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BEFORE THE

UNITED STATES SENATE COMMITTEE ON FINANCE

HEARING ON

"PHYSICIAN-OWNED SPECIALTY HOSPITALS: IN THE INTEREST OF PATIENTS OR A CONFLICT OF INTEREST?"

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INTRODUCTION

Mr. Chairman, Members of the Committee, and staff—good morning. My name is Dr. Andy Sullivan. Currently, I serve as Chairman of the Department of Orthopedics at the OU College of Medicine, and Chief Medical Officer for the OU Medical Center. OU Medical Center is a teaching hospital, operating under a joint agreement between the state, The University of Oklahoma and the Hospital Corporation of America.

As a physician leader at OU Medical Center, I have witnessed first-hand the adverse effects that physician ownership and self-referral to specialty hospitals can impose on community hospitals. I appreciate the opportunity to come before you this morning to discuss my views and experience with the proliferation of these facilities and their impact on access to emergency care.

As a practicing physician for the past thirty-six years, I know all too well the frustrations and constraints that affect our medical practices nationwide. We continually face increasing medical malpractice premiums, unpredictable Medicare and Medicaid reimbursement, the pressures of managed care, and demanding on-call requirements. For those working in a community hospital, often there is a need to engage management for purchasing and scheduling decisions. Within this environment, it is understandable that some physician specialists would be attracted to a specialty hospital's promise of personal financial gain. However, each of these challenges requires a comprehensive solution that aims to reform a fractured health care system, not an anti-competitive solution in the form of self-referral to specialty hospitals, which ultimately impacts patient access to health care. Unfortunately, this is exactly what is occurring today with the expansion of physician-owned specialty hospitals.

SELF-REFERRAL IS THE ISSUE

To be clear at the outset, it is not the existence of specialty hospitals that fosters the problem. Rather, it is *physician ownership of and self-referral to* these facilities that creates an uneven playing field and directly harms full-service community hospitals. *Physician ownership* creates the invidious potential for conflicts of interest, over-utilization of facilities, and a distortion of the free-market.

As evinced by the findings of both the Government Accountability Office ("GAO") and the Medicare Payment Advisory Commission ("MedPAC"), physician ownership and self-referral encourage favorable patient selection. The profit motive results in the diversion of the most profitable, least complex patients to specialty facilities. The sickest, most acute patients—often on Medicaid or uninsured—are left to be cared for by full-service community hospitals. Ultimately, these harmful effects threaten the long-term viability of community hospitals, which represent the cornerstone of our American health care system.

SELF-REFERRAL IMPACT ON EMERGENCY SERVICES

As the Chief Medical Officer at OU Medical Center, I see every day the adverse impact of self-referral on access to emergency services in my community. Simply put, these facilities drain essential resources from full-service community hospitals—particularly harming the capacity of full-service hospitals to provide emergency care and other vital health services. They do so by taking advantage of a loophole in the whole hospital exception to the anti-referral law, creating an unlevel playing field.

To begin with, in my professional opinion, physician-owned specialty hospitals are merely subdivisions of full-service hospitals—essentially cardiac, surgical or orthopedic wings. As such, they do not have the capability to manage complications outside their area of specialization when they occur. They specialize in these particular health services because they offer the highest profit margins and Medicare reimbursement rates. Notably, we have seen little to no market entry by physician-owned trauma units, burn centers, or children's hospitals. This is not surprising, because these services typically represent the least profitable of practice areas. When physician-owned specialty hospitals remove the most profitable practice groups, they leave the full-service community hospitals without the ability to offset the provision of critical

health care needs that generate only low margins or even revenue losses, such as emergency services.

Maintaining an operational, fully functioning emergency department is OU Medical Center's commitment to our community. We are open twenty-four hours per day, seven days per week. Unfortunately, America's hospital emergency rooms have become our *de facto* public healthcare system, the primary point of access to quality healthcare services for the nation's uninsured. The Committee undoubtedly is aware that hospitals equipped with emergency rooms must provide medical evaluation and required treatment to everyone, regardless of their ability to pay. Since the advent in recent years of these physician-owned specialty hospitals, which skim profitable service areas for low-risk patients, this burden has grown even heavier. While specialty hospitals treat the most profitable patients, full-service hospitals are left with the task of handling uninsured and high-risk patients within their community. As such, maintaining an emergency department for those who truly need it also means contending with a regular population of people with little or no health care options. Moreover, this population often seeks emergency room care only once an illness has reached a level of acuity that makes their case more complex and costly.

