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PHYSICIAN-OWNED SPECIALTY HOSPITALS: PROFITS BEFORE PATIENTS?

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

SECOND SESSION

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PHYSICIAN-OWNED SPECIALTY HOSPITALS: PROFITS BEFORE PATIENTS?

WEDNESDAY, MAY 17, 2006

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:09 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Charles E. Grassley (chairman of the committee) presiding.

Also present: Senators Baucus and Smith.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. I am going to start the hearing, although other members will not come because we are in the process of voting on the floor of the U.S. Senate. I have cast my vote. We will proceed, and hopefully members will be here before our first witness testifies. I welcome everyone.

Today, we have three separate panels of witnesses, so we will get the hearing started. Senator Baucus and I will make opening statements.

Also in our audience today are three of my constituents from Iowa. We have Jim Zahn and Sarah Rosener from the Iowa Health System, and we also have Bill Lever, who is president and CEO of Trinity Health Systems in the Quad Cities.

I welcome my constituents here. Thank you very much for coming. They represent a number of people in Iowa who are concerned about physician-owned specialty hospitals. I thank them for coming all the way to Washington, DC to participate in this hearing.

Next, we will be introduced to our first witness, Rev. Mike Wilson, from Portland, OR. We have two Senators from Oregon here, and one of them is going to be present to introduce Rev. Wilson. Then following his testimony, we are going to have Dr. Mark McClellan, and after that, the final panel of witnesses.

As Chairman of the Finance Committee, it is my constitutional duty to conduct oversight of the Federal programs to determine if the policy that the committee makes is sound, and to ensure that laws passed by Congress are implemented and enforced in a manner consistent with the spirit and intent of that legislation.

Today's hearing presents an opportunity to address the issue of specialty hospitals from an oversight perspective. This hearing will examine the impact that these facilities have on patient safety and the quality of care.

Additionally, the hearing will explore the various financial arrangements used to finance these hospitals. Finally, the hearing will address implementation and enforcement of specialty hospital legislation by CMS.

Recent oversight work by the committee raises serious questions about specialty hospitals and whether they serve the best interests of patients being treated at them, and if they are serving the best interests of physicians who own and operate them.

Further, the committee's oversight work found that, in spite of a Congressional moratorium on new specialty hospitals and an administrative extension of that ban, it appears that during that period of moratorium over 40 specialty hospitals have opened.

That is hard for those of us who made this decision on the moratorium to realize that a moratorium does not always mean a moratorium. So, obviously Congressional intent was not followed when 40 specialty hospitals opened during that period of time.

Today's hearing also comes on the heels of three new reports on specialty hospitals. The first was a follow-up review by the Medicare Payment Advisory Committee. We refer to that as MedPAC for short. That report was released at the commission meetings on April 19.

MedPAC made a number of findings regarding specialty hospitals, including that one physician-owned surgical hospital's costs were significantly higher than general hospitals, despite having shorter stays.

Physician-owned hospitals see significantly fewer Medicaid and charitable patients. Three physician-owned heart hospitals increased the number of heart procedures in the community when they opened. Four physician-owned heart hospitals divert profitable patients from community hospitals, decreasing revenue at the community hospitals.

The second report that I have referred to was a survey conducted on specialty hospitals conducted by the Government Accountability Office. We refer to that as the GAO. While advocates of specialty hospitals claim that specialty hospitals force community hospitals to improve quality and efficiency, the GAO's most recent report released in April did not support that assertion.

The third recent report on specialty hospitals was released last week, May 9, by CMS. This interim report details the progress CMS has made in creating a "strategic and implementing plan" for specialty hospitals.

The report is a starting place, but it is by no means the final strategic and implementing plan that we in Congress envisioned last December when we wrote this provision.

Our first panel today will provide testimony regarding a physician-owned facility that had no physician on-site, on-call doctors who did not answer their phones, and—can you believe this?—a standing policy to call 911 in case of patient emergency.

These policies ultimately led to the tragic death that we are going to hear about from our first witness, an 88-year-old mother. Clearly, this standard of care raises serious patient safety concerns and requires immediate attention.

On our second panel, we will hear from a friend, Dr. Mark McClellan, the Administrator of the Centers for Medicare and Medicaid Services.

Finally, our third panel will address the impact that specialty hospitals have on community hospitals, suspect financial arrangements of some specialty hospitals, patient safety, and quality of care at those facilities.

I welcome our first witness and thank him for his testimony. I would like to say a special "thank you" to Rev. Wilson for coming, and I express my condolences about the story that he is going to tell us in his testimony today.

Coming all the way to Washington, DC and testifying, all this fanfare is difficult enough, but to come here and relive the story of losing your mother is extremely difficult, I am sure, and we appreciate you sharing your story. It is my sincere belief that your testimony today will help us avoid similar tragedies in the future.

I am going to ask Senator Smith to fill in, because Senator Baucus is not here at this point, because I call on members to recognize constituents, and Rev. Wilson is a constituent.

OPENING STATEMENT OF HON. GORDON SMITH, A U.S. SENATOR FROM OREGON

Senator SMITH. Yes, he is. I am here, Mr. Chairman, first, to thank you for this important hearing. It is an issue that we have to deal with. But also, to welcome Pastor Mike Wilson and his wife, who is with him. They are great Oregonians. Mike is a pastor at the Sellwood Baptist Church, and so performs lots of valuable service to our State, our Nation, and his congregation.

Mike, the Chairman has already reviewed what happened to your mother, Helen. I know how hard it is to come and testify publicly about personal tragedies, but I have a sense your mom is very proud of you today.

We who remain behind really can find good out of our losses if we can look for that silver lining, and I am sure, again, that she is proud that you are trying to make a difference for others, so what happened to your mother does not happen to others.

But, Mr. Chairman, I have a statement. I will put it in the record. You said much of it. It would simply be repetitive. But what happened at Portland Physicians' Hospital should not happen again. We need to learn from it and fix it.

The CHAIRMAN. And we intend to do that, Senator.

[The prepared statement of Senator Smith appears in the appendix.]

The CHAIRMAN. Normally, Senator Baucus, who is now voting, would be the next person to speak, but I will break in for his opening statement when he comes.

So we are ready now for your testimony, Rev. Wilson. Would you proceed, please?

STATEMENT OF REV. MICHAEL W. WILSON, PASTOR, SELLWOOD BAPTIST CHURCH, PORTLAND, OR

Rev. WILSON. Thank you. I bring you greetings from beautiful Oregon. Our weather has been in the 90s the last few days, so this

is a nice respite from that. Thank you for the privilege of coming and sharing our family's story with you.

We have brought with us a photograph of my parents that was taken of them shortly before my mother's death on August 1, 2005. They had been married for 69 years at the time.

I know that you have heard my mother's name, because it has come before you already in your discussion of physician-owned for-profit specialty hospitals. It is our desire that, by our coming and by your efforts here, as Senator Smith mentioned, that you can help to see that this does not happen again.

My mother entered Physicians' Hospital in Portland on the 27th of July for a simple lamenectomy to correct some pinched nerves in her lower spine, to free up motion in her legs and stop the numbing and the pain that she was having. She was in general good health, though she was 88 years old.

The doctor assured us that she would be able to survive and do well through the surgery, and was confident that it would be a one-night stay. That was all she was scheduled to be in the hospital.

The surgery itself went well. It took about 2 hours. She was in recovery. The nurse, then the doctor, came out and told us that she had done well through the surgery, but was having quite a bit of pain, so they had given her several doses of pain medication. She was brought into her room, where my father and I were waiting, about 4:30 in the afternoon.

From that point on, we were never away from her. We were by her side every moment. She was coming out from under the anesthetic and was feeling well. She was able to talk. She was groggy at first, but I asked her how she was doing. She said as long as she did not move, she was fine.

At no point did she ask for more pain medication, and at no point did anyone ask her if she needed any. That is important because later, on the records, it showed that she was asked and reported that she had a pain level of 6 out of 10. That was a fabrication. It never happened.

My wife got to the hospital about 5:30, after she came from work at the Portland Police Bureau. My father, my wife and I stood around my mom's bed, talking with her. I was feeding her ice chips and she was doing well. We laughed and visited.

About 10 minutes after my wife got there, a nurse came in and injected into my mom's IV one more dose of pain medication. What was used was a medication called Dilaudid. At the time we wondered, because she had not asked for anything.

We questioned the size of the syringe, because it looked like something you would give a horse. But it was explained that it would go into the IV and it had to be diluted with saline, and so forth.

So she slowly injected it into the IV line and left the room. Within 2 or 2½ minutes, my mother's eyes drooped, her head began to loll, and she obviously went to sleep. About that time, another nurse stepped into the room, and we asked her if that was normal, that a person would have that reaction that quickly. She said, oh, yes, a person often goes right to sleep.

So my wife and my father sat down in the two chairs next to the bed, and I was standing at the foot of her bed and just watching,

and we were talking. She suddenly made a little choking sound, and I looked over at her, but she seemed to be sleeping normally. I was not alarmed, and we went back to talking.

Just seconds later, maybe a half a minute later, she made another gurgling, choking sound. I looked at her, and her mouth was open. It was obvious that she was turning very white. I stepped up to the head of the bed from where I was standing at the foot, and I could see that her chest was not rising, she was not breathing.

I checked her pulse, then I checked her carotid, and there was no sign of pulse and no breathing. So I yelled for help, and hollered for the nurses to come and help us, which they did, though to us it seemed like it was taking an eternity.

The next minutes were some of the worst of our lives as we watched perhaps one of the most egregious examples of negligence and incompetence that I have ever heard of as the nurses were trying to get her to be able to breathe.

One nurse was using a resuscitation bag, but was not having success. She was trying to get air into her lungs, but she had not cleared my mother's airway. Her tongue had fallen back in her mouth.

I had to yell at the nurse, "You're not getting any air in, it's all escaping around the mask." It was inflating her cheeks, but there was none going into her lungs. She looked at me with this look of panic. She was over her head, it was obvious. They did not intubate, which is what would be normal when a person is unable to breathe. They brought in the crash cart after several minutes. One nurse was trying to check her vitals, but was taking so long at it.

Finally, she called for the crash cart. The crash cart was not where it should have been, close by the nurse's station. We were right in front of the nurse's station. They had to bring the crash cart from a hallway, and came rolling it in.

When they did, the nurse that was looking to put it together and be able to use the paddles on my mom was hollering and saying, "Where are the paddle covers?" and where is this, and where is that? People were running to try to get equipment to be able to put the paddles on her to try to restart her heart.

One of the things that we noticed was that there was no Code Blue, or sometimes called Code 99 that was called. We kept asking, why is there not a doctor here? Have you called a doctor? All we got were stares and odd looks.

Later, someone said, well, we have called someone. They had called someone, but we were assuming that they meant it was a doctor that had been called. In reality, they called 911. They called the fire department.

Some 10 to 11 minutes into this crisis, the paramedics arrived. Of course, they operated like a well-oiled machine, which was in stark contrast to what we had been witnessing, which looked more like something from the Keystone Cops up until then.

The problem was, the damage had already been done because they had not known how to intubate and respirate and get air into my mother's lungs. By that time, she was already brain dead from lack of oxygen.

They were able to get her heart started and stabilized. They were able to get her breathing. They transported her to Adventist Hospital in Portland. That is where she remained for the next 5 days, until her death on Monday, August 1, 2005.

This was a tragic and needless death. Had my mother received the kind of care at Physicians' Hospital that she later received at Adventist Hospital, she would be alive today, and I would not be here telling her story.

No hospital should ever have to call 911 to come to rescue one of their patients. I think we all can agree on that. We assume that doctors and nurses know how to resuscitate a person who has gone into respiratory or cardiac arrest.

I believe that we, as patients, have a right to make that assumption, that we will be well cared for. What happened to my mother on July 27th was unconscionable and inexcusable, in my opinion.

As a result of the negligence, my father lost his wife of 69 years. He is now 90. He had his birthday just days after her death. My sister and I have lost a wonderful mother, our children have lost a grandmother, and obviously on down the line. My youngest daughter had a baby just days after my mother's death, and Billy will never get to know his great-grandmother as a result of these events.

My mother was a wonderful, godly woman, and I have had wonderful parents growing up. She was ready to go meet the Lord that she had served for these many years. She had been ready for many years, and at any time.

However, that does not take away from the fact that the immediate cause of her death was the negligence of a hospital that I believe has a moral obligation to do everything possible to save lives.

To summarize, the staff at Physicians' Hospital obviously did not know how to intubate, or else it was their policy not to. I do not know why that was not done. Even the paramedics asked that question.

They did not administer the antidote for the drug that they overdosed her on. They did not have a properly prepared crash cart, and it was not stationed where it should have been.

There was no Code Blue team in the hospital trained for this kind of emergency, no doctor in the hospital. No doctor ever appeared on the scene in this whole thing. I believe that my mother is kind of a poster child for what can happen when, as I have told others, the foxes own and operate the henhouse.

For instance, the doctor that operated on her, we did not know that he was one of the owners of the hospital. That had not been shared with us. We did not know that the hospital was only marginally prepared for this kind of an emergency.

There were many things we did not know, including, as Senator Grassley mentioned, that it was their policy to call 911 in case of a post-operative medical emergency. I already mentioned that when we got her medical records we could see that they had been doctored.

The times had been changed to make it look like she had received the last dose of pain medicine 40 minutes before the event occurred when she went into arrest. There were three of us standing by her bedside the whole time, and that simply is not true.

From the time the medicine was given, it was 2, 2½ minutes when she was already asleep and stopped breathing. So that was one of the things that was very troubling.

Another is the attitude that we have heard from a number of people, that, well, it is unfortunate, but it had to do with her age. This had nothing to do with her age. She was in good health.

I am 56. If I had been in there under the same circumstances and had been overdosed, I could just as easily have gone into respiratory or cardiac arrest. It could have happened to a young person as well. It had nothing to do, in my opinion, with her age.

It appears that Physicians' Hospital is going out of business, for which we are very grateful. In Saturday's paper, it said that they are trying to sell the hospital, and we are glad for that.

But our concern is that there are many others around the country that seem to be similar to this one, and it is my opinion that, when doctors own the hospital and operate it to their benefit, when the dollar is the bottom line, then patients are not going to be well served. My mother is an example of what can happen when there is no oversight, no one looking over the doctors' shoulders.

If my mother's death results in a greater public awareness and results in this Senate committee being able to close some existing loopholes and perhaps save someone else's life, then I am sure that she would say that it was worth it. We would ask that you do all in your power to make it so.

I thank you for this opportunity to come and address you today, and would be happy to take any questions you might have.

[The prepared statement of Rev. Wilson appears in the appendix.]

The CHAIRMAN. Yes. Would you wait for questions just a minute? Then I will have Senator Baucus give his opening statement at this point.

Senator BAUCUS. Thank you, Mr. Chairman.

Reverend, you have a lot of courage to come here and tell your personal story, as difficult and as heart-rending as it has to have been, and still is today. I sympathize with you and your family.

And I know I can speak for this entire committee in saying so, and I can certainly speak for the Chairman. It is my very strong view that these specialty hospitals should not be providing service. That is, they are providing a disservice to America, not a service.

I, for one, am going to do all I can to stop specialty hospitals. There are tons of reasons why, and you have given one very good one. They are just not adequately prepared to deal with emergencies.

Rev. WILSON. That is true.

Senator BAUCUS. I am sorry, very, very sorry you had to go through all this, even more sorry for your mom, but for your own family.

I am not going to give my statement. I am just going to put it in the record, Mr. Chairman. But I just want to tell you just how wrenching this is, and how it could have been prevented, as you said. It need not have happened. It is our job to do what we can to not let that happen any more in the future. We will do our very best.

Unfortunately, there are some pretty powerful interests that want to keep specialty hospitals open, and this is not an easy matter before us, that is, to stop these hospitals. I have tried hard, Senator Grassley has tried hard, and we will keep trying hard.

Your story here today, frankly, gives me even more energy to get the job done and stop these hospitals from performing. But thank you very, very much for taking the time to come here. I will have some questions a little later, but thank you very much.

[The prepared statement of Senator Baucus appears in the appendix.]

The CHAIRMAN. We will have 5-minute rounds for whoever comes, or whoever is here now. We will do it in the order of: Grassley, Baucus, and Smith, 5 minutes each.

My first question to you would be to follow up on what we often refer to as the importance of patient advocates to ensure that things go as planned in the hospital.

Now, you probably did not assume the role of a patient advocate, but you were there with your family. I am sure as you look back now, you were essentially in the dark about hospital policies and procedures for emergencies. You talked about 911 and all that.

So, just asking you to look back, what questions do you feel would have been helpful to ask prior to surgery at a limited-service hospital?

Rev. WILSON. Well, sir, we did not know enough about it to know what questions to ask. It had not crossed our minds, or our parents' minds.

The CHAIRMAN. I am asking about hindsight, now.

Rev. WILSON. Yes. Certainly.

The CHAIRMAN. Go ahead.

Rev. WILSON. Looking back, I would certainly know better the questions to ask, but it never dawned on us that, for instance, the orthopedic surgeon who was operating was one of the owners of the hospital. We knew that he had privileges there, but my parents did not know, nor did I, about how the hospital operates, so we did not ask the right questions.

One of the other issues was a fact that, for instance, we had questions about it, but it was not something we were able to ask about until afterward. My mother was never connected to a monitor, to a heart monitor, which should have occurred with a person of her age, and she had had heart surgery 15 years earlier. But they did not have her connected to a heart monitor. That is normal procedure in a hospital under these conditions.

They did not do that. So there were a number of things that simply were missing, but we did not have all of the information to work with to know the right questions to ask then.

The CHAIRMAN. Well, in regard to the possible questions you would have asked if you had thought the necessity of it, would answers to these questions have affected your decision to seek treatment at a specialty hospital?

Rev. WILSON. Absolutely. It never dawned on us that there was any hospital anywhere that did not have an emergency physician on call, or on staff and present. Yet, there was not one at Physicians'. Even with their calling, they could not come up with one from any other part of the hospital.

We did not know that there was a hospital on the planet that was in that situation. We saw the stark contrast between Physicians' and Adventist Hospital, which is a fine hospital, well run, when my mother was taken there.

Twice while she was in CCU, there were Code 99 events called in in that unit, and we saw what it was supposed to look like. When people come in immediately, they are able to give aid and to resuscitate a patient. None of that occurred with my mother.

The CHAIRMAN. Now, you spoke about not knowing that the hospital was owned, or partly owned, by the surgeon. Do you believe that informed consent for patients should include a disclaimer of any ownership interest a doctor may have had in the hospital?

Rev. WILSON. Absolutely.

The CHAIRMAN. Would knowing that a doctor had an ownership interest alter the questions you would ask prior to receiving care?

Rev. WILSON. Yes, I believe it would have altered that. The same physician had privileges at Adventist Hospital, and my mother had been there previously for another procedure.

We would have opted for that had we known there was any deficiency in the care at Physicians', but we simply did not know. None of that was shared with us, none of it was revealed.

The CHAIRMAN. I thank you.

I call on Senator Baucus.

Senator BAUCUS. Thank you very much.

Reverend, you have touched on this a little. I just want to nail it down the best I can. What did you know about Physicians'? I mean, was it your impression that Physicians' was, if not a full-service hospital, virtually the same quality of a full-service hospital, that all the procedures would be there if there was an emergency? I am curious what you knew about Physicians'.

Rev. WILSON. We had very little information about that. I asked my father about it later, what he had been told about the hospital, and he said, nothing. Because the doctor said that that is where he would prefer to do the surgery, and he had told them that the nursing staff had received nothing but high marks and recommendations from patients that he had had there previously, my parents said that they would be happy to have the surgery done there.

Senator BAUCUS. Right. So, without putting words in your mouth, the physician steered her to Physicians'?

Rev. WILSON. Yes.

Senator BAUCUS. Would that be an adequate characterization?

Rev. WILSON. Yes, sir. The surgeon did that.

Senator BAUCUS. The surgeon did that.

Did the surgeon or the referring doctor, whomever, indicate that there was another option, you say Adventist Hospital, or some other hospital? Was that relevant to her, too? Did she learn about that?

Rev. WILSON. There was no option given. He stated that it was his preference to do the surgery there where he had privileges. We found out later that he also had privileges at Adventist, so that would have been an option. But it was the doctor's choice that that would be where the surgery was performed.

Senator BAUCUS. And, I am sorry if this was covered. Was your mother told that he had an equity interest in, or ownership interest, in Physicians'?

Rev. WILSON. No, sir. No, sir. At the time, we did not know that it was a physician-owned hospital. Physicians' took over the old Woodland Park Hospital that had been there for 43 years in Portland, and was, more or less, a full-service hospital. In fact, my second son was born there.

So we made some assumptions that, looking back, we should not have made. We should have done more homework. It never dawned on my parents or myself that we were stepping into a situation such as Physicians' is, a for-profit, physician-owned hospital.

Senator BAUCUS. Just as a matter of public policy, do you think it is better to ban physician ownership or have full public disclosure of physician ownership?

Rev. WILSON. I think public disclosure. If anything, they need to come under greater scrutiny. We have many hospitals in Portland whose mission statement contains nothing to indicate that it is primarily a business. We recognize that any hospital has to make a profit to keep its doors open, but when the major mission is to make money, I think the patient is in danger. The profit motive is not necessarily a noble motive.

When doctors are in it primarily to increase their income, corners will be cut, and they were at Physicians', in training. I felt sorry for the nurses because it put them in a horrible position of being confronted with an emergency like this, but they had not been given the tools, nor the training, nor the practice to do what they were called on to do.

I will never forget the look of terror in their eyes as they worked in that room around my mother, but they, frankly, did not know what they were doing.

Senator BAUCUS. Now, do you think it is even right for a physician to have all kinds of additional equipment in his hospital? Let's say, at Physicians', I assume, because they do surgery there, and I assume—perhaps incorrectly—that they focus somewhat on orthopedics, because your mother had back surgery, that they have not only X-ray equipment, but CAT scans, maybe even an MRI there? Do you know, is that true? Do they have those?

Rev. WILSON. I do not know what level of equipment they have. I have not seen any of that. I do know that the surgery itself, from all that we have gathered, the surgical theater, the recovery room, seems to be well-equipped, from all that we know. But as far as other equipment, I do not know how well-equipped the hospital is.

Senator BAUCUS. So the things that concern you are, the service was poor and your mother died.

Rev. WILSON. Yes.

Senator BAUCUS. And you think it is largely the consequence of not only inadequacy, but malfeasance. That is, they did some bad things. That is, the medication and inadequate staff there. That is number one. Is that correct?

Rev. WILSON. I would say yes.

Senator BAUCUS. And, second, you are concerned about the financial interest that the doctors have at that facility versus other facilities.

Rev. WILSON. Yes.

Senator BAUCUS. You are concerned about the training, inadequate training at those kinds of facilities compared with full-service hospitals.

Rev. WILSON. Yes, I am.

Senator BAUCUS. And do you think that it is best that it be banned, or should they be somehow brought up to speed? What is your view on that?

Rev. WILSON. Sir, I do not think they should be banned. I believe that we need more hospitals. But we need good hospitals. We need hospitals that are well run, where patient care is put first rather than profits.

Senator BAUCUS. Now, can that happen, in your judgment? What if Congress just said, sorry, doctors, you can have no financial interest in procedures, or images, or whatnot that you perform? I had a personal experience, Mr. Chairman, not long ago.

A doctor said, well, we can do this or that. Do you want to have an MRI? he asked me. I said, what do you mean, do I want to have an MRI? I want to know what is wrong and I want your professional advice as to what is wrong. So why are you asking me my opinion? I realized, that is code. That is a way for him to cover himself, because, clearly, he had a financial interest in my getting an MRI.

The CHAIRMAN. That is why you ought to go to a veterinarian. He tells you what is wrong.

Senator BAUCUS. Yes. Right. [Laughter.] I mean, it just bothered me that something is not quite right here.

Rev. WILSON. Yes.

Senator BAUCUS. I am being asked, not for medical reasons, but he wants to get my permission so that he can, in his head, somewhat justify referring me for a pretty expensive imaging procedure where he has a financial interest.

I just found that very bothersome, frankly, and that is wrong. I mean, his decision should be based entirely on his medical judgment, his professional judgment, not on his pocketbook.

Rev. WILSON. Right.

Senator BAUCUS. I just think, Mr. Chairman, we have to find ways that doctors—most of them are really good people. They are terrific people. But, like everybody else, they are tempted. And if they have an ownership interest, they are going to be tempted to ask people like me, what do you want? Max, do you want an MRI or not? What do I know?

But thank you very much. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Smith?

Senator SMITH. Thank you, Mr. Chairman.

Pastor Mike, how is it you were directed to Physicians' Hospital?

Rev. WILSON. By the surgeon himself suggesting that that is where he wanted to do the surgery. He had privileges at two hospitals, we found out, but he opted, and he simply told my parents.

My mother, at her age, and my dad, they come from a generation that does not ask questions of doctors. That is where much of the danger is. Elderly people many times do not question anything that a doctor says, so they are open to being taken advantage of.

Senator SMITH. Did the physician tell them he had a financial ownership in this hospital?

Rev. WILSON. No, he did not.

Senator SMITH. Did they sign any kind of admittance form with real small print that people our age, to say nothing of the age of your parents, cannot read without a magnifying glass?

Rev. WILSON. They were given many things to sign in the normal procedures. There was nothing on that that I saw or read that gave any indication that the surgeon was an owner in the hospital.

Senator SMITH. Had an interest?

Rev. WILSON. Had any interest in it, or even that it was a physician-owned hospital. We did not know that. I guess by the name we should have put two and two together, but we did not connect up the dots. I had never met the surgeon until the morning of the surgery.

I came in that morning after she had gotten settled in, and then I was there for the rest of the day. I met him for the first time the day of the surgery, was impressed with him. Met the anesthesiologist.

I would say that, up until the emergency occurred when my mother went into respirator arrest, the service we received, the care, and the kindness we received from the nurses, we had no problem with any of that. It is when it all came down and hit the fan that things came unglued.

Senator SMITH. And no physician was around?

Rev. WILSON. None.

Senator SMITH. And on the form that probably your father—or did you sign the admission forms?

Rev. WILSON. My father signed the admission forms.

Senator SMITH. And is there anything in those forms, legible or not, to someone his age that talks about, their emergency policy is to call 911?

Rev. WILSON. No.

Senator SMITH. It is my understanding that the licensing of this hospital left something to be desired, that it was done in haste. Can you speak to what the State of Oregon's role was in this?

Rev. WILSON. I do not know all the details, but my understanding is that they came in basically claiming that they were a continuation of the Woodland Park Hospital. In reality, that was not true. It was new owners, new administration, everything new. They purchased the facilities, but they were under new management, a new charter. So they came in during the time of the moratorium. I am not sure how that happened.

Senator Grassley mentioned that there are others that also managed to come in under the wire. But that is how they came into existence. There were four doctors who were the primary owners, four who have controlling stock. Since then, another 35 or so physicians have come aboard, bringing the number to somewhere close to 40, who are owners of this hospital.

Senator SMITH. I want to join my colleagues, again, in thanking you, Mike. Your testimony sets the emotional bar for the work that we and CMS need to do on the whole category of physician-owned hospitals. I am not against people making a profit.

Rev. WILSON. Of course.

Senator SMITH. I am for consumers having all the information necessary, and I certainly think it is apparent we need to have some standards that patients can expect to be met if they go to this hospital or another. There just ought to be that threshold in America.

I just wanted to say publicly how sorry I am for your loss. I hope you will express to your father the same. But I thank you for your courage, and your family's, and the good you are trying to find in this tragic family experience.

Thank you, Mr. Chairman.

The CHAIRMAN. Do you have any more questions?

