S.C.

Comprehensive Cardiac & Peripheral Vascular Medicine

2424 S. 90th St.
Suite 308
West Allis, WI 53227
414 328 8720
FAX 414 328 8724
Lisa L. Armaganian, M.D., F.A.C.C.

James R. King, M.D., F.A.C.C., F.S.C.A.I.
Jack C. Manley, M.D., F.A.C.C., F.S.C.A.I.
Gerald T. McInerney, M.D., F.A.C.C.
L. Samuel Wiley, M.D., F.A.C.C.
Frank E. Cunningham, M.D., F.A.C.C.
Charles K. Hollman, M.D., F.A.C.C.
Timothy Vellinga, M.D., F.A.C.C., F.S.C.A.I.
T. Edward Hastings, D.O., F.A.C.C.
David K. Agnoong, M.D., F.A.C.C.
James L. Hoxie, M.D., F.A.C.C.
Krishna Kumar, M.D., F.A.C.C.
James A. Grazel, M.D.
Mark W. Moeksum, M.D.
Henry H. Gale, M.D., F.R.C.P. (C)
Gerald E. Auger, M.D.
Stanley Y. Higginbotham, M.D.

Brookfield
19475 West North Avenue
Suite 304
Brookfield, WI 53045
262 780 4100
FAX 414 328 8724

Burlington
248 Highway 36
Burlington, WI 53105
262 767 8004
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414 281 0229
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Milwaukee – St. Luke's
2801 W. Kinnickinnic River Pkwy.
Suite 501
Milwaukee, WI 53215-5871
414 649 3590
FAX 414 649 8140

Milwaukee – St. Luke's
2801 W. Kinnickinnic River Pkwy.
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Milwaukee, WI 53215
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Sheboygan
2414 Kohler Memorial Dr.
Sheboygan, WI 53081
920 458 1440
FAX 920 458 1447

West Allis
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West Allis, WI 53227
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Corporate Office
1087 Dominion Avenue Columbus, Ohio 43201-3201 614) 544-5424 fax 544-5244 www.ohiohealth.com

December 17, 2003

On October 1, 2002, upon the recommendation of a task force comprised of community volunteers, physicians, and administrators, the OhioHealth Board adopted a policy that a physician who has a direct or indirect investment in a competing inpatient facility has a conflict of interest that precludes the physician from being eligible to apply for medical staff privileges at an OhioHealth hospital. In the case of a physician who currently has medical staff privileges at an OhioHealth hospital, the conflict causes a voluntary resignation of such privileges.

You are identified on the public website of the investor-owned New Albany Surgical Hospital as a "Founding Physician." The OhioHealth conflict of interest policy would apply not only to an investment by you personally, but also to an investment by your employer, business partner, family member or other economically related person. For your information I am enclosing the "Procedures to Implement Board Policy on Practitioner Conflicts of Interest" that includes applicable definitions.

Under the conflict of interest policy, NASH investors at OhioHealth hospitals resign their privileges effective after the New Albany Surgical Hospital begins inpatient operations. To permit affected physicians ample time to schedule surgeries appropriately and notify their patients, OhioHealth has determined to accept NASH-investor resignations at 11:00 P.M., Saturday, January 31, 2004.

Under the OhioHealth Board policy, there will be an appeal process from the initial determination on the issue of whether you have a direct or indirect investment.
The appeal guidelines are also enclosed. In light of the upcoming holiday season, we are modifying the timelines applicable to the appeal process. If you wish to file an appeal it must be received by OhioHealth's General Counsel by 12:00 noon December 29, 2003. The appeal hearings should be completed by January 22, 2004.

If there is additional information that you would like us to consider at this time, or if you decide to file an appeal, please forward it to the OhioHealth Sr. V .P. & General Counsel, Frank T. Pandora II, at 3722 Olentangy River Road, Suite K, Columbus, Ohio 43214.

On a personal basis, we regret that these circumstances have brought you within the purview of the Board's conflict of interest policy. OhioHealth values the contribution you and your colleagues have made in the past, and we are grateful for the care you give to patients at OhioHealth hospitals.

Very truly yours,
David P. Blom
President and Chief Executive Officer
OhioHealth

PHYSICIANS >> *Susanna Duff*

Not a team player

Maine cardiac center wants to limit docs to performing surgeries only at its facility

In the latest battle for profitable cardiac cases, a controversial physician contract for a Maine heart center slated to open next year has angered some local cardiologists and state officials.

Central Maine Medical Center in Lewiston plans to open a 16-bed cardiology center in April 2003, more than two years after winning certificate-of-need approval.

Local cardiologists may apply for privileges only if they agree in writing to not participate in a competing cardiac-surgery center. Central Maine Medical Center would not release a written copy of the contract it's asking physicians to sign.

Chuck Gill, spokesman for the 172-bed hospital, said the facility wants a dedicated team that will attract a steady stream of patients to pay for the approximately $6.5 million capital cost of the heart center, as required by its CON.

"You can't be on two teams at the same time," he said.

Representatives of Maine Medical Center in Portland, which operates one of two existing heart programs in the state, and some local cardiologists argue the policy amounts to "economic credentialing" because it dictates where physicians may admit patients. They claim the policy is a way to retaliate against opponents of the hospital's CON petition.

Weiss may no longer be able to treat patients at Central Maine Medical Center.

Economic credentialing is opposed by the American Medical Association, which defines it as the "use of economic criteria unrelated to quality of care or professional competency" in determining qualifications for hospital privileges.

Among the opponents was 560-bed Maine Medical Center, which annually performs more than 1,600 open-heart surgeries and 2,000 angioplasties.

"There is no need to have another cardiology center only 40 miles away. It is a duplicative program that doesn't improve access and quite likely raises costs,"

RESOLUTION OF THE BOARD OF DIRECTORS

OF

ST. JOHN'S MERCY HEALTH SYSTEM

WHEREAS, St. John's Mercy Health System ("SJMHS") owns and operates St. John's Mercy Hospital (the "Hospital"), a nonprofit, charitable hospital in Washington, Missouri;

WHEREAS, SJMHS is committed to meeting the health care needs of the community it serves (the "Community");

WHEREAS, the SJMHS Board of Directors has a duty to preserve and protect the health care charitable assets of the Hospital so that it may fulfill its charitable mission and its healthcare ministry in the Community;

WHEREAS, the recent growth in for-profit, physician-owned specialty hospitals and ambulatory surgery centers across the nation has raised concerns that such facilities and other similar physician-owned ventures are intended to divert patient care from general acute-care, charitable hospitals, thus eroding the financial viability of neighboring general hospitals, and impairing their ability to provide emergency care and other essential community services;

WHEREAS, the investment of physicians in specialty hospitals, ambulatory surgery centers or other limited-service Hospital competitors creates financial incentives that may inappropriately affect investing physicians' clinical and referral behavior;

WHEREAS, the Board of Directors believes that the creation of such specialty hospitals, ambulatory surgery centers, or other physician-owned competing ventures will seriously impair the ongoing charitable mission of the Hospital;

WHEREAS, based on requests from physicians and other Community members, SJMHS is planning to invest more than $18 million in the Hospital to enhance the delivery of patient care and provide needed capacity for healthcare in the Community;

WHEREAS, the Board of Directors believes that certain competing investments by medical staff members are incompatible with the mission of the Hospital and conflict with the Hospital's goals to (i) care for all patients, regardless of ability to pay; (ii) maintain quality programs and facilities, including those programs that cannot be operated at a profit but that are beneficial to the overall health of the Community; and (iii) maintain an adequate and dedicated work force to achieve those goals;

WHEREAS, the Board of Directors believes that certain competing investments by individual medical staff members made on or after January 1, 2004 may create an unacceptable physician-investor conflict of interest that threatens the continued existence of the Hospital in the Community;

WHEREAS, the Board of Directors has the obligation and the moral responsibility for privileging the Hospital's medical staff in the a manner that supports the quality and availability of care and the financial survival of the Hospital's facilities and its healthcare ministry; and

WHEREAS, after considering the opportunities to enhance and maintain the mission of the Hospital, SJMHS has concluded that affecting staff membership and privileges is the only viable way to protect the Community and the assets of this charitable Hospital from physician-investors conflicting interests.

NOW, THEREFORE, BE IT RESOLVED, that this Board adopts and approves the St. John's Mercy Hospital Conflict of Interest Policy ("Policy"), which is attached to and hereby incorporated in this Resolution of the Board.

FURTHER RESOLVED, that as required by the Policy, all applications for appointment or reappointment to the Medical Staff be accompanied by the Conflict of Interest Disclosure Statement and that any failure of an applying or reapplying physician to submit the Conflict of Interest Disclosure Statement will cause the application to be incomplete and incapable of being reviewed and approved;

FURTHER RESOLVED, that the Policy be communicated to all relevant Medical Staff members and that the importance of the Hospital's continuing care to the Community be included in such communication; and

FURTHER RESOLVED, that the appropriate officers of SJMHS be and hereby are authorized and directed to perform such acts as may be necessary or appropriate to effectuate the Policy and the foregoing resolutions.

IN THE CIRCUIT COURT OF PULASKI COUNTY, ARKANSAS
THIRTEENTH DIVISION

04 MAR 22 PM 3:55
CIRCUIT-COUNTY CLERK

BRUCE E. MURPHY, M.D.,
SCOTT L. BEAU, M.D.,
DAVID C. BAUMAN, M.D.,
D. ANDREW HENRY, M.D.,
DAVID M. MEGO, M.D., AND
WILLIAM A. ROLLEFSON, M.D. PLAINTIFFS

VS. NO. CV2004-2002

BAPTIST HEALTH DEFENDANT

ORDER GRANTING PRELIMINARY INJUNCTION

On this day, comes before the Court the Plaintiffs' Motion for Temporary Restraining Order or Alternatively for Preliminary Injunction, and the Court, after reviewing all pleadings before it, doth find and order as follows:

Doctor Bruce Murphy and the other plaintiffs, all of them specialized heart doctors, have sued Baptist Health asking that Baptist be enjoined from preventing the doctors from practicing medicine at its hospitals. The court hereby grants the preliminary injunction that the doctors request.

STATEMENT OF THE CASE

Baptist Health adopted an Economic Conflict of Interest Policy (Economic Credentialing) in May, 2003. That policy mandates denial of initial or renewed professional staff appointments or clinical privileges at any Baptist Health hospital to any practitioner who, directly or indirectly, acquires or holds an ownership or investment interest in a competing hospital.

Baptist Health is a non-profit operation. Baptist and its board of trustees have a fiduciary duty to the community they serve. Baptist argues that it is only able to provide charity care if it can offset its loss with more profitable cases. James Harris, testifying in the federal court proceeding on behalf of Baptist stated,

> Maintaining a trauma center and emergency room for all hospitals is not a profitable line of service...but it's something we must do to fulfill the mission. Low birth weight babies, those are often difficult cases, and it's not a profitable line of service....another one is psychiatric care, which Baptist Health has continued to do, even though it's a very difficult issue statewide...

According to Baptist, Economic Credentialing was implemented to ensure long term viability and ability to provide such charity care.

Heart surgery and other expensive surgeries stand as high profit procedures for Baptist. The profits from these procedures are used to subsidize unprofitable operations at its hospitals.

Baptist, relying on *Mahan v. Avera St. Luke's*, 2001 S.D.9, 621 N.W.2d 150 (2001), asserts that it is in the best interest of the community that physicians who have an ownership interest in a competing hospital should not be extended privileges at Baptist facilities. The argument is that the physician's natural tendency would be to refer patients to the physician's hospital thereby jeopardizing the "charitable" activities of the enterprise to the detriment of the community. I cannot answer the question of whether the economic loss due to the "free" services is so great as to offset the revenue generated by Baptist's more lucrative activities.

Historically, all of the plaintiffs have been granted privileges by Baptist to practice in their hospitals. In March, 1997, the plaintiffs founded Arkansas Heart Hospital, which can compete with Baptist for patient referrals. Drs. Murphy and Beau were notified by Baptist Health that because of a violation of Baptist's Economic Credentialing, their privileges at Baptist Health hospitals would not be renewed effective February 26, 2004. The Plaintiffs first brought suit in federal court, however, the federal court dismissed their case for lack of jurisdiction.

The Plaintiffs filed their Motion for Temporary Restraining Order or Alternatively for Preliminary Injunction in this Court on February 25, 2004, stating that Baptist Health's policy of conditioning privileges to physicians based only on Economic Credentialing is contrary to the federal Anti-Kickback Statute, 42, U.S.C. §1320a-7b(b), the Arkansas Medicaid Fraud Act, ACA §5-55-111, the Arkansas Medicaid Fraud False Claims Act, ACA §20-77-902, and is contrary to public and

regulatory policy in violation of the Arkansas Deceptive Trade Practices Act, ACA § 4-88-101 *et seq.*

Under the Plaintiffs' interpretation of the facts in this case, Baptist's granting privileges to physicians is remuneration in exchange for possible referrals and is, therefore, a violation of the statutes cited above. The Plaintiffs allege that these acts of Baptist are contrary to the above-cited laws and interfere with the right of a patient to be admitted to a hospital and be treated by a doctor of his or her choice. Therefore, the Plaintiffs allege that Baptist's Economic Credentialing policy tortiously interferes with the Plaintiffs' relationships with their patients and tortiously interferes with the Plaintiffs' relationships with referring physicians.

In order to obtain a preliminary injunction, Plaintiffs' must prove under Rule 65 of the Arkansas Rules of Civil Procedure both irreparable harm to themselves and a likelihood of success on the merits. Plaintiffs allege that without an injunction, Baptist's enforcement of their policy will irreparably harm Plaintiffs in three ways: 1) by harming the doctor/patient relationship; 2) by causing irreparable harm to patients through inconsistent health care; and 3) by irreparably damaging the reputation of the Plaintiffs.

DISCUSSION

I. Irreparable Harm

1. The Doctor/Patient Relationship

The relationship of doctor-patient is unique. The loss of this relationship, even temporarily, causes irreparable damage to the doctor and the patient. There is no adequate remedy at law because the loss is a loss of a one-time opportunity.

Moreover, Arkansas Department of Health Rules and Regulations for Hospitals and Related Institutions in Arkansas, Section 5 (A)(10)states that. " The bylaws [of an institution] shall ensure admission of patients by a physician[,] patient choice of physician and/or dentist and emergency care by a physician." I interpret this to mean that an otherwise qualified doctor must be granted access to his patient for the purpose of treating his patient, if that is what both the doctor and patient want. Or, stated another way, a hospital cannot deny the services of a physician of the patient's choice if the hospital admits the patient and accepts the patient's insurance company or Health Maintenance Organization to cover any part

of the patient's hospital expenses.

2. The Harm to Patients through Inconsistent Healthcare

The physicians raise the possibility of having patients that cannot be referred to Arkansas Heart Hospital because the patient's insurance plan or health maintenance organization does not cover medical services provided at AHH or only provides coverage for services at a Baptist facility. The effect of Economic Credentialing therefore is to prevent a prospective or existing patient from being treated at the only facility available through insurance to them by the doctor of their choice, possibly resulting in inconsistent healthcare.