For the most part, from what I have witnessed in Oklahoma City, specialty hospitals simply do not share in this commitment to our communities. For instance, a 2003 study by the GAO found that while 92% of full-service hospitals maintained emergency departments, merely 45% of specialty hospitals had emergency rooms. Even among those few specialty hospitals with emergency departments, most provided care limited to that particular hospital's specialty, and only 63% were staffed twenty-four hours per day. Overall, specialty facilities nationwide treated less than one-tenth the number of patients admitted at the emergency

departments in full-service hospitals. And in Oklahoma, despite a licensure provision requiring that all hospitals be capable to provide emergency services, a significant number of the state's specialty facilities provide little or no emergency care. For example, one physician-owned specialty hospital in Oklahoma generated only $4,300 in charges for emergency services against its total charge base of $89 million.

By opting not to operate a fully functioning emergency department, specialty hospitals are able to enjoy a high degree of self-selection, generally treating a healthier and better paying patient population with fewer complications and shorter lengths of stay. An additional strain on full-service community hospitals is caused by the departure of physicians and surgeons who relocate their practices to specialty facilities. Not only does this reduce a community hospital's staff of specialists, specialty hospital physicians also are unlikely to accept on-call responsibility, which is a vital component in providing specialty coverage for a community hospital's emergency department.

PHYSICIAN-OWNED SPECIALTY FACILITIES HAVE PRECIPITATED A CRISIS IN ACCESS TO EMERGENCY SERVICES IN OKLAHOMA

OU Medical Center presently operates the only Level I trauma center in the state of Oklahoma. Trauma centers in the U.S., which are credentialed by the American College of Surgeons ("ACS"), require that Level I centers must be capable of treating the most severely injured patients. Typically, those requiring treatment at a Level I trauma center arrive with multiple broken bones, along with injuries to other vital body systems, such as head and chest wounds. Prior to the designation of OU Medical Center as a Level I facility in 2001, Oklahoma's health care system served a population of 3.5 million residents without a single Level I trauma center in the entire state.

Ideally, the resources of Level I trauma centers should be conserved for treatment of the most seriously injured patients. Studies by ACS suggest that under optimal circumstances within any particular service region, a Level I trauma center should treat 80% of the most serious trauma victims, but only 20% of those less seriously injured patients; the remaining less seriously injured patients instead should be treated at Level II trauma centers or full-service community hospitals. With the migration of specialists to specialty hospitals, however, this scenario was not the case in Oklahoma. Despite its mission, OU Medical Center was treating a full 80% of all trauma patients across the Oklahoma City metropolitan area, along with transports from other areas of the state. This overloading of our Level I trauma center with less seriously injured patients taxes our capacity, and jeopardizes its continued survival.

Very much like police and fire departments, a full-service hospital must maintain a complete state of readiness around the clock, every day of the year. Yet given the proliferation of specialty hospitals, a number of physicians and surgeons have removed their practices from operating within community hospitals. Among other harmful effects, this pattern has created a significant strain on staffing. At the same time, many specialists have reduced their community hospital standing to "courtesy" staff, or even resigned their medical staff privileges altogether. In particular, this trend imposes a significant burden on the ability of hospitals within our community to meet on-call requirements, which ensure adequate staffing outside normal work hours, as well as on holidays and weekends for hospital emergency departments.

Trauma centers rely upon six surgical sub-specialties, including anesthesiology, which are essential to providing adequate trauma care. Nonetheless, the unavailability of sufficient specialty physicians for on-call duty is not rooted in a lack of specialists. For example, the United States averages one neurosurgeon for every 59,000 citizens, yet the Oklahoma City

metropolitan area is home to one neurosurgeon for every 39,000 residents. Despite this seemingly adequate supply of qualified specialty doctors, Oklahoma is witnessing a crisis in on-call coverage for neurosurgery, and nearing a crisis for meeting on-call coverage demands within the sub-specialties of orthopedics, facial trauma, anesthesiology, and general surgery. Clearly, the issue does not derive from a lack of capacity.