Senator BAUCUS. No, thank you. I just thank you for your testimony, very, very much. Appreciate it.

The CHAIRMAN. And we thank you very much for your testimony, and we thank you for coming. You are welcome to stay if you want to hear the rest of the testimony from other people.

Rev. WILSON. Thank you very much.

The CHAIRMAN. Thank you very much.

I think Dr. McClellan is not here right now. If he does not show up, then we will go on to the third panel. We will wait just a moment.

[Pause.]

The CHAIRMAN. We thank you very much for coming, Dr. McClellan. For those of you who do not know Dr. McClellan, he appears before this committee very often. He has been very thorough in his testimony and very helpful to this committee.

Most recently, as we expressed concerns to him about the implementation of the Part D drug program, and as it turned out now, 4 or 5 months later after we first met with him, it has turned out to have a very successful sign-up. We thank you for your leadership in that area, and we know it is going to continue.

It is very important, for those of you who are in the audience, for people who administer our laws—and in this case it is Dr. McClellan—people who make tough decisions, to do so with an understanding of those who are impacted by their decision.

So, he is here to discuss the 3-month interim report on strategic and implementing plans for specialty hospitals. The interim report was issued, as I said in my opening statement, by his agency last week.

The interim report was mandated by section 5006 of the Deficit Reduction Act of 2005, and that provision required the Secretary of Health and Human Services to issue the interim report 3 months prior to the full Strategic and Implementing Plan on Specialty Hospitals.

When Congress passed the Deficit Reduction Act, it was envisioned that the strategic and implementing plan would be more than just another report to Congress and would include meaningful disclosure requirements.

I trust that Dr. McClellan's testimony will address this point, as well as provide the next steps that the law requires in creating that final strategic and implementing plan. Thank you very much. We have given you extra time, so proceed.

STATEMENT OF HON. MARK McCLELLAN, ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Dr. MCCLELLAN. Thank you very much, Mr. Chairman, Senator Baucus. I appreciate the opportunity to talk with you about the critically important topic of the quality of care that our beneficiaries receive.

I want to start by saying that, as a physician, it is unacceptable that a patient in this country could get care like we have heard about this morning, and I want to offer my condolences to Rev. Wilson and his family for their loss. Their mother seems like a wonderful woman. This should never happen, and CMS is in the process of terminating the hospital from the Medicare program.

Tragically, things like this that never, ever should happen in our health care system do happen every single day. Last year, for example, 84 patients got surgery on the wrong part of their body; hundreds of patients died of infections they got after they were admitted to a hospital.

Our quality oversight activities are designed to prevent this by prohibiting payments to providers that do not meet appropriate standards of care. We would like to work with you to do more to prevent poor care that should never happen. As Senator Smith said, if there is a silver lining to these tragic events, it is that they remind us of the opportunity for action.

With that goal in mind, I would like to describe the application of our quality standards and the new steps we are taking to improve quality of care in hospitals.

Rev. Wilson put it best: we need hospitals that are well run, and that demonstrate that by putting patients first. That is what we should be supporting.

Our quality standards apply to all hospitals, whether a facility is rural or urban, for-profit or nonprofit. These quality requirements are enforced through Medicare's Conditions of Participation and the survey and certification process.

When CMS receives a credible report of a quality concern, the agency authorizes State survey agencies to investigate. We did this thousands of times in the past year. If there is evidence of persistent problems at a particular hospital, one of our regional offices will conduct a Federal survey. This is what happened in the case of this specialty hospital in Oregon, and this is what is leading to the hospital termination.

CMS used this targeted approach with inspections because, as you know, the agency has a limited budget for survey and certification. For the past 2 years, our survey and certification functions for Medicare have been funded at levels well below the President's budget request, and I look forward to continuing to work with this committee to ensure the agency receives continued strong support for these essential functions.

At the same time, we also believe that Medicare can do more through its payment system to improve quality and prevent adverse events in hospitals. This is particularly important, as it provides an opportunity to improve care and identify quality issues sooner before quality problems result in serious adverse events.

CMS has worked with a number of key stakeholders through the Hospital Quality Alliance to develop a shared national strategy for improving the quality of care provided at all hospitals, including physician-owned specialty hospitals.

The authority to adjust payments and collect quality measures was initiated in the Medicare Modernization Act, that very important law that you mentioned at the outset, and it was expanded through the Deficit Reduction Act. This gives us a solid foundation for not just passable performance, but high-quality performance in our health care system.

I appreciate and support your leadership in building on these steps by implementing performance-based payments. Patients should know not just that a hospital has met minimum standards, but whether it is achieving up-to-date and error-free care, and hospitals need better rewards and support for improving quality above the minimum standards.

If we truly want to prevent quality problems, there is no place for paying for poor care every day that should not happen at all. The Deficit Reduction Act will allow CMS, beginning in 2008, to adjust payments for hospital-acquired infections, which many hospitals have shown can be reduced, if not eliminated entirely, through evidence-based medical practices.

We should build on this step. CMS is now considering administrative and legislative changes to address "never" events. These are serious, preventable medical errors that should never happen. I mentioned a few "never" events that are currently regular occurrences in this country, like surgery on the wrong body part.

There are many others: foreign bodies left in patients after surgery, mismatched blood transfusions, major medication errors, major pressure ulcers acquired during a hospital stay, and preventable post-operative deaths.

Paying for "never" events, and in many cases paying more for such events, is contrary to the goal of getting better-quality care through how we pay. We just cannot afford to keep paying for things that should not be happening.

We cannot afford it from the standpoint of Medicare's finances and, more importantly, we cannot afford it from the standpoint of our beneficiaries' health. We want to eliminate payments for "never" events, and we want to work with you to make this happen.

CMS has also taken more immediate steps designed to improve quality by more accurately reflecting the cost of providing care in hospitals. Payments that accurately reflect resource needs create a level financial playing field for all hospitals and discourage hospitals from concentrating on certain services because they are more profitable rather than because they are more needed by patients.

In particular, we have proposed the most important reforms in the Diagnosis-Related Group payment system for hospitals since this system was created more than 20 years ago. CMS has also responded to concerns raised by Congress and others regarding physician-owned specialty hospitals.

CMS implemented the whole hospital exception moratorium that you mentioned earlier, Mr. Chairman, for new specialty hospitals

as part of the Medicare Modernization Act. That moratorium began on December 8, 2003 and ended on June 8, 2005.

During this period of time, new physician-owned specialty hospitals, except those that were found to be in existence or under development as of November 18, 2003, were unable to take advantage of the whole hospital exception of the physician self-referral law.

In other words, these physician-owned specialty hospitals were prohibited from billing Medicare for services furnished to patients referred to the specialty hospital by a physician owner. It is important to be clear that the moratorium did not prevent these hospitals from opening or from receiving a Medicare provider number.

It also did not prevent the physician-owned specialty hospitals from billing Medicare so long as the services were provided to patients other than those referred to the specialty hospital by its owners.

Now, although CMS did not have the regulatory authority to extend this moratorium, we took action after it expired to suspend the enrollment of all new specialty hospitals while we reviewed our enrollment procedures.

The Deficit Reduction Act built on this action by the agency. It continued our enrollment suspension until we developed the strategic and implementing plan you mentioned regarding physician investment in specialty hospitals, and I look forward to discussing that with you further.

In response to this mandate, we issued an interim report last week, as you referenced. The report described the legislative and administrative action taken to date regarding specialty hospitals. It outlined the data that the agency needs to address the investment issues, including the transparency you mentioned, as raised in the Deficit Reduction Act.

As part of the interim report, CMS is now surveying specialty and general acute care hospitals about physician investment interests and the provision of care to low-income and charity patients.

This survey will be used to develop the final report and the strategic plan that we will release later this year, and we look forward to your strong interest in this issue and your continued input in making sure that that strategic plan is implemented effectively.

We are also very interested in comments from others in the public on how we can promote the availability of accurate information and disclosure of physician investments in hospitals, and how we can support enforcement against improper investment.

Evaluating the propriety of financial investment goes beyond our usual mandate at CMS, and goes beyond our capacities to promote quality care and to pay appropriately for care provided to our beneficiaries.

Consequently, we are also assessing the extent to which the Office of the Inspector General and other Federal agencies, as well as State agencies, have authorities that can be supported by the information that we develop to prevent investments that are not bona fide or that have dubious rates of return. Again, we look forward to continuing to work with you closely as we finalize our strategic plan.

I want to thank you for this opportunity to discuss our efforts to improve quality of care in hospitals. I am very sorry about the oc-

casion that brings us together, but, again, if there is a silver lining here, it is that we can find better ways to use our limited resources to move forward with major reforms to our payment systems to improve quality and assure a level playing field.

As I have made clear today, these reforms should also include eliminating payments to hospitals for "never" events. I want to thank the committee for its attention to these crucial quality issues, and I welcome any questions that you have.

[The prepared statement of Dr. McClellan appears in the appendix.]

The CHAIRMAN. I will not go back through the dates about the moratorium, because I think they are well in your mind.

Dr. MCCLELLAN. Yes.

The CHAIRMAN. We heard testimony earlier about the death of a patient resulting from treatment at Physicians' Hospital. This hospital received its provider number in January 2005, right in the middle of the moratorium.

It is my understanding that CMS is collecting in excess of $500,000 in payments made by Medicare during the moratorium. Further, it has come to our attention that CMS is seeking in excess of $100,000 for Medicare payments from another moratorium violator.

According to your agency's own data, 43 new specialty hospitals have opened since the moratorium, 9 during the CMS administrative moratorium. Can you tell me why CMS did not enforce the moratorium, except in two instances after Congress pointed out the lack of enforcement?

Dr. MCCLELLAN. That is a very good question that goes to understanding exactly what was and was not included in the moratorium enacted by Congress and the Medicare Modernization Act.

That was a moratorium on the so-called "whole hospital exception" under the Stark referral law. What that means is, specialty hospitals that had not opened before November 18, 2003 were not able to bill for patients who had been referred to those hospitals by a physician owner.

It was not a prohibition on opening. It was not a prohibition on getting a Medicare provider number. It was not even a prohibition on billing Medicare at all. But it was a prohibition, a moratorium, on billing for patients who had been referred by the owners of the hospital.

So, because we take our enforcement of this moratorium seriously, and we know this is extremely important to you, we have gone back and looked carefully at the billing that has occurred to Medicare by physician-owned hospitals during this time period.

We have investigated, as you said, and found two hospitals, including this one in Oregon, that were billing improperly for patients who had been referred by the physician owners. So we are collecting that money back.

That is the way our billing systems work, as you know. We conduct fraud and program integrity protections by reviewing the billing information that comes in.

So, we have been collecting that money from the hospitals that billed improperly, and we are continuing to look closely at whether there were any other improper billings. As you mentioned, the hos-

pital included here had significant billings, half a million dollars, over the first half of 2005.

The CHAIRMAN. Then could you tell me, why did you choose to enforce the administrative moratorium more stringently than the Congressionally passed moratorium?

Dr. MCCLELLAN. Well, we believe that there do need to be a number of important changes related to payment, oversight, and disclosure for specialty hospitals, and that is reflected in the interim report that we issued earlier this month. It is also reflected in my prior testimony on this issue, and the testimony of other members of my staff at CMS.

The moratorium that we imposed was on issuing new provider numbers. We did not have the statutory authority to discontinue an exception to the Stark law. That is something that is set in statute. That whole hospital exception is a feature of the statute and is not something we can change administratively.

But we felt we did have the authority to suspend new enrollments in the Medicare program of new specialty hospitals, and that is what we did last year. That moratorium on new enrollments is continuing, in effect, right now until we finish this specialty hospital strategic plan.

The CHAIRMAN. Yes.

Dr. McClellan, as you mentioned, the Deficit Reduction Act included a requirement that CMS issue a strategic and implementing plan for specialty hospitals. When Congress included this provision, we discussed that this strategic plan would be more than a report.

You gave me your personal guarantee that this would include meaningful disclosure requirements for physician investors in specialty hospitals, as well as enforced prohibitions on shaky backdoor investment deals in specialty hospitals.

You just testified, I believe, that you would proceed with more than just mere disclosure requirements. Will you publicly reaffirm that guarantee that you made to me, that this strategic plan will be more than another report and require more than just disclosures, and also include enforcement against improper investments?

Dr. MCCLELLAN. Well, we definitely intend for this report to be more than just another paper that gathers dust on a shelf. It is already including the most fundamental reforms in Medicare's payment mechanisms for hospitals in more than 20 years to get at this issue of some patients just being inherently too profitable under our current payment mechanisms.

It includes new requirements on specialty hospitals under the so-called EMTALA law, and right now we are conducting a major survey of financial investments by physician owners in these hospitals.

We intend to use that information, as I mentioned in my testimony, and share it with the Office of Inspector General and other State and Federal regulatory agencies that have oversight ability for improper investments, for kickbacks and other investments that should not take place in our health care system.

We are going to help provide them with the information they need to enforce those investments properly, so that means we are going to be going beyond just issuing a report. We are going to be taking some important steps to get to more disclosure of relevant

information so that we can help prevent any improper investments in hospitals.

The CHAIRMAN. And then you would enforce against the improper investment?

Dr. MCCLELLAN. Well, we use the enforcement authority that we have under the law. As you know, there are two kinds of statutory authorities that I think are relevant here. One is our authority under the whole hospital exception, the Stark law, to enforce restrictions against improper referral.

So if a physician owner makes a referral that is not accepted under the Stark law, then we are able to recoup those payments, as we are doing in the case of certain specialty hospitals, and make sure that Medicare payments do not go to physicians who are referring patients to their own facilities improperly.

But the other relevant law here is the anti-kickback law that is enforced by the Office of Inspector General, and that law is designed to prevent improper investments to help promote bona fide investments and prevent excessive rates of return, again, for financial gain. So we will be working with the OIG to make sure that those provisions are enforced effectively.

The CHAIRMAN. I think you are telling me what I want to hear, but I want to——

Dr. MCCLELLAN. Well, I am trying to. It is a little bit complicated.

The CHAIRMAN. Between the two approaches, you are telling me that what we have talked about, that we will have enforcement one way or the other against improper investments.

Dr. MCCLELLAN. And that we will need to work with the Office of Inspector General. I know you worked closely with that office and have an excellent relationship with them as well. We will need to work with them because their office, and other Federal and State agencies, have the enforcement authority for kickbacks and related improper investments.

The CHAIRMAN. While Senator Baucus is asking his questions, I will find out if that is enough of an answer for me.

Dr. MCCLELLAN. All right.

Senator BAUCUS. Thank you, Mr. Chairman.

Is it true, Dr. McClellan, that specialty hospitals care for healthier, more profitable patients compared with other hospitals?

Dr. MCCLELLAN. They do, according to a lot of the studies that have been performed, including one that we did.

Senator BAUCUS. Why do you suppose that is?

Dr. MCCLELLAN. Well, for a couple of reasons. Different hospitals specialize in different kinds of patients. There are not just specialty hospitals, but limited service, general hospitals, critical access hospitals in rural areas that do not have a full line of medical services for the most severely ill patients.

Senator BAUCUS. I am talking about in a metropolitan area. I am not talking about rural areas. I am talking about metropolitan areas with a lot of hospitals. Is it not true that specialty hospitals tend to get the healthier, more profitable patients?

Dr. MCCLELLAN. Well, I think what you are getting at is the other reason I was going to mention, and that is our payment systems, right now, pay better for certain kinds of patients.

Senator BAUCUS. All right.

Dr. MCCLELLAN. There are patients who are less severely ill who need elective procedures that tend to be lower cost. Right now, our reimbursement system pays more for those kinds of patients.

Senator BAUCUS. How many general practitioner/family practitioner specialty hospitals are there, where that is all they do?

Dr. MCCLELLAN. Very few. The specialty hospitals do specialize.

Senator BAUCUS. And again, why do they specialize? It is money. Let us be honest about it. It is money. That is where the money is. What are the procedures generally at specialty hospitals that are compensated a lot more? What are they?

Dr. MCCLELLAN. Well, that is why we need to change our payment systems.

Senator BAUCUS. Tell me what they are. They are cardiac.

Dr. MCCLELLAN. Cardiac, orthopedic.

Senator BAUCUS. Orthopedic.

Dr. MCCLELLAN. Some specialize in other types of relatively minor general surgical procedures.

Senator BAUCUS. Because that is where the money is.

Dr. MCCLELLAN. That is where the money is.

Senator BAUCUS. It is kind of like Willy Sutton.

Dr. MCCLELLAN. Yes. I agree completely with that, so I am not disagreeing with you. I would just also add that there are other facilities that are not specialty hospitals that also specialize or expand into other kinds of services.

Senator BAUCUS. But for other reasons. Not to get money, but for other reasons. You mentioned critical access. Let us be honest here. Please be straight with me on this. You mentioned critical access. That is irrelevant to the question we are addressing here. You are going to find no specialty hospitals out in Circle, MT.

Dr. MCCLELLAN. Right. There are none.

Senator BAUCUS. Those are critical access, a different kind of provider.

Dr. MCCLELLAN. Getting back to urban areas——

Senator BAUCUS. Let us get back to big, urban areas.

Dr. MCCLELLAN [continuing]. There are, in addition to specialty hospitals that have increased service for certain kinds of patients, general hospitals that have built new wings that specialize in the same kinds of patients. They have increased their capacity for the same types of specialized services.

I do think that there is a financial problem here and that we are paying too much for these kinds of patients, and that is why we have to reform our payment system.

Senator BAUCUS. So what are you going to do about that? How much are you going to knock down DRG payments to these specialists? What percentage, roughly?

Dr. MCCLELLAN. In the inpatient rule that we announced, I believe the reduction for some of the types of specialty hospitals is on the order of 11 percent, so that is a big difference in payments. According to MedPAC, these steps would make a huge difference in getting rid of the over-payments that now exist for certain kinds of patients.

Senator BAUCUS. And what do you think the over-payment rate is today?

Dr. MCCLELLAN. According to MedPAC, I think their estimates were in the 9 percent range. So we are aiming to get at most, if not all, of this differential between payments that we are making and the cost of caring for the patients.

Senator BAUCUS. But that is not going to address the separate problem here, and that is self-referral. You can get the rates down all even-Steven, but then you have the self-referral problem. That is, where there is a financial interest to refer to me because I get paid more if you do it in my facility.

Dr. MCCLELLAN. That is right. The Stark law, as you know, the self-referral law, puts a lot of restrictions on how physicians can refer patients for services that they own.

Senator BAUCUS. That is correct.

Dr. MCCLELLAN. But there is a whole hospital exception built into the law.

Senator BAUCUS. I am just talking about policy for a moment. We have self-referrals to labs that are banned. Is that not correct?

Dr. MCCLELLAN. Right. That is correct.

Senator BAUCUS. And what other medical services are there with self-referral?

Dr. MCCLELLAN. Imaging procedures. Restrictions exist for imaging procedures.

Senator BAUCUS. Imaging is another one. What else?

Dr. MCCLELLAN. Well, one of the major cases that is allowed is the whole hospital exception. Most other types of physician self-referral are restricted under the law.

Senator BAUCUS. But if there are restrictions on self-referral there, why should there not be restrictions on self-referral with respect to specialty hospitals? Just as a matter of policy, what is different?

Dr. MCCLELLAN. Well, I believe the policy intent is, because the investment is in a whole hospital, a whole set of procedure services for patients, there is not the same kind of narrow, direct ties that there would be with an imaging machine or——

Senator BAUCUS. I am talking about specialty hospitals, like Physicians'.

Dr. MCCLELLAN. Right. I think that is what I am talking about as well. The investment is in the whole facility. I think many of the physician owners would argue that, because they are involved in decisions about the management of the hospital rather than—I have talked to a lot of these physicians myself.

They do not like what they call the "suits" in hospital management. They think that physicians should be in charge of making decisions about what is best for the hospital, what types of activities the hospital should engage in to serve patients the best. They would rather have physicians involved in management decisions than non-physicians who are focused more on finances.

Senator BAUCUS. You are not answering my question.

Dr. MCCLELLAN. I am trying to.

Senator BAUCUS. I know, but you are trying to in a certain little very clever way. I am not asking you what physicians want. I am asking you, what is good public policy?

Dr. MCCLELLAN. And I think that is the argument. Look, right now for general hospitals there is a disconnect. We pay physicians

in one way, we pay the hospitals another way. There are a lot of good reasons for that.

On the other hand, it can get in the way of the managers in a hospital working, as well as possible, aligning as well as possible, with the physicians to promote quality care and avoid unnecessary costs.

Now, we do not have a health care system that does that today. There are a lot of good ideas, I think, and you will hear some on the next panel, how hospitals might be better able to support physicians to deliver quality care more effectively if we had better payment systems there as well. But that is why we need the kinds of reforms in our payment system that I have just been talking about.

Senator BAUCUS. To be honest, I think the reforms in the payment system that you are talking about are within the context totally in the current system. They do not get at what you just mentioned, where doctors can be involved. It is a whole zero-sum game, kind of a holistic sense of health care in the institution. That is a whole different thing.

Dr. MCCLELLAN. It is, but with the steps that we are taking right now because of, frankly, your leadership and Chairman Grassley's, we are much closer than ever before.

You all had a landmark piece of legislation last year on paying for better performance in health care generally, including in hospitals, where hospitals and the doctors would get paid more when patients have better outcomes and when overall costs of care are lower.

That is what we ought to be aiming for. And you are right that we are in a payment system right now that is a long way from there, but we have made a lot of progress, and I think we should keep making more.

Senator BAUCUS. My time is about to expire, but I have one more question, if I might.

The CHAIRMAN. Yes.

Senator BAUCUS. That is, you administratively extended the moratorium, and then Congress came along and said, yes, that is the right thing to do.

Now, what was your authority to administratively extend that moratorium?

Dr. MCCLELLAN. We have the authority to determine circumstances under which Medicare issues Medicare provider numbers for participation in the program. We have regulatory authority there to determine some aspects, at least, of what constitutes an appropriate provider in the Medicare program.

We believe that we needed to review our Medicare provider enrollment process in light of further developments in the hospital industry, and this is including some of these developments related to specialty hospitals. So, that is the authority that we use.

Senator BAUCUS. Will you have the same authority on August 10?

Dr. MCCLELLAN. Well, a lot of the reason for our moratorium on issuing enrollment numbers was because we wanted to review whether our definition of a hospital was keeping up with the care that should be provided in hospitals today, because many specialty hospitals, for example, offer a lot of outpatient care as well.

Part of the question was whether a better definition of a hospital might limit enrollment as an inpatient hospital for certain kinds of facilities. We have looked at that a lot since then.

There does not seem to be an easy definition based on something like percentage of inpatient services, so we have reached some conclusions about whether or not our enrollment rules are appropriate, and I do not think that is something we can continue indefinitely. It depends on whether there are any very important unresolved issues about whether our current Medicare enrollment rules are adequate.

Senator BAUCUS. So what is the answer?

Dr. MCCLELLAN. So I do not think the same kind of reasons——

Senator BAUCUS. I did not ask that.

Dr. MCCLELLAN. No, I do not think so, not past August.

Senator BAUCUS. You feel, even though you had the prior authority on your own administratively, are you telling this committee now that when the legislatively mandated authority expires on, what is it, August 8, 9, something like that, you are telling me that although you had the administrative power before, that you do not have the administrative power?

Dr. MCCLELLAN. Senator, the reason we used that administrative power before is, we had some unanswered questions about the adequacy of our definition.

Senator BAUCUS. If I might ask, what are the questions and what are the answers?

Dr. MCCLELLAN. The question was, is our definition of a hospital appropriate given some of the recent trends in the hospital industry? So we looked at whether we should change that definition to exclude hospitals, for example, that had below a certain percentage of inpatient services.

On looking more closely, there are many hospitals, including some in the rural areas, including some in urban areas, that specialize in certain types of care, much of which is delivered on an outpatient basis today.

We did not see a way of changing our definition that would not also have excluded many general hospitals or many hospitals in rural areas that we think are providing legitimate and effective services. So, I do not think we can extend the same thing.

Senator BAUCUS. I am asking you to revisit that question, to keep an open mind.

Dr. MCCLELLAN. All right.

Senator BAUCUS. And I am asking you just that.

Dr. MCCLELLAN. I will keep in touch with you about that.

Senator BAUCUS. Keep revisiting that question. I am quite disappointed for you to summarily say you do not have the power now, but you had then. I just ask you to keep looking at that.

Dr. MCCLELLAN. I will do so. We will keep talking with you about that.

Senator BAUCUS. And not have a closed mind about that.

Dr. MCCLELLAN. All right.

Senator BAUCUS. Because you are going to hear from us.

Dr. MCCLELLAN. I know I will. [Laughter.]

Senator BAUCUS. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Yes. Thank you, Senator Baucus.

I have just a couple of questions to finish up here. One of them is a carry-on where I left off with you. Nothing you said is inaccurate, but I want to kind of clarify a couple of things in regard, first of all, to what you said about working with the Office of Inspector General.

So, referring violations to the OIG for enforcement of criminal violations of the anti-kickback statute is good, but there is a very high standard in criminal violation, and it is a big challenge to take action under the anti-kickback statute. So, that is the criminal aspect of it.

Now, you have civil enforcement authority at CMS, and your commitment to me was civil enforcement by CMS. Are you committed to that?

Dr. MCCLELLAN. Well, we absolutely want to use the civil enforcement authorities we have. I believe those civil enforcement authorities are under the Stark rule, which goes to payments for patients who are referred by physician owners, not in the same way the OIG has enforcement authority. But I would be delighted to work more closely with you on examining just how far we can take our authorities.

The CHAIRMAN. You have general civil enforcement authority, and that was the authority used for the moratorium that Senator Baucus was talking about, why you cannot continue that.

So we are asking you, within the same realm of authority that you had to do that, to make sure that we have civil enforcement against improper investments.

Dr. MCCLELLAN. I would need to talk with you further about how that civil authority would work toward improper investments. It certainly works towards violations of the Stark rule, so that is exactly the authority that we are using to recapture these payments that went out to this hospital in Oregon that we are in the process of terminating, and that has happened improperly in at least one other instance.

So, we are definitely using our civil authorities there, and we will use them to the maximum extent. I would be happy to discuss with you and your staff further how we can continue to do so.

The CHAIRMAN. Well, then I think I read you as saying, in principle, you are willing to work with us and make it work so that we can have, without a doubt, enforcement against improper investment.

Dr. MCCLELLAN. Well, I know how important this issue is to you. We are, as you know, in the process of gathering a lot of information right now on the kinds of investments that are occurring in specialty hospitals.

That, and further discussion with the OIG and other State and Federal agencies, we hope, by working with you, can lead to a very effective and comprehensive approach to these investment issues.

The CHAIRMAN. Then my last question is an understanding that CMS, MedPAC, and the Government Accountability Office found that physician-owned limited service hospitals provide a lower percentage of care to Medicaid patients, or poor people generally.

For instance, USMD Hospital in Texas, the hospital that Dr. John House, one of our witnesses on the next panel, represents,

has less than 1 percent of its admissions coming from Medicaid. This is another form of patient selection. Fixing the Medicare payment system will not address that issue.

So the question is, is this not an indication that there are broader issues involving physician self-referral that should be addressed, issues that go beyond CMS's recommendations to date? What actions is CMS considering to address this issue?

Dr. MCCLELLAN. Well, we are doing, as part of that survey I mentioned, a review of the uncompensated care, and also Medicaid services provided by both specialty hospitals and general hospitals in the same areas.

There has been a fair amount of evidence developed on this already. I think while there are in many cases the circumstances that you describe of limited use of Medicaid in some of the specialty hospitals, there definitely are exceptions to that.

Some specialty hospitals are providing more care to Medicaid patients, and specialty hospitals as a whole are providing a lot of contributions to the community in the form of tax revenues that local governments and State governments obtain from the specialty hospitals that they do not obtain from the general hospitals that have the nonprofit status exception.