3. The Reputation of the Plaintiffs

Baptist states that the granting of the injunction requested by the doctors will harm Baptist's reputation because the only inference to be drawn is that Baptist has violated state and federal statutes. The doctors state that, on the other hand, in addition to the disruption to the doctor-patient privilege, their reputations will be harmed if they are not granted privileges or renewal of their privileges because the non-renewal must be disclosed to insurance companies and to other hospitals. A real possibility exists that the denial of privileges to a doctor on purely economic grounds would be interpreted by patients as reflective on the doctor's competency as a physician and disrupt the doctor-patient relationship. Both sides have valid points. However, the fracture of the doctor-patient relationship is paramount, and, therefore, the equities and public policy weigh in favor of the doctors.

II. Bar to Enjoining Criminal Activity

Baptist cites the bar to enjoining criminal activity. However, as the doctors point out, Justice Robert A. Leflar was quoted by the by the Arkansas Supreme Court in *Masterson v. State Ex Rel. Bryant*, 329 Ark. 443, 949 S.W.2d 63 at 64 (Ark. 1997), stating:

> That equity will not act to restrain ordinary violations of the criminal law, but will leave the task of enforcing the criminal laws to courts having criminal jurisdiction, is basic learning in our legal system. But it is equally

> basic that if grounds for equity jurisdiction exist in a given case, the fact that the act to be enjoined is incidentally violative of a criminal enactment will not preclude equity's action to enjoin it.

Baptist argues that Dr. Leflar went further in his analysis, stating that injunctions against criminal acts are sustained when the threat of punishment is not a deterrent, or because it is difficult to obtain a jury conviction. However, as pointed out by the Plaintiffs, Baptist would not voluntarily delay enacting its policy until the conclusion of the court proceedings, and apparently will not be deterred short of an injunction.

* * *

On all of these points, it appears likely that the plaintiffs will ultimately prevail at trial.

* * *

Therefore, it is hereby ordered and adjudged that until a full hearing on the merits of this case, defendants are enjoined from enforcing its Economic Credentialing policy against the plaintiffs and must grant them privileges at its hospitals if, but for the Economic Credentialing policy, the doctors meet the criteria for privileges.

IT IS SO ORDERED.

Collins Kilgore

COLLINS KILGORE

DATE MAR 2 2 2004

December 1, 2004

To All Medical Staff Members:

St. Rita's Medical Center Board of Trustees has approved the addition of a Financial Conflict of Interest policy to our Medical Staff Development Plan in an effort to strengthen relationships with committed and independent physicians who support our mission.

The policy, which is effective immediately, reserves medical staff membership and privileges for those physicians who can partner with us to advance hospital / community goals as well as insure patient choice of hospital/treatment facility. For example, staff members who have entered into employment agreements with competing health systems or whose medical practice is managed by a competing health system which results in material conflict of interest may not be eligible for appointment or reappointment to the medical staff.

Physicians who are impacted by the policy and have utilized Medical Center services can retain eligibility for staff status. The policy, which has been established by the Board of Trustees, asks for self-disclosure of relationships as part of the application process for appointment or reappointment to the medical staff.

The attached information is being provided to assist you in understanding this policy. If you have questions that remain unanswered, please do not hesitate to contact me (419.226.9100).

Sincerely,

Jim Reber
President and CEO

St. Rita's Medical Center 730 West Market Street Lima, Ohio 45801-4667 TELEPHONE: 419/227-3361
A Member of Catholic Healthcare Partners

ST. RITA'S MEDICAL CENTER

FINANCIAL CONFLICT OF INTEREST CREDENTIALING POLICY

DATE ADOPTED: September 24, 2004

POLICY

A. Prohibition Against Material Financial Relationships

It is the policy of St. Rita's Medical Center ("SRMC") to prohibit members of SRMC's Medical Staff from having a material financial relationship with any health care system or hospital (or an entity controlled by a health care system or hospital) or any other provider of health care services (i.e., an ASC, a physician group practice, an IDTF, or a clinical lab) not affiliated with SRMC that competes with SRMC. All members of the Medical Staff and applicants for appointment or reappointment to the Medical Staff are required to disclose to SRMC all material financial relationships.

All applicants for appointment or reappointment to SRMC's Medical Staff shall fully and truthfully complete the Conflict of Interest Questionnaire attached to this policy disclosing all material financial relationships to SRMC. If an applicant for appointment or reappointment to the Medical Staff is determined to have a material financial relationship with any health care system or hospital (or an entity controlled by a health care system or hospital) or any other provider of health care services not affiliated with SRMC that competes with SRMC, such applicant's application for appointment or reappointment to the Medical Staff of SRMC may be denied.

All individuals on the Medical Staff of SRMC shall have a duty to supplement the attached Conflict of Interest Questionnaire attached to this policy within fifteen (15) days of the adoption of this policy or entering into a material financial relationship. If an individual currently on the Medical Staff of SRMC currently has or enters into a material financial relationship with any health care system or hospital (or an entity controlled by a health care system or hospital) or any other provider of health care services not affiliated with SRMC that competes with SRMC during the term of his/her appointment to the Medical Staff of SRMC his/her Medical Staff privileges and/or membership appointment may be revoked immediately. Revocation of Medical Staff privileges and/or membership appointment for violation of this policy is not an event reportable to the National Practitioner Data Bank.

B. Definition of Material Financial Relationships

For purposes of this policy a material financial relationship shall include, but is not limited to the following:

(1) *Employment Relationship*: An employment relationship with a hospital or health care system (or an entity controlled by a health care system or hospital) or any other health care provider not affiliated with SRMC that competes with SRMC.

(2) *Independent Contractor Relationship*: An independent contractor relationship (such as paid medical director, paid consultant or income guarantee) whereby the individual receives more than de minimis compensation from a hospital or health care system (or an entity controlled by a health care system or hospital) or any other health care provider not affiliated with SRMC that competes with SRMC. An individual providing services on an infrequent basis will not be deemed to have such a material financial relationship.

(3) *Contractual Relationship*: A contractual relationship pursuant to which an individual's professional practice or the professional practice employing the individual is managed by a health care system or hospital (or an entity controlled by a health care system or hospital) not affiliated with SRMC.

(4) *Investment Interest*: Holding a partnership interest, membership interest, shareholder interest or other ownership or investment interest directly or through a group practice in any hospital or health care system (or an entity controlled by a health care system or hospital) or any other health care provider not affiliated with SRMC that competes with SRMC

Membership alone on the medical staff of another hospital or health care system not affiliated with SRMC is not a material financial relationship for purposes of this policy.

C. Exceptions

The Chief Executive Officer of SRMC may grant individual exceptions to this policy prohibiting members of the Medical Staff from having a material financial relationship with a health care system or hospital (or an entity controlled by a health care system or hospital) or any other provider of health care services not affiliated with SRMC that competes with SRMC. In determining whether or not to grant an exception to this policy the factors to be considered shall include, but shall not be limited to, community need, availability of services, scope of the conflict, and staffing needs for effective operation of SRMC. The reasons for such exceptions will be documented in writing and the benefits accruing to SRMC must sufficiently outweigh the risks presented by the conflict of interest caused by the material financial relationship present between the practitioner and the competing health care entity.

October 25, 2004
The Medical Executive Committee
Lawwood Regional Medical Center,
Fort Pierce, Florida

To Whom It May Concern,

This letter is to document why I have chosen to resign my position at Lawnwood Pavilion. I have concerns about my authority to make clinical decisions regarding patient care, and feel that I have been pressured to pursue treatment for patients that is financially rewarding to the hospital, but not necessarily in the patient's best interest. My concerns became more apparent when it was implied that my employment at the hospital was conditional on my agreement to proceed with Electroconvulsive therapy in the future.

Electroconvulsive therapy can be beneficial to some patients, but in my opinion it should be the treatment of last resort and should not be used without careful analysis of the risks and benefits. Since I felt threatened when I made a decision to hold on proceeding with ECT (Electroconvulsive Therapy) training, I had serious concerns about my authority to decide who would be a good candidate for this therapy. Furthermore, those who were pressuring me to obtain ECT training for future use were not physicians and not responsible for the well being of the patient. I feel this situation has several conflicts of interest and ethical considerations that could potentially harm patients.

It was therefore necessary for me to submit my letter of resignation effective sixty days from October 21, 2004 pursuant to Paragraph 3.2 of the Employment Agreement dated April 1, 2004 between Lawnwood Medical Center, Inc. and Ed Jackson, M.D. I believe that Lawnwood Medical Center, Inc. has clearly violated the provisions of Paragraph 11 of the referenced agreement "Patient Care" by failing to allow me to exercise complete control over the treatment of patients. I would, however, like to thank my colleagues in Psychiatry and in the Medical Executive Committee for their support and guidance.

Sincerely,

Ed Jackson MD

Ed Jackson M.D.

OCT 25 P3:50

ARTICLE II

GUIDELINES FOR EVALUATING CANDIDATES FOR PRIVILEGES IN OPEN SPECIALTIES

A. **Mission**

Eastern Idaho Regional Medical Center is committed to providing to the community a full range of health care services of the highest quality. This mission is furthered by the selection and retention of qualified practitioners on the medical staff who share the Medical Center's mission. Specifically, in furtherance of this mission, the Medical Center seeks:

(1) To select and retain qualified practitioners who are:

(a) able to provide timely care to their patients;

(b) committed to care for all Medical Center patients, regardless of their ability to pay;

(c) committed to utilize the Medical Center's facilities to the fullest extent possible consistent with sound medical judgment and their patients' medical needs, so as to permit the ongoing monitoring and evaluation of their practices; and

(d) willing to make an active commitment to assist the Medical Center in continually overseeing and improving the Medical Center's facilities and services;

(2) To have appropriate facilities and equipment and ensure that they are used efficiently and cost-effectively by selecting and retaining only those clinically competent practitioners who intend to use them appropriately; and

(3) To continually monitor the quality of the services that the Medical Center provides.

B. **Threshold Criteria**

Only those applicants who satisfy the following threshold criteria shall be eligible for medical staff appointment and clinical privileges at Eastern Idaho Regional Medical

Center.

(1) The applicant must have an unrestricted Idaho license and federal DEA number and Idaho controlled substance registration (if needed to practice in his or her specialty).

(2) The applicant must be willing and able to provide timely care to his or her patients, as defined in bylaws, policies or rules and regulations.

(3) The applicant must have professional liability insurance coverage in form and amounts that are satisfactory to the Medical Center and no unusual malpractice litigation history.

(4) The applicant must be board certified by the appropriate board of the American Board of Medical Specialties,[1] the American Board of Oral and Maxillofacial Surgery, or the American Board of Podiatric Surgery, or have completed the educational and clinical requirements for an application for certification in his or her specialty to be accepted by one of those boards and be working toward board certification. If the applicant is not board certified at the time of the initial inquiry, board certification must be obtained within five years of the completion of the educational and clinical requirements in order for the individual to be eligible to apply for appointment or reappointment and clinical privileges.

(5) The applicant must possess excellent professional credentials. As a threshold, the individual must demonstrate:

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[1]The equivalent of certification by the American Board of Medical Specialties may also be considered. Equivalency should be measured by the education, training and experience required to take the examination, as well as the comprehensiveness of the examination process. This requirement does not apply to current members of the medical staff. Practitioners currently maintaining membership on the medical staff and applying for re-application must demonstrate current competence in their respective fields, ability to perform the clinical privileges requested and an adherence to the standards of character and ethics established in their respective professions. Any qualification requirements in this article or any other article of this plan not required by law or by governmental regulation may be waived at the discretion of the medical center and the Board of Trustees upon recommendation of the Executive Committee, upon determination that such waiver shall serve the best interests of the patients at the medical center.

(a) a reputation for good character and ethical practice, as well as an ability to work cooperatively and harmoniously with others;

(b) no history of criminal conviction nor disciplinary action by any licensure board or government agency; and

(c) no history of disciplinary action or revocation, suspension or restriction of clinical privileges at this Medical Center or any other Medical Center.

(6) The applicant must be willing to actively utilize the Medical Center's facilities so as to permit reasonable monitoring and evaluation of his/her practice in accordance with the Medical Center's quality assessment/performance improvement plan and JCAHO standards, and to promote and ensure familiarity with the Medical Center's facilities and practices.

(7) The applicant must disclose if s/he has a contract, employment or investment interest with an entity that would cause his or her financial interests to be substantially in conflict with the Medical Center's commitment to the community or provide a significant economic incentive for the practitioner to refer patients to other facilities or otherwise discriminate against the Medical Center in the referral of patients for reasons unrelated to patient preference or medical needs. The Medical Center will utilize the process detailed in Section C of this Article to request this information from the applicant.

(8) Applicants must be willing to have a full-time practice in the Medical Center's service area. A full-time practice shall be defined to be a minimum of 40 weeks per year and a minimum of three days per week.[4]

(9) The applicant must satisfy all of the specialty-specific criteria that exist in the specialty in which he or she wishes to practice.

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[4]This threshold criterion does not apply when the Medical Staff Development Plan indicates that a specialty is open for someone other than a full-time practitioner and the potential applicant seeks to fill such an opening.

(10) If an initial applicant is determined to be ineligible for appointment, his or her application shall not be processed and appointment will not be granted. If an applicant for reappointment is determined to be ineligible for reappointment, his or her current medical staff appointment shall continue until its natural expiration.

(11) A determination of ineligibility to seek initial appointment and clinical privileges shall not be considered an adverse professional review action, and shall not be subject to the hearing and appeal provisions under the Appointment Policy nor considered a denial of appointment. Similarly, such a determination shall not be reportable to the National Practitioner Data Bank or the State Medical Board.

(12) Nothing in this Medical Staff Development Plan or in the Medical Staff Bylaws requires the Board of Trustees to grant privileges to a physician who satisfies the minimum criteria set forth in this Plan or in the Medical Staff Bylaws.

C. <u>Credentialing Physicians with Competing Interests</u>

(1) During the pre-application, application, or re-application process, a copy of these criteria shall be provided to all applicants and they will be asked to indicate whether or not they have a financial relationship with or concerning, or an investment interest in, a Competing Entity.[3] If the applicant replies in the affirmative, s/he shall be required to supply appropriate information concerning that financial relationship or investment interest (hereinafter "Financial Relationship") to the Board. Failure to provide relevant information to the Medical Center will result in the application being deemed incomplete. Incomplete applications will not be processed. The purpose of

[3]The term "competing entity" means any competing facility, hospital, provider/payor organization or its affiliated organizations with which a practitioner has a compensation arrangement or an investment interest.

the information will be to assist the Board in determining whether the Financial Relationship is significant and is inconsistent with, or detrimental to, the interests of the Medical Center.

(2) The Board, or a designated subcommittee, shall review the information collected pursuant to the above provisions to determine the implementation of the provisions of Article II, Part C, Section 3.