Rather, the problem is attributable directly to the many specialists who have relocated their practices away from the community hospitals, to specialty hospitals in which they have an equity interest. Before the advent of physician ownership of specialty facilities, physicians typically would maintain an affiliation with multiple hospitals within their geographic service region. As a result, the various hospitals would have access to a substantial universe of available doctors when assigning their on-call schedule. With the introduction of physician ownership and self-referral, however, this scenario has changed dramatically. Rather than retaining privileges at hospitals in which they do not own a financial stake, many specialty physicians have reduced or eliminated their affiliations with other facilities, instead committing their practice to where they have an equity stake.

Doctors establishing a specialty hospital practice, for the most part, no longer will agree to provide on-call duties at the community hospitals. Generally, a doctor withdrawing to a hospital's courtesy staff list is relieved from meeting any hospital requirements to accept on-call hours. Worse yet, those terminating their affiliation are removed entirely from the pool of qualified and available medical professionals, upon whom the hospital can depend to meet its on-call needs. The loss of on-call specialties is extremely problematic for a trauma center, but even more so for a general acute care hospital with nowhere to turn for on-call coverage.

As specialists drop out of the call schedule rotation, a vicious cycle forms—increased on-call duties among those remaining specialists cause them to become dissatisfied, and can prompt them to leave full-service hospitals. In addition, an escalation in on-call obligations increases physicians' stress, and reduces their ability to control their time and practice. Moreover, call coverage obligations reduce a specialist's earnings potential, because emergency patients bring relatively poor reimbursement for most specialties and crowd the available time spent treating other patients.

At the inception of our Level I trauma center, OU Medical Center boasted a staff of six neurosurgeons. We now struggle to maintain just two neurosurgeons on staff in order to sustain our emergency coverage for head trauma patients. In fact, the hospital recently committed nearly $1 million annually in temporary staffing (*in locum tenum*) for the required neurosurgery coverage, just to keep the doors open to our trauma center. We also were forced to resort to a stop-gap on-call system for trauma. Under this plan, OU Medical Center, the other full-service hospitals, the county medical society, and the state hospital association developed a voluntary Level II trauma rotation. As a result, a group of neurosurgeons and other critical sub-specialists who had dropped out of call rotation agreed on a voluntary basis to provide coverage at one Oklahoma City hospital each night, ensuring that our metropolitan region continually maintains the Level I center, as well as one additional full-service hospital able to accept Level II trauma patients around-the-clock. The state also agreed to provide a $5.7 million subsidy to support the operations of OU Medical Center's Level I trauma center. These various short-term measures, though costly, have ensured at least the temporary survival of a single Level I trauma center and other viable trauma facilities to serve the needs of our state.

Let me stress, however, that these solutions only are temporary. Without stable, permanent neurosurgery staffing, OU Medical Center risks losing the accreditation of our neurosurgery residency training program, which would create yet another vicious cycle—the loss of accreditation in one residency training program invariably would affect and risk the loss of accreditation for our other residency programs. Together, these programs train many of the physicians who choose to remain in practice in the state of Oklahoma. Their loss would be devastating, resulting in fewer specialty physicians practicing in Oklahoma, and a further exacerbation of our state's crisis in emergency service coverage. In addition, the loss of our neurosurgery residency program even would put our Level I trauma center designation at risk. In my view, this crisis in emergency services simply would not have occurred in Oklahoma but for the rapid growth of physician-owned specialty hospitals.

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

Full-service community hospitals long have used funds generated by profitable services to subsidize the losses suffered by unprofitable services. Only by maintaining the successful product lines are full-service hospitals able to financially support such services as trauma and burn centers, as well as special programs for uninsured and underinsured patients. In June 2002, OU Medical Center suffered a major loss when our private cardiovascular group left to become owners in a nearby specialty cardiology hospital, the Oklahoma Heart Hospital ("OHH"). OU Medical Center witnessed a steep decline in cardiovascular admissions—from over 150 patients per month before that center opened, to *zero* by August 2002. All told, OU Medical Center has suffered losses of $11.6 million in cardiovascular operating income between 2002 and 2004.