In fact, in the study that we did last year, if you put the two together, uncompensated care and contributions through tax revenues, the specialty hospitals, on average, are putting in more money than the general hospitals.

So, this is an issue that we need to look at more closely, but I want to make sure we do it comprehensively and that is why we are gathering more information in a survey right now.

The CHAIRMAN. Well, then let me ask you, yes or no, whether or not you are basically then concerned about the referral of most of these Medicaid and poor people to general hospitals.

Dr. MCCLELLAN. I am concerned about that. That is one reason we are taking our action under the EMTALA rules, to make clear that if a specialty hospital can treat an unstable patient or a patient who needs services, regardless of their ability to pay, the specialty hospital needs to take them.

The CHAIRMAN. All right.

Did you have something else?

Senator BAUCUS. Just a couple questions, Mr. Chairman.

The CHAIRMAN. Go ahead.

Senator BAUCUS. Dr. McClellan, is it not true that the specialties we are talking about here are not whole hospitals, and that therefore the whole hospital exception should not apply?

Dr. MCCLELLAN. Well, we have looked very closely at this definition of a hospital. We have just been around the block on this right now.

Senator BAUCUS. No, no, no. Let us be honest. We are generally talking about specialties, the nature of Physicians'. When people talk about the whole hospital exception, that is a larger hospital owned by physicians.

The rationale is, the physicians have the entire facility and lots of different procedures are performed, and it is all diluted—that is the argument—and so that is different, that is "all right." I have

a question about that, personally, but I am just giving you the rationale.

Whereas, the specialties, it is like, four or five beds, or six beds, or a wing of a hospital. That is what we are talking about, generally, when we are talking about specialties. Is there not a difference in referral to a whole hospital compared with referral to an orthopedics hospital or a cardiac-only hospital?

Dr. MCCLELLAN. There are a broad range of facilities out there now delivering health services, and some of this diversity is unquestionably good. We are seeing more specialization, more localized care for many patients. You do not have to go 20 miles downtown to a major teaching center to get the care that you need.

Now, some of these facilities are clearly not inpatient hospitals, and we have recently turned down a number that sound just like what you described, a facility that is operating a 25-bed emergency ward, plus two inpatient beds. We turn that down and say that does not meet what we view as a definition of a hospital.

But I think there are some legitimate hospitals, specialty or otherwise, that focus on certain kinds of patients that deliver inpatient and outpatient care together, maybe deliver mostly outpatient care, but that still are providing valuable hospital services.

Senator BAUCUS. How much outpatient care is provided at Physicians' Hospital?

Dr. MCCLELLAN. Off the top of my head, I do not know. I expect a large part of the care that they delivered was outpatient care. They had a medical ward and a surgical ward, but they do have a lot of outpatient care, too.

Senator BAUCUS. I was trying to get at, they are small organizations that serve the wealthier, the healthier, and therefore the more profitable, where physicians not only provide some service, but also to make a buck, more than they otherwise would make as physicians. That is what I am focusing on.

Dr. MCCLELLAN. Right.

Senator BAUCUS. And I think there is way too much self-referral. It is going to be almost impossible to guard against. That is why we have self-referral prohibitions for imaging, lab, and so forth. Even with all the disclosure and so forth in the Congress, the country has decided that is not a good thing to do.

So I am asking, why is it not also good public policy with respect to the smaller kinds of specialties we are talking about today represented by physicians?

Dr. MCCLELLAN. Well, again, I do think some specialization is good in 2006, in modern medicine.

Senator BAUCUS. You are not answering my question. That is not the question I asked. I am not talking about "some" are. I did not ask about "some." I am asking about these.

Dr. MCCLELLAN. Well, I think if we change our payment system so that the patients who currently are profitable under the mechanism that Medicare uses to pay, because of the way we pay, if we are paying a lot more than it costs to treat a patient, that is just wrong. We need to change that. That is why we are implementing these major reforms in our payment system.

Senator BAUCUS. If these doctors get two fees, are reimbursed twice, one for the procedure—and is there not something else? I

forgot what the phrase is. Some kind of transaction fee. There is a certain separate amount that physicians who own specialties get in addition to performing the services.

Dr. MCCLELLAN. Well, they get the usual Medicare payments for their surgical services.

Senator BAUCUS. Right. Right.

Dr. MCCLELLAN. And they will get the payment, their share, their revenues from the payments to the hospital in which they are a part owner. That is the ownership piece.

Senator BAUCUS. There is no other Medicare payment?

Dr. MCCLELLAN. Our payments in traditional Medicare are fee-for-service based.

Senator BAUCUS. What are facility fees?

Dr. MCCLELLAN. Facility fees? I do not think we have a separate category of facility payments to physicians. We make payments to the provider. We will make a payment to the hospital for the hospital admission and we will make a payment to the surgeon for the delivery of the surgical service, sort of a global fee for performing the surgery and any of the peri-operative care.

Senator BAUCUS. Say if this procedure were at Adventist Hospital. Would the same exact fees be paid to that hospital?

Dr. MCCLELLAN. Well, maybe this is what you are getting at. If a service is not performed in a hospital, the payment rate may be different. There may be a technical component that we include with the physician fee that covers the cost of the ambulatory center or the place where they are delivering the service.

I am sorry if I am not getting at what you want to know, but I would be happy to follow up with your staff afterwards on the total payment.

Senator BAUCUS. Well, the lady behind you is giving me information by nodding her head. The answer to my question is that, no, there is no difference, according to her, if that is accurate.

Dr. MCCLELLAN. All right. All right. That makes sense to me.

Senator BAUCUS. All right. Thank you. [Laughter.] Well, it is the answer that you would like her to give, that is right. Exactly. My time has expired.

My basic point is this. We are the hired hands. I work for people, the public. You work for the public. It sounds corny, but it is true. We are supposed to do the right thing. That is what it comes down to.

We can parse this thing all kinds of ways. We hear all kinds of people, special pleaders, coming in saying, you have to do this, you have to do that, and they have all kinds of rationalizations why they should be paid this, paid that, and so forth, and we have to be fair, clearly.

But our default should be what is right for the people we serve. That is the default. That is the bias we should have. I would just encourage you, when you are thinking through all this and you are getting all the pressures on you, just remember the people we serve. That is all it comes down to. It is not all the economic interests, but it is the people. So, please, I know you will do the right thing. Thank you.

Dr. MCCLELLAN. Thank you.

The CHAIRMAN. Yes. Well, you have always been very cooperative with our committee, and thank you for your cooperation today. We will be in touch. This is an ongoing issue.

Dr. MCCLELLAN. It is.

The CHAIRMAN. We will talk to you.

Dr. MCCLELLAN. I will look forward to that. Thank you.

The CHAIRMAN. Our next panel is Ms. Cindy Morrison, vice president of public policy, Sioux Valley Hospital, Sioux Falls, SD; Dan Mulholland, attorney at Horty, Springer & Mattern, a law firm based in Pittsburgh; Dr. John House, urologic surgeon and founder of USMD, a company that helps physicians develop specialty hospitals; and Dr. James Cobey, an orthopedic surgeon who practices at Washington Hospital Center in Washington, DC.

I am going to have you testify in the order I stated. If you folks have a longer statement than the 5 minutes we gave you to summarize, the longer statement will be printed in the record. So, we would ask you to stay within your 5 minutes so Senator Baucus and I could have time to ask questions.

We are going to go in the order you were introduced, so we will start with Ms. Morrison.

STATEMENT OF CINDY MORRISON, VICE PRESIDENT, SIOUX VALLEY HOSPITAL, SIOUX FALLS, SD

Ms. MORRISON. Thank you, Mr. Chairman. My name is Cindy Morrison, and I am vice president of public policy at Sioux Valley Health System in South Dakota. We are an integrated system with 24 hospitals and 300 physicians located in South Dakota, Iowa, Nebraska, and Minnesota.

South Dakota has a population of only 750,000, and we have eight physician-owned specialty hospitals. I am here today on behalf of a grassroots coalition of community hospitals which was formed to raise awareness of the problems like those faced by Helen Wilson and her family, problems associated with physician self-referral.

The coalition has over 100 hospitals located in 20 States. Many of these hospitals have been impacted by physician-owned facilities.

My testimony today will focus on three key points. The first is physician self-referral. There is no greater market force in health care than the ability of physicians to admit patients to hospitals. This market force cannot be competed with and can, in effect, eliminate the patients' free market choice when physician owners direct patients to hospitals they own.

Second, community hospitals have been negatively impacted by the entrance of physician-owned specialty hospitals in several ways, including weakened financial condition, ER crises, and recruitment challenges, to name a few.

Third, payment changes alone will not address physician self-referral problems because of the physicians' unique ability to react to payment changes that community hospitals simply cannot do. Physicians alone are the only persons with the authority to admit a patient to a hospital.

This unique responsibility is placed solely with the physician and puts the physician owners of specialty hospitals in a position to

self-refer patients away from community hospitals to be admitted to specialty hospitals they own.

Because community hospitals cannot admit patients, the hospital is at a tremendous competitive disadvantage. Community hospitals simply cannot compete with the power of a physician's admitting privileges. In effect, the community hospital is dealing with a competitor that is also in control of its business.

Community hospitals of all types and sizes have been impacted: urban and rural hospitals, nonprofit, and for-profit hospitals. Typically, physician owners come from the community hospital setting, and once their facility is built and opened, the community hospital is essentially drained of its profitable services.

In Ruston, LA, 65 percent of the community hospital's active medical staff became investors in a physician-owned specialty hospital. Once financially healthy, Lincoln General Hospital, the community hospital, lost $8 million in operating margin in just one fiscal year after the emergence of Green Clinic Specialty Hospital.

That is $8 million that could have been reinvested back into the community, spent on disaster preparedness, emergency room improvements, and other community health care needs.

In Rapid City, SD, the community hospital was unable to maintain emergency room neurosurgery coverage when the neurosurgeon owners built a specialty hospital and abandoned taking ER calls.

As a result, patients were transported hundreds of miles away when gaps in neurosurgery coverage occurred. This situation created disturbing consequences for patients and families.

While others have asserted that there has been no impact on community hospitals, that is simply not true. Financial challenges, recruitment problems, staffing issues, and a whole host of other challenges have impacted community hospitals in markets where physician-owned specialty hospitals have emerged.

Although inpatient payment changes have been recommended that would remove some of the financial incentives associated with physician-owned specialty hospitals, coding and payment changes alone will not address self-referral.

In publicly reported documents, the before-tax margins of two specialty hospitals in South Dakota are 49.4 percent and 45.6 percent, respectively. Looking at cost report data, the proposed payment reductions to these two physician-owned facilities would be minimal, at a 2- to 3-percent reduction.

Physician owners could also compensate for lower procedure payments by recommending the patient undergo more outpatient procedures and ancillary tests that are paid separately from the procedure.

Further, only physicians have the ability to react to payment changes that others do not because of their singular and unique role in prescribing treatment. Physicians are the gatekeepers to health care services. Only they have the ability to admit patients to hospitals, prescribe treatment, and to order services.

Physician-owned facilities, by themselves, are not the problem. The problem lies in physician self-referral practices that create conflicts of interest, with disturbing results for patients, families, and community hospitals.

I would be happy to answer any questions.

The CHAIRMAN. Thank you, Ms. Morrison.

[The prepared statement of Ms. Morrison appears in the appendix.]

The CHAIRMAN. Mr. Mulholland?

STATEMENT OF DAN MULHOLLAND, HORTY, SPRINGER & MATTERN, P.C., PITTSBURGH, PA

Mr. MULHOLLAND. Thank you, Mr. Chairman and Senator Baucus. It is a pleasure to be here today. My name is Dan Mulholland. I am an attorney from Pittsburgh, PA with the law firm of Horty, Springer & Mattern.

Our firm practices exclusively in the area of health care law. We represent hospitals and health care systems around the country. I routinely provide advice to them about financial relationships with physicians, other relationships with physicians, and also represent them in litigation when those relationships break down.

Based on my experience in the health care field for about 30 years, a number of things have come to my attention in terms of how specialty hospitals that are owned by physicians operate and their impact on the health care system.

First of all, physician-owned hospitals run counter to the letter and the spirit of the fraud and abuse laws. Second, they raise serious ethical issues relative to the disclosure of ownership, or the lack thereof. Third, they have an unfair competitive advantage over their full-service community hospital—often nonprofit hospital—competitors.

It is important to understand how the relationship between hospitals and doctors has evolved and how the phenomenon of physician ownership of hospitals has had a negative impact on that relationship.

Most physicians are not employed by hospitals. They are simply granted medical staff appointment and clinical privileges to practice medicine at the hospital. They get to use the hospital's space, equipment, and personnel, and in return they provide services for the hospital in terms of covering the emergency room, providing peer review, and other services.

But the payment system has really driven a wedge between doctors and hospitals. Not only does the payment system permit, but it actually encourages, physicians to own hospitals, surgi-centers, and in-office ancillary equipment. That has created a lot of problems, not only the kind of tension that Ms. Morrison mentioned, but also some serious problems with respect to how the laws are implemented.

Now, it is important to understand that the anti-kickback statute and the physician self-referral law were initially designed to address this inherent conflict of interest when a doctor has an ownership interest in a hospital or any other facility, as were existing AMA ethical standards that would only suggest that physicians should have an ownership in a hospital or health care facility when there is a clear need in the community.

The whole hospital exception in the physician's self-referral law was initially intended only as a grandfather clause for physician-owned hospitals in small communities where access would be

threatened if they were shut down. It had nothing to do with the kind of operations that you now see with or without the moratorium.

It is fairly easy, based on the exceptions and the safe harbors that exist under these statutes, to design a structure for a specialty hospital that would either meet the requirements of the existing legislation or skirt around the edges of them.

We have seen a number of examples of this. Promoters of specialty hospitals make no bones about the fact that the reason that they are promoting physician ownership is to increase referrals and to get better financial return.

They are often structured in a way to make it easy for the doctors to come in. For instance, most of the financing in a lot of these hospitals is provided by debt rather than equity, so the doctors have little risk up front.

Then they are often given assistance by the promoters, sometimes actually a joint venture partner that is a hospital in the community, to come in and have an investment interest without having to provide any guarantees of the large amount of debt on the facility. There are also pre-determined buy-out arrangements.

Now, the OIG has said that this can raise some serious issues under the anti-kickback law. But during the moratorium and after it, some new hospitals that were clearly specialty hospitals tried to pretend that they were general hospitals, either to avoid the moratorium or to gain financing that might have been difficult to get because of the moratorium's effect and the possibility it would be extended.

Many others have been reluctant to reveal that physicians have an ownership interest, either to the public, but more importantly to the patients, which can result in the kind of tragic situation that Rev. Wilson described to the committee. This not only raises ethical issues, but creates an unfair competitive advantage for these hospitals over their community hospital competitors.

Community hospitals are ill-equipped to fight back because oftentimes these doctors are on the medical staff of the community hospital, and take advantage of that relationship by essentially having a free ride on the community hospital to the community hospital's detriment and to the advantage of their financial investment.

When physicians are called on this by community hospitals who raise a question about the possible conflict of interest, they will often accuse the community hospital of economic credentialing or some other pejorative term.

So to address this problem, I would strongly suggest that Congress consider repealing the whole hospital exception, or at least bring it back to its original intent to just ensure access in smaller communities.

Short of that, Congress should require full disclosure to the public and patients of ownership, and also allow hospitals to respond to the conflict of interest by physicians on the medical staff who compete with them.

Thank you very much. I will be glad to answer your questions as well.

The CHAIRMAN. Thank you.

[The prepared statement of Mr. Mulholland appears in the appendix.]

The CHAIRMAN. Now, Dr. House?

STATEMENT OF JOHN M. HOUSE, M.D., MANAGING PARTNER, UROLOGY ASSOCIATES OF NORTH TEXAS; AND CHAIRMAN OF THE BOARD, USMD HOSPITAL, REPRESENTING THE AMERICAN SURGICAL HOSPITAL ASSOCIATION, SIOUX FALLS, SD

Dr. HOUSE. Thank you, Mr. Chairman and members of the committee.

My name is John House. I am a practicing urologist from Irving, TX, and a member of the board of USMD Hospital in Arlington, TX. I am one of the many physician investors in that facility.

SMD is a member of the American Surgical Hospital Association, which represents physician-owned hospitals with specialized capabilities. I am testifying today on behalf of ASHA.

Let me begin by explaining one major reason why my colleagues and I developed our hospital. It is a simple story. Our urology group asked three hospitals to acquire new robotic technology to improve treatment for prostate cancer, a common disease and a major cause of cancer deaths among men.

This technology is a major advance in surgical care, allowing men who undergo radical surgery shorter hospital stays, fewer complications, and the ability to return to normal activities much faster.

We wanted to use this technology to further our mission of delivering world-class care to our patients. Those hospitals told us the technology was too expensive and they refused to obtain the equipment.

So my group went out and we bought the robot, spending over $1.2 million. Along with other physicians and Texas Health Resources, the largest not-for-profit in North Texas, we acquired a hospital.

Today, USMD Hospital has one of the world's finest centers for robotic surgery for the treatment of prostate cancer and the world's leading program for cryosurgery for the treatment of renal and prostate cancer, and provides excellent care in many other areas of medicine.

Physician ownership and initiative made possible this quantum leap in surgical quality.

We are all saddened by the death of Helen Wilson following surgery at Physicians' Hospital in Portland. Any unanticipated death in a hospital is tragic. Unfortunately, these deaths occur in hospitals almost every day.

In April, HealthGrades released its report, "Patient Safety in American Hospitals." According to this report, if all hospitals performed at the level of the top 15 percent, 280,000 fewer patient incidents and 44,000 fewer deaths among Medicare patients would have occurred, saving Medicare $2.45 billion in the years 2000 through 2004.

These facts, of course, in no way diminish the loss to Mrs. Wilson's family and her friends. However, the HealthGrades report

should serve as a wake-up call that a much greater focus on quality is needed.

When CMS looked at quality of care in specialty hospitals, it found it to be equal to, and often superior to, the care provided in general hospitals. An important reason for this is the level of nursing care we provide.

Simply adopting the average nurse-to-patient ratios found in specialty hospitals could significantly reduce errors and improve care. Regrettably, too many hospitals refuse to adopt this basic strategy, despite extensive research establishing the link between the number of nurses and patient outcomes. They choose to put profits before patients.

General hospitals come to Congress and complain that they cannot compete with physician-owned facilities, that we take away funds needed to meet their community obligations. Perhaps they should look more closely at how the money they have is spent.

For example, according to public records, Sioux Valley Hospital pays its administrator nearly $900,000 a year. This not-for-profit hospital employs many physicians and pays them very, very well. The hospital pays one cardiologist $1.8 million annually.

A number of other physicians are paid salaries in excess of $1 million. Just imagine how many uninsured individuals in South Dakota could have received care if the hospital were just a bit thriftier. This is an institution that does not need the protection of the Federal Government.

If you are concerned about potential conflicts of interest when physicians have an ownership interest in a hospital, perhaps you should look closely at the potential for conflict when the hospital owns the physicians and restricts their ability to refer patients to other facilities, as is the case in many general hospitals across this country.

The Federal Government has conducted numerous studies of physician-owned specialized hospitals. The net result is that there is no evidence that ASHA members are harming general hospitals financially. There is no evidence of over-utilization of services. It has been firmly established that our members provide high-quality medical care.

It has been shown that our physicians do not abandon the community, but continue to maintain privileges at local general hospitals. Our model is popular with other physicians who have no financial stake in the facility. These studies have rebutted virtually every allegation that opponents of specialty hospitals have made over the last 5 years.

Thank you. I would be pleased to answer any questions.

The CHAIRMAN. Thank you very much, Dr. House.

[The prepared statement of Dr. House appears in the appendix.]

The CHAIRMAN. Dr. Cobey?

STATEMENT OF JAMES COBEY, M.D.,
ORTHOPEDIC SURGEON, WASHINGTON, DC

Dr. COBEY. Thank you, Senator Grassley and Senator Baucus, for the chance to appear before this committee about an issue I have been worried a lot about for the last 30 years that I have been in practice. I practice at many hospitals in this city.

This is an issue of safety, specifically patient safety. In preparation for this testimony, I reviewed the case of Ms. Wilson and what happened, the respiratory arrest she had after surgery. The staff could not do CPR, or cardiopulmonary resuscitation.

No one was available to put an endotracheal tube in the patient or give Narcain, which would have solved the problem in a few seconds. The patient died from anoxic brain injury.

We should expect any hospital providing major elective surgery to have someone on the staff who can resuscitate a patient and maintain an airway, especially in an urban environmental system.

When I look at my practice, the concept of orthopedic surgeons owning hospitals for elective cases, I worry about the health care of patients in these settings where we need other medical specialties around. Though 95 percent of my patients and patients of my friends and colleagues have no problems, we must always be prepared for the unexpected emergency.

Let me give you some examples of my own. In the last 10 years, I have had three patients, after total knee or total hip replacement, develop acute abdominal obstruction and had to have emergency abdominal surgery within 12 to 18 hours to save their lives.

I remember clearly one situation, after a total knee replacement, the patient in the recovery room had no pulse in her foot, a rare injury. She had a plaque under the tourniquet which we used break off and clog the artery.

Within 20 minutes, we had a special vascular procedure, after doing an arteriogram, and we returned flow back to the artery. If we did not have a good vascular surgeon in-house to do that, she would have lost the leg in about 2 hours.

I have informally canvassed a number of my colleagues in the city, and we all agree there are real problems, especially in older patients over age 65, with vascular, urinary, and abdominal problems.

A few more examples. One of my colleagues a few years ago, during an excellent operation changing a total knee, cut the major vessel to the leg—nothing he did wrong. It was repaired by a vascular surgeon in the hospital within a half an hour. Again, she would have lost a leg.

Another of my colleagues had almost an identical operation happen about 2 weeks ago. These are good, competent surgeons, and unexpected things happen to patients who are older.

One could say that specialty hospitals should only do simple procedures and let the more difficult ones go to the community hospitals. That is not fair. Vascular compromise can happen to anybody in an unexpected way. Other specialists must be immediately available in-house for big procedures.

The urinary system. Often during a total hip, total knee, or back procedures, we put a catheter in before surgery. I have had five cases in the last 10 months where that could not be done because of totally unexpected strictures.

We were lucky to get a urologist in to put a catheter in or do supra-pubic or transabdominal catheterizations. If that could not have been done, we would have had to wake the patient up and send them elsewhere, which is not a benign procedure.

Besides the life- and limb-threatening medical needs of patients in major surgical procedures, I am worried about the financial viability of general hospitals. These have emergency rooms and end up caring for many patients with no insurance. The multiple specialty hospitals need the revenues submitted from elective surgery to survive to give care to the general community.

There is concern that most of these specialty hospitals take far fewer Medicaid patients. According to a recent article in the *New England Journal of Medicine,* since 1990 the number of U.S. specialty hospitals that are owned by physicians has tripled to over 100. Physicians are attracted for two reasons: to control the hospital setting and for income.

MedPAC has found, again, that generally these hospitals do not take serious patients, and many hospitals have an average of only 16 beds. If you have a 16-bed specialty hospital, there is no way you can afford to keep multiple specialties there. You cannot keep vascular surgeons in-house. You cannot get high-tech radiologists in-house to do angiograms. It is too small of a hospital to do that kind of work. The sicker patients, therefore, end up in the community hospitals.

I have personally served on the board of a community hospital for over 9 years. I know that hospitals cannot survive with Medicare and Medicaid alone. It is unfair of specialty hospitals to discriminate against Medicaid patients to the detriment of community hospitals that are struggling to pay off their debt. So the major hospitals in the city run an excess of 1.5 percent—a 1-percent operating margin. It is amazing they can survive at all.

In conclusion, all hospitals must be able to take care of the unexpected any time. They cannot let dollars get ahead of patient safety and quality of issues.

Thank you.

The CHAIRMAN. Thank you.

[The prepared statement of Dr. Cobey appears in the appendix.]

The CHAIRMAN. Ms. Morrison, the Government Accountability Office released a report I have referred to on the effect of physician-owned hospitals on community hospitals. The report did not find that general hospitals made more competitive changes in response to specialty hospitals entering the market.

The Government Accountability Office also found no statistical difference in terms of clinical or operational changes. Your testimony, however, provides specific examples of changes made because of specialty hospitals.

Would you comment on the GAO survey and its findings?

Ms. MORRISON. Yes. Sioux Valley, along with a number of our coalition hospitals, received that survey and responded to it. The survey itself was very general and it did not probe deep enough to undercover circumstances like those mentioned in my testimony.

It also appeared that the results of the GAO survey contradicted some of Medicare's findings that were just released last month. A couple of those examples would be that heart hospitals do divert patients away from community hospitals. Also, community hospitals have higher Medicaid populations and community hospitals have lower margins.

The CHAIRMAN. Thank you.

Mr. Mulholland, CMS stated in its interim report that, outside the whole hospital exception to self-referral law, there is no additional restriction in the self-referral statute or regulations regarding legality of physician investment.

However, in CMS's own regulation implementing the self-referral law, CMS also recognized that physician ownership of hospitals, particularly specialty hospitals, could complicate the anti-kickback statute.

CMS, in its final rule issued March, 2004, clearly saw the nexus between the two laws. But today CMS tells us that the investigation and prosecution under these laws are beyond mandates and someone else's concerns, and that is the discussion I had with Dr. McClellan about the role played by the Office of Inspector General.

A question. Why is the government looking at physician investment in two different silos? What is the real connection between the anti-kickback statute and the self-referral law, and why is the government only using the one to enforce those arrangements?

Mr. MULHOLLAND. Well, I, of course, cannot speak for the government, but I can speak to my opinion as to how those two laws intersect with one another.

Whenever you are looking at a financial relationship between a doctor and a hospital, ownership, employment, whatever, you start with the physician self-referral law, because unless you can fit within an exception, then the doctor is prohibited from referring patients to the hospital.

But you also have to look at the anti-kickback statute, because as CMS recognized in the preamble to the March, 2004 regulations under the referral law, the kickback law could still apply to physician ownership in hospitals, especially if the physician ownership in the equity that the doctors had invested was nominal or the equity investment was merely a way of directing a lot of revenue to the doctors for relatively little up-front investment.

The Office of Inspector General recognized that last year, in its compliance guidance for hospitals that came out in January, where they said there are a number of things that they would look at in any kind of joint venture, whether it is a hospital, a surgi-center, a diagnostic treatment center, which is whether or not the doctors have a bona fide investment, whether or not there is disproportionate return on investment.

So these issues have been around for a while, and I think that both CMS and the Office of Inspector General would do well to coordinate, as I am sure they do, in terms of their enforcement policy and in terms of how they would view these hospitals before they are allowed to participate in the Medicare program.

The CHAIRMAN. Thank you.

Dr. House, MedPAC recently issued an update to its last report on specialty hospitals. That report found that, compared to general hospitals, specialty hospitals, on average, had a shorter length of stay.

However, the report also found that these same surgical hospitals had costs that were significantly higher than general hospitals. How do you reconcile the difference?

Dr. HOUSE. I cannot reconcile the difference. I can only speak to our particular hospital. We were part of the contractual arrange-

ments with a big not-for-profit and we chose to go out and get contracts on our own, and we took a significant reduction in per-payment contracts with the insurance companies.

So in our particular hospital, what we have found is that we have had to cut costs significantly to make up for those costs. Now, how do we do that? This is an example of why physician ownership of hospitals can have a very positive impact on the payment system.

We had a neurosurgeon who was part of our board. At our monthly board meetings, we looked at our expense lines. Our neurosurgeon said, what is this expense here? We said, well, that is the expense for the implants that you are putting in.