(a) If the Board, or its subcommittee, makes the determination that the applicant has a significant economic conflict, it shall notify the individual that the applicant is not eligible to vote or to hold leadership positions as described in Article II, Part C, Section 3.

(b) If the Board is unable to reach a definitive decision about whether the applicant has a significant conflict or if the Board determines that an applicant who is already a member of the Medical Staff of the Medical Center and is re-applying for medical staff appointment and clinical privileges has a significant conflict, it may specify that appointment and clinical privileges are subject to the following terms:

(i) any person who resides within the Medical Center's primary service area and is in need of services available at the Medical Center, inpatient or outpatient, will not be referred by the physician to the Medical Center or to a Competing Entity solely on the basis of economic incentives resulting from the physician's Financial Relationship with a Competing Entity. Referrals to a Competing Entity that are unrelated to patient preference, specific medical needs, or third party payor requirements will be presumed to be motivated by the physician's Financial Relationship with the Competing Entity;

(ii) prior to referring any patient to another facility, the physician will advise the patient of whether the same or similar services

are available at the Medical Center;

(c) Noncompliance with any of the above terms will be deemed to constitute a voluntary and unilateral relinquishment of appointment and clinical privileges by the physician.

(3) Practitioners who are appointed to the medical staff having a Financial Relationship with a Competing Entity are subject to the following terms:

(a) Such practitioners are ineligible to vote or hold office or serve as chairperson of any clinical department or medical staff committee for as long as the Financial Relationship with the Competing Entity exists. If an applicant for reappointment has already been elected or appointed to a leadership position for his or her next term of appointment, or has already begun to serve a term as an elected or appointed officer or committee member, s/he shall be considered to have voluntarily resigned that position as of the effective date of the Financial Relationship with the Competing Entity.

(b) Such practitioners may be assigned to take ER and service call[4] by the decision of the Board or by the decision of the administration of the Hospital in accordance with Medical Center policy. The call schedule is the property of the Medical Center. Service on the call roster is an obligation, not a privilege. The call service is intended to serve the best interests of patients in the community by providing round-the-clock response to patients' emergent medical needs. The call roster is not a physician referral service and is not to be treated as such. It is the policy of this Medical Center to treat each patient arriving at the

[4]The call schedule is a list of medical staff physicians who are on call for duty in three situations: (1) if the emergency department needs specialized assistance in determining if an emergency medical condition exists; (2) if an emergency condition exists and the Medical Center needs an on call physician to assist in treating the patient; and (3) if a Medical Center patient is in need of specialized assistance in the course of their care and treatment.

ER as having made a choice to receive treatment at this Medical Center. Practitioners serving on the call roster are expected to observe this policy.

If the Board determines that a practitioner is using the call roster to divert patients to other facilities for reasons related to that practitioner's financial or other gain, it may, in its discretion, remove that practitioner from the call list. Since service on the call list is not a clinical privilege or a benefit of medical staff appointment, such a determination shall not implicate the hearing and appeal provisions under the Appointment Policy or be considered a denial of appointment.

(c) If the Board determines by objective criteria that a practitioner is diverting patients to other facilities for reasons related to that practitioner's financial or other gain, it may, in its discretion, remove that practitioner's appointment and clinical privileges.

(d) Upon a Board determination that a practitioner has diverted patients consistent with the above terms, that practitioner will be deemed to have voluntarily and unilaterally relinquished his appointment and clinical privileges.

(4) To avoid the possibility of ineligibility for medical staff leadership or participation on the ER or service call schedule, an applicant may provide the Board with a letter of intent, prior to entering into any Financial Relationship, that describes his or her intended Financial Relationship with an entity that may compete with the Medical Center. The Board will review the letter and request additional information, if necessary or helpful. The Board will provide the applicant with a response as to whether the arrangement would constitute a Financial Relationship with a Competing Entity.

(5) If after application and before re-application a physician acquires a financial

relationship with or concerning, or an investment interest in, a competing entity, the physician shall within thirty (30) days advise the Board of Trustees of such fact and provide to the Board of Trustees the necessary information concerning that financial relationship or investment interest.

ARTICLE III

GUIDELINES FOR DETERMINING NEED FOR ADDITIONAL FRACTITIONERS ON AN ANNUAL BASIS AS AN EXTENSION OF THE MEDICAL CENTER'S LONG-RANGE PLANNING PROCESS

A. Each determination shall be based on the Medical Center's need or plan to:

(1) provide better or more comprehensive services;

(2) promote the efficient utilization of its facilities; and

(3) enhance its financial viability and thus its ability to serve.

(4) determine what new services should be offered;

(5) determine what services should be phased out;

(6) determine what services should be expanded or reduced;

(7) determine what additional specialties are needed; and

(8) determine what geographic or demographic areas should be served.

B. The reports and information provided by each department chief are critical to the periodic reevaluation of practitioner utilization and medical staffing needs. The Medical Staff Development Committee or its designated representative shall solicit information from time to time from each department chief regarding Medical Center and patient needs. Information sought from each department chief will relate not only to his or her department, but to perceived needs within the Medical Center and community generally.

C. Active Staff practitioners shall be surveyed periodically to determine their views on services needed, current utilization of facilities and medical staffing needs.

D. The Chief Executive Officer of the Medical Center or his designee shall report

Statement of

John W. Strayer III

of the

National Center for Policy Analysis

before the Senate Homeland Security and Government Affairs

Subcommittee on Federal Financial Management,

Government Information, and International Security

May 24, 2005

Mr. 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.

# # #

PREPARED STATEMENT OF THOMAS C. HOWARD, M.D.,
PRESIDENT OF THE MCBRIDE CLINIC, INC., OKLAHOMA CITY, OKLAHOMA

US Senate Committee of Homeland Security and Government Affairs
Subcommittee on Federal Finance Management, Government Information, Security

Overview of Competitive effects of specialty hospitals

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to testify. I am Thomas C. Howard, M.D., an orthopedic surgeon practicing in Oklahoma City and I serve as president of the McBride Clinic, Inc. Our medical group is developing a specialty hospital in Oklahoma City. I am submitting this testimony to provide information regarding the competitive effects of specialty hospitals. McBride Clinic physicians have practiced at Bone & Joint Hospital since 1924, when Bone & Joint Hospital commenced operations. Bone & Joint Hospital consistently satisfies patients, performs impeccably when tested by quality measurement standards, patient satisfaction, and clinical outcomes. With McBride Clinic physicians, Bone & Joint Hospital has served patient needs on a community, state wide, and regional basis for Orthopedic and arthritis care. Bone & Joint Hospital maintains state of the art medical technology. For a variety of reasons – demographics, patient aging, growth, - more specialty hospital beds are needed in our area. There are a number of quality care factors associated with specialty hospitals, and I am happy to provide examples of those for you. Specialty hospitals provide excellent patient outcomes. Our physicians provide care for patients with acute problems. Specialty hospitals maintain specialized equipment and technology. Our experience is that state of the art implants are available to patients without restrictions or barriers to care that might be imposed at other hospitals. The narrow scope of the specialty hospital provides more competitive bidding on these implants. At specialty hospitals, physicians can rely on ancillary support personnel - nurses, technicians, physical therapists, - and can entrust our patients to these professionals with the fullest of confidence. Physicians find ease in scheduling patients for admissions in surgery. Operating efficiencies allow physicians to concentrate on delivering excellent patient care with a complete focus on the patient, as well as, improved productivity in the delivery of care to patients. Specialty hospitals also allow focused peer review. Specialty hospitals facilitate specialized training and education for physicians, residents, medical students, nurses, and ancillary support personnel. Bone &

Joint Hospital, as a specialty hospital, provides direct care for orthopedic emergencies and does not comprise the evaluation of other systems. Significantly, specialty hospitals provide patient choice.

McBride Clinic, which has relied on Bone & Joint Hospital to care for its patients, has become a victim of its own success. Patients needing specialized orthopedic and arthritis care overwhelms Bone & Joint's capacity. Delays in scheduling, cancellations of admissions, cancellations of procedures, prolonged waiting time for admission, and diversion of patients to other facilities have caused patients unnecessary discomfort and inconvenience. These concerns have arisen as a result of success and not the shortcomings of specialty hospitals. This is evidence that additional specialty care facilities – not general acute care facilities - are needed. To meet the demands of the ever increasing aging population in our state, McBride Clinic is developing an orthopedic hospital in Oklahoma City. McBride Clinic physicians intend to continue to provide care and treatment to patients at Bone & Joint Hospital. However, due to lack of capacity at Bone & Joint Hospital, the McBride Clinic determined several years ago that additional specialized orthopedic and rehabilitation inpatient beds where needed. McBride Clinic physicians expect to continue the tradition of providing high quality of care at the new hospital, which is schedule to open August 2005. The McBride Clinic Orthopedic Hospital will have 40 inpatient beds and 40 rehabilitation beds, in addition to an emergency department that will be available to provide comprehensive emergency care and treatment for all patients with emergency orthopedic condition. McBride Clinic physicians, through McBride Clinic Orthopedic Hospital, will address the increasing orthopedic care needs of the patient population including the elderly and rural population through out Oklahoma and neighboring states. With our history, experience, and insight we can provide such services in a competitive and economically advantageous manner. Finally there have been studies suggesting over utilization at physician owned specialty hospitals. Enclosed is a copy of a recently published article from the Journal of Bone and Joint Surgery, Volume 87A Number 6, June 2005. The Journal of Bone and Joint Surgery is a prestigious peer publication. The enclosed article presents statistical significant data supporting the fact that "... specialty hospitals did not increase the surgical volume or the surgical rate for 10 orthopedic surgeons who held a financial interest in the facility." Specialty hospitals address the ever-increasing need of the population for hospital beds. They do so in a focused fashion. They do so in a fashion that allows patient choice and promotes competition without over utilization.

McBride Clinic and McBride Clinic Orthopedic Hospital appreciates the opportunity to present this testimony.

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ORTHOPAEDIC SURGEONS DO NOT INCREASE SURGICAL VOLUME AFTER INVESTING IN A SPECIALTY HOSPITAL

BY G. WILLIAM WOODS, MD, DANIEL P. O'CONNOR, PHD, AND PEGGY PIERCE, BBA

Investigation performed at the Fondren Orthopedic Group and the Joe W. King Orthopedic Institute, Houston, Texas

Background: The number of surgical specialty hospitals with physician investors in the United States has increased in the last ten years. Opponents to these hospitals have argued that surgeon investors will perform more surgery in order to maintain the hospital's profitability. The purpose of the present study was to determine whether the surgical volume or the surgical rate increased for a group of ten orthopaedic surgeons after the opening of an orthopaedic surgery specialty hospital in which they held a financial interest.

Methods: We analyzed the practice data for ten orthopaedic surgeons during an interval spanning seven years before and eight years after the opening of an orthopaedic surgery specialty hospital in which they held a financial interest. The average rates of change in the number of surgical procedures per year for each period were computed and compared with use of regression analysis. The percentages of patients who underwent surgery before and after the opening of the specialty hospital were also compared.

Results: The ten orthopaedic surgeons did not increase their surgical volume or surgical rate after the specialty hospital opened. The ten surgeons performed an average of 4399 surgical procedures per year before the hospital opened and 4542 surgical procedures per year after the hospital opened. The rate of change in the number of surgical procedures per year (19.1 compared with 8.9 procedures per year) did not increase after the specialty hospital opened. The annual patient volume (16,019 compared with 15,982 patients) and the percentage of patients who underwent surgery (27.5% compared with 28.4%) did not significantly change after the specialty hospital opened.

Conclusions: The opening of an orthopaedic surgery specialty hospital did not increase the surgical volume or the surgical rate for ten orthopaedic surgeons who held a financial interest in the facility.

The number of specialty hospitals in the United States that focus on surgical services has increased substantially in the last ten years[1,2]. About 70% of these specialty hospitals have surgeon investors who also practice in the facility[2]. The American Hospital Association and several legislators have expressed concerns about this recent trend[3-5]. Specifically, they contend that physician investment in certain types of specialty hospitals creates an unfair competitive advantage over full-service hospitals[3-5]. In response to these concerns, an amendment to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 placed a moratorium on the construction of particular types of specialty hospitals and directed various government agencies to study specialty hospitals that have physician investors[6].

Several government studies and privately commissioned reports have described various characteristics of full-service and specialty hospitals, such as geographic location, market share, extent of services provided, financial performance, case mix, and quality of care[1,2,7]. None of those studies investigated whether physician investors changed their practice patterns after the opening of a specialty hospital.

The purpose of the present study was to compare the surgical practices of a group of ten orthopaedic surgeons before and after they invested in a specialty hospital. Our hypothesis was that the amount of surgery performed by these surgeons would have increased after the surgical specialty hospital opened. We also calculated the proportion of surgical procedures that were performed in the specialty hospital and outside of the specialty hospital in order to examine the extent to which the surgeon investors utilized the facility.

A commentary is available with the electronic versions of this article, on our web site (www.jbjs.org) and on our quarterly CD-ROM (call our subscription department, at 781-449-9780, to order the CD-ROM).

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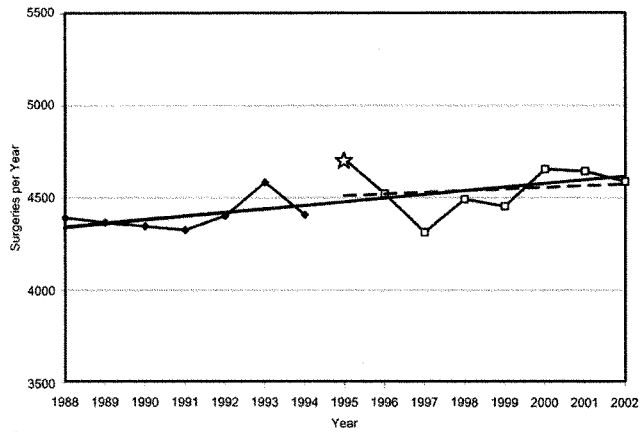

Fig. 1

Graph showing the number of surgical procedures, by year, for ten orthopaedic surgeons who held a financial interest in an orthopaedic surgery specialty hospital. The star represents the year that the specialty hospital opened. The solid line represents the annualized rate of change in the number of surgical procedures per year (growth in surgical volume) before the hospital opened, as extrapolated through the entire study period, and the dashed line represents the annualized rate of change after the hospital opened. These two rates were not significantly different ($p = 0.691$).

Materials and Methods

The practice data for ten orthopaedic surgeons in a single group practice were analyzed. The study period was seven years before and eight years after the opening of an orthopaedic surgery specialty hospital in which the surgeons held a financial interest.

At the beginning of the study period, the ten orthopaedic surgeons had been in practice for an average of 8.4 years (range, one to seventeen years) beyond residency and fellowship training. The ten orthopaedic surgeons held a financial interest in the specialty hospital and had participated in planning and designing the facility. The ten orthopaedic surgeons maintained their clinic in the same building as the specialty hospital, which is located near a large urban medical center in the southern United States.