With the income previously flowing from cardiovascular services no longer available, OU Medical Center was forced to curtail unprofitable programs that could not support themselves. In doing so, programs that provided services to the uninsured and underinsured became targets for reductions. For instance, an outpatient retail pharmacy formerly provided drugs to qualified patients at a greatly reduced or no cost. This program was eliminated, saving $2.6 million per year. And the scope of a planned facility renovation was severely reduced, resulting in a reduction of facility enhancements in areas that directly affected the provision of health care to women and children within the community. These unfortunate but necessary cuts compromised the mission of our academic medical center to provide safety net coverage for the most needy residents in the state of Oklahoma—particularly those who are uninsured or otherwise lack access to specialized care.

As a consequence of removing the most profitable services from full-service community hospitals, physician-owned specialty facilities also have incentive to refer only those better-funded and less severely ill patients. This leaves the uninsured, underinsured and more severely ill patients to be treated by community hospitals, often without adequate (or any) compensation. While paying and less severely ill patients are diverted to physician-owned specialty facilities, community hospitals are left with the burden of caring for a higher percentage of the uninsured, underinsured and the sickest patients, with fewer resources to cover the vast and unreimbursed costs involved.

Besides diverting revenue from full-service community hospitals, physician-owned specialty hospitals also divert limited human resources. Within the one-year period following the departure of our cardiovascular group, OU Medical Center lost fifty-six staff members who joined that facility, forty of whom were registered nurses. The estimated cost of

turnover—including increased salaries, retention bonuses, and recruitment training costs—totaled approximately $2.6 million. We narrowly avoided the closure of our intensive care unit by paying nearly $500,000 in retention bonuses.

CONCLUSION

To summarize, I understand the role that specialty hospitals can play in response to consumer demands. Nevertheless, when using physician self-referral as a means of attracting and sustaining a steady flow of low-risk, highly-insured patients, these facilities create both a conflict of interest for the physicians and an unfair competitive advantage, which I believe is unethical.

It is my hope that Congress will protect community hospitals like OU Medical Center by removing the opportunity for self-referral. I understand the Congress is weighing recommendations by MedPAC that would seek to level the playing field through Medicare payment adjustments. With over thirty years of Medicare reimbursement experience, I can assure the Committee that Medicare payment adjustments alone will not solve the self-referral problem. The fact of the matter is that any of my medical specialty staff could leave tomorrow and double their income at a specialty hospital, where the value of their investment increases as a direct result of the self-referral. As long as any financial gain can be generated through a referral, competition will be neither free nor fair between community hospitals like OU Medical Center and our neighboring specialty facilities.

Improper financial motives simply do not serve the best interest of our patients, and threaten to undermine the vital health care services that communities expect from a local full-service hospital. I ask this Committee to eliminate these concerns by ensuring the current moratorium does not lapse, and by supporting legislation to prohibit physician self-referral

before the network of full-service community hospitals in this country becomes irreparably impaired.

Thank you for your time, and I'd be glad to answer any questions.

BIOGRAPHY OF J. ANDY SULLIVAN, M.D.

Dr. Sullivan is Chairman of the Department of Orthopedic Surgery at the University of Oklahoma College of Medicine, and Chief Medical Officer of the University of Oklahoma Medical Center.

Following training in orthopedic surgery at Barnes Hospital and St. Louis Children's Shriners Hospital, Dr. Sullivan began his career in 1974 as a Medical Corp Major at Womack Army Hospital in Fort Bragg, North Carolina. He joined the Department of Orthopedic Surgery at the University of Oklahoma College of Medicine in 1976, was named Professor in 1989, and Chairman in 1992.

In 2003, Dr. Sullivan became Chief Medical Officer of the University of Oklahoma Medical Center. In addition, he has served in several other leadership positions, including Chief of Staff and Medical Director of the Children's Hospital of Oklahoma, and President of the University of Oklahoma College of Medicine Professional Practice Plan.

Dr. Sullivan's spends the majority of his time teaching orthopedic surgery residents in various settings. He also has been the principal investigator on several research grants and has authored numerous publications and presentations, including two books, nineteen book chapters, forty-four articles, and thirty-two abstracts.

In 1993, Dr. Sullivan was honored with the Governor's Commendation as a "Hope Builder Award Recipient" and in 1999 was included on the list of "Best Doctors in America."

Dr. Sullivan received his bachelor's degree from Texas A&M University in 1965 and his M.D. degree from the Washington University School of Medicine in 1969. He and his wife, Sue Moss, reside in Oklahoma City.