He said, well, how much are they? The administrator said, they are around $5,000 apiece. He said, $5,000 apiece for that? That is ridiculous. Mind you, this is a neurosurgeon who has been in practice for probably 20 years in a community hospital and has really never known what the cost of these implants were.

So what happened is the neurosurgeons all got together and they went to the vendors and said, look, the quality difference between all of these implants is negligible. We want the lowest price. We subsequently cut the cost of our implants by approximately 50 percent. The surgeons did not trade off quality, but we certainly reduced the costs significantly.

Ultimately, the physician is going to be in charge and the physician is actually going to have to be with the patient if there is a complication, so he has to make that choice of cost versus outcome, and is in a better position to do that—reduce costs and still maintain outcomes—because he is ultimately liable and responsible for the patient care.

The CHAIRMAN. All right.

Dr. Cobey, my last question for this panel is for you. Your testimony provided some insight into the potential dangers of limited service facilities. Oftentimes, procedures performed at these facilities are complex, highly specialized, and invasive. Given the complexity of these procedures, do you believe that safe care can be provided to patients at specialty hospitals?

Let me follow up at the same time. Keeping in mind that there are many rural critical access centers without the ability to have a physician on hand 24 hours a day, in your opinion should all hospitals conducting invasive procedures be required to have a physician on hand following a complex procedure?

Dr. COBEY. In terms of, can specialty hospitals safely function, they do in terms of pediatric orthopedic hospitals. There is a network around the country of pediatric orthopedic hospitals that do excellent work. Mainly, children do better than older adults with complications, and they are well prepared for problems.

In terms of having a doctor on staff, in every rural hospital you cannot afford it, but you must have somebody there 24 hours a day who can resuscitate a patient. It can be a nurse, it can be a respiratory therapist, or a physician's assistant.

You must have somebody who can resuscitate, be qualified in resuscitation, somebody who is trained by an anesthesiologist, possibly. Otherwise, you should not have the doors open.

The CHAIRMAN. Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

Dr. House, I am just trying to explore why doctors want to form these specialty hospitals, what is really going on here.

You mentioned in your testimony that you tried to get certain equipment in your area, you went to the community hospitals and they did not provide it, and so on, and so forth. So one reason, is to get the best, latest available equipment. I assume that is one reason why doctors do this.

Dr. HOUSE. Yes, sir.

Senator BAUCUS. Are there other reasons? What I am getting at is, obviously, compensation. That is, to what degree is it that, generally, doctor's frustrations that not only is it difficult with community hospitals to get the right equipment, but also compensation and remuneration are just going south in the physician community, whether it is medical malpractice premiums or whether it is inadequate Medicare reimbursement, or whatever it is? Why do doctors want to form these arrangements?

Dr. HOUSE. I think you hit on it right away. A lot of it is frustration. We spend a lot of money on health care in this country, $2 trillion, per capita more than any place in the entire world. Physicians, as far as physician reimbursement for their fees, is only about 15 percent of that.

So, we really own and control only about 15 percent of the health care system, but we are ultimately responsible and liable for the outcomes that the patients have. In the hospitals that most of us work in, we are still liable and responsible, but we do not have any control. You can only have control through ownership.

You can be on committees, but when you are in control and you are in charge, you can make changes. If I go up to the floor and a nurse is not doing the proper thing, I can go directly to that administrator and say, this needs to change. We need to have something changed, and changed now. I do not have to go through a bunch of committees. I do not have to go through all the typical hospital bureaucracy. We can make the changes.

This frustration that we feel—and I know the hospitals are under a lot of payment pressures as well and they have a lot of different decisions to make in trying to figure out where to allocate their resources—but when we are the ones who are liable and responsible for the care of the patient and we really do not have any control over that, where most of our health care is actually delivered in our hospital, then it becomes very frustrating. What is happening is the physicians are going out and saying, you know, we have to change this.

Senator BAUCUS. All right. As I hear you, the frustration is essentially inadequate community hospital response to health care needs. That is basically what I hear you saying.

Dr. HOUSE. I think that is a lot of it.

Senator BAUCUS. All the paperwork and all of the frustration and so forth. So, what can be done at hospitals to address that?

Dr. HOUSE. Well, I think that alignment of the physicians' and the hospitals' economic interests is valuable. There are a lot of ways to do that. One is that the doctors can own the hospital, or I have really no problem whatsoever with the hospitals owning the doctors, as in Sioux Falls, because then the hospitals and the doc-

tors are all lined up together for exactly the same thing. We do not need to be pulling apart, we need to be pulling together.

The economic interests of what we do, need to be lined up with the economic interests of what the hospital does. I do not know, at the end of the day, if we as the physicians who are in absolute control because we own the majority of it are going to be better than the hospital administrators, but I think that we ought to have the chance and the opportunity to try.

Senator BAUCUS. What if you did not own your hospitals, but that when you had a legitimate concern about the quality of care at a hospital, that was reasonably and well taken care of? Would that be a better system?

Dr. HOUSE. I think it would be a great system to have. Whether or not that is possible in a capitalist——

Senator BAUCUS. I am not asking that question. I am asking, would that be better in terms of patient care?

Dr. HOUSE. Well, I think as long as the doctors truly had control. I do not know how you can get control without ownership.

Senator BAUCUS. No. That is my question. Control is kind of an interesting term. I am saying, if doctors' legitimate concerns for the well-being of their patients were addressed at a hospital, but doctors could not own the facilities, would that be a better system?

Dr. HOUSE. I think if we could figure out a way to do that, and you guys are smarter than I am to try to figure it out——

Senator BAUCUS. No, we are in this together.

Dr. HOUSE. Well, I have been in practice for 18 years, and it is getting increasingly more difficult.

Senator BAUCUS. We do not have a lot of time here. I would like to ask Ms. Morrison, and maybe Dr. Cobey, what about doctors' frustrations that, hey, we cannot get this equipment, or patients need this, and so on and so forth?

Dr. COBEY. I have been in practice 30 years. I know nursing staff; my wife is a nurse. I know the hospital. When I have a problem, I have no problem going to the chief nurse of the hospital, a 900-bed hospital, or the hospital administrator and talking with them in solving the problem. My experience is, the administration is very open to physicians who have suggestions on how to give better care.

Senator BAUCUS. All right.

Ms. Morrison?

Ms. MORRISON. Just one addition to that. I cannot comment on Dr. House's situation, but I can tell you that it is in the best interests of the community hospital to have a good relationship with their physicians.

After all, it is the physicians who have the admitting power that puts the patients into the hospital. So in my experience, the administration has been very open to the requests of the physicians and has been responsive.

Senator BAUCUS. I know it is kind of hard to answer this question, but just your honest kind of subjective assessment. To what degree are these specialty hospitals formed because of the frustration that doctors have with the administration? On the other hand, to what degree is it because it is an opportunity to not only have more control generally, but also to increase their income?

Ms. MORRISON. My personal opinion?

Senator BAUCUS. Yes, I am asking your personal opinion.

Ms. MORRISON. My personal opinion is that, in my experience, it is not about frustration, it is about the financial incentives that are associated with a specialty hospital.

Senator BAUCUS. Dr. House, you were quite critical of Ms. Morrison's hospital's CEO's remuneration. How much did you say it was?

Dr. HOUSE. Almost $900,000 a year.

Senator BAUCUS. And that is public information, is it not?

Dr. HOUSE. Yes, it is.

Senator BAUCUS. What do you make a year?

Dr. HOUSE. My group——

Senator BAUCUS. Total. What you, Dr. House, make a year.

Dr. HOUSE. In my practice?

Senator BAUCUS. Associated with your practice.

Dr. HOUSE. Approximately $500,000.

Senator BAUCUS. And what do the other doctors make?

Dr. HOUSE. We all pretty much are paid the same. Our average partner income is about $500,000 a year. That is probably the top. We are in a very, very relatively wealthy area, like you mentioned earlier. We do not have a huge Medicaid/Medicare population. We are probably in the top 95th percentile of physicians as far as our practice income is concerned.

Senator BAUCUS. Right.

Dr. HOUSE. Which, when I saw that the doctors in South Dakota make $1.8 million, that just sort of shocked me.

Senator BAUCUS. You have to move! [Laughter.]

Dr. HOUSE. Yes. I actually went to school there. I went to undergraduate school there, and I went to 2 years of medical school there in South Dakota, and maybe I should think about going back.

Senator BAUCUS. Well, I do not know a lot about your financial arrangements, obviously. But that figure you gave, is that in addition to or does that include, say, Medicare fees or other payments you get as a physician?

Dr. HOUSE. It is from hospital distributions and everything.

Senator BAUCUS. That is total.

Dr. HOUSE. Yes. Our clinical income is probably—well, income is not cash, of course, because we actually take less cash than income, because much of our income goes back into investment.

For instance, if we have to make principal payments to the hospital, that is income to us, but we do not actually get the cash. So I think last year, $500,000 was our income, but our cash was probably around $390,000.

Senator BAUCUS. Do you have any investment income from the hospital?

Dr. HOUSE. Yes.

Senator BAUCUS. And that is included?

Dr. HOUSE. Well, hopefully some day. Our net cash flow since we opened the hospital to the physicians, we are on the hook for about $41 million. We leveraged our entire group, and most of the physicians did. Our net cash flow—I actually got this number from my CFO—as of April 30, 2006 is minus $12 million as far as what we put in versus what we have gotten out.

Senator BAUCUS. Mr. Chairman, I do not want to take a lot of time here, but I want to ask one more question.

Let me ask this question. How much time do you and your associates spend on management issues as opposed to health care issues?

Dr. HOUSE. I personally have a significant input because I am the managing partner of our urology group. We have a very large group. We have 48 urologists, the biggest urology group in the country. As the managing partner, and the fact that I am also on the board of the hospital itself, then I personally have a significant amount of time.

We were fortunate in that when we purchased the hospital we had an administrator of our practice, our CEO, who had extensive hospital administrative experience before he came to our practice, so we moved him over to the CEO position of our hospital.

So, I have a day-to-day working relationship with him from a long-term relationship when he was the administrator of our practice. So, I personally do have a fair amount.

Senator BAUCUS. All right.

Are you aware of any AIDS specialty hospitals?

Dr. HOUSE. Excuse me?

Senator BAUCUS. Any hospitals that specialize in AIDS?

Dr. HOUSE. No, sir. I am not aware of that.

Senator BAUCUS. Are there any hospitals that specialize with pneumonia care?

Dr. HOUSE. I am not aware of that.

Senator BAUCUS. There are not any, that I am aware of. Why do you suppose that is?

Dr. HOUSE. There are a lot of reasons. Probably if someone tried to specialize in pneumonia care alone, which would probably be a very good thing for the patients——

Senator BAUCUS. Or AIDS.

Dr. HOUSE. Or AIDS, too. If you had a hospital that specialized and focused just on AIDS treatment, I can almost assure you that the treatment would be better.

It is probably, however, very, very difficult for that particular facility, under the payment system we live under, to actually get paid enough money for that to make sense. They probably economically could not do it.

All institutions, all hospitals have to put more money on the books than expenses or they would not survive. Maybe that is something that we should think about, the way the payment system is, and we could encourage more specialization, specialty hospitals in AIDS, pneumonia, and some other diseases.

Senator BAUCUS. Well, I thank you, Mr. Chairman, for being so indulgent. Frankly, this whole area is raising lots of provocative questions which we do not have time to get into right now. I wish we did, frankly.

Dr. HOUSE. Yes, sir.

Senator BAUCUS. I wish we had a lot of time, Mr. Chairman, to get into our health care system and address costs and reimbursement. There are a lot of things here, because our system is really strained a lot.

You said yourself, Dr. House, you had a figure that we have twice as much per capita health care in this country.

Dr. HOUSE. Than anywhere in the world. We are not getting the bang for our buck.

Senator BAUCUS. And we are not twice as healthy.

Dr. HOUSE. Yes, sir. That is absolutely right.

Senator BAUCUS. And it is a huge issue.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

I have a summation. First of all, for members who have questions or prepared remarks, I would like to have them submitted no later than May 26th.

It is important, first and foremost, for us to strengthen oversight of all hospitals to ensure that no patient is provided care that fails to meet basic standards for quality and safety.

Also, it is clear from today's testimony that something other than just another report needs to be done, so I have asked the Office of Inspector General to review patient safety and quality care at specialty hospitals.

Further, I have asked the Government Accountability Office to review financial arrangements to ensure that these complex business deals are not providing sweetheart deals in exchange for patient referral.

The committee also anxiously awaits the Strategic and Implementing Plan that I talked to Dr. McClellan about. We trust that CMS will provide some real reforms in the final version.

Payment reforms are only part of the solution. Clear disclosure to patients about the investment interest physicians have in specialty hospitals will provide much-needed transparency that is needed for peace of mind for patients.

CMS also needs to enact regulations preventing sweetheart deals from being a key financial arrangement for these facilities. Physicians' investments which could lead to conflict of interest need to be disclosed, just like conflict of interest for lawyers and accountants.

These investments should be bona fide to ensure that it is not just a cash pay-out in disguise. Physicians' disclosures should not be limited to finance. Informed consent for patients should include information regarding the quality of care that patients will receive.

CMS should make serious commitments to oversight of specialty hospitals, and more generally the Stark law as a whole. This oversight should include providing clear, universal guidance in the form of regulations.

These regulations should address the disclosure of investment interests, penalties under 18 U.S.C. 1001 for failing to disclose, and implementing systems and controls to ensure that abusive practices and fraudulent activities are quickly detected and prosecuted.

I thank all of you for participating in this panel. The hearing is adjourned. Thank you very much.

[Whereupon, at 12:21 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Statement of Senator Max Baucus
Specialty Hospitals
Senate Finance Committee Hearing
May 17, 2006

Thanks, Mr. Chairman. And thank you to our witnesses for being here today. You have some important testimony to give.

Today we examine the issue of specialty hospitals. These are physician-owned facilities primarily or exclusively engaged in cardiac, orthopedic, or surgical care. Specialty hospitals are typically small. They range in size from a few beds to a few dozen. There are more than 100 specialty hospitals nationwide.

One might wonder why these relatively few, and relatively small, facilities have led to such heated debate in Congress. Why is there a moratorium on their expansion? Why is this issue such cause for concern? There are at least three reasons.

Reason number one: As we will hear from Ms. Cindy Morrison, specialty hospitals can have a significant effect on the ability of full-service hospitals to sustain critical health care services in their communities. The GAO recently found that, in the aggregate, specialty hospitals had little effect on the survival of full-service community hospitals.

But as we'll hear from Ms. Morrison, that is hardly true of the examples that she'll cite in South Dakota, Kansas, and Louisiana. I look forward to hearing Ms. Morrison's examples of the profound effects specialty hospitals have had on these communities.

Reason number two: Specialty hospitals contribute to rising health costs. America spends $2 trillion a year on health care. That's 50 percent more than the next-highest-spending country. We need to get more for our health-care spending. And it appears that specialty hospitals aren't helping.

The independent Medicare Payment Advisory Commission found that specialty hospitals are *more* expensive than full-service hospitals. Specialty hospitals are not focused factories of efficiency. MedPAC found that orthopedic and surgical hospitals are actually 20 percent *more* expensive than their full-service counterparts. The nonpartisan Congressional Budget Office also believes that specialty hospitals drive up health costs.

Last year, Chairman Grassley and I wrote legislation to prevent the growth of further specialty hospitals. CBO told us that this bill, if enacted, would save Medicare money over the long term.

These findings are consistent with those of past independent analyses regarding self-referral. In 1989, the HHS Inspector General looked at cases where referring physicians owned or invested in independent clinical labs. The IG found that patients in these cases received 45 percent *more* lab services than Medicare patients in general. Other studies showed that patients of physician-owners received imaging at a rate of 4 to 4½ times more than patients referred to independent radiologists. And these patients received physical therapy at rates about 40 percent higher than patients referred to independent practitioners.

As a result of these analyses, Congress passed legislation to prohibit self-referral in Medicare, with a few exceptions. But 17 years after the first self-referral law was enacted, self-referral to specialty hospitals has not been permanently prohibited. Despite repeated, independent reports that

specialty hospitals care for the healthiest and most profitable patients, specialty hospitals are allowed to carry on.

I understand that physicians are often frustrated with hospital management. I am not here to defend that management. I know that the physician-owned specialty hospital model is attractive in part because it allows doctors to have more control over their workplace.

But we cannot ignore the other side of this story We can't ignore that several independent analyses have shown that specialty hospitals care for healthier, more profitable patients. The GAO said so in 2003 HHS said so in 2005. And MedPAC said so in 2005 and 2006.

In short, four government reports have shown that specialty hospitals care for healthier, more profitable patients.

Reason number three, my final concern with specialty hospitals, is the issue of patient safety

We just heard from Reverend Michael Wilson, who told the story of his mother, Helen Wilson. Helen Wilson had back surgery at a physician-owned specialty hospital in Portland, Oregon. The surgery went well. But she went into sudden cardiac arrest after receiving pain medication during recovery

Ms. Wilson was in the specialty hospital when her heart stopped. We would all expect her doctors to come running to save her. But there were no doctors around. Instead, nurses at the specialty hospital had to call 911 for help. The specialty hospital had to call 911, so that a full-service hospital could care for the specialty hospital patient.

For Ms. Wilson, the help from the paramedics came too late. She passed away as a result of the loss of oxygen to her brain during her cardiac arrest.

This was a preventable death. Had Ms. Wilson known then what this committee knows now, I can't imagine that she would have chosen to undergo surgery at Physicians' specialty hospital.

Regrettably, preventable deaths—deaths from medical errors—do occur every day in this country, including at full-service hospitals. This Congress should be doing all it can to fix that, by rewarding quality in Medicare, and investing in health IT

But one thing we should *not* be doing is promoting the development of more facilities—like Physicians' Hospital—that are hospitals in name only

Reverend Wilson, I appreciate your coming here today to share your mother's story My heart goes out to you. And I extend my sympathy to you for your loss.

Mr. Chairman, specialty hospitals have had significant, negative effects on many full-service hospitals. Specialty hospitals cost Medicare more. And in the case of Helen Wilson, specialty hospitals failed to care for her when she needed it most.

Let us do what we can to protect all of our hospitals. Let us do what we can to control medical costs. And let us do what we can to see that there is not another case like Helen Wilson's.

Senate Finance Committee

May 17, 2006 James C. Cobey, M.D., M.P.H., F.A.C.S.

Good morning, Senator Grassley, Senator Baucus and Committee Members. It is an honor for me to appear before your committee on an issue of patient care that has concerned me for a number of years. That is the issue of patient safety and specialty hospitals.

I have been a practicing orthopaedic surgeon for 30 years in Washington, DC. I have a Masters in Public Health from Johns Hopkins and have been looking at issues in health care in the United States and abroad for most of my career I have worked with many international organizations and non-governmental organizations in disaster relief, refugee health care, medical education, and most recently on the epidemiology of landmine injuries.

In preparation for this testimony I have reviewed the case in Portland, Oregon where a patient died in the evening following a lumbar laminectomy The removal of a lumbar spinal disk in a lumbar spine laminectomy can be relatively simple, but it is a delicate operation and at times it can be very difficult. The patient had a respiratory arrest and died unexpectedly on the ward the evening after surgery There were no physicians in the hospital (which is not a requirement for hospitals since there are many small hospitals in rural areas where it is impossible to staff hospitals with physicians around the clock.) However, the hospital in question was not in a rural environment but in a large metropolitan area. The staff should have been able to use the crash cart to perform CPR or cardiopulmonary resuscitation. No one was available to put in an endotracheal tube to ventilate or breathe for the patient. Maintaining an airway is the most necessary first thing that must be done to resuscitate a patient. The patient died before the ambulance could arrive on a 911 call. We should expect that any hospital providing major surgery would be staffed with someone who can resuscitate a patient and maintain an airway, especially in an urban environment for elective major surgery

In the last three decades I have observed health care in large hospitals such as the Washington Hospital Center and Georgetown University Hospital as well as smaller ones such as Providence Hospital and Sibley Hospital in Washington, DC and a community hospital in Charles County, Maryland.

When I look at my practice and the concept of orthopaedists starting hospitals just for elective orthopaedic cases, I worry about the health of patients in these setting unless there are physicians from other medical specialties there in-house. Though ninety-five plus percent of I and my colleagues doing elective orthopaedic procedures have no problems, one must always be prepared to handle the unexpected.

Let me give you some specific examples:

- In the last ten years I have had at least three patients who developed, with no preoperative signs, acute bowel obstructions that needed specialist work-up and emergency surgery within 12 to 18 hours of my elective total joint procedures.
- I remember clearly one situation where a patient in the recovery room was noticed to have a cold pulseless foot after total knee surgery Fortunately we had an expert radiology team in house and a vascular surgeon. We found that a simple atherosclerotic plaque had broken off in the femoral artery under where we commonly place the tourniquet. The plaque caused an occlusion to all blood flow in the leg. After we obtained an emergency angiogram from an interventional radiologist, a vascular surgeon was able to do an endarterectomy within two hours of my surgery and save the leg.
- I had another patient a few years ago come in for routine total shoulder replacement surgery Everything was going well in what is usually a straightforward procedure when there was severe unexpected bleeding. I needed the help of a vascular surgeon to control the bleeding. The patient did well, and when we did a postoperative angiogram we found a rare vascular malformation.
- Just two months ago during a routine total hip procedure on a patient with mild hypertension controlled by a mild diuretic, the patient developed severe hypertension during induction for surgery The anesthesiologist was able to control it, but the patient developed severe cardiac arrhythmias after the surgery started. Postoperatively she kept having arrhythmias. We were able to have the patient monitored after surgery and seen that day by a cardiologist in-house to change the medications and stabilize the patient.

I have informally canvassed a number of my colleagues about postoperative or intraoperative problems they have had for elective orthopaedic

procedures. It is the elderly patients over sixty-five where most of the complications may occur. The most acute problems are vascular, urinary, or abdominal.

Let me give you a few more examples. Many, if not most, older patients undergoing elective joint surgery have some underlying vascular problems. In any case, sudden unexpected vascular compromise needs immediate care, as did the problems I mentioned above. One of my colleagues had torn popliteal vessels (the large blood vessel behind the knee) during revision knee surgery The vessel had been scarred into the tissues around the prosthesis that was being removed. When the vessel tore during careful removal of the prosthesis it took emergency vascular surgery to successfully save the leg. Another of my colleagues had a similar problem just a few weeks ago.

One of the best spine surgeons in the city injured an aberrant vertebral artery during routine anterior cervical spine surgery a few years ago. The patient almost died. The interventional radiological vascular team was able to stop the bleeding and the patient did very well.

Another of my colleagues had a patient develop a stroke during surgery that was first noticed in the recovery room. The stroke team consisting of neurologists and radiologists took over and handled the patient well. The patient recovered well with appropriate therapy

One can say that specialty hospitals should only do the simple procedures where these complications are not expected, but that means the more costly cases are shifted to the community hospital. Vascular compromise is rare and too often completely unexpected, but when it happens there is little time to call in help. For safe orthopaedic surgery, other specialists must be immediately available to handle these problems.

Another problem area is urinary system function. I have had many cases of spine surgery and total joint surgery where I needed to have a urinary catheter placed, due to the length of the procedure. Many times I have found totally unexpected strictures where I have needed to call in a urologist to pass a special catheter often by fiberoptic endoscopy, and a few times by a suprapubic approach. If a urologist had not been available in-house, we would have had to cancel the case and wake the patient up. Remembering

that the most difficult times in anesthesia are induction and waking the patient, that is not a great choice for the patient.

Besides the life- and limb-threatening medical needs of patients with major surgical procedures, I am worried about the effect on the financial viability of general hospitals which have emergency rooms and end up caring for many patients with little or no insurance. The major multiple specialty hospitals need the revenue from patients admitted for elective surgery if they are going to survive with adequate resources to take care of the general community I am concerned that these specialty hospitals take a smaller percentage of Medicaid patients compared to community hospitals.

When I was in medical school at Hopkins forty years ago our philosophy as students was to take care of patients as our calling. Making money was irrelevant to our reason to become physicians. I feel that many of the physician-owned facilities exist more to help doctors in business than in taking excellent care of all patients irrelevant of their ability to pay for care. Of course physicians are small businesses and need to make enough income to cover their costs—especially medical liability insurance costs. Once those costs are covered—which is by no means small (in DC it is $100,000 a year for an orthopaedist)—our goals should be to treat patients in facilities that best meet their needs, not a physician's convenience or profit.

According to an article in the *New England Journal of Medicine* April 2005, since 1990 the number of U.S. specialty hospitals that are partly owned by physicians has tripled to approximately 100 Physicians are attracted to investing and practicing in specialty hospitals for two main reasons: to directly control hospital operations in relations to patient care, and to augment their income. MedPAC has found that these hospitals generally take patients with less severe illnesses than do community hospitals and provide less uncompensated care. The average size of orthopaedic specialty hospitals reviewed by MedPac in 2005 was only 16 beds. It is hard to keep meaningful ancillary facilities for emergencies for hospitals that small. The sicker patients then end up at community hospitals costing them disproportionately more money in resources.

The American Hospital Association has also reviewed the issue and is concerned about the problem of physician conflict of interest when they have ownership in a hospital. I am concerned about this conflict of interest for hospitals and also for the proliferation of outpatient surgical centers

owned by physicians. There is an obvious conflict of interest in all of these facilities encouraging physicians to refer the best-insured patients to facilities that they have an interest in. The MedPac study showed the specialty hospitals have a lower share of Medicaid patients than community hospitals.

I personally served on a board of a community hospital for nine years, and I know that hospitals cannot survive on Medicaid and Medicare alone. It is unfair for specialty hospitals to discriminate against Medicaid patients to the detriment of community hospitals who are struggling to give excellent care to all regardless of ability to pay or insurance type.

In conclusion, all hospitals must be able to be ready for the unexpected. We cannot let dollars get ahead of patient safety and quality of care issues.

1 Report to the Congress: Physician-Owned Specialty Hospitals, Medicare Payment Advisory Committee, March 2005

2. Protecting the Health Care Safety Net: Limited-Service Hospitals, the American Hospital Association.

3 Oregon Department of Human Services—Complaint Investigation Report: Physicians Hospital, August 2005

4 Iglehart, J, The Uncertain Future of Specialty Hospitals: New England Journal of Medicine, 4/7/2005, pp. 1405-1407

5 Hackbarthm G, Physician-owned specialty hospitals, Medicare Payment Advisory Commission, May 2005

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TESTIMONY OF THE

AMERICAN SURGICAL HOSPITAL ASSOCIATION

TO THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

MAY 17, 2006

PRESENTED BY JOHN M. HOUSE, MD

Mr. Chairman and Members of the Committee:

My name is John M. House, MD, a practicing urologist from Irving, Texas. I am a member of the Board of USMD hospital in Arlington and also one of almost 60 physician investors in that facility USMD is a member of the American Surgical Hospital Association (ASHA), the trade organization for physician owned hospitals with specialized capabilities. I am testifying on behalf of ASHA today

In addition to our physician partners, more than 200 doctors maintain privileges at our facility, providing a broad array of surgical services. In fact, our busiest surgeon is not an investor. He, like the others, is drawn to USMD because of the high quality of care and focus on patients that are the hallmark of our hospital and other physician owned facilities.

Texas Health Resources, the largest health care system in north Texas, is also a partner in USMD Mat-Rx Development, LLC is another investor. As the Committee knows from earlier GAO reports, this type of mixed joint venture in not uncommon among specialty hospitals.

USMD opened in 2003 We have 18 inpatient beds and are in the process of expanding our space and our services. When completed as planned, USMD will have capacity for 80 beds, and ICU and be able to provide obstetrics, coronary care, oncology and neonatal intensive care in addition to the multiple surgical and medical services now offered. The hospital is located in an area of rapid population growth and demand for our services is growing exponentially Other hospitals are experiencing similar demand.