For each calendar year of the study period, the number of patients who were encountered, the number of surgical procedures that were performed, and the locations at which the surgical procedures were performed were abstracted from archival practice data for each doctor. Surgical procedures were identified with use of Current Procedural Terminology codes ranging from 10000 to 69999. Procedures in this range of Current Procedural Terminology codes that had been performed in the clinic (e.g., joint injections, closed fracture reductions, castings, etc.) were excluded. Only surgical procedures that had been performed in a hospital or surgical center were counted. The location of the surgical procedures after the specialty hospital opened was classified as either in the specialty hospital or outside of the specialty hospital.

Data Analysis

Means and standard deviations were computed for the number of surgical procedures per year. Regression analysis was used to determine the average rates of change in the number of surgical procedures per year. The regression slope coefficients represented the rates of change in the number of surgical procedures per year before and after the specialty hospital opened, or the respective annualized rates of surgical growth. A regression slope coefficient of 0 would be equivalent to no change in surgical volume, a negative slope would be equivalent to a decreasing rate of surgical procedures per year, and a positive slope would be equivalent to an increasing rate of surgical procedures per year. The proportion of all surgical procedures performed by the ten surgeons inside and outside of the specialty hospital after it opened also was computed.

To test our primary research hypothesis, the numbers of

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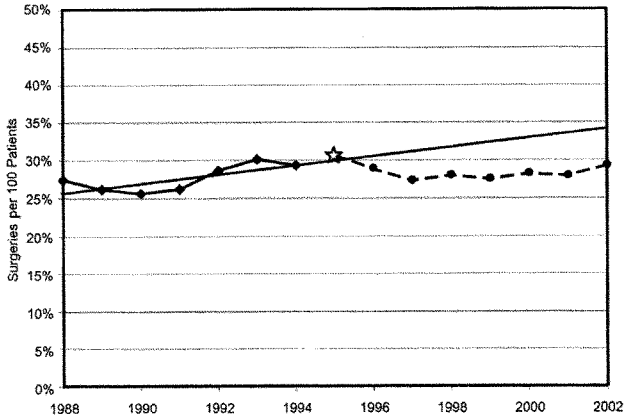

Fig. 2

Graph showing the percentage of patients undergoing surgery, by year, for ten orthopaedic surgeons who held a financial interest in an orthopaedic surgery specialty hospital. The star represents the year that the specialty hospital opened. The solid line represents the annualized rate of change in the percentage of patients undergoing surgery per year before the hospital opened, as extrapolated through the entire study period. The percentage of patients undergoing surgery per year did not change significantly after the specialty hospital opened ($p = 0.705$).

surgical procedures per year before and after the opening of the specialty hospital were compared with use of a paired t test. The regression slope coefficients were compared with use of a paired t test to determine whether the rate of change in the number of surgical procedures per year had changed after the opening of the specialty hospital. The annual patient volumes before and after the opening of the specialty hospital also were compared with use of a paired t test. Finally, the percentages of patients who underwent surgery before and after the opening of the specialty hospital were compared with use of the Friedman test (analysis of variance by ranks); this nonparametric test was used because percentage values cannot be assumed to be normally distributed.

Results

The number of surgical procedures per year ($p = 0.302$), the average rate of change in the number of surgical procedures per year ($p = 0.691$), total patient volume ($p = 0.933$), and the percentage of patients undergoing surgery ($p = 0.705$) did not significantly change after the opening of the specialty hospital.

Surgical Procedures per Year

The opening of the specialty hospital did not have a significant effect on the average number of surgical procedures per year ($p = 0.302$) (Fig. 1). In the seven years before the specialty hospital opened, the ten orthopaedic surgeons performed an average (and standard deviation) of 4399 ± 84.5 surgical procedures per year. In the eight years after the specialty hospital opened, the surgeons performed an average of 4542 ± 127.6 surgical procedures per year. This difference of 143 surgical procedures per year indicated a 3.3% increase in surgical volume.

Rate of Change in Number of Surgical Procedures per Year

The opening of the specialty hospital did not have a significant effect on the rate of change in the number of surgical procedures per year ($p = 0.691$). Before the surgical hospital opened, the number of surgical procedures for the entire group had been increasing at an average rate of 19.1 surgical procedures per year, equivalent to an average of 1.9 surgical procedures per surgeon per year and indicating an average growth in surgical volume. After the specialty hospital opened, the number of surgical procedures for the entire group increased at an average rate of 8.9 surgical procedures per year, equivalent to an average of 0.9 surgical procedures per surgeon per year. Thus, surgical volume continued to

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increase after the specialty hospital opened, but at a slightly lower rate.

The average number of surgical procedures per year as predicted by the surgical growth rate before the specialty hospital opened (4485 procedures) was slightly lower than the actual average number of surgical procedures performed per year after the hospital opened (4542 procedures). The difference of fifty-seven surgical procedures was within the standard error of prediction for the trend (183 surgical procedures), which indicates that there was no significant difference from the predicted value ($p = 0.582$).

Percentage of Patients Undergoing Surgery

The opening of the specialty hospital did not have a significant effect on the percentage of patients undergoing surgery ($p = 0.705$) (Fig. 2). The average number of patients seen per year by the ten orthopaedic surgeons also did not change significantly after the specialty hospital opened (16,019 compared with 15,982 patients per year; $p = 0.933$). In the seven years before the specialty hospital opened, 27.5% of patients underwent surgery. In the eight years after the specialty hospital opened, 28.4% of patients underwent surgery. This increase of 0.9% was equivalent to 1.2 additional patients undergoing surgery per doctor per month.

Proportion of Surgical Procedures Performed in the Specialty Hospital

In the last year of the study period, the ten surgeons performed 91.7% of their surgical procedures at the specialty hospital. Eight of the ten surgeons performed 99.2% (3447) of their 3474 surgical procedures at the specialty hospital that year. The remaining two surgeons accounted for 92.9% of the surgical procedures that were performed outside of the specialty hospital that year. One of these two surgeons performed 33.4% of his surgical procedures at a local full-service hospital in which he had practiced before the specialty hospital opened. This surgeon's practice consisted nearly entirely of joint replacement surgery. Consequently, many of his patients were elderly and had medical problems in addition to degenerative joint disease. These patients usually were receiving care for these medical problems from various physicians who were affiliated with the local full-service hospital. Many of these physicians had referred patients to this orthopaedic surgeon for treatment. This orthopaedic surgeon performed the surgical procedures for the referred patients at the local full-service hospital. The second orthopaedic surgeon performed 31.4% of his surgical procedures at two local full-service hospitals. This surgeon was an orthopaedic consultant for diabetes centers that were located at those full-service hospitals. Because of these relationships, he often provided surgical treatment for patients of the diabetes centers who had musculoskeletal problems related to diabetes. This surgeon performed those surgical procedures at the full-service hospital at which the patient had already been receiving treatment.

Discussion

There are numerous specialty hospitals that provide limited services in one particular branch of medicine. Many of these specialty hospitals are subsidiaries of larger full-service hospitals or belong to large hospital systems. In the last ten years, however, a substantial number of cardiac and orthopaedic surgery specialty hospitals have opened, and most have physician investors who practice at the facility[1,2]. The American Hospital Association and various legislators have argued that physician investment in cardiac and orthopaedic specialty hospitals constitutes a conflict of interest and provides an unfair competitive advantage over full-service hospitals[3-5].

Representatives of the American Hospital Association have alleged that surgeon investors will increase surgical volume and admit only relatively healthy patients who have good health insurance to the specialty hospital, thus ensuring a profit for the hospital and themselves[4,5,8-10]. According to this argument, the local full-service hospitals would then be caring for a greater number of less healthy and uninsured patients, which would decrease the profitability of those hospitals. This decrease in profitability would cause financial problems for the full-service hospitals since they use the profits from certain services, including orthopaedic surgery, to support other important but less profitable services, such as trauma centers, burn units, and emergency departments[4].

The ten surgeons in the current study had a financial incentive to increase their surgical volume to support the specialty hospital, but this incentive had a negligible effect on their behavior. The surgical volume and surgical rate essentially did not change after the specialty hospital opened. The small fluctuations in surgical volume can be attributed to factors other than financial incentive, such as continued practice growth, increased operating room time, fewer deferred ("bumped") surgical procedures, and increased efficiency due to highly trained surgical staff and specialized equipment[8,11-13].

The surgeons also did not appear to be admitting only their relatively healthy patients who had good health insurance to the specialty hospital. On the contrary, the ten orthopaedic surgeons attempted to perform all of their surgical procedures at the specialty hospital. In the last year of the study period, eight of the ten surgeons performed >99% of their surgical procedures at the specialty hospital. The other two surgeons performed surgical procedures outside of the specialty hospital only when specifically consulted by local full-service hospitals.

The orthopaedic surgeons did not exclude patients who had difficult or challenging medical conditions from the specialty hospital. Their group practice had been in existence for more than twenty years before the specialty hospital opened. Many of their patients were referrals from other orthopaedic surgeons, and many of the referred patients had multiple orthopaedic and medical problems and had undergone multiple surgical procedures. Nearly all of these referred patients were managed at the specialty hospital after it opened.

Another criticism of specialty hospitals with physician investors is that they may only accept insured patients, thereby increasing the burden on local hospitals to care for financially or

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medically indigent populations. In the county where the specialty hospital is located, 75% of indigent medical care is provided by two large full-service public hospitals. In addition, the county's nineteen nonprofit hospitals are required to provide charity care equal to at least 4% of their net revenues. The thirty for-profit hospitals in this county are not required to provide any charity care. Thus, by intent, the vast majority of the indigent and charity care in this county is provided by two public hospitals and the nonprofit facilities[14,15]. The specialty hospital in the current study accepts a small number of charity and indigent cases, although it is not required to do so.

The physicians' group practice and the specialty hospital are Medicare and Medicaid providers. Medicare and Medicaid account for approximately 20% of the gross revenues of the specialty hospital[15]. Before the specialty hospital opened, the ten orthopaedic surgeons had been performing surgery in two nonprofit full-service hospitals. The opening of the specialty hospital did not affect the relative amount of Medicare and Medicaid revenues in those facilities. Medicare and Medicaid represented 50% of gross revenues at those two hospitals, both before and after the specialty hospital opened.

An orthopaedic surgery specialty hospital increases the local capacity to deliver orthopaedic care by increasing the available operating room time[1]. Ideally, increased capacity matches an increased need for orthopaedic surgery. The need for orthopaedic surgery depends primarily on the size of the local population[16-19].

The average need for orthopaedic surgery in the United States, based on thirty years of data collected by the American Academy of Orthopaedic Surgeons, depends on the ratio of orthopaedic surgeons to the total population, irrespective of geographic region[19]. During the fifteen-year period described in the present study, the ratio of orthopaedic surgeons to the total population averaged one surgeon per 16,675 people. This ratio stayed fairly consistent as the number of orthopaedic surgeons grew in proportion to the population. This ratio of surgeons to population equates to an annual rate of approximately 800 orthopaedic surgical procedures per 100,000 people[19].

The population of the metropolitan area in the present study increased from 3.6 million people just before the specialty hospital opened to 4.4 million people in the last year of the study period[20]. Population growth should have created a need for 6400 additional orthopaedic surgical procedures in the last year of the study period relative to the year before the specialty hospital opened. According to the American Academy of Orthopaedic Surgeons, the typical orthopaedic surgeon performs nine surgical procedures per week and practices forty-seven weeks per year[21,22], which amounts to 423 surgical procedures per year. At this rate, population growth alone would have required the equivalent of fifteen additional full-time orthopaedic surgeons to accommodate the need for orthopaedic surgery. The specialty hospital thus did not create excess capacity in the local health-care system, but it did help to meet the increasing need for orthopaedic surgery in a rapidly growing population.

The accuracy of these estimates may be questioned. According to the Texas Department of State Health Services, however, the total number of all surgical procedures performed per year in our region during the study period was highly correlated with the growth of the population ($r = 0.96$); during that time, the total number of all surgical procedures performed in the metropolitan area increased by 22.6% whereas the population increased by 21.4%[20,23]. Orthopaedic surgical procedures represent a relatively consistent percentage of all surgical procedures performed, averaging about 10% nationally[24]. Thus, one might reasonably assume that the need for orthopaedic surgery increased proportionately with the population, just as the need for all types of surgery increased.

Some opponents of specialty hospitals also contend that physician investment decreases patient volume and decreases revenues at the local full-service hospitals[3-5]. In the eight years since the specialty hospital opened, the two full-service hospitals at which the orthopaedic surgeons had been practicing increased their annual total surgical volume by 9173 surgical procedures[25]. During that same period, the hospitals increased the amount of services that they delivered by 81% (as indicated by inflation-corrected gross revenues, the sum of charges for all services rendered)[15]. Thus, after the orthopaedic specialty hospital opened, the full-service hospitals dramatically increased the volume of health-care services that they were providing.

With respect to revenues, during the last year of the study period, the two full-service hospitals reported net revenues (realizable collections) of >1.2 billion dollars[14], none of which was subject to taxes. The ratio of net revenue to gross revenue (that is, the ratio of the collectible amount to the total amount charged) for the two full-service hospitals was 41.3% that year. In contrast, the orthopaedic surgery specialty hospital reported net revenues of 56.5 million dollars[14], which, after deduction of business expenses, was subject to taxation. The ratio of net revenue to gross revenue for the specialty hospital was 42.6%, nearly the same as that for the full-service hospitals. The specialty hospital's reported bad debt (1.2% of gross revenues) was essentially equal to the bad debt reported by the two larger, nonprofit, full-service hospitals (1.0% and 1.3% of gross revenues, respectively)[14]. If only 10% of the nonprofit full-service hospitals' net revenues had been subject to taxes, those facilities would have paid approximately 42 million dollars in taxes in 2002. Hence, the relative financial benefit of having tax-exempt nonprofit status far exceeded the net profits of the specialty hospital. Direct revenue comparisons between different types of medical facilities should be interpreted with caution. The specialty hospital, however, did not appear to be having any substantial long-term effect on either the delivery of care or revenues at the local full-service hospitals.

According to a study by the United States General Accounting Office, most of the surgical specialty hospitals built since 1990 have opened in densely populated areas that have population growth rates much higher than the national average[2]. The General Accounting Office study also reported that the locations of specialty hospitals do not appear to be related to the number of physicians or hospital services that are otherwise available in the area[2]. The specialty hospital in the current study is located in an area for which the projected ten-year population growth is 23% and in which there currently

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are more than fifty hospitals, 11,000 staffed beds, forty-seven ambulatory surgery centers, and more than 250 board-certified orthopaedic surgeons. The General Accounting Office concluded that "specialty hospital location was associated with regulatory and demographic conditions that may facilitate or encourage hospital development."[2] In other words, specialty hospitals tend to be built in communities that have a high need for the services that they provide.

Surgical specialty hospitals have several potential advantages. They may provide patients with more efficient services and a higher quality of care than do full-service hospitals[8,11]. In a privately commissioned report in which several cardiac surgery specialty hospitals were compared with local full-service community hospitals with regard to the same services, the specialty hospitals were shown to be associated with better outcomes while treating patients who had a greater severity of illness[7]. The quality of care increases and the length of stay decreases as the volume of similar surgical procedures increases, thus supporting the concept of a specialty unit or specialty facility[25,26]. Since opening, the inpatient and outpatient surgical services at the specialty hospital in the current study, on the average, have been rated at or above the ninety-fifth percentile for all indicators of patient satisfaction when compared with acute-care hospitals in the Gallup healthcare database. The latest available twelve-month risk-adjusted complication rate of 4.5% in the specialty hospital compares favorably with the national average of 4.9% for acute-care hospitals over the same period. Increased efficiency and higher quality of care would, theoretically, lower the per-patient health-care cost.

In conclusion, the average number of surgical procedures per year performed by investing surgeons was not affected by the opening of the specialty hospital. Patient volume and the percentage of patients receiving surgery also were not affected. ■

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The authors did not receive grants or outside funding in support of their research or preparation of this manuscript. One or more of the authors received payments or other benefits or a commitment or agreement to provide such benefits from a commercial entity (G.W.W. and P.P. are affiliated with Fondren Orthopedic Group, which has some partners who hold a financial interest in Texas Orthopedic Hospital, the specialty hospital in this study). In addition, a commercial entity (Texas Orthopedic Hospital) paid or directed, or agreed to pay or direct, benefits to a research fund, foundation, educational institution, or other charitable or nonprofit organization with which the authors are affiliated (Joe W. King Orthopedic Institute).

doi:10.2106/JBJS.D.02228

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Specialty Hospitals, Induced Demand and Certificate of Need

Written Testimony to the Senate Homeland Security and Governmental Affairs Committee, Subcommittee on Federal Financial Management, Government Information, and International Security, by Sean Parnell, Vice President - External Affairs, The Heartland Institute

Submitted May 24, 2005

Introduction

The issues surrounding specialty hospitals and the soon-to-expire moratorium on the development of new physician-owned medical facilities[1] are many and complex. Over the past several months, I have researched and written on this subject for *Health Care News*, a monthly newspaper covering public policy. I have attached to my written testimony excerpts from four articles published in the October and December 2004 as well as the January and May 2005 issues of *Health Care News*.

These four articles focus on issues relating to quality of care, the historical development of specialty hospitals, the charges leveled against specialty hospitals by industry rivals, and the potential benefits of allowing specialty hospitals to resume their expansion.

In my written testimony, I would like to focus on two particular areas relevant to the moratorium: the argument that specialty hospitals create what is known as "induced demand," and arguments that Certificate-of-Need legislation is an appropriate policy to keep specialty hospitals from competing with general hospitals. Nearly all of my research is based on publicly available documents, including several produced or commissioned by the federal government and state governments.

Induced Demand

One major concern of the American Hospital Association (AHA) is that because specialty hospitals are typically owned by doctors, there is an incentive for doctors to recommend treatment and refer patients to a specialty hospital in order to generate profits, regardless of what is in the best interest of patients.[2]

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[1]Technically, the moratorium is only on referral of Medicare patients to facilities in which a physician has an ownership interest. However, since the effective result is that no new facilities are likely to be developed due to Medicare representing a substantial share of potential patients, it is generally referred to as a moratorium or even a "ban" on all new development of such facilities.

[2]"Impact of Limited-service Providers on Community and Full-service Hospitals," September 2004 issue of *TrendWatch*, published by the American Hospital Association, p. 2

This problem is connected to the economic ideas of agency, asymmetric knowledge, and supplier-induced demand. Dr. Douglas Popp, Chair of the Department of Emergency Medicine at Advocate-General Lutheran Hospital in Chicago, described the problem as follows:

> ...agency refers to... where one person with unique knowledge (e.g. the physician agent) is given the authority to make decision by, and for the less informed principal (patient)... [The] physician can order expensive tests and/or medications for the patient, based on asymmetric knowledge, while transferring the financial risk to the patient or third party payer (insurance company) for that decision... This creates the opportunity for supplier induced demand where the physicians is increasing the cost of care (e.g. ordering more tests) with the ulterior motive presumably being to positively impact their own wellbeing (e.g. personal income).[3]

In layman's terms, the concern is that most patients don't have the medical knowledge necessary to know if medical treatment is needed or not, so doctors may order excessive and unneeded health care in order to generate more income for themselves. The American Hospital Association notes physician ownership of specialty hospitals "can create an inherent conflict between the clinical needs of the patient and the financial interests of the physician."[4]

The risk of such a conflict, however, seems remote. Doctors earn their incomes almost entirely through fees charged for medical services, not profits at medical facilities they may have an ownership stake in. Whatever incentive exists for an unethical doctor to induce demand, the incentive is irrelevant to whether the surgery is performed in a general hospital or a specialty hospital.

As recent GAO reports demonstrate, the potential profits from referring any one case to a specialty hospital are relatively small. Margins at for-profit specialty hospitals average about 12.4% for Medicare patients and about 9.7% for all payers. These margins are not significantly out of line with those of for-profit general hospitals, which average 14.6% for Medicare patients and 9.2% for all payers.[5]

Also according to the GAO, 72.5% of physicians with admitting privileges at specialty hospitals had no financial interest in the hospital[6] and at 70.4% of hospitals the largest share owned by a

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[3] *Macroeconomics of Healthcare*, Dr. Douglas Propp, online at the IL College of Emergency, http://www.icep.org/edsurvival/documents/HealthcareEconomics_000.doc.

[4] "Impact of Limited-service Providers on Community and Full-service Hospitals," September 2004 issue of TrendWatch, published by the American Hospital Association, p. 2.

[5] "Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance," October 2003, United States General Accounting Office, pp. 25 – 26.

[6] "Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served," April 2003, United States General Accounting Office, p. 10.

physician was 6% or less.[7] The median ownership share for an admitting physician with an ownership interest was 2%.[8]

Putting together the modest operating margins and the low physician ownership stakes typical of specialty hospitals, and factoring in the relative income potential from surgeon's fees vs. hospital profits, the incentive created by physician ownership of specialty hospitals to induce is extremely small.

Consider the case of a relatively expensive surgical procedure, coronary bypass surgery. There are two primary DRG's for Medicare reimbursement of coronary bypass, 107 and 109. According to MedCath, a national chain of 12 specialty hospitals focusing on cardiac care, the average reimbursement for DRG 107 is $26,434 and represents approximately 64% of bypass surgeries performed in their hospitals, and the average Medicare reimbursement for DRG 109 is $23,499, representing the remaining 34% of procedures performed.[9]

MedCath also reports that the reimbursement for participating surgeons under DRG 107 is $3,622 and for DRG 109 it is $2,910.[10]

By applying the information on operating margins and physician ownership of specialty hospitals to the data on reimbursement, we can get an idea of what the potential increase in income would be for a surgeon who is recommending unneeded treatment. Performing an unnecessary DRG 107 coronary bypass, a for-profit specialty hospital could expect an operating margin of $3,277.82 (12.4% avg. operating margin x $26,434). If the surgeon performing the procedure owns 2% (the median ownership share), their share of that would be $65.66. These raw figures are before taxes and other expenses - the actual amount of profit is even less than these numbers might indicate.

Comparing the surgeon's expected fee of $3,622 to the potential profits from an ownership share of a specialty hospital, it is hard to imagine that these few extra dollars would be sufficient incentive to induce demand.

The case of Richard Mathews[11], an executive at a benefits consulting company in Michigan, is a real life example of how the induced demand argument made against specialty hospitals does not stand up in the real world.

Mathews had reconstructive knee surgery in February of 2004 at the Beaufort Surgical Center, a specialty orthopedic hospital in Beaufort, South Carolina. His insurance company paid the entire

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[7]Ibid.

[8]Ibid.

[9]Information from Alanna Porter, MedCath Inc., received March 3, 2005 via e-mail.

[10]Ibid.

[11]Based on interview with Richard Mathews on 2/15/05.

bill, approximately $1,227 for hospital charges and $2,059 for the surgeon's and anesthesiologist's fees plus other expenses. Reviewing the hospital bill, Mathews noted that "There is simply no way that there is any huge profit in using his hospital. There may be a little -- but the real advantage is for better patient service and excellence."

Even if the surgeon operating on Mathews was one of the very few in the country who has an ownership interest of 15% or more in a specialty hospital[12], the potential income gains are too small to realistically think a doctor would recommend unnecessary treatment. Assuming a 9.7% margin on this procedure, a doctor with a 15% stake in the hospital would gain less than $18 in income through that ownership, minuscule compared to their share of the nearly $2000 in doctors fees. A doctor with the average 2% ownership stake would stand to gain less than $2.38. Again, these potential gains are before taxes and other expenses.

Mathews also described the strict disclosure standards that his surgeon followed. As a patient, he had to sign a disclosure acknowledging he was aware of the surgeon's financial interest in the hospital.

Adding to his description of his surgery, Mathews said "My doc told me straight out that he and [his] peers started their specialty hospital solely for access to excellence — they control the entire surgical team and every part of the process. They simply cannot get the excellence they need to have and offer to patients from local area hospitals."

Plainly, the charge that physician ownership of specialty hospitals create incentives for doctors to abuse their position and recommend unneeded treatment is not supported by the facts.

Certificate of Need

The issue of Certificate-of-Need (CON) laws is relevant to the issue of specialty hospitals for two reasons:

The American Hospital Association, one of the main advocates for extending the moratorium on specialty hospitals, noted that what they call "limited service providers"[13] are mostly located in states without CON laws.[14] A reasonable assumption is that should the moratorium end as it is scheduled to, the AHA and other opponents of specialty hospitals will turn their lobbying efforts to enacting CON laws at either the federal or state level in order to impede competition.

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[12]"Specialty Hospitals: Information on National Market Share, Physicians Ownership, and Patients Served," April 2003, United States General Accounting Office, p. 10.

[13]"Limited-service provider" is the AHA's term which they (and others) apply to both specialty hospitals, which generally require overnight stays, and ambulatory surgical centers, which do not.

[14]"Impact of Limited-service Providers on Community and Full-service Hospitals," September 2004 issue of *TrendWatch*, page 2, published by the American Hospital Association.

The history of CON laws demonstrates succinctly how attempts to limit or prevent competition between health care facilities does not benefit patients or control costs, and more often only protects the market share and profits of existing providers.

CON laws were first enacted in 1964 in New York as a response to rising health care costs driven in part by what was then a common health insurance reimbursement system known as retrospective reimbursement, also called "cost-plus." Under retrospective reimbursement, insurers would pay hospitals an amount equal to their costs, plus a certain percentage above cost for profit and overhead.

With the cost-plus system, there was little if any incentive for medical providers to become more efficient or for patients to be price sensitive. CON was a clumsy way to try to stop the inevitable spending binge the system created.

In 1972, Congress voted to require states review and approve all capital expenditures of $100,000 or more, as well as changes in bed capacity or what they termed a "substantial change" in services. By 1980, all 50 states had imposed CON laws

By 1986, it was evident that CON laws were not succeeding in keeping health care costs down, and by limiting competition were even contributing to rising costs. Congress repealed the federal CON requirement. Since then, fourteen states have followed by repealing CON entirely, and six more have repealed it for everything except nursing homes and long term care services.

Some of the most extensive research on CON laws has been done by Christopher Conover, Ph.D., and Frank Sloan, Ph.D., with Duke University's Center for Health Policy, Law, and Management. Their research, originally done for the Delaware Health Care Commission in 1996, was published in a June 1998 article in the *Journal of Health Politics, Policy and Law.* [15]

Conover and Sloan found that CON laws had no effect on overall health care spending. While they found a modest reduction in hospital costs, this decline was offset by an increase in physician costs.[16] They also note that CON laws "result in a slight (2 percent) reduction in bed supply but higher costs per-day and per admission, along with higher hospital profits."[17]

In a later study prepared for the Michigan Department of Community Health, Conover and Sloan confirmed their earlier findings. Among their major conclusions was that repeal of CON laws does not "lead to a 'surge' in either acquisition of new facilities or medical expenditures."[18] They also found evidence to suggest that CON results in an increase in costs, contrary to the goal

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[15]"Does Removing Certificates-of-Need Regulations Lead to a Surge in Health Care Spending?" Christopher Conover, Ph.D., and Frank Sloan, Ph.D., June 1998 *Journal of Health Politics, Policy and Law*, pp. 455

[16]Ibid, p. 463

[17]Ibid, p. 466.

[18]"Evaluation of Certificate of Need in Michigan," by Christopher Conover, Ph.D. and Frank Sloan, Ph.D, May 2003 report to the Michigan Department of Community Health, p. 74.

of these laws. [19]

Another study, prepared by the University of Washington's school of public health for the state legislature, had similar findings. The authors found "strong evidence that CON has not controlled overall health care spending or hospital costs."[20]

The Federal Trade Commission (FTC) and U.S. Department of Justice (DOJ) have also weighed in on the impact of CON laws. In a July 2004 report jointly prepared by the two agencies, they concluded that there is "considerable evidence that [CON laws] can actually drive up prices by fostering anticompetitive barriers to entry."[21]

This is only a sampling of the literature available on the failure of CON laws to restrain health care costs. CON today is little more than a shield that protects incumbent providers from competition, allowing entrenched interests to maintain market share and profits. Congress rightly repealed this law in 1986, although it remains on the books in many states.

General Hospitals Face Real Challenges

The final issue I would like to address, if only briefly, is the condition many general hospitals find themselves in.

Although I do not find most of the American Hospital Association's charges against specialty hospitals to be either credible or relevant, I recognize that they face real and pressing challenges. Competition from smaller specialty hospitals, which often provide superior care at a lower overall cost, is just one of the challenges that general hospitals must deal with. Some of these challenges are self-inflicted, while others are largely imposed by a dysfunctional health care market burdened by excessive regulation, third-party payment, bureaucratic central planning, price controls, and monopsony power.[22]

Many procedures hospitals perform are reimbursed at less than cost by both private insurers and government payers like Medicare and particularly Medicaid. To a limited extent this can be offset by generous margins for other procedures, reimbursed well above cost. However, many of the financial difficulties experienced by hospitals today are the result of a mix of patients where profitable procedures do not make up for losses caused by unprofitable procedures.

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[19] Ibid, pp. 30.

[20]"Effects of Certificate of Need and Its Possible Repeal," Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine, January 8 1999 report to the State of Washington Joint Legislative Audit and Review Committee, p. 9.

[21]"Improving Health Care: A Dose of Competition," July 2004 report prepared jointly by the Federal Trade Commission and the U.S. Department of Justice, p. 302.