Our current inpatient capacity is similar to that of most ASHA members, except for cardiac hospitals that are usually much larger. The surgical specialties that use USMD and similar facilities have seen the site for their surgery move rapidly from inpatient service to outpatient setting. There is simply less inpatient surgery being performed in urology, orthopedics, general surgery, and ENT, to name a few, at all hospitals. This shift is not limited to surgery Many diseases, such as pneumonia, that used to call for routine inpatient admission, are being managed by physicians on an outpatient basis, often in the patient's own home.

As a result of these changes, many general hospitals have downsized their inpatient service, converting the space to other use. Many new hospitals are designed with far fewer inpatient beds than would have been the case twenty five years ago. Much of this shift has been driven by payment policies of Medicare and other health plans. Improvements in anesthesia, surgical technique and equipment and drug therapies have played a significant role in altering the face of hospital medicine today

As required by Texas law, USMD has an emergency department. Last year 30,000 people were seen in the USMD emergency facility Our expansion of the physical plant is also driven by our need to support the increased ER activity

Mr. Chairman, your letter of May 2, 2006, asked that ASHA provide information on the following topics:

- Background information on the benefits of physician-owned specialty hospitals,
- Information on the types of investment practices physician-owned specialty hospitals utilize to recruit and retain physician investors,
- Information regarding accreditation and other efforts to maintain a standard for patient safety and quality of care for patients receiving care at physician-owned specialty hospitals,
- Background regarding the different types of joint-venture arrangements that community hospitals are entering into with specialty hospitals.

I will address each issue in turn, but would like to first comment on two topics of very current interest. The first is the interim report on specialty hospitals that was released on May 9 by the Centers for Medicare and Medicaid Services (CMS). The second is the unfortunate death of Helen Wilson, following surgery at Physicians Hospital in Portland, Oregon.

CMS Interim Report

The CMS interim report, required by the Deficit Reduction Act, has two main parts. It addresses issues that CMS Administrator Mark McClellan raised in testimony before the House Energy and Commerce Committee in May 2005 when CMS filed its first report on specialty hospitals, mandated by the Medicare Modernization Act. ASHA members have cooperated fully with CMS in both the MMA and DRA reports.

The CMS interim report also updates Congress on specific steps underway to meet the requirements for a strategic plan for specialty hospitals. The final report is expected in August.

Congress had also received a 2005 report from the Medicare Payment Advisory Commission (MedPAC) analyzing other issues in the specialty hospital debate. MedPAC recently looked at those questions again using a much larger Medicare database. It confirmed the original findings and shed additional light on some items, such as comparative costs, that could not be resolved in the original report because of sample size. Based on the more recent findings, MedPAC decided not to make any new recommendations regarding specialty hospitals. Importantly, their most recent work confirms that the presence of physician owned specialty hospitals in a community does not affect the overall profitability of the general hospitals. Nor do they lead to increased utilization of services that would be above the level that would be consistent with population growth.

As in the case with the CMS analyses, our members have fully cooperated with MedPAC staff, providing opportunities for site visits and responding to data requests from the Commission. In fact, in every one of the many government reports on specialty hospitals conducted since 2003, we have made every effort to work with the responsible agencies when they have asked for our assistance. Our members have nothing to hide from the government, or anyone else, and have consistently offered full disclosure of data needed by investigators and analysts.

It is in that spirit of openness that ASHA is supporting the efforts of Congress and the Administration to achieve greater transparency in quality and price information available to patients. We know that there are circumstances, like emergency trauma, when price and quality comparisons are not possible. However, when patients are considering elective surgical and medical procedures, this information can have great value to consumers and help them receive better medical care.

As the Committee may recall, the 2005 CMS report found that, based on an analysis of claims data, cardiac specialty hospitals delivered high quality care that was as good as or better than their competitor hospitals. A similar assessment could not be made for orthopedic and surgical hospitals because of data limitations; however, the experience of ASHA members specializing in a variety of surgical disciplines, as measured by independent reviewers such as HealthGrades, is comparable to that found by CMS for cardiac facilities. Attached to our testimony are charts from the CMS report documenting the quality of care that was found.

CMS made four recommendations as a result of that report. First, in agreement with MedPAC, it recommended reform of payment rates for inpatient hospital services. Second, CMS called for changes in the reimbursement for services provided in ambulatory surgical centers. Third, CMS planned to review if specialty hospitals met the Medicare definition of hospital. Finally, CMS planned to review the procedures it used to approve hospitals for participation in Medicare. CMS also announced that it would consider how provisions of EMTALA should apply to specialty hospitals.

ASHA had supported the MedPAC recommendation to make changes to hospital payments to better recognize severity of illness, and subsequently endorsed Medicare's first changes to cardiovascular DRGs. In the recently released proposed rule on the hospital inpatient prospective system, CMS lays out a much broader set of changes that would expand this notion to all DRGs in all hospitals. ASHA is reviewing the proposed rule to determine how it will affect our members and may offer comments on technical issues in the proposal. However, our primary goal is to assure that the changes apply equally to all hospitals, providing a level playing field for all. If the final rule meets that standard, then ASHA will continue to support the DRG reforms, even though CMS suggests in its impact analysis that specialized hospitals could see significant reductions in Medicare revenue.

ASHA likewise supports the CMS effort to make changes in the ASC payment system, which has not been updated in any significant way for more than 20 years. This step

would help align payments across sites of service and address anomalies in rates that have developed over the last 20 years.

Regarding the definition of what is a "hospital" for Medicare purposes, the program has wisely remained flexible in its interpretation of the law, recognizing that medical care has evolved greatly since 1965 Evaluations have been made on a case by case basis as hospitals have applied for Medicare numbers or under other circumstances that prompted a review ASHA members are licensed by their states as acute care hospitals as are general hospitals. It is rare that a state provides a different kind of license to a specialty hospital.

ASHA is gratified that CMS has decided to retain this flexibility and the current enrollment process, which has served the program well since its inception. Hospital services will continue to evolve and it is important that Medicare not be locked into a rigid definition of "hospital" that would preclude innovation.

The EMTALA Technical Advisory Group (TAG) carefully studied the relationship between physician owned specialty hospitals and EMTALA requirements at its October 2005 meeting. EMTALA is a broad law and covers all hospitals in one way or another. Our members are no different and their operating policies make clear the specific obligations each facility has under the law The TAG considered and rejected a proposal that all hospitals be required to have an emergency department. As the Committee knows, a number of states do not require that licensed hospitals have an emergency department. All of the major hospital associations opposed the recommendation and CMS has concurred with the action of the TAG. ASHA agrees with this decision, believing that the states are in the best position to determine the emergency care needs in their jurisdiction.

CMS has, in its proposed rule on hospital payment, clarified the obligations of hospitals with specialized capabilities to accept transfers consistent with the services provided at the facility We support this clarification in policy, consistent with our belief that federal laws and regulations should be fairly applied to all.

The balance of the interim report deals with CMS' efforts to examine physician investments and return on those investments, as well as levels of Medicaid and charity care provided.

Federal law places numerous requirements on the ways physicians can invest in hospitals and other health facilities. These laws also address returns on investment. Our members make every effort to comply fully with these requirements, relying on expert legal counsel as the investment is first organized. ASHA hospitals also maintain internal compliance programs to ensure that these financial arrangements with physician investors remain consistent with state and federal law ASHA recently provided each member with information about these requirements as a reminder of the great importance of maintaining full compliance. That document is attached also.

ASHA members are working with CMS on the collection of data needed to complete the DRA strategic plan. Notwithstanding allegations by critics of specialty hospitals, we are confident that CMS will find that our members are making every effort to stay within the boundaries of federal law

The complexities of these laws, and the difficulties with compliance, are amply demonstrated by the fact that more than ninety general hospitals have entered into corporate integrity agreements or entered into settlement agreements with integrity provisions with the HHS Office of Inspector General. None of these facilities are, to the best of our knowledge, physician owned specialty hospitals.

Two of the largest for profit systems, HCA and Tenet, also have reached such agreements. In fact, Medicare is currently moving to disenroll a Tenet hospital in San Diego, another in a series of federal actions affecting the company

HCA's own history with the enforcement of federal law is well known to this Committee. Given their history, we find their aggressive stance in opposition to physician owned specialty hospitals somewhat hypocritical. Not only was the company founded by physicians who purchased a hospital in Nashville, it continues to have multiple joint ventures with physicians. HCA, with annual earnings of over $1 4 billion, owns almost 100 ambulatory surgery centers, many in partnership with physicians. To us, this company's attacks on physician ownership are simply inexplicable.

This level of vigilance by the Inspector General, and the current political focus on physician ownership, force our members to be as conscientious as possible in maintaining compliance with all relevant state and federal laws that govern these business arrangements.

We will continue to work closely and cooperatively with CMS as it completes the strategic plan and look forward to seeing their final report and recommendations.

Physicians Hospital, Portland, Oregon

The death last summer of Helen Wilson following surgery at Physicians Hospital in Portland, Oregon, is a tragedy to her family and friends. Indeed, any unanticipated death in a hospital is tragic. Unfortunately, such deaths occur in every hospital, despite efforts by physicians and hospitals to prevent them.

Neither ASHA nor this Committee is in a position to judge the actions of Physicians Hospital, the doctors or the staff that were involved in this case. Oregon state authorities, CMS and perhaps a court of law will be the ultimate determiners of responsibility and will take whatever steps are appropriate and necessary

However, because her death has become so highly politicized, we do feel compelled to make some observations that will give Congress more context in which to evaluate this situation.

First, this Committee and others have made much of the fact that a physician was not physically present at the hospital at all times. However, Medicare does not require that its hospitals provide such coverage, mandating only that physicians be available on call. The state of Oregon, like the states of Iowa and Montana, follows the same rule.

As noted, unanticipated and/or preventable death is all too common an occurrence in our nation's hospitals. In April 2006, HealthGrades released its third "Patient Safety in American Hospitals" report. This is the largest annual study of its kind. The statistics are sobering. According to their report, if "all hospitals performed at the level of the top 15 percent, 280,134 fewer patient incidents and 44,153 fewer deaths among Medicare patients would have occurred, saving $2.45 billion during the years 2002 through 2004." The HealthGrades eighth annual "Hospital Quality in America" study released last October reached similar conclusions.

These facts in no way diminish the loss to Mrs. Wilson's family and friends, but should serve as a wakeup call to Congress, the Administration and all of us who serve patients that much more is needed beyond the steps already taken or recommended to improve quality Simply adopting the average nurse to patient ratios found in specialty hospitals (one nurse for every three and one half patients) in all community hospitals could significantly reduce errors and improve care. But community hospitals in California fought imposition of a much weaker standard, claiming it was too expensive to implement. Could it be that many of the nation's hospitals are unwilling to invest the time and money it takes to improve quality? Are they putting profits before patents?

Benefits of Physician Owned Specialty Hospitals

Before reviewing the benefits of these hospitals, it is important to understand why they are built in the first place. Since these are major undertakings, involving substantial financial risk to physicians and other partners, it is not a decision to be entered into lightly Typically, the decision is driven by the behavior of general hospital management that has refused to listen to the concerns of surgeons about quality of care, scheduling, equipment and the like. In some cases, like in Sioux Falls, SD, hospital management made decisions that physicians would not accept. A few years ago, the new administrator of Sioux Valley Hospital decided that all physicians had to be employees of the hospital. The cardiovascular team was unwilling to accept that demand and created a heart hospital in partnership with the other general hospital in town. A similar situation occurred in Green Bay, Wisconsin, and many of the medical staff left to organize a physician owned general hospital. In both cases, the physicians' decision was provoked by management intransigence.

In Modesto, California, the Stanislaus Surgical Hospital was built after surgeons spent ten years trying to get other local hospitals to address their concerns. Incidentally, those physicians maintain their privileges at the other general hospitals in the area, a common practice among physicians who invest in specialty hospitals. In fact, the only physicians I know who do not maintain privileges at another facility are those who have been denied them because they invested in a "competing" entity This "economic credentialing" is

another example of general hospitals putting "profits before patients." Not long ago, Aberdeen, South Dakota, lost a promising young orthopedic surgeon due to economic credentialing. ASHA wonders how general not for profit hospitals defend that result? Is it part of their much vaunted service to the community?

Another driving force is the increased specialization of medical care. Specialized physicians require specialized facilities, equipment, infrastructure and, most importantly, specialized staff. Frustration with the unwillingness of some general hospitals to meet these needs, so essential to good quality medical care today, also motivates physicians to find a better way

For the elective surgical patient, the advantage of a physician owned specialty hospital is high quality care. For example, the infection rate in ASHA member hospitals is substantially below the rate in general hospitals. The 2005 CMS report to Congress previously established the fact that specialty hospitals provide high quality care and, recent studies in Pennsylvania have shown how an infection slows recovery and significantly increases medical costs. It raises an important question—given a choice, why would any surgeon admit an elective surgical patient to a hospital where the risk of infection is substantially higher than an alternative site?

Patients benefit from clinical staff that is expert in the areas in which they work. By specializing in surgical care, they have increased competence in patient management. As already noted, our average nurse to patient ratio is 1.3.5 This is far better than the 1:6 mandated by the state of California. Published research clearly demonstrates that hospital quality is closing linked to the level of nurse staffing.

Our hospitals also try to focus on the needs of the patient and family For example, most of our rooms are single rooms that protect the patient's privacy, with comfortable facilities for family members to stay overnight in the room if they want to. We make an effort to provide food that is not only edible, but also truly palatable. I would point out that we achieve these results with payments that are no greater, and often less than, those received by general hospitals.

Physicians want the best care for their patients that can be provided. Our hospitals make every effort to meet that need. According to the 2005 CMS report, we have been successful. That report demonstrated very high patient satisfaction levels and a superior level of medical quality compared to general hospitals. After all, our names are on the door, and we have every motivation to provide the best care we can to our patients.

If you believe that hospital quality is not an issue, then why is CMS working so hard to improve it through reporting of quality measures? Why did 60 physicians in New York announce they would no longer use Catskill Regional Medical Center because of their concerns over poor patient safety standards? Why are physicians being urged to report quality measures?

Surgeons also want control over their schedules so that there is predictability for them and for their patients. In far too many general hospitals, elective surgery cases are bumped time and time again, with the result that the surgeon is not able to do the case until much later in the day That wastes the surgeon's time and also means that the patient has been waiting for hours, without food and water, to their great unhappiness. While some general hospitals manage to address this scheduling problem, too many others refuse to try Perhaps this would cost the hospital more money, which they would rather put into executive salaries. Is this another example of general hospitals putting profits before patients?

As a physician, I understand that emergencies will bump elective procedures. However, why should my patient suffer if there is another facility well equipped to provide the care needed in an orderly manner? If hospital management does not want to accommodate the needs of its elective surgical patients, then they should not complain if I, and other surgeons, make better arrangements for them.

These qualities are attractive to physicians who are not investors. As I noted, more than 200 physicians practice at USMD In a 2004 ASHA survey, we found that the average member hospital had 30 investors, but that more than 90 physicians had privileges. The use of these facilities by non investors has been corroborated by studies conducted by the Government Accountability Office (GAO). Clearly this is a model that works well.

The other great advantage of physician owned hospitals is the high level of satisfaction for the staff who work there. Nurses get to practice nursing, not pencil pushing. It has often been said that there is no shortage of nurses, simply a shortage of jobs that they want. ASHA member hospitals make every effort to create a climate that recognizes the value of nursing personnel. Other clinical staff develop specialized expertise and we also make a point to value their contributions. At USMD every effort is made to focus on the needs of patients, physicians and the staff. This is the case at other surgical hospitals as well.

In sum, the benefits of physician owned hospitals are high quality care for patients, efficiency for surgeons and high staff satisfaction, which in turn contributes to the high quality of care provided.

Investment Practices

Physician investment in hospitals is governed by complex federal and state laws. We make every effort to assure that our financial relations with our physician partners meet the requirements of these laws. Our hospital, like all others, operates an internal compliance program to make sure that investments and distributions meet all legal standards.

Your letter, Mr. Chairman, asks us to "Provide information regarding the types of investment practices physician-owned specialty hospitals utilize to recruit and retain physician investors." However, I believe this reflects an inherent misunderstanding of the reason for physician investment in the first place. Remember that these hospitals

arise out of unresolved conflict between general hospitals and their medical staff. If the physicians make the decision to build a hospital, they need to put their own money at risk before a bank or other financial partner will become involved. Since there is no guarantee that a physician owned hospital will succeed, these doctors take a substantial financial risk. That risk can be diluted by increasing the number of partners, and, in fact, GAO found that the average physician investor had a very small ownership percentage.

If and when the hospital becomes profitable enough to make distributions to the investors, these distributions are strictly in proportion to their share of investment. Anything else would be illegal.

If USMD wanted to recruit a new surgeon as an investor, perhaps to replace a physician who is retiring or to expand the services that could be offered to patients, the physician would be offered shares in the hospital corporation. That doctor would have to assume risk for that money, as well as sharing in the liability for any borrowing that the hospital might do in the future. These transactions are arms length and based on fair market value. Physicians and hospitals that do not adhere to these standards do so at great risk.

Some specialty hospitals have prospered and the investors have received generous distributions, according to their share of investment. Many others have not reached that level and the distributions have either not been made or are very limited. The fact that most physicians have a small level of investment in the facility is also a limiting factor in terms of the size of the distribution any one investor might receive.

In some cases, a hospital seeks a new partner, like a general hospital or a corporate investor. Under those circumstances, existing shareholders may receive additional distributions based on the amount of third party investment and the share held by the physician. A good example is taking place in Iowa right now Mercy Medical Center in Sioux City is a partner with 43 physicians in the Siouxland Surgery Center in Dakota Dunes, SD Mercy has decided to increase its share in the surgical hospital from 6% to 40%. Incidentally, the Dakota Dunes facility treats many Iowa residents and a number of physicians and staff who work there also live in Iowa.

I don't know if any of the physician investors will benefit financially from this transaction. However, it will certainly help support physician recruitment to the Sioux City area, maintain the existing coverage of Mercy's emergency room and enhance the services at the 80 rural outreach clinics in the tri-state area served by the specialty hospital.

It is also important to remember that the majority of physicians using specialty hospitals are not investors. They practice at these facilities for reasons quite independent of the possibility of any distribution.

Physicians invest in these hospitals to achieve goals that cannot be achieved elsewhere—better quality of care for their patients, efficiency for the surgeons and high quality staff and equipment.

Maintaining Quality of Care

ASHA member hospitals take many steps to maintain the quality of care that is provided in their facilities. All of them are Medicare certified, meeting the conditions of participation required by the federal government. Our members are licensed as general acute care hospitals, and as such must meet all state requirements relating to quality and patient safety In addition, many of our hospitals, like USMD, are certified by JCAHO

Each physician owned hospital, in common with general hospitals, is required to have numerous internal processes to maintain quality and address problems should they arise. Attached to this statement is the Sioux Fall Surgical Center 2006 continuous quality management/risk management strategic plan which covers all facets of the hospital's operations, down to assuring that the temperature of food delivered to patients meets state requirements. National Surgical Hospitals, Inc. is a corporate partner with physicians in ten hospitals and has an extensive program for continuous quality improvement in every facility Details on their efforts can be provided to the Committee if the Members wish to have a better understanding of this well designed program.

Specialty hospitals that partner with general hospitals typically adopt the standards used by the general hospital that are relevant to the specialized services being provided.

Physicians who partner with corporate developers, like National Surgical Hospitals, operate within a rigorous framework of continuous quality improvement. In fact, hospitals under the National Surgical Hospitals flag make every effort to establish standards that exceed accepted industry requirements. They emphasize communications at all levels within the hospital, through formal and informal processes.

Each specialty hospital has a comprehensive quality program, which involves the governing body, medical staff, clinical and non-clinical staff and patients. Each program is based on a written plan, which defines planned operations to assure the safe and effective delivery of patient care. These processes are constantly monitored and include state and federal regulatory requirements as well as the hospital's own standards of care. Responsibility for maintenance of quality starts with the hospital's board of directors and includes medical staff and other clinical and non clinical personnel. Regular surveys of patient satisfaction are also used to identify areas for improvement.

In many respects these are the same steps that general hospitals follow However, we believe that physician ownership drives our hospitals to strive for even higher levels. It is like the difference between renting a house and owning it. An owner will pay much closer attention to details and outcomes than a mere tenant. Physician ownership brings active involvement by the doctors in all facets of the hospital's operations. This strengthens every aspect of our quality control efforts.

Joint Ventures with Community Hospitals

Despite the vitriol directed at specialty hospitals by competitors and other hospital trade groups, joint ventures between physician owned specialty hospitals and community hospitals are common. In its first report on specialty hospitals in 2003, GAO noted that approximately one third of identified specialty hospitals had a general hospital partner. Our own membership surveys confirm that finding.

These joint ventures are guided by the same federal and state laws that govern any physician investment in a health facility Great care is taken by all parties to ensure that the transactions, no matter how complex, are consistent with all legal requirements.

The nature of these ventures can vary widely, depending on community, hospital and physician need. The previously mentioned joint venture between Mercy and Siouxland Surgery Center involves a sharing of services, equipment and medical personnel, designed to strengthen both facilities and provide patients with choice of the site of care.

In some cases, general hospitals will partner with a specialty hospital to turn over entire service areas to the specialized facility This is particularly true in cardiovascular care. Through specialization a new level of quality can be attained, while freeing up inpatient rooms and operating suites in the general hospital that can be put to use for other needed medical and surgical services.

Some of these ventures involve the general hospital, physicians and a corporate developer. Baylor Hospital, working with its physicians and United Surgical Partners International, has been a leader in this area.

The important point about the trend to establishing these ventures is that they signal the recognition of hospital managers that there is a better way to align hospital, physician and staff incentives to improve the services provided to patients.

ASHA considers these arrangements far superior to general hospitals employing physicians or buying practices and then restricting their referrals to the closed shop of the hospital and its staff, regardless of quality Unfortunately this trend is all too common and ASHA believes that the arrangements serve no purpose except to allow hospitals to control their service area and maximize earnings. This is another example of general hospitals putting profits before patients.

Conclusion

The federal government has conducted numerous studies of physician owned specialized hospitals. Some have been mandated by law, while others stem from requests by this committee and others with jurisdiction. The net result is that no evidence has been adduced that ASHA members are harming general hospitals financially There is no evidence of overutilization of services. Physician ownership does not lead to improper referrals or unnecessary medical services. It has been firmly established that our members provide high quality medical care, equal or superior to the best that general hospitals have to offer. It has been shown that our physicians do not abandon the

community but continue to maintain privileges at local general hospitals. Our model is popular with other physicians who have no financial stake in the facility These studies have rebutted virtually every allegation that opponents of specialty hospitals have made over the last five years.

The American Surgical Hospital Association urges the Senate Finance Committee to recognize the reality about physician ownership, not the hype from opponents afraid of innovation and competition, and lay this issue to rest.

I would be pleased to respond to any questions the Committee members may have.

Study of Physician Physician-owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003

(Charts Pulled Directly from the CMS Study)

Table 5.1
Cardiac Specialty Hospitals and Community Acute Care Hospital Competitors: AHRQ Inpatient Quality Indicators, Mortality Rates among Select Surgical Procedures* For the Population of All Specialty Hospitals and Their Competitors

	Specialty	Competitor
AAA repair		
Number of deaths	16	101
Population at risk	206	948
Observed rate	77.67	106.54
Expected rate	99.91	141.82
Observed/expected ratio	***0.78***	***0.75***
CABG		
Number of deaths	152	484
Population at risk	4,036	10,922
Observed rate	37.66	44.31
Expected rate	47.87	51.50
Observed/expected ratio	***0.79***	***0.86***
PTCA		
Number of deaths	93	469
Population at risk	8,925	24,706
Observed rate	10.42	18.98
Expected rate	14.70	19.71
Observed/expected ratio	***0.71***	***0.96***
Carotid endarterectomy		
Number of deaths	4	19
Population at risk	142	315
Observed rate	28.17	60.32
Expected rate	49.05	49.31
Observed/expected ratio	***0.57***	***1.22***

*NOTE: The data for observed and expected rates are per 1,000 discharges.

SOURCE: CY 2003 Medicare IPPS claims.

Observed/Expected ratios less than 1 indicate better than expected performance or fewer than expected deaths.

Table 5.2
Cardiac Specialty Hospitals and Community Acute Care Hospital Competitors: AHRQ Inpatient Quality Indicators, Mortality Rates among Select Medical Admissions* For the Population of All Specialty Hospitals and Their Competitors

	Specialty	Competitor
In-hospital mortality rates		
CHF		
Number of deaths	95	1,408
Population at risk	3,001	30,859
Observed rate	31.66	45.63
Expected rate	76.39	76.92
Observed/expected ratio	***0.41***	***0.59***
AMI, without transfer cases		
Number of deaths	197	1,649
Population at risk	3,094	14,804
Observed rate	63.67	111.39
Expected Rate	91.78	128.51
Observed/expected ratio	***0.69***	***0.87***

* NOTE: The data for observed and expected rates are per 1,000 discharges.

SOURCE: CY 2003 Medicare IPPS claims.

Observed/Expected ratios less than 1 indicate better than expected performance or fewer than expected deaths

The overall mortality rates for inpatient, and for inpatient plus 30-day also indicate that the quality of care in specialty hospitals is good (***see Tables 5.3 – 5.5***). Across the three specialty hospital types, for both moderately ill (APR-DRG Minor or Moderate) and severely ill patients (APR-DGR Major or Extreme), the percentage of patients who died while hospitalized was significantly less for specialty hospitals than that for competitor hospitals, for all DRG groupings. This trend holds true for inpatient plus 30-day mortality rates. The t-test on the difference between the means (average) indicates that these differences are significant at the .1% ($p < 0.001$) level.

Table 5.3
Heart Specialty Hospitals and Community Acute Care Hospital Competitors: Overall Mortality Stratified by Patient Severity and by DRG Groupings (MDC=5) For the Population of All Specialty Hospitals and Their Competitors

	Inpatient Mortality						Inpatient + 30 day Mortality					
	Specialty			Competitor			Specialty			Competitor		
	# died	N	% died	# Died	N	% died	# died	N	% died	# died	N	% died
Moderate Severity												
Major												
Heart	16	3,326	0.48*	63	8,934	0.71	39	3,326	1.17*	147	8,934	1.65
PTCA, Etc.	19	8,046	0.24*	70	22,525	0.31	72	8,046	.90*	240	22,525	1.07
Other	39	6,690	0.58*	543	53,593	1.01	128	6,690	1.91*	1,886	53,593	3.52
Severe												
Major												
Heart	201	2,076	9.68*	935	7,810	11.97	279	2,076	13.44	1,245	7,810	15.94
PTCA, Etc.	27	1,125	2.40*	231	4,356	5.30	66	1,125	5.87	408	4,356	9.37
Other	157	1,912	8.21*	2244	20,848	10.76	299	1,912	15.64	4,000	20,848	19.19

* indicates the differences between specialty and competitor hospitals are statistically significant at a .1% level.
NOTE: Moderate Severity includes APR-DRG both severity categories Minor and Moderate; Severe includes APR-DRG both severity categories Major and Extreme
SOURCE: CY 2003 Medicare IPPS claims.