[22]Monopsony power exists where there is a single or dominant *purchaser* of a good or service. Just as monopoly power allows a single *seller* of a good or service to demand higher prices than would exist in a competitive market with multiple sellers, monopsony power allows the buyer to dictate lower prices than would exist in a competitive market with multiple buyers.

Another challenge facing many hospitals is a series of lawsuits stemming from a pricing system that bears little resemblance to reality.[23] These lawsuits have been filed against both non-profit and for-profit hospitals over pricing practices that frequently charge the highest prices to uninsured patients while large insurers and government programs get substantial "discounts" from "list prices" for the same procedures. These pricing practices are difficult to defend, since they often impose large bills on low-income individuals.

Congress would be wise to review and examine policies imposed on hospitals that contribute to these challenges. The reality of these challenges and others, however, should not justify preferential treatment from Congress or state legislatures that would shield them from competition and protect their market share and profits.

Conclusions and Recommendations

On the two points I specifically address two conclusions are warranted:

Physician ownership of specialty hospitals does not create a significant incentive for physicians to perform unnecessary procedures.

The history of Certificate-of-Need laws demonstrates that polices that restrict or prevent competition among health care providers do not benefit patients or lower costs, and unnecessarily protect the profits and market share of incumbent firms.

On the broad question of whether to continue the moratorium on physician ownership of new specialty hospitals, I would urge the Congress to take the following steps:

1. Allow the moratorium to expire in June 2005, as it is presently scheduled to do.

2. Monitor and take action where needed to ensure the U.S. Department of Justice is examining potential anti-competitive actions by existing providers attempting to use Certificate-of-Need laws to restrain trade in violation of anti-trust laws.

3. Continue to collect, examine, and make available information regarding the quality of care provided by specialty hospitals, ambulatory surgical centers, and general hospitals.

4. Review and consider revising laws and regulations imposed on health care providers, particularly general hospitals that create unneeded burdens and financial difficulties.

I believe that if Congress takes these actions, the result will be increased excellence and lower costs for health care.

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[23] "6 More Class Action Lawsuits Filed Against Nonprofit Hospital Systems and Hospitals By Uninsured Patients," August 27, 2004, *MedicalNewsService.com*

Sean Parnell is Vice President - External Affairs for The Heartland Institute, *a non-partisan research institute in Chicago. He is a regular contributor to* Health Care News, *a monthly public policy newspaper sent to state and national elected officials across the country. He has a degree in economics from Drake University in Des Moines, Iowa. Prior to joining* Heartland *he worked for then Congressman Greg Ganske, M.D.*

Selected Excerpts from *Health Care News*

October 2004 Issue: *Specialty Surgical Hospitals Deliver Quality Care and Comfort* by Sean Parnell

> ...By freeing themselves of the bureaucracy of a traditional general hospital, [Ambulatory Surgical Centers] have been able to provide high-quality care at a lower cost. The key is specialization: A surgeon or facility devotes all of its energies to a few specific areas of care, resulting in increased efficiency and effectiveness...
>
> ...Many specialty surgical hospitals appear to provide better care than their traditional counterparts, as measured by patient outcomes...The mortality rate from open heart surgery for Medicare cases at MedCath hospitals was 16 percent lower than at community hospitals and 12.5 percent lower than at teaching hospitals...The average length of stay for MedCath patients was 21.9 percent shorter than at community hospitals, and 25.6 percent shorter than at teaching hospitals.
>
> ...A major reason for the lower rate of infection is that specialty surgical hospitals focus on elective and pre-planned surgeries. A patient who is scheduled for heart surgery and shows up at a specialty surgical hospital with a cold or the flu can be rescheduled for surgery after the illness goes away. In the Surgicenter Online interview, Lipomi noted infection rates in specialty surgical hospitals are lower because they don't perform surgery on "someone who is throwing up or bleeding or presenting with possible infectious conditions ... We think the otherwise healthy patient needs a place to go where ...infection rates are less than 1 percent instead of 5 percent or more."

December 2004 Issue: *Specialty Hospitals Criticized by Competitors* by Sean Parnell

> ...Greg Scandlen, a health policy expert at the Galen Institute in Washington, DC, expresses doubt about the charge that doctors improperly direct patients to clinics in which they have an ownership stake... Scandlen writes, "Given the scandalous track record of hospitals in patient safety and quality, it is entirely possible that physicians invest in facilities in order to assure better quality, and naturally refer their patients to facilities in which they have some influence over the quality of the care provided."

..."These hospitals are more efficient exactly because of specialization. They deliver the highest standard of quality care since they are not expected to be all things to all people by offering everything from an ER to a maternity ward," says Conrad Meier, senior fellow in health care for The Heartland Institute. "This is like a supermarket trying to shut down a drugstore because it doesn't sell fresh meat and produce, but it's ok for the supermarket to sell prescription drugs."

...In a study of MedCath's 13 hospitals, Lewin researchers found Medicare cardiac patients treated by MedCath had a Case Mix Index (a measure of patient severity and case complexity) 20 percent higher than their counterparts at general hospitals, indicating MedCath facilities were generally treating patients less healthy than those of competing hospitals.

It is not difficult to understand why doctors might refer their most difficult cases to specialty hospitals, where they feel the most confident about being able to offer the best care to these patients. Linda Gorman, who follows health care policy for the Colorado-based Independence Institute, noted, "specialty hospitals may provide an alternative for doctors who are dissatisfied with the quality of care, efficiency, and bureaucracy of general hospitals."

January 2005 Issue: *Specialty Hospitals Offer Savings, Improved Care in Future*, by Sean Parnell

... by adding new capacity to the health care system, particularly in areas like cardiac surgery and orthopedics, specialty hospitals could play a major role in ensuring there is enough capacity to treat the growing number of elderly who require more health services, particularly as the Baby Boomer generation begins to retire...

May 2005 Issue: *Consumers Lose Round in Battle over Specialty Hospitals, by Sean Parnell*

...(MedPAC)--ignoring its own research and new studies showing the benefits of competition and specialization--recommended to Congress that it extend the moratorium on development of new specialty hospitals until January 2007.

The MedPAC study compared profit margins at community hospitals in markets that have specialty hospitals with the profit margins of such hospitals in markets that don't. In both markets, profit margins declined modestly between 1997 and 2002, but the decline in profits was greater for community hospitals that did not face competition from specialty hospitals.

Another report, released on February 4, 2005, found many of the same benefits from specialty hospitals the MedPAC study did, and also confirmed that community hospitals did not suffer financial losses as a result of competition from specialty hospitals. The report was prepared by the Health Economics Consulting

Group (HECG) of Iowa City, Iowa and was commissioned by the American Surgical Hospital Association.

In a March 8 presentation to the Ways and Means Committee of the U.S. House of Representatives, MedPAC Chairman Glenn Hackbarth recommended an 18-month extension of the moratorium. His recommendation was based not on any finding of harm caused by specialty surgical hospitals, but rather on concerns that such harm may occur in the future.

Specialty Hospitals, Induced Demand and Certificate of Need

Written Testimony to the Senate Homeland Security and Governmental Affairs Committee, Subcommittee on Federal Financial Management, Government Information, and International Security, by Sean Parnell Vice President - External Affairs, The Heartland Institute

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Statement of

Jane Orient, M.D.

Executive Director of the

Association of American Physicians & Surgeons

before the Senate Homeland Security and Government Affairs

Subcommittee on Federal Financial Management,

Government Information, and International Security

May 24, 2005

Mr. Chairman and Members of the Committee:

The Association of American Physicians and Surgeons was founded in 1943 to preserve private medicine. We represent thousands of physicians in all specialties nationwide, and the millions of patients that they serve. I am the executive director.

Members of the Association of American Physicians and Surgeons are pleased that this subcommittee has undertaken this hearing as a means to assess the role of specialty hospitals in the delivery of quality health care. The AAPS membership can attest to the quality of care these hospitals deliver and we regard them as a sensible and proper element of American medicine.

We agree that Congress should not extend, make permanent or broaden the moratorium on physician-owned specialty hospitals contained in the Medicare Modernization Act. A resolution to this effect was passed without dissent at our 2004 annual meeting.

Responsible competition and the dynamics of the free-market encourage innovation and reduce costs. Furthermore, specialty facilities have consistently delivered superior results in terms of patient outcomes, operating efficiency, and patient satisfaction; therefore AAPS believes that it is not in the best interests of patients, physicians or taxpayers for government to arbitrarily limit the growth of physician-owned single-specialty hospitals.

A joint study by the Federal Trade Commission and the Department of Justice strongly endorsed expansion of competitive, free-market choice as a means for improving quality 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 affecting 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.

Written Testimony Submitted By
Karen Kerrigan
President & CEO
Small Business & Entrepreneurship Council

On

An Overview of the Competitive Effects of Specialty Hospitals

Before the

Homeland Security and Governmental Affairs Committee,
Subcommittee on Federal Financial Management, Government Information, and International Security

United States Senate
Dr. Tom Coburn, Chairman

May 24, 2005

Chairman Coburn, Ranking Member Carper, Members of the Subcommittee on Federal Financial Management, Government Information, and International Security, I am pleased to provide this written testimony with respect to physician-owned specialty hospitals on behalf of the Small Business & Entrepreneurship Council (SBE Council) and its nationwide membership of small business owners and entrepreneurs.

The SBE Council is a nonpartisan small business advocacy organization with more than 70,000 members nationwide. For more than ten years the SBE Council (formerly the Small Business Survival Committee) has worked to advance policies that protect small business and promote entrepreneurship. We are proud to count physician owners/investors of specialty hospitals among our diverse members. My name is Karen Kerrigan and I serve as President & CEO of the SBE Council.

As you know, the Medicare Payment Advisory Commission (MedPAC) recently presented a report to Congress on the costs, utilization rates, and practice patterns of physician-owned specialty hospitals as compared to full-service general hospitals. While MedPAC made some positive recommendations, including changes to the diagnostic related group (DRG) payment system, they also recommend the extension of the 18-month moratorium on physician-owned specialty hospitals. Such an extension is pointless and would be a serious mistake.

On May 11, Senator Chuck Grassley, chairman of the Committee on Finance, and ranking member Senator Max Baucus, introduced a bill that would create a permanent moratorium. The bill would prohibit physicians from referring Medicare and Medicaid patients to new specialty hospitals.

On behalf of the SBE Council, we urge Committee members to reject legislative efforts that would hamstring these innovative hospitals from fully providing the health care services that patients need and want. Patients deserve quality health care, not needless meddling by government.

Opponents of specialty hospitals, including the American Hospital Association (AHA) and the Federation of American Hospitals (FAH), have unfortunately resorted to spreading misinformation in an effort to suppress the healthy competition provided by specialty facilities.

Opponents of competition have made numerous, inaccurate accusations regarding specialty hospitals. These fallacious claims were addressed by Dr. John C. Nelson, president of the American Medical Association (AMA), in a recent letter-to-the-editor in *The Washington Times.* As Dr. Nelson points out the hospital industry is offering "a blizzard of skewed statistics," yet conveniently ignores straightforward economic principles with respect to the benefits of

specialty hospitals – namely, that "...Competition works. **And in the hospital industry, the addition of specialty hospitals to the mix gives patients more choice, forcing existing hospitals to innovate to keep patients coming to them. This is a win-win situation in providing better quality of care."**[1]

The *Wall Street Journal* editorial board also expressed its forthright assessment when it wrote, "**what the critics really want is to take away consumer choice**, forcing patients into treatment at less-optimal facilities for no reason other than to prop up the current system. But the other side of the equation is ensuring that consumers have a choice of places to spend those dollars, which means competition among hospitals."[2]

Not only are specialty hospitals important to the marketplace because they provide competition to incumbents, but they are well regarded by patients, who give them high marks. Specialty hospitals have a very high rate of successful procedures; higher nurse-to-patient ratios; and with their innovative care and extra attention to customer service they serve as a welcome development for health care consumers. Furthermore, physicians are attracted to specialty hospitals because they provide faster, surer access to operating rooms with fewer bureaucracy-induced delays, quality nursing staffs, readier access to the latest medical and information technologies, and well-trained support personnel.

In his recent testimony before the U.S. House Energy and Commerce Committee, Mark McClellan, CMS Administrator, stated that "his agency found specialty hospitals provide high patient satisfaction, high quality of care and patient outcomes in some important dimensions, greater predictability in scheduling and services, and significant tax contributions to the community." As a result of these findings, Dr. McClellan was opposed to any extension of the moratorium.

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.

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[1] Dr. John C. Nelson, "Competition works", *The Washington Times, 2/10/05*
[2] Editorial, "In the (Specialty) Hospital", *Wall Street Journal*, 1/3/05.

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 Coburn for hosting this important hearing. I urge you to give every consideration to legislation that would hamper the ability of specialty hospitals to deliver their innovative, efficient and live-saving services to patients. As *The Washington Times* editorial board recently advocated, "In the new Congress, the **Republican leadership should make sure choice and competitiveness in health care trump special interests like the AHA's...We hope to see a law that keeps specialty hospitals going and ignores MedPAC's advice**."[3]

We couldn't agree more, and the SBE Council urges you, and committee members, to oppose the extension of the moratorium on specialty hospital development.

Karen Kerrigan
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[3] Editorial, "Bolstering specialty hospitals", *The Washington Times*, *1/24/05*

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United States Senate

COMMITTEE ON FINANCE
WASHINGTON, DC 20510–6200

May 5, 2005

Mark Miller, Ph.D.
Executive Director
Medicare Payment Advisory Commission
601 New Jersey Avenue NW
Suite 9000
Washington, DC 20001

Dear Dr. Miller:

As you know, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established a moratorium on physician investment in and referrals to certain specialty hospitals. This moratorium, which is set to expire June 8, 2005, applies to facilities primarily or exclusively engaged in cardiac, orthopedic or surgical care.

As MedPAC's March 2005 report showed, physician-owned specialty hospitals tend to treat patients who are less sick - and therefore, more profitable - than those treated at community hospitals. MedPAC's report also showed that physician-owned specialty hospitals tend to treat a lower share of Medicaid patients than their community hospital counterparts.

Relative to other major insurers, Medicaid covers a large share of ethnic and racial minorities, including roughly one in five non-elderly African-Americans and Latinos. Therefore, it may follow that physician-owned specialty hospitals, which have a comparatively small Medicaid share, tend to care for a smaller percentage of ethnic and racial minorities than full-service community hospitals.

We request that MedPAC conduct an analysis of the racial and ethnic composition of specialty hospital patients compared to those treated by community hospitals. We request that the data be analyzed according to the following hospital types: non-profit, for-profit (excluding specialty hospitals), government, and physician-owned specialty (using MedPAC's definition).

Thank you in advance for your prompt response to this request.

Sincerely,

Chuck Grassley
Charles Grassley
United States Senator

Max Baucus
Max Baucus
United States Senator

Medicare admissions by type of hospital and race

As you requested in your letter dated May 5, 2005, we examined the extent to which physician-owned specialty hospitals and several groups of community hospitals serve Medicare patients in different race categories. This analysis is based on the same data we used in our recent mandated report to the Congress on physician-owned specialty hospitals. This memo summarizes our methods, data, and findings.