Table 5.4
Orthopedic Specialty Hospitals and Community Acute Care Hospital Competitors: Overall Mortality Rates Stratified by Patient Severity and DRG Grouping (MDC=8) For the Population of All Specialty Hospitals and Their Competitors

	Inpatient Mortality						Inpatient + 30 day Mortality					
	Specialty			Competitor			Specialty			Competitor		
	# died	N	% died	# died	N	% died	# died	N	% died	# died	N	% died
Moderate Severity												
Major Ortho	0	3,954	0.00*	124	40,192	0.31	5	3,954	.13*	660	40,192	1.64
Minor Ortho	0	1,614	0.00*	6	13,960	0.04	1	1,614	.06*	96	13,960	.69
Medical	0	79	0.00*	102	14,583	0.70	1	79	1.27*	620	14,583	4.25
Severe Severity												
Major Ortho	2	346	0.58*	526	14,178	3.71	4	346	1.16*	1228	14,178	8.66
Minor Ortho	0	24	0.00*	28	829	3.38	0	24	.00*	50	829	6.03
Medical	0	1	0.00	315	4,484	7.03	0	1	.00	830	4,484	18.51

* indicates the differences between specialty and competitor hospitals are statistically significant at a .1% level.
NOTE: Moderate Severity includes APR-DRG both severity categories Minor and Moderate; Severe includes APR-DRG both severity categories Major and Extreme

SOURCE: CY 2003 Medicare IPPS claims.

Table 5.5
Surgery Specialty Hospitals and Community Acute Care Hospital Competitors: In-Hospital and 30 Day Mortality reported by patient severity (MDC = 8, 12, 13) For the Population of All Specialty Hospitals and Their Competitors

	Inpatient Mortality						Inpatient + 30 day Mortality					
	Specialty			Competitor			Specialty			Competitor		
	# died	N	% died	# died	N	% died	# died	N	% died	# died	N	% died
Moderate Severity												
Major Surgery	0	191	0.00*	2	2,347	0.09	1	191	0.52*	22	2,347	0.94
Minor Surgery	0	253	0.00	0	877	0.00	0	253	0.00*	1	877	0.11
Severe Severity												
Major Surgery	0	38	0.00*	18	694	2.59	0	38	0.00*	40	694	5.76
Minor Surgery	0	1	0.00	1	8	12.50	0	1	0.00	3	8	37.50

* indicates the differences between specialty and competitor hospitals are statistically significant at a .1% level.

NOTE: Moderate Severity includes APR-DRG both severity categories Minor and Moderate; Severe includes APR-DRG both severity categories Major and Extreme

SOURCE: CY 2003 Medicare IPPS claims.

Complications During Hospitalization: The occurrence of adverse events and complications during hospitalization is another important aspect of health care quality. The Agency for Healthcare Quality and Research's (AHRQ) Patient Safety Indicators (PSIs) reflect the quality of care inside hospitals by focusing on potentially avoidable complications and iatrogenic events. They are not intended to be definitive quality measures as there are many factors that influence performance on quality indicators - some of which are independent of quality of care. However, high rates may indicate possible quality problems. Because no "right rates" have been established for most indicators. AHRQ suggests comparing rates among providers that are, ideally, as similar as possible in case-mix, socioeconomic status and other demographics (i.e., "peer groups"). We attempted to account for these differences by comparing the ratio of the observed to the expected complication rates, which focuses on performance of specialty and competitor hospitals given their patient mix. The tables below show only a sample of the PSI measures that were computed.

The PSIs indicate that, overall, cardiac specialty and competitor hospitals are performing better than expected in terms of in-hospital complications and adverse events in some PSIs and worse than expected in others ***(see Table 5.6)***. Note the PSIs where the observed/expected ratios are less than one, indicating that the cardiac specialty hospitals performed better than expected given the hospitals' case mix. For example, cardiac specialty hospitals have lower than expected rates of infections due to medical care, post operative hip fractures, post operative deep vein thrombosis and post operative sepsis. Both cardiac specialty and competitor hospitals have higher than expected rates of iatrogenic pneumothorax. Competitor hospitals have higher than expected rates on several other PSIs. A similar analysis of Patient Safety Indicators was also performed for orthopedic and surgery specialty hospitals. The small number of discharges prevented us from drawing strong conclusions concerning complication rates for these hospitals.

Table 5.6
Cardiac Specialty Hospitals and their Acute Care Community Hospital Competitors: Select AHRQ Patient Safety Indicators
For the Population of All Specialty Hospitals and Their Competitors

Patient Safety Indicators (PSIs)	Specialty Hospitals	Competitor Hospitals
Iatrogenic pneumothorax		
Number of Cases	36	246
Population at risk	24,605	136,056
Observed Rate	1.46	1.81
Expected Rate	0.80	0.76
Observed/expected ratio	***1.83***	***2.38***
Selected infections due to medical care		
Number of Cases	39	539
Population at risk	28,562	137,988
Observed Rate	1.37	3.91
Expected Rate	2.42	2.94
Observed/expected ratio	***0.56***	***1.33***
Post-op hip fracture		
Number of Cases	4	33
Population at risk	19,549	58,853
Observed Rate	0.20	0.56
Expected Rate	0.36	0.41
Observed/expected ratio	***0.57***	***1.37***
Post-op pulmonary embolism or DVT		
Number of Cases	98	576
Population at risk	19,658	59,058
Observed Rate	4.99	9.75
Expected Rate	9.36	10.49
Observed/expected ratio	***0.53***	***0.93***
Post-op sepsis		
Number of Cases	22	165
Population at risk	3,848	11,791
Observed Rate	5.72	13.99
Expected Rate	8.53	13.62
Observed/expected ratio	***0.67***	***1.03***
Accidental puncture or laceration		
Number of Cases	174	630
Population at risk	30,704	155,441
Observed Rate	5.67	4.05
Expected Rate	4.47	3.07
Observed/expected ratio	***1.27***	***1.32***

* indicates the differences between specialty and competitor hospitals are statistically significant at a .1% level.

NOTE: Observed and Expected rates are per 1,000 cases.

SOURCE: CY 2003 Medicare IPPS claims.

The complete table is in the appendix as Table A1

Table 5.7
Cardiac Specialty Hospitals and Competitor Acute Care Hospitals:
Readmission Rates Stratified by Patient Severity and DRG Grouping
For the Population of All Specialty Hospitals and Their Competitors

	Specialty Hospitals			Competitor Hospitals		
	# readmissions	N	% readmissions	# readmissions	N	% readmissions
Moderate Severity						
Major Heart	278	3,326	8.36	536	8,934	6.00*
PTCA, Etc.	403	8,046	5.01	1,080	22,525	4.79**
Other	594	6,690	8.88	3,902	53,596	7.28*
Severe Severity						
Major Heart	305	2,076	14.69	860	7,812	11.01*
PTCA, Etc.	169	1,125	15.02	477	4,356	10.95*
Other	317	1,912	16.58	2,270	20,849	10.89*

NOTE: Comparisons are limited to patients in MDC 5; non-cardiac admissions are not included in this analysis.

*, ** indicates the differences between specialty and competitor hospitals are statistically significant at the .1% and 5% levels respectively.

SOURCE: CY 2003 Medicare IPPS claims.

In orthopedic specialty hospitals, the percentage of patients in the moderate severity category readmitted after treatment at a specialty hospital ranged from roughly 1.2% to 1.6% (***see Table 5.8***). The percentage of readmissions was slightly higher for competitor hospitals than for orthopedic specialty hospitals, ranging from, approximately, 1.8% to 4.3%. A t-test of the difference between means showed that the difference between orthopedic specialty and competitor hospitals is significant for all DRG groupings. The percentage of orthopedic patients in the severely ill category readmitted to the hospital in all DRG groupings was similar across hospital types. The t-tests showed that the difference in proportion between specialty and competitor hospitals were significant at the $p<0.05$ level only for major and minor orthopedic surgical procedures and not significant for medical procedures. This suggests that the competitor and specialty hospitals performed about the same with respect to severely ill orthopedic patients. However, as with moderately ill patients, the number of readmissions at orthopedic specialty hospitals was very small.

Table 5.8
Orthopedic Specialty Hospitals and Competitor Acute Care Hospital Competitors: Readmission Rates reported by Patient Severity and DRG grouping (MDC=8) For the Population of All Specialty Hospitals and Their Competitors

	Specialty Hospitals			Competitor Hospitals		
	# readmissions	N	% readmissions	# readmissions	N	% Readmissions
Moderate Severity						
Major Ortho	63	3,954	1.59*	1,008	40,193	2.51
Minor Ortho	22	1,614	1.36*	251	13,961	1.80
Medical	1	79	1.27*	638	14,584	4.37
Severe Severity						
Major Ortho	17	346	4.91**	843	14,179	5.95
Minor Ortho	1	24	4.17**	54	829	6.51
Medical	0	1	0.00	317	4,484	7.07

* ** indicates the differences between specialty and competitor hospitals are statistically significant at the .1% and 5% levels respectively.

NOTE: Moderate Severity includes APR-DRG both severity categories Minor and Moderate; Severe includes APR-DRG both severity categories Major and Extreme

SOURCE: CY 2003 Medicare IPPS claims.

Readmissions to both surgical and competitor hospitals for patients in MDC 8, 12 and 13 were too few in number to draw any significant conclusions from the data (especially among severely ill patients). Readmission rates for moderately ill patients with a major surgical procedure were lower for specialty hospitals whereas rates for minor surgical were lower for competitor hospitals, however, these were not statistically significant. There were very few severely ill patients discharged from specialty hospitals and consequently, the numbers of admissions and readmissions for both DRG groupings are too small relative to competitor hospitals to allow us to have confidence in these results. We would need to repeat these analyses with multiple years of data to reach any reliable conclusions regarding differences in the quality of care provided in surgical specialty hospitals versus their community acute care hospital competitors on this measure.

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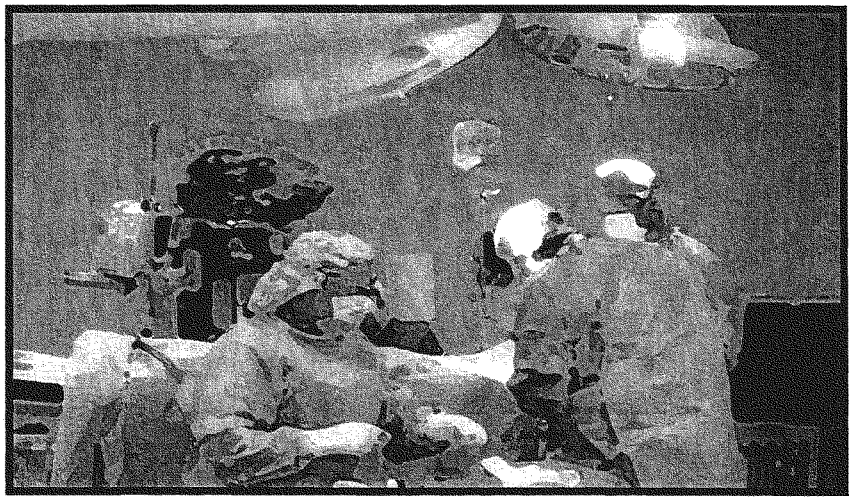


EXECUTIVE SUMMARY – THE APPLICATION OF THE FRAUD AND ABUSE ANTI-KICKBACK STATUTE AND EMTALA TO SPECIALTY AND SURGICAL HOSPITALS[1]

March 2006

[1] This Executive Summary has been authored by Scott Becker and Nathan Kottkamp, each of McGuireWoods LLP, on behalf of the American Surgical Hospital Association.

I. Medicare/Medicaid Fraud and Abuse and Anti-Kickback Law

The Anti-Kickback Statute, 42 U.S.C. §1320a-7b, prohibits the offer, provision, solicitation, or receipt of any sort of remuneration in exchange for the referral of any service potentially reimbursable under Medicare, Medicaid, or other federal health program. There are several issues that are raised with regard to physician ownership of surgical and specialty hospitals under the Anti-Kickback Statute.

Each hospital is encouraged to consult with their own legal counsel as to issues arising under the Anti-Kickback Statute.

There is no safe harbor that provides comfort for the development of surgical hospitals. There does exist a safe harbor for certain investment interests in small entities. However, the safe harbor requires that investing physicians own no more than forty percent of the hospital and generate no more than forty percent of the volume of the hospital's business. Thus, it may not be applicable to many surgical and specialty hospitals. As no safe harbor protection exists for such investments, it is extremely important that the offering of shares in the development of the hospitals be done under carefully constructed prophylactic rules that help demonstrate that the investors are not given special terms or remuneration in exchange for referrals. These rules might include:

- Each investor will have an equal opportunity to purchase shares;
- Investors will pay fair market value for shares and will not pay more or less per share based on their ability to generate referrals for the hospital;
- No investor will receive financing from another investor or the hospital for the purchase of shares;
- All returns on investment will be based on ownership of shares and not on the referrals generated by the physician;
- Investors should be required to disclose to patients their ownership in the hospital;
- Physicians should not be expected to make any level of indirect referrals to the hospital;
- The hospital will not discriminate against Medicare or Medicaid or governmental health care program business;
- Services of the entity will be marketed or furnished to all persons in a manner that is the same (i.e., marketing of services will not be different based on who is an owner of the facility);
- The potential ownership group should not be differentiated or based on the volume or value of referrals;
- The center will not track or distribute referrals from investor owners to all members;
- The real estate lease for the hospital will be consistent with fair market value for the space leased;

- Shares should not be reallocated based on the volume or value of referrals;
- Hospitals should not develop elaborate "target" lists of investor physicians based on revenues or referrals;
- No physician should be offered special remuneration to encourage use of the facility; and
- Physicians should not be pressured to withdraw if they do not generate business for the hospital.

Finally, the Department of Health and Human Services' Office of Inspector General ("OIG") has expressed concerns in other contexts that should be carefully considered in this context. First, the OIG has commented negatively on arrangements that may enable investors to derive profits from the provision of indirect referrals. Specifically, in Advisory Opinion 98-12, the OIG outlined its concerns with respect to ambulatory surgery centers ("ASCs") as follows:

> [T]his Office is concerned about the potential for investments in ambulatory surgical centers to serve as vehicles to reward referring physicians indirectly For example, a primary care physician, who performs little or no services in an ambulatory surgical center in which he has an ownership interest, may refer to surgeons utilizing the ambulatory surgical center, thereby receiving indirect remuneration for the referral through the ambulatory surgical center's profit distribution. Similarly, an investment by orthopedic surgeons in an ambulatory surgical center that is not equipped for orthopedic surgical procedures, or that is exclusively used by anesthesiologists performing pain management procedures on patients referred by the orthopedic surgeons, would be suspect.

As there is no specific safe harbor for surgical hospitals that invokes the extension of practice concept that exists in the ASC safe harbor, many parties have viewed surgical hospitals as providing an opportunity for the involvement of primary care physicians as owners in surgical hospitals. However, one should be aware of the OIG's concerns regarding arrangements in which physicians who are indirect referral sources are brought in as owners. I.e., any such parties should be allowed to invest, for example, because they make a capital investment to the hospital and not to induce or encourage referrals.

II. EMTALA

This section provides background guidance on Emergency Medical Treatment and Labor Act (EMTALA) obligations for both hospitals with emergency departments and hospitals that do not have emergency departments. A good deal of the guidance contained herein is derived from guidance that CMS has provided to states survey agency directors pursuant to a memo related to EMTALA Interpretive Guidelines. Each hospital is urged to consult with their own legal counsel and review the regulations located at 42 CFR §§ 489.20 and 489.24

Medicare participating hospitals, including specialty hospitals, must comply with the EMTALA statute and accompanying regulations in 42 CFR §489.24 and 42 CFR §489.20(l),(m), (q) and (r). EMTALA requires hospitals with emergency departments to provide a medical screening examination ("MSE") to any individual who "comes to the hospital" (including presenting on the hospital's campus) and to provide stabilizing medical treatment within its capacity It also prohibits hospitals with emergency departments from refusing to examine or treat individuals with an emergency medical condition (EMC). The term "hospital" includes specialty hospitals.

A dedicated emergency department is defined as meeting one of the following criteria regardless of whether it is located on or off the main hospital campus. The entity· (1) is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; or (2) is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for EMC on an urgent basis without requiring a previously scheduled appointment; or (3) during the preceding calendar year (i.e., the year immediately preceding the calendar year in which a determination under this section is being made), based on a representative sample of patient visits that occurred during the calendar year, it provides at least one-third of all of its visits for the treatment of EMCs on an urgent basis without requiring a previously scheduled appointment. This includes individuals who may present as unscheduled ambulatory patients to units (such as labor and delivery or psychiatric units of hospitals) where patients are routinely evaluated and treated for EMCs.

A. Requirements for Hospitals With Emergency Departments

Hospitals with dedicated emergency departments are required to take the following measures:

- Adopt and enforce policies and procedures to comply with the requirements of 42 CFR §489.24,
- Post signs in the dedicated ED specifying the rights of individuals with EMCs and women in labor who come to the dedicated ED for

health care services, and indicate on the signs whether the hospital participates in the Medicaid program;

- Maintain medical and other records related to individuals transferred to and from the hospital for a period of five years from the date of transfer;
- Maintain a list of physicians who are on call to provide further evaluation and/or treatment necessary to stabilize an individual with an EMC;
- Maintain a central log of individuals who come to the dedicated ED seeking treatment and indicate whether these individuals:
  - Were refused treatment;
  - Were denied treatment;
  - Were treated, admitted, stabilized and/or transferred or were discharged,
- Provide for an appropriate MSE,
- Provide necessary stabilizing treatment for EMCs and labor within the hospital's capability and capacity;
- Provide an appropriate transfer of an unstabilized individual to another medical facility, but only if:
  - The individual (or person acting on his or her behalf) after being informed of the risks and the hospital's obligations requests a transfer;
  - A physician has signed the certification that the benefits of the transfer of the patient to another facility outweigh the risks or
  - A qualified medical person (as determined by the hospital in its by-laws or rules and regulations) has signed the certification after a physician, in consultation with that qualified medical person, has made the determination that the benefits of the transfer outweigh the risks and the physician countersigns in a timely manner the certification. (This last criterion applies if the responsible physician is not physically present in the emergency department at the time the individual is transferred.)

Additionally, prior to, and as part of the transfer, the transferring hospital must:

- Provide treatment to minimize the risks of transfer;
- Send all pertinent records to the receiving hospital;
- Obtain the consent of the receiving hospital to accept the transfer;
- Ensure that the transfer of an unstabilized individual is effected through qualified personnel and transportation equipment, including the use of medically appropriate life support measures; and

- Provide the name and address of any on-call physician who refused or failed within a reasonable time to provide necessary stabilizing treatment.

- Not delay in the MSE and/or stabilizing treatment in order to inquire about payment status;
- Accept appropriate transfer of individuals with an EMC if the hospital has specialized capabilities or facilities and has the capacity to treat those individuals; and
- Not penalize or take adverse action against a physician or a qualified medical person because the physician or qualified medical person refuses to authorize the transfer of an individual with an EMC that has not been stabilized or against any hospital employee who reports a violation of these requirements.

B. Requirements for Hospitals that Do Not Have Emergency Departments

A hospital that does not have a dedicated emergency department, as defined by 42 CFR §489.24(b), generally does not have an EMTALA obligation to provide screening and treatment, and is not required to be staffed to handle potential EMC. Nevertheless, EMTALA, per 42 CFR §482.12(f), requires the hospital's governing body to assure that the medical staff has written policies and procedures for the appraisal of emergencies, initial treatment (within its capability and capacity, and makes an appropriate referral to a hospital that is capable of providing the necessary emergency services. (See Form CMS-1537, Medicare/Medicaid Hospital Survey Report). Such a facility must have policies and procedures in place for handling patients in need of immediate care. For example, the facility policy may direct the staff to contact the emergency medical services/911 (EMS) to take the patient to an emergency department or provide the necessary care if it is within the hospital's capability

A hospital without an emergency department should review the bylaws, rules and regulations of the medical staff to determine if they reflect EMTALA requirements.

C. Hospital Signage Requirements

Hospital signage must at a minimum:

- Specify the rights of individuals with EMCs and women in labor who come to the emergency department for health care services; and
- Indicate whether the facility participates in the Medicaid program. Signs must also be clear and use simple terms and language(s) that are understandable by the population served by the hospital.

Furthermore, the sign(s) must be posted in a place or places likely to be noticed by all individuals entering the emergency department, as well as

those individuals waiting for examination and treatment (e.g., entrance, admitting area, waiting room, treatment area).

D. Call Responsibilities

As a requirement for participation in the Medicare program, hospitals that have an emergency department must maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an EMC. The on call list identifies and ensures that the emergency department is prospectively aware of which physicians, including specialists and sub-specialists are available to provide care.

A hospital can meet its responsibility to provide adequate medical personnel to meet its anticipated emergency needs by using on call physicians either to staff or to augment its emergency department, during which time the capability of its emergency department include the services of its on call physicians.

CMS does not have requirements regarding how frequently on call physicians are expected to be available to provide on call coverage. Nor is there a pre-determined ratio CMS uses to identify how many days a hospital must provide medical staff on call coverage based on the number of physicians on staff for that particular specialty No physician is required to be on call at all times. In particular, CMS has no rule stating that whenever there are at least three physicians in a specialty, the hospital must provide 24-hour/7 day coverage in that specialty Instead, each hospital has the discretion to maintain the on call list in a manner that best meet the needs of the hospital's patients who are receiving services required under EMTALA in accordance with the resources available to the hospital, including the availability of one call physicians.

Call coverage should be provided for within reason depending upon the number of physicians in a specialty A determination about whether a hospital is in compliance with these regulations must be based on the facts in each individual case. Surveyors will consider all relevant factors including the number of physicians on staff, the number of physicians in a particular specialty, other demands on these physicians, the frequency with which the hospital's patients typically require services of on call physicians, vacations, conferences, days off and the provisions the hospital has made for situations in which a physician in the specialty is not available or the on call physician is unable to respond.

The best practice for hospitals, which offer particular services to the public, is that those particular services should be available through on call coverage of the emergency department.

Physician group names are not acceptable for identifying the on call physician. Individual physician names are to be identified on the list.

Hospitals have the ultimate responsibility for ensuring adequate on call coverage. Hospitals have an EMTALA obligation to provide on call coverage for patients in need of specialized treatment if the hospital has the capacity to treat the individual.

A determination as to whether the on call physician must physically assess the patient in the emergency department is the decision of the treating emergency physician. The ER physician's ability and medical knowledge of managing that particular medical condition will determine whether the on call physician must come to the emergency department.

When a physician is on call for the hospital and seeing patients with scheduled appointments in his private office, it is generally not acceptable to refer emergency cases to his or her office for examination and treatment of an EMC The physician must come to the hospital to examine the individual if requested by the treating emergency physician. If, however, if it is medically appropriate to do so, the treating emergency physician may send an individual needing the services of the on call physician to the physician's office if it is part of a hospital-owned facility (department of the hospital sharing the same Medicare provider number as the hospital) and on the hospital campus.

If a physician who is on call does not come to the hospital when called, but directs the patient to be transferred to another hospital where the physician can treat the individual, the physician may have violated EMTALA.

For physicians taking call simultaneously at more than one hospital, the hospitals must have policies and procedures to follow when the on call physician is not available to respond because he has been called to the other hospital to evaluate an individual. Hospital policies may include, but are not limited to procedures for back up on call physicians, or the implementation of an appropriate EMTALA transfer according to 42 CFR §489.24(e).

The decision as to whether the on call physician responds in person or directs a non-physician practitioner (physician assistant, nurse practitioner, orthopedic tech) as his or her representative to present to the dedicated ED is made by the responsible on call physician, based on the individual's medical need and the capabilities of the hospital and applicable State scope of practice laws, hospital bylaws, and rules and regulations. The on call physician is ultimately responsible for the individual regardless of who responds to the call.

On call physicians may utilize telemedicine (telehealth) services for individuals in need of further evaluation and/or treatment necessary to stabilize an EMC, as permitted by applicable State scope of practice laws, hospital bylaws, and rules and regulations. Individuals are eligible for telemedicine services only when, because of the individual's geographic location, it is not possible for the on call physician to physically assess the patient.

Physicians that refuse to be included on a hospital's on call list but take calls selectively for patients with whom they or a colleague at the hospital have established a doctor-patient relationship while at the same time refusing to see other patients (including those individuals whose ability to pay is questionable) may violate EMTALA. If a hospital permits physicians to take calls selectively take call while the hospital's coverage for that particular service is not adequate, the hospital would be in violation of its EMTALA obligation by encouraging disparate treatment.

E. Specialist Not Available

The medical staff by-laws or policies and procedures must define the responsibility of the on call physicians to respond, examine and treat patients with an EMC.

Physicians, including specialists and sub-specialists (e.g., neurologists) are not required to be on call at all times or required to be on call in their specialty for emergencies whenever they are visiting their own patients in the hospital. The hospital must have policies and procedures (including back-up call schedules or the implementation of an appropriate EMTALA transfer) to be followed when a particular specialty is not available or the on call physician cannot respond because of situations beyond his or her control. The hospital is ultimately responsible for providing adequate on call coverage to meet the needs of its patients.

F Central Log

A central log on each individual who "comes to the emergency department", as defined in §489.24(b), seeking assistance and whether he or she refused treatment, was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred, or discharged. The provisions of this regulation apply to all hospitals that participate in Medicare and provide emergency services.

G. MSE Is Not Triage

A hospital must screen individuals to determine if an EMC exists. CMS has expressly stated that it is not appropriate to merely "log in" an individual and not provide a MSE. Individuals coming to the emergency department must be provided a MSE beyond initial triaging. Triaging is not equivalent to a MSE. Triage merely determines the "order" in which individuals will be seen, not the presence or absence of an EMC.

A MSE is the process required to reach with reasonable clinical confidence, the point at which it can be determined whether a medical emergency does or does not exist.

A hospital, regardless of size or patient mix, must provide screening and stabilizing treatment within the scope of its abilities, as needed, to the individuals with EMCs who come to the hospital for examination and treatment.

H. Transfers

Under EMTALA, transfer is permitted if the individual (or a legally responsible person acting on the individual's behalf) requests the transfer, after being informed of the hospital's EMTALA obligations and of the risk of transfer The request must be in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of the transfer Transfer is also permitted if a physician has signed a certificate that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based.

EMTALA requires an express written certification. Physician certification cannot simply be implied from the findings in the medical record and the fact that the patient was transferred.

The certification must state the reason(s) for transfer The narrative rationale need not be a lengthy discussion of the individual's medical condition reiterating facts already contained in the medical record, but it should give a complete picture of the benefits to be expected from appropriate care at the receiving (recipient) facility and the risks associated with the transfer, including the time away from an acute care setting necessary to effect the transfer The risks and benefits certification should be specific to the condition of the patient upon transfer This rationale may be on the certification form or in the medical record. Certifications may not be backdated.

I. Requirements for a Proper Transfer

There are four requirements of an appropriate transfer·

First, the provision of treatment to minimize the risks of transfer is the first requirement of an appropriate transfer If the patient requires treatment, it must be sufficient to minimize the risk likely to occur or result from the transfer

Second, the receiving facility must have available space and qualified personnel for the treatment of the individual; and must have agreed to accept transfer of the individual and to provide appropriate medical treatment.

Third, the transferring hospital must send to the receiving facility all medical records (or copies thereof) related to the emergency condition which the

individual has presented that are available at the time of the transfer, including available history, records related to the individual's EMC, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) required under paragraph (e)(1)(ii) of this section, and the name and address of any on call physician (described in paragraph (g) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records (e.g., test results not yet available or historical records not readily available from the hospital's files) must be sent as soon as practicable after transfer

Fourth, the transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer

SIOUX FALLS SURGICAL CENTER

QUALITY IMPROVEMENT / RISK MANAGEMENT PLAN

ORGANIZATION

Each patient has needs, including psychosocial, economic, spiritual and physical, which comprise the individual. Sioux Falls Surgical Center is responsible for meeting the patients' needs according to their individual state of health. We shall strive for optimal outcomes with continuous improvements that consistently represent a high standard of practice, minimize risks to patients and are cost effective.

MISSION

The Sioux Falls Surgical Center shall be the leader in providing the highest quality surgical, recovery care and diagnostic imaging services in an environment that is safe, convenient, and comfortable for our patients, their families, our employees and the health care practitioners who use our surgery, recovery care and imaging facility

QUALITY PHILOSOPHY

In accordance with our mission statement, administration, management, and all employees are committed to the continuous improvement of patient care. This commitment will be nurtured in an environment supportive of excellence, non-threatening in nature, open to suggestion and conducive to positive change. Administration, management, and staff will take an active part in a planned, systematic organization wide approach to the monitoring, analysis and improvement of performance and / or processes.

GOALS

A. Assure the delivery of patient care at an optimally achievable level of quality in a safe, professional, and cost-effective manner.
B. Improve the quality of care provided through ongoing, objective and systematic measurement, analysis and improvement of performance.
C. Maximize patient safety and minimize patient and organization risk of adverse occurrence.
D Advance awareness and knowledge of continuous quality improvement among administration, management and patient care providers.

E. Educate personnel to facilitate and promote organization wide philosophical commitment to quality of care, service and leadership. Ensure that leadership and staff understand the tenets of quality improvement.
F Respond proactively to customer expectations and feedback concerning the quality of care delivered.
G. Provide an efficient, competent and pleasant work environment for employees and physicians.
H. Meet the needs of third party payers and maintain requirements for regulatory compliance and accreditation

OBJECTIVES

A. Maintaining and monitoring an evaluation system to determine if providers of care and service are practicing optimally and identify opportunities for improvement.
B. Utilize appropriate quality tools to assist with problem identification and to ascertain improvement opportunities. Tabulate, aggregate, and summarize data and present in a meaningful format to assist in problem solving. Maintain a system of corrective action to assure problems or concerns are identified and resolved. Re-evaluation to determine that the corrective actions have sustained the desired result. If the problem or concern remains, alternative action will be taken to resolve the problem.
C. Proactively reduce the risk to patients by periodic review of resources, equipment and policies. Hold quarterly meetings of the Safety Committee, where safety issues are identified and researched.
D Administration, management, as well as all departments will participate in continuous quality improvement activities. Ideas will be encouraged from all employees. Front line employees will serve on process improvement teams. Those who know the most about a specific process will be involved in the evaluation and submit recommendations for improvement.
E. QI training is incorporated in orientation. Comprehensive training for all employees at all levels of the organization will be completed annually
F Patient satisfaction questionnaires will be evaluated. All patients' comments will be assessed with individual follow-up. Patients concerns and comments will be tracked and trended for problematic areas and improvement opportunities.
G. Identification of problems or opportunities for improvement is encouraged from staff and practitioners. On site continuing education will be provided as well as ongoing inservicing of new equipment and surgical procedures. Physician and staff satisfaction will be assessed biannually
H. Policies and procedure compliance will be randomly reviewed to ensure that all Federal, State, accreditation requirements are met and also to assure organization wide adherence with the compliance program.

QUALITY IMPROVEMENT / RISK MANAGEMENT COUNCIL

The Quality Improvement Council shall be comprised of, administrative, management, and direct patient care employees. Individuals within the team will represent the entire facility, providing a cross/functional group that possesses an overall knowledge and understanding of the surgical center as a whole. Members shall include, but not be limited to:

- Quality Improvement Director-Chairperson
- Medical Director, acts as representative from the Management Committee
- One representative from the Credentials Committee
- Two SFSC practicing physicians
- One representative from Anesthesia Department
- Two representatives from the Surgery Department
- Two representatives from PACU
- Two representatives from Recovery Care Department
- One representative from Admissions Office
- One representative from the Business Office
- Infection Control Nurse
- Risk Manager
- Director of Nursing

AUTHORITY AND RESPONSIBILITY

ALL MEMBERS

1. Meet quarterly; date shall be determined by the Quality Improvement Coordinator to coincide with the schedules of Council members and staffing needs of the Sioux Falls Surgical Center.
2. Assist in the preparation of the annual quality improvement strategic plan.
3. Evaluate the scope, organization and effectiveness of the quality improvement plan and make revisions as necessary
4. Assist in the identification and monitoring of QI activities.
5. Coordinate a system of problem identification, problem resolution and re-evaluation.
6. Act as the organizational body responsible for risk management activities.
7 Evaluate trends of employee / patient / visitor occurrence reports.
8. Constantly evaluate quality and be on the lookout for ways to improve.

MANAGEMENT COMMITTEE

1. Is responsible for overall care at the Sioux Falls Surgical Center.
2. Provides one representative to the Quality Improvement Council.
3. Evaluates and approves the Quality Improvement and Risk Management Plan.
4. Receives and reviews Quality Improvement Council minutes and reports.
5 Participates in the review of credentials as well as quality of care issues and concerns of all active staff prior to their reappointment.

PHYSICIAN REPRESENTATIVES

1. Contribute to medical staff quality assurance activities.
2. Act as a resource in the development of Case Review protocol.
3. Provide input in the development of criteria to be monitored in order to evaluate the quality and appropriateness of clinical performance.

MEDICAL DIRECTOR

1. Is responsible for and accountable to the Management Committee for the facility's QI program.
2. Acts as a liaison between the Management Committee and organizational departments for matters affecting operations.
3. Reports improvement activities to the Management Committee.

QUALITY IMPROVEMENT DIRECTOR

1 Designs and implements the QI plan for the SFSC.
2. Initiates policy and procedure development for the QI department.
3 Conducts QI activities in a manner that complies with regulatory and AAAHC accreditation standards.
4. Educates new staff and provides ongoing educational activities for the facility to support quality activities. Facilitates and promotes organization wide philosophical commitment to quality
5 Acts as Chairperson for the QI committee. Serves as the focal point of QI activities.
6. Directs prioritization of issues for assessment and improvement based on effect on patients and available resources.
7 Acts as a resource person to provide input to infection control activities.

8. Promotes and supports systems and processes to achieve safe, cost effective, high quality healthcare.
9 Reviews, tracks and trends employee/visitor / patient occurrence reports.
10. Coordinates events for QI activities. Provides guidance and organization to the activities of quality improvement.
11. Uses collaborative efforts and teams to study and improve specific existing processes.
12. Coordinates the activities of process improvement teams by providing guidance and instructions. Functions as a team facilitator as needed. Coordinates team efforts to monitor and evaluate patient care
13. Prepares and displays quality improvement reports and activities utilizing data in a meaningful format. Tabulates, aggregates, summarizes and displays pertinent data.
12. Develops complete, timely reliable reports. Shares information with appropriate staff, including reports to the D.O.N., the Medical Director, and the Executive Director. Submits QI reports and minutes to the Management Committee for review at their meetings.

RISK MANAGER

1. Supervises credentialing committee appointment and reappointment activities.
2. Investigates employee/visitor / patient occurrence reports.
3. Monitoring of surgical outcomes.
4. Acts as a resource person to provide input on all regulatory and compliance issues.
5. Provides input into employee health/risk management/ infection control / education and safety activities.
6. Promote process improvement for the ongoing prevention and reduction of risk.
7 Functions as liaison to liability insurance company

INFECTION CONTROL NURSE

1. Responsible for the new employee orientation of infection control practices.
2. Responsible for the annual mandatory in-service of bloodborne pathogens.
3. Acts as a resource for employees and managers providing information and support as needed.
4. Investigates all surgical site infections and reports information to appropriate managers and the QI Director.
5. Conducts surveillance rounds addressing potential high-risk issues.

SAFETY OFFICER

1. Works with Risk Management personnel to develop and implement employee injury prevention strategies and programs. Monitors program effectiveness and makes adjustments as necessary
2. Reviews all employee / visitor / patient occurrence reports.
3. Investigates occurrences regarding malfunctioning medical devices.
4. Promotes an atmosphere of "culture of safety" without blame.
5. Ensures compliance with all environmental health and safety standards promulgated by all local, state, and federal agencies.
6. With the Environmental Services Director, conducts building and grounds hazard surveillance surveys on a periodic and regular basis to detect code violations, hazards, and incorrect work practices and procedures.
7 Develops and recommends new procedures and approaches to safety and loss prevention based on reports of occurrences, accidents and other relevant information.

Members of the safety committee, which meets quarterly, monitor safety issues. Findings/concerns will be submitted to QI and included in the quarterly report to Management Committee

DEPARTMENTAL REPRESENTATIVES

1. Actively participate in the identification of objectives for the annual specific plan.
2. Participate on specific process improvement teams as activities indicate.
3. Assist in data collection, analysis and finalizing reports to support departmental goals.
4. Responsible for reporting findings, actions and follow-up of activities to his/her department. Reports are to be reflected in unit meeting minutes.

EMPLOYEES

1. Are knowledgeable of and actively participating in and supporting the QI process.
2. Are involved in a daily search for improvements in all services, products and organizational processes.
3. Contribute to the achievement of improvement goals through individual action or in partnership with others.
4. Communicate and work together to achieve the mission statement, values and goals of Sioux Falls Surgical Center.
5. Develop a teamwork relationship with all customers and suppliers.

6. Focus on the QI process to exceed the needs and expectation of the customers, suppliers.
7 Are committing to making customer satisfaction and safety top priority

CUSTOMER SERVICE AND SATISFACTION

Satisfaction evaluation will be utilized and completed to determine facility and staff strengths and weaknesses. Data will be analyzed to identify specific areas, which need improvement and /or trending patterns. Patient satisfaction will be assessed regarding care received and patient outcomes. Customer feedback will be utilized for providing direction for improvement opportunities.

QUALITY OF CARE PEER AND MEDICAL RECORDS REVIEW

Quality of care Peer and Medical Records review shall be completed to assist in credentialing as well as being a mechanism for evaluating the quality of patient care in an environment that is safe, convenient and comfortable. Evaluating the health care provided insures that the health care professionals are providing the quality of patient care that the SFSC makes every effort to achieve. Case review shall involve a continual, routine gathering of information. Objective and systematic monitoring will be utilized in the evaluation of documentation and unexpected outcomes Staff members as well as physicians shall be engaged in this process. Case review information will be incorporated into the reappointment process.

CONTRACTED SERVICES

There is an ongoing collection of information from contracted services to assist in determining that the use of these services is consistent with the patient's needs. By evaluating the level of health care provided, we ensure that the contracted service is meeting the high level of care that the SFSC strives to achieve This monitoring of contracted services shall be comprehensive and shall utilize TQM tools in order to adequately address the full scope of services provided, identify and address any problem areas.

QUALITY IMPROVEMENT STRUCTURE

A. The review of patient care shall include the following characteristics:

1. Ongoing and Systematic Process

a. Tracking data over time (Ongoing) and evaluation of this data determines what elements of patient care best reflect the overall care provided by the department, what kinds of information needs to be collected about these elements of care, and how often the information should be collected and evaluated. This approach is outlined in the yearly strategic plan and is evaluated and updated annually
b. A systematic process for data collection and evaluation means that information about various elements of patient care and clinical performance is collected as part of the daily functions of the department when appropriate. The information is collected at the various agreed on intervals of time and is representative of the practitioners involved and the type of service provided.
c. Monitoring of care and outcomes shall be comprehensive, not limited to problem focused studies,

2. Problem Identification
   a. Methods of assessment, monitoring and problem identification shall include, but not be limited to:
      1. Observation
      2. Interview
      3. Record Review
      4. Concurrent Monitors
      5. Brainstorming
      6. Retrospective Monitors
      7 Benchmarking
      8. FMEA
   b. Identification of problems and/or opportunities may be revealed by utilizing the following sources:
      1. Policies and Procedures
      2. Standards of care
      3. Guidelines for documentation
      4. Current literature teaching
      5. Cost of care

   c. Other means of problem identification utilized in the continued effort to improve patient care include that which comes through:

      Internal methods
      - Medical Records
      - Infection/Hospitalization follow up
      - Management Committee
      - Quality of care Peer and Medical Records Review
      - Occurrence Reports

External Methods

- Regulatory Agencies
- Federal Legislation
- Professional Organizations
- Networking/ Benchmarking

d. Each department participates in the development and application of the objectives used to evaluate the care they provide. They shall identify problems that have an impact on patient care and outcomes, clinical performance and overall process. All staff will observe clinical performance and identify patterns or trends and be constantly on the lookout for ways to improve.

e. The primary approaches/methods of problem assessment and evaluation are:

Structure

Structure is the arrangement of the care system or elements that facilitate care; resources, staff, equipment, policies etc., evidence of the facilities ability to provide care; the care environment.

Process

Refers to the method, means, sequence of steps or procedures for providing care and producing outcomes. There may be many or few processes directed towards the evaluation of activities carried out by health care personnel in the delivery of patient care.

Outcome

Directed toward the evaluation of a patient's health status as a result of patient care delivered, the end results of care. It is retrospective as the patient's chart is reviewed following discharge. The audit is done with a focus on a specific problem or concern identified, or specific processes, as well as any potential problems that could affect the patient's outcome.

3. Analysis

Analysis of information about important aspects of patient care and patient outcomes shall utilize statistical methods and tools to interpret data accurately and produce meaningful information in order to adequately address the full scope of services provided including high risk, high volume, new procedures and problem prone areas.

a. Analysis of ongoing data collection and/or identified problems may be completed by utilizing, but not limited to, the following tools.
    1. Process Improvement Teams
    2. Brainstorming
    3. Control Charts
    4. Flow Charts
    5. Pie Charts
    6. Pareto Charts

d. If problems are suspected, problem focused studies may be performed to determine the cause, magnitude and impact of the problem.

e. In some cases, a combination of any or all of the approaches/methods may be used. The type of problem identified determines the method chosen for monitoring/evaluation/improvements.
    1. Procedural (process-observation)
    2. Documentation (outcome / process record review)

4 Action

Action is taken as appropriate when negative findings, trends, special cause variation, problems or opportunities to improve care are identified. Actions may include:

a. Changes or modification of equipment/supplies.
b. Process analysis and review
c. Development / review / revision of policy, procedures, standards, and guidelines.
d. Assessment and / or modification of contracted services.
e. In-service education
f. Employee / Practitioner counseling
g. Re-evaluation of identified problems or concerns is performed to assure that the corrective measures have achieved and sustained the desired result.
h. Alternative corrective actions are taken as needed with continuing re-evaluation.
i. Documentation of findings, conclusions, recommendations, action taken and results of action taken will be documented in:
    1. Quality Improvement Committee meeting minutes.
    2. Reports and monitors to the Quality Improvement Council
    3. Reports and minutes to the CEO and Management Committee.
    4. Each department representative must submit a written or oral report of QI activities at his / her unit meetings. This report should be reflected in the unit meeting minutes.
j. Corrective actions take into account the following:
    1. Resources available
    2. Time involved

3. Cost

MEASURES OF EFFECTIVNESS

The QI Director is responsible for the facilitation, documentation, and reporting of the day-to-day functions of the overall quality program.

The objectives, scope, organization and effectiveness of the activities of the Quality Improvement Program are evaluated at least annually and revised as necessary Quality plans will be reviewed at the Management Committee meetings. This review of the overall quality plan and annual strategic plan evaluates the effectiveness of the program. Emphasis will be placed on areas monitored, evaluated, identified problems, opportunities for improvement, success of actions taken toward problem resolution and improvements made in patient care. Efficiency and cost-effectiveness will also be evaluated. Revisions to the program will be effective upon approval of the Management Committee.

CONFIDENTIALITY

All copies of minutes, reports, and worksheets will be handled in a manner ensuring strict confidentiality These may be stamped or marked "CONFIDENTIAL" Results of quality assurance activities and reports will not contain identifiable client information. Information may be coded or reported in aggregate.

MEDICAL DIRECTOR DATE

_____ _____

SIOUX FALLS SURGICAL CENTER 2006
CONTINUOUS QUALITY MANAGEMENT / RISK MANAGEMENT
GOALS AND STRATEGIC PLAN

I. EMPLOYEE EDUCATION, CERTIFICATIONS, TRAINING

Comprehensive training of employees at all levels of the organization will be completed. QI training is incorporated into the new employee orientation. A facility wide QI educational week will be held annually This week will include training sessions that will include an overview of our QI program as well as descriptions and clarifications of staff responsibilities. The program will be presented at various times during the week to accommodate the employees work schedules.
The program will include:

a. Quality awareness
b. Staff participation
c. The SFSC's mission statement and goals.
d. Customer Satisfaction
e. Employee Suggestions

In addition to the training sessions the week will include poster presentations, quality quizzes, and prize drawings.
Just in time training will be utilized for process improvement teams. Just in time training will include:

a. Definition of the team assignment.
b. Identification of the scope of responsibility of the team
c. Use of basic quality improvement tools.
d. Role of team leaders and facilitators

II. REGULATORY GOALS

- Remain compliant with the South Dakota Department of Health Hospital rules and HCFA regulations.
- Documentation for each year will be maintained and summary will be broken out per quarter. The supporting statistics will be maintained in a locked file cabinet.
- Policies and Procedures will be reviewed annually
- Annual employee education will be provided.

III. BENCHMARKING

Comparison of key performance measures with other like organizations or with best practice of national or professional targets will be completed. Accurate facility historical data will be collected to be compared now and in the future.

- A procedure specific benchmarking study will be completed with like facilities.
- Comparative analysis from FASA will be utilized to determine best practice for benchmarking purposes.
- SFSC will participate in ASHA benchmarking activities.

IV ONGOING EVALUATION OF PATIENT SATISFACTION

Satisfaction evaluation will be utilized and completed to determine facility and staff strengths and weaknesses. Data will be analyzed to identify trends and/or specific problem areas. Patient satisfaction will be assessed regarding care received. Patient feedback will be utilized for providing direction for improvement opportunities.

- Satisfaction survey and/or input received verbally via phone calls, letters, etc., will be dated when received.
- The numeric portion of the surveys will be entered into a data sheet for evaluation and trending by the quality department. This information will be incorporated into a graph and included with the monthly narrative report. Cumulative monthly ratings of individual questions will be tracked and trended on a run chart.
- Any survey with a numeric rating of 2 or lower in any area will be investigated and forwarded to SFSC management as deemed necessary by the quality department.
- The quality department will review all narrative comments. These comments will be compiled and shared with staff monthly
- Patient's comments will be shared with individuals whose names were specifically mentioned on the survey
- Target for follow up on patient comments/concerns will be two weeks from the time the patient survey is received.
- Monthly summaries of comments will be posted in a binder in the staff lounge.

V SURGICAL COMPLICATIONS

Each month all surgeons performing cases will receive a Patient Outcome Survey listing their patients and procedures

- Infection Control
  - All patients who have a reported infection will be assigned a classification by the Infection Control nurse.
  - The Infection Control Nurse or designee will complete follow up on all patients sustaining a post-operative surgical site or other infection.
  - All reported infections will be tracked, trended, and investigated for commonalities.
  - All reported infections will also be tracked by specialty Comparative analysis will be completed with data received from FASA and ASHA quarterly reports.
- Hospitalizations
  - Patients admitted to a hospital within 72 hours are designated on the returned survey
  - A discharge summary will be obtained from the admission hospital.
  - All hospital admissions will be tracked and trended.
  - Comparative analysis will be completed with data received from FASA and ASHA quarterly reports.
- Complications
  - All complications will be investigated, tracked and trended.
  - Comparative analysis will be completed utilizing internal historical trends.

VI. REVIEW MEDICAL RECORDS AND STAFF PEER REVIEW FOR QUALITY OF CARE AND COMPLETENESS

- Chart assessment will be ongoing to assure completeness of routine documentation within 30 days. This review will be consistent with our goal to achieve and maintain optimal documentation of patient care.

VII. PHYSICIAN CREDENTIALING/PEER REVIEW

The physician members of the Board of Directors will review credentials as well as the results of quality management outcome measurements of all active staff prior to their reappointment. Outcome measures include but may not be limited to:

- Hospital transfers and admissions with-in 72 hours.
- Post-op surgical site, or other infections.
- Number of surgical procedures.
- Patient return to the Operating room.
- Surgical complications

The area under review and the method of chart selection will be outlined specifically in the Peer Review Plan. An annual profiling report including outcome measures will be placed in each physician's peer review folder.

VIII. QUALITY IMPROVEMENT/RISK MANAGEMENT COMMITTEE QUARTERLY MEETINGS

The Quality Improvement committee will provide organizational direction and oversee all of the continuous quality improvement activities. The committee will be utilized to sustain, facilitate, and expand the quality improvement activities based on the organization's mission statement and goals. There will be medical staff, management, and front line staff participation. The committee will strive to provide clear communication of quality measures throughout all levels of the organization. Department delegates will be responsible for communicating quality activities at his/her department staff meeting. Quarterly summaries will be posted in the employee lounge.

IX. MONTHLY TRACKING AND TRENDING OF EMPLOYEE AND / OR PT VISITOR INCIDENT REPORTS

Tracking and trending of incident reports will focus on analysis of data and decision-making techniques to predict potential risk and to estimate financial impact on the facility Reports will be prioritized by frequency, severity, and potential reduction.

- Ongoing evaluations of all incidents will take place. A report will be presented at the quarterly Quality Improvement meeting.
- Follow-up will be completed immediately on all contaminated exposures.
- The employee health nurse will complete an annual report including all employee-contaminated exposures.
- Comparative analysis will be completed utilizing internal historical trends and data received from like facilities and FASA.

- Ongoing tracking to identify trends will be completed.

X. FACILITY WIDE GOALS

IMPROVING FACILITY WIDE COMMUNICATION

- 2006 Quality focus will be on improving the communication at SFSC. Several communication models will be evaluated. After a model is selected we will trial, educate and implement the new communication model.

BAPTIST INSTUTUTE LEADERSHIP PROGRAM

- Achieving facility excellence by focusing on employee satisfaction, physician satisfaction, customer satisfaction, leadership development and accountability activities into a comprehensive method for focusing SFSC's culture on service and operational excellence.

XI. DEPARTMENTAL GOALS

A QI folder will be available to each department. The contents of this folder shall include the departmental goals and activities for the calendar year. Studies from the department and other pertinent QI information will be included. Patient confidentiality and privacy will be maintained at all times.

A. Front Desk

1. Evaluate process for forwarding Operative note to referring physicians. Identify problems and opportunities for improvement.
2. Evaluate patient use of web site pre registration. Identify ways of increasing patient awareness and use of web site.
3 Develop a method to survey family/friends of patients waiting in the lobby Identify problems and opportunities for improvement.

B. Admission to the Pre-Operative Department

1. Evaluate pre-op time frame (wait), assess and trend. Identify problems and opportunities for improvement.

C. Operating Room

1 Surgical Indications Monitoring (SIMS) study for a high frequency procedure done at SFSC.
2. Assess patient wait time in the Operating room from time brought to OR to actual incision time. Identify problems and opportunities for improvement.
3 Decrease surgical delays by improving accuracy of scheduled operative times.
4. Improve the adherence in the completeness of preference cards, to assure accuracy of supplies.

D. PACU

1. Track and trend telephone advice calls.
2. Improve effectiveness of discharge planning and teaching. Form a process improvement team for the evaluation and improvement of discharge planning and teaching. Main focus would be crutch instructions and microdisc teaching.
3. Perform chart audits of staff to be utilized with performance reviews.
4. Increase quality and consistency of message to patient's with the development of scripted statements regarding 02 saturations and prior to pain medication administration.
5 Achieve PALS certification for all PACU nurses.
6. Follow up of Versed FMEA, evaluate any reports of problems after Versed administration.

F Recovery Care

1 Ensure that patient food is being served in accordance with state regulations by monitoring food temperatures. A quarterly report will be submitted. Improve quality and selection of patient food.
   - Assess timeliness of dinner order receipt to assure delivery at 6 pm.
2. Tracking of unscheduled admits to Recovery Care, monitor admission diagnosis for trends.
3. Track patients' questions by phone, post discharge to assess areas that we may be able to improve.
4. Evaluate 100% of patient satisfaction questionnaires. The same guidelines listed above will be followed. Maintain or improve our present level of satisfaction.

G. Business Office

1. Focus on obtaining accurate patient and responsible party accurate demographic information.
2. Coding audits—internal x 2, external x 1.
3 Transcription—broaden the capability of the dictation system, restructure filing of specific patient dictation to allow easier location and electronic communication.

H. Regulatory affairs

1 Re-evaluate completion of medical records within 30 days.

2. Re-evaluate timeliness of H&P completion. Assessment of adequacy and timeliness will be based on state and federal regulations.

3 Compliance with HIPAA Security Rule requirements by April 20, 2006.

4. Improve current process for obtaining and tracking physician privileging. Research core privileging for physicians.

5 Improve occurrence reporting.

a. Research and employ on-line reporting with the development of the intra-net service. (This will be a joint venture with the IS department)

I. Information systems

1 Implementation of the Network Recovery System
2. Development and implementation of an intranet.

J MRI

1 Evaluate 100% of patient satisfaction questionnaires. The same guidelines listed above will be followed.

K. Safety

1 Conduct a FMEA (Failure Mode and Effects Analysis) on medication administration
2. Develop a team to look at the process for delivering medications – from taking the orders, signing off orders, and administering the medication. Evaluate process for opportunities to reduce medication errors.
3 Develop a team to evaluate the current patient handoff process for problem areas and improvement opportunities.
4 Research and evaluate potential new safety sharps devices.

XII. CONTRACTED SERVICES

Maintain a continuous effort by all members of our facility to meet the needs and expectations of the customer, the staff and the regulatory agencies. In our commitment to continuous quality improvement we include our contracted services in our QI program. This will assist us in determining if providers of a service are practicing optimally and identify opportunities for improvement.

A. Dietary Department

1 Assess patient satisfaction survey (incorporated into RCC Patient Satisfaction Questionnaires
2. Spot check – food temperature (RCC food temperature record)

B. Laboratory

1 Obtain CLIA certificate from contracted Labs. Obtaining certificate will insure that contracted laboratories are in compliance with regulatory standards.
2. Patient Satisfaction Questionnaires (any questionnaires with specific lab related complaints / concerns will be referred to the laboratory director)

C. Avera McKennan Hospital Radiology

1 Report of re-takes provided annually to the QI committee for review; a comparison of nationwide statistics will be made.
2. Report of integrity of X-ray aprons annually

3 Ongoing review of chart completion to include radiology reports and/or physician note of use of radiology

D Pharmacy

1 Ongoing monitor of drug outdates.
2. All medication errors will be reported to the P & T committee for review
3 Copies of all adverse drug reactions will be reported to the P & T committee for review
4. Copies of all adverse drug reactions will be forwarded to the QI department for tracking and trending.

E. Anesthesia

1 Re-evaluation and continuation of a written post-anesthesia evaluation with-in 48 hours of surgery and prior to patient discharge. Improve the compliance of postop visits to RCC by anesthesia personnel.
2. Re-evaluation of noting of pre-op orders. By completing all necessary documentation of pre-op orders we can insure that our patients are receiving the highest level of quality care in the most efficient, safe, and accurate way possible.
3 Track and trend all post-operative complications. Data will be collected via incident reports and / or monthly physicians' patient outcomes survey
4. Development and implementation of an Anesthesia Peer Review Program.