Methods and data

To carry out this analysis, we estimated Medicare patient shares by race category for 11 physician-owned heart hospitals and 79 community hospitals that are located in the same markets, and compete with, the physician-owned heart hospitals. Competitor community hospitals are defined as general acute care hospitals that are located in the same hospital referral regions as the physician-owned heart hospitals and treated at least 10 Medicare patients in common heart-procedure diagnosis related groups (DRGs) in 2002.[1] As requested, we also made separate estimates for the competing community hospitals in three ownership groups:

- 52 not-for-profit hospitals,
- 20 proprietary hospitals, and
- 7 government-owned hospitals.

To ensure comparability between hospital groups, we limited the analysis in two ways. First, we examined only heart specialty hospitals because physician-owned orthopedic and surgical hospitals had too few discharges to draw conclusions with confidence about their patient shares by race category. Second, we compared heart specialty hospitals only with competitor hospitals serving the same markets to avoid the potential bias of comparing populations with different underlying race shares.

For each hospital group, we estimated hospitals' shares of Medicare inpatient discharges among four race categories, as defined in the MedPAR claims files:

- white,
- black,
- Hispanic, and
- other (which includes Asian American, native American, and all other patients, including those with unknown race).

We calculated overall estimates for each hospital group based on all Medicare hospital inpatient claims for the group in the MedPAR file for fiscal year 2002. We also examined the distribution of patient shares by race category among the hospitals within each hospital group to determine if the hospitals in each group exhibited similar or different patterns.

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[1]Hospital referral regions are defined in the Dartmouth Atlas of Health Care based on referral patterns for coronary artery bypass graft surgery.

Findings

Based on 2002 data, physician-owned heart hospitals appear to treat smaller shares of black patients, on average, while their shares of Hispanic and other patients are similar to those in not-for-profit or proprietary community hospitals (Table 1). In contrast, government-owned competitor hospitals have substantially higher shares of black, Hispanic, and other patients than any other hospital group.

Among the hospitals within each group, patient shares for black Medicare patients appear to vary widely and some hospitals in every group treat low shares of black patients (Chart 1). For example, black patients account for less than 2 percent of all Medicare patients in one-quarter of all not-for-profit hospitals. At the high end, nearly 60 percent of government-owned competitor hospitals have more than a 9 percent share of black Medicare patients.

Finally, it is important to bear in mind that the race classifications on the source data may not be precise, for example, Hispanic beneficiaries may classify themselves as black, white, or Hispanic.

Table 1. Specialty heart hospitals and their local competitors treat different mixes of Medicare patients
Average shares of Medicare discharges by race for heart specialty hospitals and competitors in 2002

Hospital group	Number of hospitals	Discharges in group	Share of discharges by race			
			White	Black	Hispanic	Other
Physician-owned heart hospitals	11	23,526	92.1%	3.6%	1.7%	2.6%
All local competitors	79	363,960	85.2%	9.6%	2.2%	3.1%
Not-for-profit	52	272,663	86.1%	9.3%	1.7%	2.9%
Proprietary	20	67,463	87.2%	7.6%	2.5%	2.7%
Government	7	23,834	69.3%	17.8%	6.8%	6.1%

Note: Local competitors are located in the same hospital referral region (as defined in the Dartmouth Atlas) as the physician-owned heart hospitals and performed a minimum volume of certain heart procedures.

Source: MedPAC analysis of discharge data for Medicare beneficiaries in the fiscal year 2002 MedPAR file from CMS.

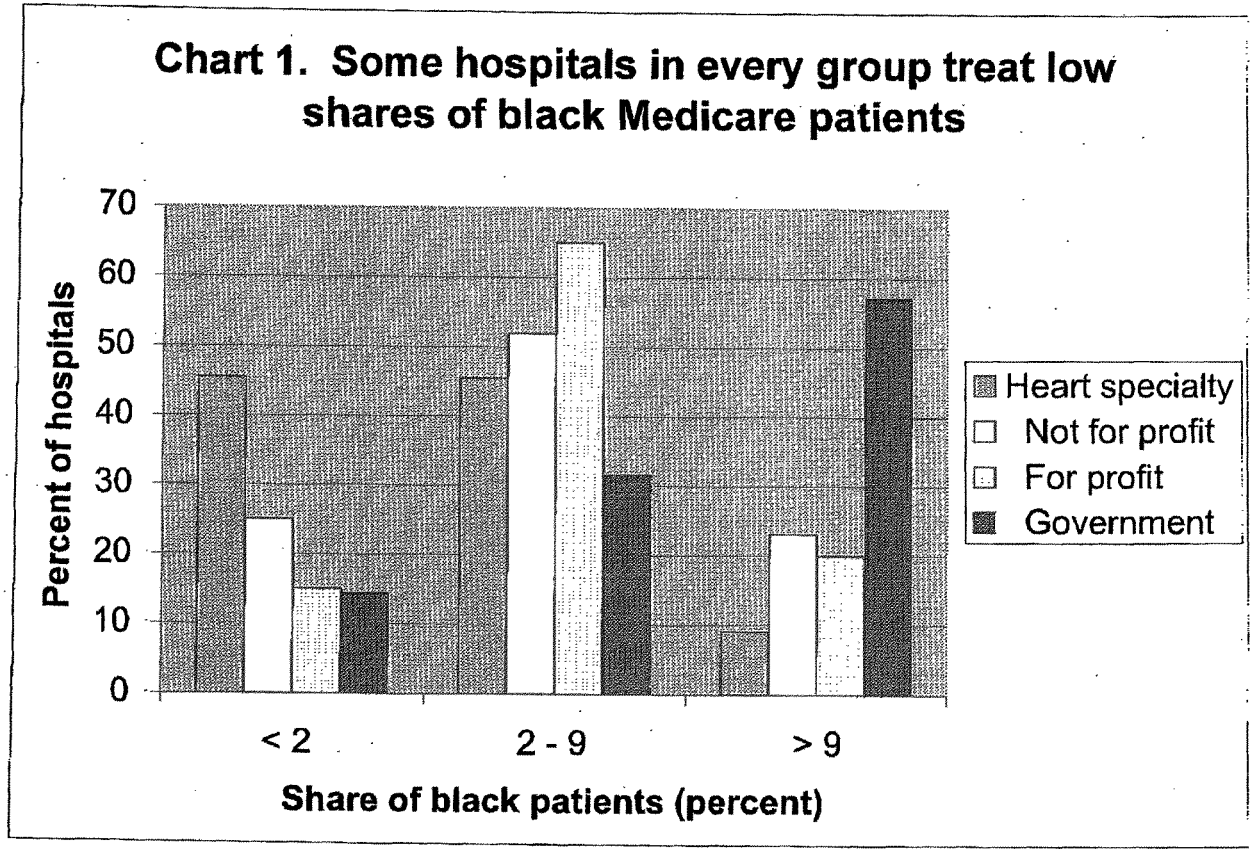


Chart 1. Some hospitals in every group treat low shares of black Medicare patients
Percent of hospitals
70
60
50
40
30
20
10
0
< 2
2 - 9
> 9
Share of black patients (percent)
Heart specialty
Not for profit
For profit
Government

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Office of the General Counsel

August 9, 2005

The Honorable Tom Coburn, MD, Chairman
Subcommittee on Federal Financial Management,
Government Information, and International Security
Committee on Homeland Security & Governmental Affairs
United States Senate
Washington, DC 20510

Dear Chairman Coburn:

I appreciated the opportunity to present the Commission's testimony at the Subcommittee's hearing on new entry into hospital competition on May 24, 2005. This letter responds to several follow-up questions arising from that hearing.

Follow-up questions and responses:

1. **Heartland Hospital has filed an antitrust suit in Kansas alleging collusion by hospitals and health plans to put it out of business. Has the Federal Trade Commission received any other complaints similar to Heartland's from other specialty hospitals?**

   The FTC has not received any specific complaints similar to Heartland's from other specialty hospitals. Moreover, the FTC has not brought a case alleging collusion between hospitals and health plans to put single specialty hospitals out of business.

   During the hearings it was suggested that in at least one case a hospital and a health plan with common ownership might be attempting to make it more difficult for a single specialty hospital to compete. The FTC understands that various private lawsuits have been brought making similar allegations.

2. **During the series of healthcare hearings, you indicated that Federal Trade Commission learned that some community hospitals are eliminating the admitting privileges of physicians involved with specialty hospitals (removing specialty hospital-related physicians from emergency on-call panels), making scheduling surgeries more difficult for these physicians, and limiting physicians' access to operating rooms. Can you describe and estimate the extent of anti-competitive actions which community hospitals have taken against specialty hospitals as indicated in your hearings?**

   For antitrust purposes for actions to amount to anticompetitive behavior it makes a difference whether the conduct is unilateral or collusive. There is a broad spectrum of

conduct that a single firm may take that generally will not create an antitrust issue. Unilateral conduct, assuming no significant market power, will generally not pose an antitrust issue. Agreements between competitors, however, generally will. Our concern would be whether the conduct in question harmed competition as a whole, not just whether individual physicians are harmed.

The FTC has no specific information that would allow it to "estimate the extent of anti-competitive actions" taken by general hospitals against specialty hospitals.

3. **Your report recommends that governments reexamine the role of subsidies in healthcare markets because they are inefficient and they distort competition. Do you think that patients would be best served by changing Medicare payment policy such that it eliminates the extent of such practice?**

Yes. The Commission recommended consideration of a payment system that directly subsidizes necessary, but under-provided services. We observed that, in a competitive market, cross-subsidization would become impossible: increased competition will reduce the profits that are being used to subsidize other services. We recommend that if society wants more of those previously subsidized services, to the extent possible government policy should support them directly rather than relying on the less transparent, less predictable, and less controllable system of cross-subsidization.

4. **The FTC report recommends that Certificate of Need (CON) policies that some states have hinder competition. Can you elaborate more on this finding?**

By way of clarification, our recommendation was to reconsider whether such programs really serve legitimate goals, and in so doing we expressed serious concerns about the competitive effect of CON proceedings.

On quantifying the costs, we cite many studies of CON experience in Chapter 8 of our report, particularly footnote 37. Unfortunately it is very difficult to measure the costs from lost competition, which would include not only higher prices but lost innovation, product choice, and quality. One older study, from 1987, estimated price increases of 4.0 to 4.9%, in metropolitan areas, resulting from existence of CON laws. Similarly, a 1991 study indicated hospital costs were approximately 10% higher in states that had CON laws for at least ten years. One of our witnesses at the hearing testified that his research had found price increases as high as 20% attributable to CON laws.

5. **Community hospitals complain that specialty hospitals have an unfair advantage because of physician ownership and their ability to direct patients to the hospitals they own. Is this a legitimate complaint? Do community hospitals have tools they can use to address competition from specialty hospitals?**

The FTC has not evaluated the impact physician ownership in specialty hospitals has on competition within particular geographic or relevant markets. Evidently, CMS' research indicates that physicians do not refer their patients exclusively to the specialty hospitals

they own.[1] It appears physician referrals are constrained by a number of factors including patient preferences, insurance plans, and hospital location. Additionally, general hospitals may get referrals from doctors in the area who do not have an ownership interest in the specialty hospital and general hospitals may recruit new physicians to an area to provide services that compete with the specialty hospital.

From our hearings we learned that some general hospitals have planned for competition with SSH's by competing more vigorously themselves, establishing their own single-specialty wings, or partnering with physicians on their medical staff to open an SSH.

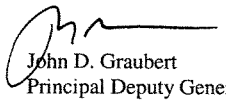
6. Have you looked at the impact of competition on hospital closures? Can you give us an estimate of the number of hospitals that have closed because of competition from specialty hospitals?

We have been concerned about mergers in this industry, but in recent years the courts have not been supportive of that effort. Currently, the FTC is engaged in litigation with Evanston Northwestern Healthcare Corporation ("Evanston"). The FTC administrative complaint alleges that following Evanston's acquisition of Highland Park Hospital competition in the relevant geographic market decreased, prices charged to health insurers for medical services increased, and higher costs for health insurance were passed on to consumers.

As to the question posed, the FTC has not done a general study examining the impact of competition on hospital closures. Thus, the FTC has no specific information on this question and cannot provide an estimate of the number of hospitals that have closed because of competition from either general or specialty hospitals. In general, competition will create a situation where hospitals providing high quality of care at competitive prices will thrive. If hospitals are delivering low quality care at non-competitive prices, then they may not fare well.

I hope that the information that I have provided to you in this letter will be useful. In addition, I am enclosing the errata sheet containing corrections to my testimony. If you have any further questions, please feel free to contact Anna Davis, Director of Congressional Relations, at (202) 326-2195.

Very truly yours,



John D. Graubert
Principal Deputy General Counsel

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[1]CMS, *Study of Physician-owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003* at ii (2005).

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Robert D. Reischauer, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

July 28, 2005

The Honorable Tom Coburn
Subcommittee on Federal Financial Management,
Government Information, and International Security
Senate Committee on Homeland Security and Government Affairs
172 Russell Senate Office Bldg.
Washington, DC 20510

Re: Specialty Hospitals

Dear Senator Coburn:

This letter is in response to the questions you sent us on June 8th. Answers to your questions are as follows:

(Q1) "The committee would ask that MedPAC support their allegation that specialty hospital costs are equal to or higher than those of the general hospital by demonstrating that their analysis has adjusted for the differences between the general hospital and the specialty one in each of these two items, as detailed below."

Item 1. Differences in objects of expense

MedPAC found that some physician-owned hospitals had above average costs per discharge and some had below average costs per discharge. On balance, the standardized costs per discharge were higher at specialty hospitals, but the difference was not statistically significant.

Your questions imply that MedPAC should adjust specialty hospital costs downward to account for their income tax expenses, property taxes, some depreciation expenses, pre-opening expenses, and some interest expenses. Some of these factors do not directly affect the reported costs of physician-owned hospitals (income taxes, pre-opening expenses), but some of the other factors you mention (property taxes, depreciation) could be adjusted for, see below.

Income Taxes. None of the physician-owned hospitals that we are aware of (including all the hospitals in the two publicly traded companies, MedCATH and Medical Facilities Corporation) pay income taxes. They are structured as limited partnerships or other pass-through entities. The income is passed through to the partners to avoid double taxation. No income tax is recorded on the hospitals' financial statements; therefore, the computed costs for these hospitals do not include income tax expenses.

Property and Sales Tax: It could be argued that we should have adjusted cost estimates for property taxes; however, the magnitude of these taxes is small relative to hospital revenue. A survey by the American Surgical Hospital Association (ASHA) found that the property tax paid by their members was roughly 0.5% of gross revenue on average. Prior studies from the 1990s estimated average level of property taxes paid by for-profit hospitals was equal to roughly 1.6% of fixed assets.[1] A tax of 1.6% of fixed assets would be roughly 0.5% of revenue at a hospital with a low level of fixed assets (e.g. Medical Facilities Corporation) and between 1% and 2% of revenue for a more capital-intensive operation (e.g. MedCATH).

Some community hospitals may spend less than specialty hospitals on property taxes. However, it should be noted that some community hospitals in our sample are for-profit hospitals. In addition, some non-profit hospitals pay fees to local governments in lieu of taxes.

Depreciation: Accounting rules may not accurately reflect the true cost of capital. However, differences in the age of the facility are likely to have a small affect on depreciation expenses. We have found that differences in capital costs per discharge appear to be more dependent on two factors (1) whether the hospital has a capital intensive or a capital minimization strategy and (2) the patient volume.

Respondents to the American Surgical Hospital Association (ASHA) survey had 2,269 inpatient days on average, which equates to an average census of 6. The survey also reported that hospitals had 5 operating rooms and 3,823 surgeries per year on average. This equates to an average of 2 operations per operating room per day. Thus some physician-owned hospitals may have high depreciation costs per discharge due to having low patient volumes.

Costs of gaining entry into a market: Our sample of MedCATH hospitals were all opened prior to 2002; therefore, they did not have any pre-opening expenses on their 2002 financial statements. However, if MedCATH hospitals borrowed money to pay for their pre-opening expenses, then the interest on those expenses would have been included in our calculations. However, the interest expense on $200,000 of pre-opening expenses that you cite would be very small, less than $10 per discharge.

Interest expenses: We did not adjust for differences in interest expenses. An adjustment mechanism would have to factor in the wide variance in hospital's debt levels (some specialty hospitals have no debt), the wide variance in interest rates paid by non-profit hospitals, and the fact that some community hospitals are for-profit entities that do not have access to the municipal bond market.

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[1] W. Gentry and J. Penrod, "The Tax Benefits of Not-For-Profit Hospitals", National Bureau of Economic Research Working Paper 6435, 1998.

Item 2. Overhead allocation

Q1.a "The Subcommittee would like to know what accounting methodology MedPAC used in its analysis of community hospital versus specialty hospitals? If MedPAC did not use the ABC methodology, why not?"

MedPAC used cost data from the Medicare cost reports that hospitals are required to file annually. The cost report uses a type of activity-based costing (ABC) to allocate overhead costs to patient care departments. MedPAC used reported charges and reported cost-to-charge ratios to allocate costs from departments to individual patient discharges.

(Q1.b) If MedPAC did not use this accounting method in its analysis, the Subcommittee Chairman would ask if MedPAC would be willing to re-analyze the data in their report using the ABC method of accounting and submit the reanalysis for the subcommittee record? If yes, when could the subcommittee expect to receive the results?

MedPAC does not generate cost accounting data; it uses cost accounting data supplied by hospitals. Hospitals often maintain two cost accounting systems. One is the Medicare cost-report system shared by all hospitals. The second is an internal cost accounting system that differs from hospital to hospital. We cannot require hospitals to start using a new cost accounting system and report that data to the Federal government, that would require an action by the Secretary of HHS or the Congress. Using existing Medicare cost accounting data is the only way MedPAC can conduct a study of all the nation's hospitals.

Question 2 – Cram et al. – New England Journal of Medicine

MedPAC's understanding of Cram's work is outlined below.

(Q2.a) "Therefore, the study only looks at specific types of cardiac procedures. Are these findings generalizable to other types of cardiac or surgical hospitals? Why or why not?"

Cram's results are for cardiac hospitals and not necessarily generalizable to orthopedic and surgical hospitals.

(Q2.b) "Could it be that heart hospitals' direct competitors have improved their quality due to competition from heart hospitals?"

Dr. Cram's paper does not address this issue.

(q2.c) "Does MedPAC agree with this analysis? Why or why not?" (Regarding Cram's separating the volume effect from the specialization effect)

We understand Dr Cram's objective of separating out the effect of specialization from the effect of volume. If community hospitals with high volumes have the same outcomes as specialty hospitals with high volumes, then there would not be an improvement in quality by carving out the cardiac business from a community hospital and placing it in a specialty hospital.

In addition, adding a specialty hospital to a market may spread cardiac surgery volume over more hospitals, causing patients in the market (on average) to go to a lower-volume hospital than they would have if fewer providers of cardiac surgeries existed. The entrance of a specialty hospital may not necessarily lead to the provision of care being more concentrated in fewer hospitals, it could result in spreading cases across more hospitals.

(q2.d) "Does MedPAC agree with this analysis? Why or why not?" (regarding costs).

We are not aware of the source you are using to conclude that specialty hospitals operating costs are 6-7% lower than community hospitals. As we stated earlier, income taxes are usually not included as an expense on physician-owned hospitals' financial statements. Previous research suggests that for-profit hospitals' property taxes are generally in the range of 1% of costs.

(Q2.e) "MedPAC found that the better outcomes at specialty hospitals are explained by higher procedural volume. How sensitive are these findings to different definitions of 'low volume' or 'high volume'?"

MedPAC did not study the relationship between procedural volume and outcomes. Dr. Cram did address this issue in his paper, but his paper does not report any sensitivity analysis.

(Q2.f) "How do specialty hospitals generate their volumes? Does the paper lend any support, direct or otherwise, to the contentions that (a) specialty hospitals are unfairly competing with general hospitals?; (b) physician owners are basing their admission decision on the small share of the hospital payment they are likely to receive, rather than other quality and convenience factors? And (c) there are no particular efficiency aspects of specialty hospitals that are noteworthy? Does MedPAC know what Dr. Cram's thoughts on these questions? Would they be willing to inquire and report back to the Subcommittee? If yes, when could the subcommittee expect MedPAC to report back?"

We found that the vast majority of heart hospital volume is captured from community hospitals. All of the physician-owned cardiac hospitals we visited had cardiologist investors who could refer patients to the invasive cardiologists and cardiac surgeons conducting procedures at the cardiac hospital.

Part a. On our site visits, community hospitals accused owners of specialty hospitals of directing the healthier patients with better insurance to physician-owned specialty hospitals and directing the sicker, less profitable patients to community hospitals. Some physician investors countered that they did not restrict admission to their hospital in any way. We did find some differences in patient severity and payer mix (i.e. lower complexity and fewer Medicaid patients in specialty hospitals), but our analysis cannot answer the normative question of what is "fair" or "unfair" competition.

Part b. CMS found that physicians with higher ownership shares of cardiac hospitals admitted a larger share of their patients to the specialty hospitals than physicians with smaller ownership shares. For example, on page 25 of its report, CMS states that only 10% of owners with less than a .5% ownership share admitted most of their patients to the cardiac hospital, while 46% of owners with more than a 1% interest admitted most of their cardiac patients to the specialty hospital. CMS found an even more pronounced relationship between ownership and admission patterns at orthopedic and surgical hospitals.

Part c. On our site visits, physicians who worked in specialty hospitals told us that surgeons could do more surgeries in a shorter period of time at specialty hospitals. We were also told that investing physician are more willing to accept restrictions on their choice of devices and supplies because investing physicians share in gains associated with a reduction in hospital costs.

(Q2.g) "What are MedPAC's and Dr. Cram's thoughts on consumer preferences, after having studied the specialty hospital industry? Do they matter? Are patients indifferent between specialty and general hospitals? Why or why not?"

MedPAC did not study consumer satisfaction. CMS discussed consumer satisfaction with focus groups and found that patients were happy with both the specialty hospitals and the community hospitals. In our site visits, physicians informed us that patients often like the ease of using surgical hospitals, especially for simple outpatient procedures.

(Q 2.h) "Does MedPAC know why Dr. Cram chose to study these facilities from afar? Does MedPAC believe that site visits might have improved the study results?"

Dr. Cram compared 30-day mortality rates. MedPAC conducted site visits because we had a broader range of questions to answer.

(Q2.i) "Does MedPAC, as a group of experts in fields of medicine, economics, health insurance, etc. support innovation and competition in health care? Does MedPAC believe that innovation and competition virtually always lead to higher overall levels of consumer welfare?"

As was stated in our January public meeting on specialty hospitals, MedPAC is in favor of fair competition. The current payment system permits specialized hospitals to make large profits through the selection of certain patients rather than through efficiency; those selection opportunities undermine the accuracy and equity of the payment system.

(Q2.j) "The Cram et al. paper indicates that severity-adjusted average length of stay is not lower for heart specialty hospitals. Others found that, using APR/DRG as the severity measurement device, heart hospital stays are significantly shorter. MedPAC found a similar result. Can MedPAC explain this difference between the two studies and its significance?"

Dr. Cram's results are not inconsistent with MedPAC's findings. First, Dr. Cram only looked at length of stay for CABG and Angioplasty patients; MedPAC examined length of stay for all Medicare patients. Therefore, the studies are not strictly comparable. Second, even if they were comparable, they would not be inconsistent. Dr. Cram's confidence interval for patients' length of stay includes a range where the specialty hospital has a lower length of stay.

(Q2.k) "In conclusion, the Chairman finds that the Cram et al. paper is far from definitive on indicating that heart specialty hospitals do not provide value to their communities." Does MedPAC agree with the Chairman's findings? Why or why not?

The Cram paper found that specialization by itself did not result in better or worse risk adjusted mortality. Cram did not reach conclusions about whether there was some other benefit from specialty hospitals. However, on our site visits, we heard that some specialty hospitals provide greater convenience and amenities than some competing community hospitals.

Q3.a: "Is it not true that ambulatory surgical centers owned by physicians have similar incentives but have not demonstrated a significant increase in unnecessary utilization and unnecessary surgery?"

The Office of Inspector General at HHS has developed safe harbors under the anti-kickback statute for physician investment in ambulatory surgical centers (ASCs) to which they refer patients. These safe harbors limit physician investment in ASCs to physicians who routinely use the facilities and to facilities that do not provide ancillary services other than those included in Medicare's bundled ASC facility fee. These two conditions reduce the financial incentive to overuse services and to profit from services that physicians do not personally perform. The whole-hospital exception under the Stark law does not contain either of these conditions. We are

not aware of any studies that examine whether or not physician-owned ASCs are associated with unnecessary utilization or unnecessary surgery.

Q3.b:"To our knowledge significant abuses have occurred not in physician-owned specialty hospitals, but flagrant abuses has been noted in for-profit "community" hospitals that have no physician owners. To the Chairman's thinking perhaps the most abusive Medicare case has been the Tenent/HCA case? Does MedPAC not agree that abuses of doctor-patient relationships can and do occur across the health care system?"

Fraud and abuse does occur in the health care system.

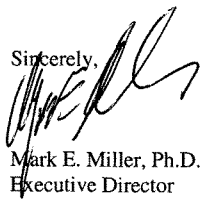
Q4.a. "What additional information do you expect to gain from adding a few additional hospitals? What methodology will you employ?"

If the data become available, we hope to reexamine some of the questions we were asked in the MMA with two additional years of data.

Q4.b. "For example, what accounting methodology will you employ? Will you consider the tax costs that specialty hospitals must incur in your methodology? Will you look at the quality of care in the specialty hospitals? Will you consider all of the published data on specialty hospitals available now? If possible, I would like my staff to get together with MedPAC staff to understand the study design and data needs and proposed analytical plan. Would MedPAC be willing to include them in a meeting to discuss this prior to the commencement of the study?"

We are open to discussions with all relevant parties and are willing to meet with Committee staff to hear their suggestions for future research. Please contact Annissa McDonald at 202-220-3724 to set up a date and time.

Sincerely,



Mark E. Miller, Ph.D.
Executive Director

MM:am:j

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July 11, 2005

Dr. Tom Coburn, Chairman
Subcommittee on Federal Financial Management
Government Information and International Security
c/o Liz Scanton, Chief Clerk
U. S. Senate
Room SH-436, Hart Senate Office Building
Washington, DC 20510-6250

Dear Dr. Coburn:

Enclosed please find the transcript of my testimony with minor corrections.

In response to your questions, may I offer the following replies:

Question No. 1 deals with the cost of training a nurse at the Oklahoma Spine Hospital.

Dr. Coburn, as you know, tens of thousands of dollars a year are spent on training a nurse. At the Oklahoma Spine Hospital it takes approximately one year for a nurse to be expertly trained. It requires full-time personnel to do the training, which, again, is a bottom-line hospital cost. During the training period, the nurse who is fully salaried is not as productive as she or he needs to be, simply because he or she is in the training phase. All of these costs cut to the bottom line. We estimate that it costs the Oklahoma Spine Hospital as well as a community hospital over $50,000 a year to train a nurse. It is essential that a hospital, to maintain its clinical excellence and to decrease its bottom-line costs, does everything in its power to retain nursing staff. That is why at the Oklahoma Spine Hospital we provide incentives to our nurses in the form of increased salary, time off, bonuses, special "perks," and almost daily thanking them for a job well done. A thank you and "I appreciate your excellence as a nurse in taking care of my patients" goes a long way to maintaining the team loyalty we have established at the Oklahoma Spine Hospital. It starts with the physician/owners, and this attitude raises the bar for everyone. It is a major reason our clinical outcomes are so good.

Dr. Tom Coburn
July 11, 2005
Page 2

Question No. 2 .

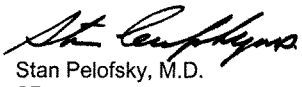
Our low infection rate does not necessarily have to do with policies or protocols. Our low infection rate has to do with the expertise and skills of the entire team taking care of the patient, including surgeon, nurse, scrub techs, floor personnel, floor nurses, housekeeping, engineering, etc. We spend "insane" attention to detail. We have minimum movement of personnel in and out of the operating room. Each operating room is totally equipped so we do not move image intensifiers, microscopes, anesthetic machines, etc., between rooms. Ultimately, it is the excellence in surgical technique with minimum associated tissue trauma, minimum bleeding, and decreased operating room time that lead to our excellent results. Again, we incentivize our staff to help us constantly improve our outcomes, decrease our costs, and improve patient satisfaction.

Question No. 3.

I believe that the model that we use at the Oklahoma Spine Hospital could easily be employed at hospitals across the United States. This model would have to allow physicians to have the authority to lead the model we presented.

Again, thank you for allowing me to give testimony before your Senate Subcommittee. I truly appreciate the opportunity.

Sincerely,



Stan Pelofsky, M.D.
SP:em

Enclosure: Transcript of Testimony

Dictated: 07/11/05
Transcribed: 07/11/05

Dr. Pelofsky

1. You mentioned that your hospital has a lower nurse turnover rate at the Oklahoma Spine Hospital than other community hospitals in your area and that this has saved your hospital thousands of dollars. Can you estimate the cost of training one of your nurses in the Oklahoma Spine Hospital? Is this typical of training costs for neurosurgical nurses in Oklahoma?

2. Why does your hospital have such a low infection rate? What policies in the clinical and/or administrative protocols do you believe contribute to these low infection rates?

3. What do you believe could be done to implement effective infection rate reduction policies, such as those employed at the Oklahoma Spine Hospital, in hospitals across the United States?