F Physical Therapy

1 Assure physical therapy visits / treatments are appropriately documented.

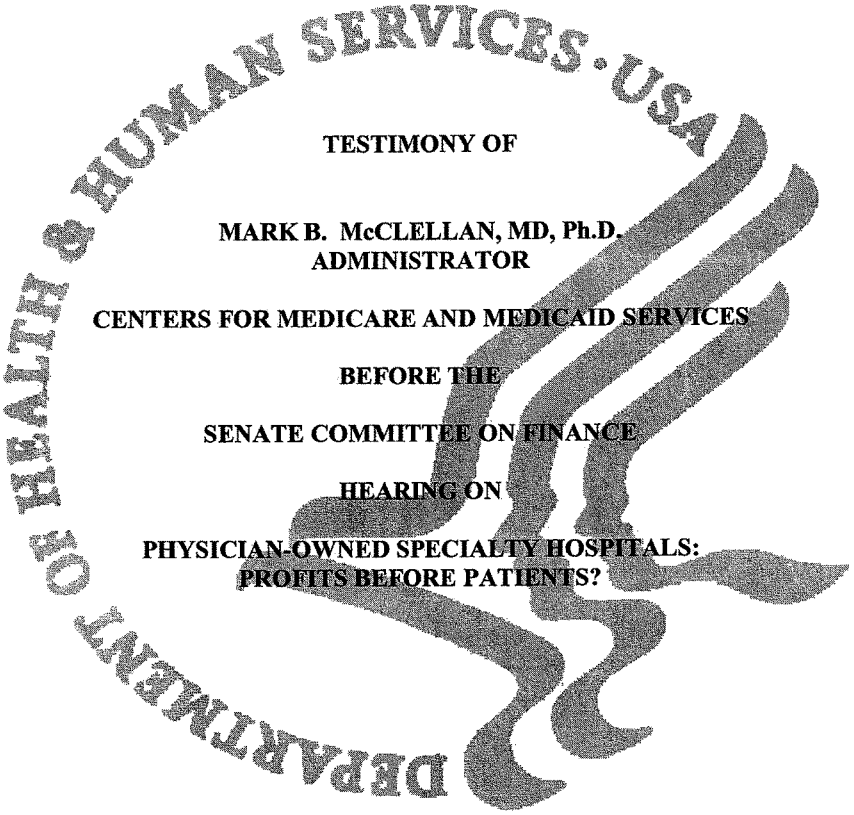
G. Laundry

1 Assure that the appropriate water temp. of 160 F (71 C) is being utilized on all laundry If chlorine bleach is added to the laundry process to provide 10 parts per million or more of free chlorine the minimum hot water temperature may be reduced to 140 F (60 C). Spot checks of laundry temp will be completed. An annual written report will be submitted.

The quality improvement plan will remain flexible as other problems – suggestions for QI activities arise.

_____ Medical Director Signature _____ date.

_____QI Director



TESTIMONY OF

MARK B. McCLELLAN, MD, Ph.D.
ADMINISTRATOR

CENTERS FOR MEDICARE AND MEDICAID SERVICES

BEFORE THE

SENATE COMMITTEE ON FINANCE

HEARING ON

PHYSICIAN-OWNED SPECIALTY HOSPITALS: PROFITS BEFORE PATIENTS?

MAY 17, 2006

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Testimony of
Mark B. McClellan, MD, Ph.D.
Administrator, Centers for Medicare & Medicaid Services
Before the Senate Committee on Finance
Hearing on
Physician-Owned Specialty Hospitals
May 17, 2006

Chairman Grassley, Senator Baucus, distinguished Committee members, thank you for inviting me to testify today about the Centers for Medicare & Medicaid Services' (CMS) role in ensuring its beneficiaries have access to quality health care. Through our payment systems and quality efforts, CMS is working to promote a level playing field for all health care providers, including both community hospitals and physician-owned specialty hospitals.

At CMS our chief concerns are the quality of care for people with Medicare and Medicaid and the efficiency of Medicare and Medicaid spending. We make no differentiation in the application of our quality standards whether a facility is rural or urban, or for-profit or not-for-profit. Through Medicare's conditions of participation requirements and the survey and certification process, CMS monitors and enforces quality requirements for all hospitals. If necessary, CMS has the authority to terminate a hospital's participation in the Medicare program; and, CMS recently used this authority to put a facility in Oregon on track for such action.

CMS also is actively working to ensure payments for services promote quality and accurately reflect the cost of providing care. As you know, how Medicare pays for medical services can significantly impact quality and medical costs for our beneficiaries and our overall health care system. With a reimbursement system based on admissions and procedures and not outcomes or efficiency, the current system may pay for services that are ineffective, inefficient and out-of-date, instead of recognizing and encouraging quality care that prevents complications and errors. Moving toward a performance-based

payment system could potentially enhance fair competition across health care settings. By leveling the financial playing field for all hospitals, Medicare payments to hospitals will more accurately reflect actual resource needs. This can be achieved, in part, for example, by reconfiguring payments to better recognize severity of illness. CMS also is considering ways to improve patient safety and the Medicare payment system by addressing "never events," which are serious, preventable medical errors.

Public disclosure of hospital pricing and quality data also has the potential to spur quality improvements at all hospitals. Quality and cost information is increasingly available and being used by patients to create a health care system that is more transparent. We hope that this will eventually provide every patient with an opportunity to get a clear idea of the quality of providers and the price of treatment options available to them and will help them to make an informed choice about their own health care. And people may find more opportunities to save when they use such information effectively

In addition to promoting quality at all hospitals and improving the accuracy of Medicare's payment systems, CMS has responded to questions raised by Congress regarding physician-owned specialty hospitals. Last year, CMS completed a study on referral patterns and quality in physician-owned specialty hospitals, finding that certain specialty hospitals delivered high quality care that was as good as or better than their competitor hospitals. CMS also implemented a moratorium for new specialty hospitals included in the Medicare Modernization Act (MMA). This moratorium began on December 8, 2003 and ended on June 8, 2005 During that period of time, new physician-owned specialty hospitals (excluding those physician-owned specialty hospitals that were found to be "under development" as of November 18, 2003) were unable to take advantage of the "whole hospital exception" of the physician self-referral statute. In other words, these physician-owned specialty hospitals were prohibited from billing Medicare for services furnished to patients referred to the specialty hospital by a physician-owner. The moratorium did not prevent such hospitals from opening and receiving a Medicare provider number. It also did not absolutely prevent the physician-owned specialty hospital from billing Medicare during the moratorium for

services furnished to patients referred to the specialty hospital by non-owner physicians. Following this moratorium, CMS went even further, suspending the enrollment of new specialty hospitals, while reviewing the Agency's enrollment procedures. The Deficit Reduction Act (DRA) built on this action, continuing the enrollment suspension until CMS developed a strategic and implementing plan regarding physician investment in specialty hospitals.

CMS' On-Going Quality Assurance Operations

CMS has had responsibility for ensuring the quality of hospital care from the inception of the Medicare program in 1965 In order to participate in the Medicare program, all hospitals, regardless of whether they are general or specialized, must meet the Conditions of Participation (CoPs), as laid out in regulation.

These minimum health and safety standards cover a broad range of operational requirements and represent the foundation for improving quality and protecting the health and safety of Medicare beneficiaries. Every hospital seeking a Medicare billing number must pass an in-depth survey to demonstrate that it meets all applicable Conditions of Participation.

Hospitals have two options when it comes to the survey They can seek accreditation from an approved body such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or they may apply directly to CMS for a review Reviews for CMS are carried out by individual State Survey Agencies, under contract with CMS.

Hospitals choosing accreditation through accrediting organizations must undergo on-site surveys by such organizations at least every three years to maintain their accreditation. As of 2006, these surveys are made on an unannounced basis. Surveys include evaluation of care processes throughout the hospital, meetings with senior management and selected caregivers, a review of medical records and a physical inspection of the hospital building.

The surveys ascertain whether a provider/supplier meets applicable requirements for participation in the Medicare and/or Medicaid programs, and evaluate the hospital's performance and effectiveness in rendering safe care of an acceptable quality Each survey also examines a provider's efforts to prevent environmental hazards due to contagion, fire, contamination, or structural design and maintenance problems. It also ascertains that the responsible provider officials and key personnel are effectively doing all they must do to protect health and safety

If the hospital is surveyed by the State Survey Agency or an accrediting body other than JCAHO, such survey organization officially recommends its findings regarding whether health care entities meet applicable legal and regulatory definitions and requirements. Based on such information, CMS then makes a decision as to initial certification and issuance of a provider number. Pursuant to statute, JCAHO-accredited hospitals are automatically deemed to be in compliance with CMS standards.

As a general rule, State Survey Agencies and accrediting bodies do not have Medicare determination-making functions or authorities; those authorities are delegated to CMS' Regional Offices. However, they provide the crucial evidence relied upon by the Regional Offices in approving health care entities to participate in the Medicare program.

When CMS receives a credible report of the existence of potential threats to the health and safety of patients, the Agency authorizes the State Survey Agency to conduct a complaint investigation. In FY 2005, for example, 4,876 such complaint investigations were conducted by State Survey Agencies in general hospitals, 143 complaint investigations were conducted in Critical Access Hospitals, and 32 complaint investigations were conducted in specialty hospitals. CMS encourages anyone with information regarding a quality concern to refer the matter to one of our ten Regional Offices for investigation.

An institution that fails to comply with every condition cannot participate in Medicare.

If the State Survey Agency or accrediting body discovers deficiencies in a hospital's operations, it prepares a certification of such finding for the CMS Regional Office and sends the institution a "Statement of Deficiencies" form. Unless an immediate jeopardy deficiency is found, the institution is given 10 calendar days in which to respond with a Plan of Correction for each cited deficiency, and enters this response on the form containing the statement of deficiencies.

If the institution has not come into compliance with all Conditions within the time period accepted as reasonable, the State Survey Agency certifies noncompliance, notwithstanding a Plan of Correction. At this point, CMS may begin termination procedures to revoke the institution's Medicare billing number. If an immediate jeopardy deficiency is found, the institution's Medicare agreement is terminated within 23 days, unless prior to the scheduled termination the following occurs: the immediate jeopardy situation is corrected, the CMS Regional Office receives an acceptable Plan of Correction from the institution, and compliance is achieved and documented through onsite verification during a full survey of all Medicare Conditions of Participation.

As part of ongoing quality monitoring activities for all hospitals that treat Medicare patients, CMS recently found significant quality concerns with a Portland Oregon hospital, and has placed it on a termination track. Termination of a hospital's enrollment in Medicare can have severe adverse impacts on access to health care in a community, as well as resulting in loss of employment for hospital staff. Consequently, hospitals usually undertake significant responses to improve quality and safety when these steps are taken by CMS. CMS' first emphasis is on bringing a hospital into compliance, with termination occurring when that proves impossible.

CMS Focuses on Improving Quality of Care at All Hospitals

CMS recognizes the potential of the Medicare payment system to encourage and reward quality care in the hospital setting. This is particularly important, as it provides an opportunity to address quality concerns proactively Therefore, CMS has worked with a number of key stakeholders, including hospital representatives and consumer groups,

through the Hospital Quality Alliance to develop a shared national strategy for improving the quality of care provided at all hospitals, including physician-owned specialty hospitals. Since 2003, CMS has supported and advanced the Hospital Quality Alliance, which is an unprecedented public-private partnership that has helped develop strategies that improve quality, promote health, and prevent complications and duplicative or unnecessary services.

The Hospital Quality Initiative is designed to stimulate improvements in hospital care by standardizing hospital performance measures and data transmission to ensure that all payers, hospitals, and oversight and accrediting entities use the same measures when publicly reporting on hospital performance. Although hospitals are not mandated to submit clinical performance data to CMS, the Medicare Modernization Act (MMA) gives CMS the authority to pay hospitals the full market basket update – a 0.4 percentage point differential – upon submission of performance data for a "starter set" of 10 quality measures. This payment adjustment resulted in near-universal reporting of the measures.

The reporting requirements were further expanded through the Deficit Reduction Act (DRA) to include the reporting of additional measures in FY 2007 Failure to report on this expanded set of measures will result, effective for FY 2007, in a reduction of 2 percentage points in hospital payment. Importantly, the DRA will, for the first time, allow CMS, beginning in FY 2008, to begin to adjust payments for hospital acquired infections. Currently, infections acquired in any hospital can trigger higher Medicare payments because these cases are assigned to higher paying diagnosis related groups. CMS intends to use this new provision, as well as a growing set of measures related to patient satisfaction and outcomes, to ensure that our payment system encourages all hospitals to treat patients efficiently and effectively

For example, two quality measures endorsed by National Quality Forum for heart failure patients include placing the patient on blood pressure medications and beta blocker therapy Here too, these therapies have been shown to lead to better health outcomes and reduce preventable complications. Together, diabetes and heart failure account for a

large share of potentially preventable complications. Measures of effectiveness and safety of some surgical care at the hospital level have been developed through collaborative programs like the Surgical Care Improvement Program (SCIP), which includes the American College of Surgeons. Preventing or decreasing surgical complications can result in a decrease in avoidable hospital expenditures and use of resources. For example, use of antibiotic prophylaxis has been shown to have a significant effect in reducing post-operative complications at the hospital level. This measure is well developed and there is considerable evidence that its use could not only result in better health but also avoid unnecessary costs. These post-operative complication measures, which are in use in our Hospital Quality Initiative, are being adapted for use as physician quality measures. Application of this type of post-operative complication measure at the physician level has the potential to help avoid unnecessary costs as well as improve quality

Transparency of Quality Data Aids Consumer Choice

The data from the "starter set" of 10 quality measures, as well as additional voluntarily-reported data on other quality measures are available to the public through the Hospital Compare website at http://www.hospitalcompare.hhs.gov This website provides information on hospital quality of care for consumers to use to select a hospital. It further serves to encourage consumers to discuss the quality of care provided with their doctors and hospitals, thereby providing an additional incentive to improve the quality of that care. In addition to the Compare website, CMS is working on ways to provide even more comparative information to drive improvements in the quality of care. This includes the Hospital CAHPS (HCAHPS) survey, which provides a standardized instrument and data collection methodology for measuring patients' perspectives on hospital care.

CMS is implementing a number of demonstration projects aimed at encouraging quality care and designed to lay the groundwork for performance-based payments in the future. These include the Physician Group Practice Demonstration, the Premier Hospital Quality Incentive Demonstration, the Health Care Quality Demonstration, and the Care Management Performance Demonstration. These projects are helping us to examine our

current systems to better anticipate patient needs, especially for those with chronic diseases, and explore whether incentives lead to better results -- across-the-board improvements in quality, fewer complications, and reduced costs.

CMS is using the Premier demonstration as a pilot test of the effectiveness of quality incentives and is considering ways to apply this concept to additional hospitals, and to other types of providers. The Premier Hospital Quality Incentive Demonstration recognizes and provides financial rewards to hospitals that demonstrate high quality performance in a number of areas of acute care. Under the demonstration, top performing hospitals will receive bonuses based on their performance on evidence-based quality measures for Medicare patients with: heart attack, heart failure, pneumonia, coronary artery bypass graft, and hip and knee replacements. Poorly performing hospitals will face financial penalties in the third year. More than 255 hospitals are participating voluntarily in the demonstration. For the first year of the program, hospitals received incentive bonuses totaling $8.9 million. The first year's bonus incentive payments ranged from $900 to $847,000.

CMS also is examining the concept of "value-based purchasing," which may use a range of incentives to achieve identified quality and efficiency goals, as a means of promoting better quality of care and more efficient resource use in the Medicare payment systems. In considering the concept of value-based purchasing, CMS is working closely with stakeholder partners, including health professionals and providers. In addition, CMS is developing a plan to implement a value-based purchasing plan beginning in FY 2009 for Medicare hospital payments. This plan, as required by the DRA, will address issues regarding quality measures, data infrastructure, incentive methodology, and public reporting.

CMS Investigates Ways to Prevent Serious Medical Errors

In a March 2001 report, "Crossing the Quality Chasm," an Institute of Medicine (IOM) committee proposed six aims for improving health care quality, and CMS has adopted the six aims in our Quality Improvement Roadmap. Safety is the first of those aims. Very

simply, care that is intended to help patients should never injure them. Unfortunately, patients all too often suffer injuries caused by medical errors. Another IOM committee issued the landmark "To Err Is Human" report in November 1999 That report found that as many as 98,000 Americans die each year as a result of medical errors. Both reports recommended a systems approach to quality improvement, called for a nationwide mandatory adverse event reporting system, and recommended that public and private purchasers use incentives to encourage providers to improve patient safety

During the six years since "To Err Is Human" was released, some progress has been made in combating medical errors. However, our progress in the struggle against medical errors has been slow Medical errors continue to be a common cause of death in the United States, and we certainly have not met the IOM report's challenge of a 50 percent reduction in medical errors over five years. A number of obstacles hinder improvement in patient safety Some of these obstacles, such as the overall complexity of health care, may not be readily amenable to the promises of a value-based purchasing program. However, value-based purchasing may help overcome other obstacles, including the lack of commitment to safety, a lack of safety measures, underreporting of errors and the role of fear in undermining reporting, and the perverse payment incentives that may result from paying more for the complications caused by errors.

Based on the experiences CMS has had with the voluntary reporting of quality measures, our demonstration programs that are testing important concepts for value-based purchasing programs, and our new authority to address hospital acquired infections, CMS is considering ways to facilitate even greater safety and improvement in the Medicare payment system by addressing "never events," which are serious, preventable medical errors, such as medication errors, surgery on wrong body parts or mismatched blood transfusions. For example, in 2005, 84 wrong site surgeries were reported to JCAHO Hospital payments should be based on the premise of supporting higher quality and efficiency Paying for "never events" – and in many cases, paying more for such events – is contrary to this goal. As a necessary step toward encouraging better care and lower

overall heath care costs, we support further steps such as eliminating payments for "never events" and want to work with the Congress to take such steps.

CMS Proposes to Level the Financial Playing Field for All Hospitals

In addition to the above mentioned long-range plans and goals for improving the quality of care provided at all hospitals, CMS also has taken more immediate steps designed to improve quality and tailor its payment systems to more accurately reflect the cost of care. CMS has undertaken a number of activities to improve the quality and efficiency of care delivered to Medicare beneficiaries, but also recognizes the ability of Medicare payment systems to promote quality and more accurately reflect the costs of providing services to our beneficiaries. Currently, there are several different fee-for-service payment systems under Medicare that are used to pay health professionals and other providers based on the number and complexity of services provided to patients. In general, all providers to which a specific Medicare payment system applies receive the same amount for a service, regardless of its quality or efficiency. As a result, Medicare may often pay more to hospitals that deliver care that is not of the highest quality or include unnecessary services.

CMS Developing Refinements for Hospital Inpatient Services

In the April 12, 2006 notice of proposed rulemaking, CMS has proposed a number of regulatory changes that would lead to significantly more accurate payments for acute care furnished to hospital inpatients, with a particularly important impact on specialty hospitals. Specifically, one proposal would restructure the diagnosis-related groups (DRGs) that serve as the basis for payment to reflect a patient's actual cost of care more accurately. These reforms also further CMS' quality goals, as more accurate payments may encourage better care for patients. Currently, DRG payments are set to reflect the average resource use of treating a patient with a particular diagnosis. In general, when hospital costs are less than the DRG payment, the hospital keeps the difference. However, hospitals absorb the loss if costs are more than the DRG payments.

CMS is moving toward the most significant revision of the DRG payment methodology since its introduction in the 1980s. In the hospital inpatient prospective payment system (IPPS) final rule for FY 2006, we found a sound analytical basis for revising nine cardiovascular DRGs that account for nearly 700,000 cases to better recognize severity in the DRG system. Further changes as recommended by Medicare Payment Advisory Commission (MedPAC) are proposed in the FY 2007 IPPS proposed rule. In that proposed rule, CMS' analysis suggests that the current, charge-based weights and the current DRG classifications result in notable distortions between payments and the relative cost of care. The proposed rule for FY 2007 includes two major types of reforms. First, the proposed payment changes would assign weights to DRGs based on estimated hospital costs, rather than reported charges. Second, the DRGs would be reconfigured to better recognize severity of the illness. These changes are expected to reduce incentives for hospitals to "cherry pick" or treat only the most profitable patients, and ensure that whether services were furnished in a specialty hospital or a community hospital, the payment would more closely reflect the costs of treating the patient, in light of the severity of illness. This would eliminate potential financial incentives for over-investment in treating less complex but more profitable case, which often reduce the support available to the more severely ill and more costly patients.

CMS Developing Revisions to Ambulatory Surgical Center Payment System

In its 2005 Report to Congress, CMS found that many orthopedic and surgical specialty hospitals were more similar to ambulatory surgical centers (ASCs) than to acute care hospitals. Despite the similarity in the care provided, difference in payments for the same services encourages providers to enroll what are essentially ASCs as specialty hospitals.

To address this problem, CMS is developing revisions to the list of procedures eligible for payment in ASCs to include most surgical procedures performed in hospital outpatient departments. The basic structure of the payment rates for ASCs has not been updated since 1990 and CMS is considering revising the payment methodology in ASCs to align more closely with the payment rates in other payment systems for the same procedures, which would remove much of the incentive for physicians and other

investors to form orthopedic and surgical specialty hospitals in order to take advantage of the typically higher payments under the inpatient and outpatient hospital prospective payment systems.

Both the expansion to the list of procedures eligible for payment in ASCs and the payment revisions are expected to be in effect by January 1, 2008. When implemented, Medicare payments to ASCs are expected to better reflect the resources required to perform specific surgical procedures and to be similar to payments under other payment systems.

CMS Clarifies EMTALA Responsibilities in Proposed Rule

Many specialty hospitals, especially orthopedic and surgical hospitals, do not have emergency departments. As a result, there has been some confusion regarding whether these facilities are required under the Emergency Medical Treatment and Labor Act (EMTALA) to accept an appropriate transfer of an individual from a requesting hospital. The FY 2007 IPPS proposed rule clarifies that all hospitals (including specialty hospitals) with specialized capabilities must accept, within the capacity of the hospital, appropriate transfers of unstable individuals covered by EMTALA, without regard to whether the hospital has an emergency department. This clarification of current policy may result in an increase in the number of specialty hospitals accepting transfers of individuals with emergency conditions on nights and weekends. This clarification was recommended by the Secretary's EMTALA Technical Advisory Group. The community hospital associations have supported this position. Public comments on the proposed rule are due by June 12, 2006.

CMS Examines Process for Hospital Participation in Medicare

In addition refining Medicare's payment systems and clarifying emergency requirements under the program, CMS is more closely scrutinizing whether specialty hospitals meet the definition of a hospital. Under existing law, a hospital, for Medicare purposes, must be, among other requirements, primarily engaged in furnishing services to inpatients. Although CMS has not promulgated a regulatory definition of "primarily engaged" in

furnishing services to inpatients, we have studied whether specialty hospitals (and other hospitals) are primarily engaged in furnishing services to inpatients. Based on an analysis of inpatient and outpatient claims data regarding community hospitals and specialty hospitals, our research indicates that cardiac specialty hospitals resemble full-service community hospitals in many ways. Orthopedic and surgical specialty hospitals, which typically have far fewer beds than cardiac hospitals, are probably no less engaged in furnishing care to hospital inpatients than are some community hospitals, including some small rural hospitals.

We have not yet identified any quantitative method, such as percentage of services or ratio of inpatient to outpatient services, which could gauge whether a facility is primarily engaged in furnishing services to inpatients without disqualifying both community hospitals and specialty hospitals. As a result, CMS does not currently intend to define by regulation the statutory requirement that a hospital is an entity that is "primarily engaged" in furnishing services to hospital inpatients for the purpose of differentiating specialty hospitals from community hospitals. Instead, CMS will continue to interpret "primarily engaged" on a case-by-case basis as it continues to explore other options for addressing this issue. For example, CMS recently denied a provider agreement to an entity that intended to create an emergency department with 25 bays and an inpatient area with two beds. In addition, CMS terminated the provider agreement of an Arizona hospital following an action by the State prohibiting any inpatient stays at the hospital.

CMS Enforces Payment Restrictions for New Specialty Hospitals

The MMA's 18-month "specialty hospital moratorium" prohibited physicians from referring Medicare patients to specialty hospitals in which the physicians had an ownership interest. In addition, the moratorium prohibited specialty hospitals from billing, and Medicare from paying, for inpatient and outpatient hospital services that were furnished as a result of a physician owner's referral. The moratorium did not apply to physician owner's referrals to (and claims billing by) specialty hospitals that the Secretary determined were in operation, or "under development," as of November 18, 2003. However, the MMA prohibited these hospitals from increasing the number of

physician investors or the number of beds, or changing the type of specialty services provided by the hospital. Recently, CMS identified two hospitals that billed Medicare for services in violation of the specialty hospital restrictions imposed under the MMA moratorium. We have initiated procedures to recover improper Medicare payments made to these hospitals.

To obtain a determination regarding whether it was "under development," as of November 18, 2003, a specialty hospital could request an advisory opinion from CMS using the procedures already set forth in CMS's physician self-referral regulations. In processing advisory opinion requests, CMS reviewed financial and other information relating to the requesting specialty hospital. The advisory opinions were reviewed by HHS's Office of the General Counsel. CMS also consulted, where necessary, with the Office of Inspector General (OIG) and the Department of Justice.

CMS Suspends Enrollment of Specialty Hospitals

Separate from the moratorium on payments to new specialty hospitals, CMS temporarily suspended the processing of new provider applications for specialty hospitals in order to comprehensively review the procedures used to determine if these hospitals qualify for participation in the Medicare program. This suspension, which was continued by section 5006 of the DRA, does not apply to specialty hospitals that already had provider agreements or those specialty hospitals that had requested an Advisory Opinion from CMS prior to June 8, 2005.

Currently, the Medicare enrollment application does not contain a separate category for specialty hospitals. If, based on the continued review of the issues identified in the DRA, it is determined that requirements specific to physician-owned specialty hospitals are warranted, CMS would be prepared to change the enrollment application form to identify such hospitals. However, the enrollment form without a separate category for specialty hospitals may be a potential advantage for purposes of implementing the current suspension of enrollment of new specialty hospitals. Any entity seeking to enroll as a hospital does not have the opportunity to self-select and specify that it is not a specialty

hospital. Therefore, should an applicant identify itself as any type of hospital, the fiscal intermediary must investigate further as to whether the applicant will be a specialty hospital. If enrollment requirements specific to specialty hospitals were implemented, it may be necessary for CMS to provide formal guidance as to what constitutes a "specialty hospital."

In contrast to the current suspension on enrollment of new specialty hospitals, the moratorium on physician referrals to specialty hospitals imposed under the MMA did not restrict specialty hospitals from obtaining a provider agreement, or from billing Medicare for services furnished to patients referred by physicians who did not have an ownership interest in the specialty hospital.

CMS Begins Development of Strategic Plan Regarding Physician Investment in Specialty Hospitals

In connection with the recently released Secretary's Interim Report to Congress, CMS sent a survey to approximately 130 specialty hospitals and 270 general acute care hospitals seeking information about physician investment interests and provision of care to low income and charity patients. The information gained from the survey will be used to develop the final report and the Strategic Plan that will be released later this year.

The survey is designed to provide comprehensive information on how physician investment arrangements are structured. For example, the survey asks hospitals to identify their physician investors, the returns on their investments, whether the physicians have stop losses or other types of limitations on liability available to them, whether the physicians received a loan from the hospital to purchase their investment interest, and whether the physicians have or have had a compensation arrangement (such as a management contract) with the hospital or an entity related to the hospital.

CMS also anticipates that this survey will provide much more information about the provision of charity care and care to Medicaid patients by specialty hospitals and their general acute care hospital competitors than has previously been obtained. That is, the

survey also asks questions about the hospital's number of Medicaid patient discharges, its revenue from Medicaid patients, and the amount of charity care it provides.

To ensure a high quality survey, we sought and received input from the American Surgical Hospital Association, National Surgical Hospitals Incorporated, the MedCath Corporation, the Federation of American Hospitals and the American Hospital Association. Because CMS would not want to make recommendations to Congress without thorough, timely information, all of these hospital organizations have committed to contacting their member hospitals to encourage their participation in the survey.

CMS Supports Enforcement against Improper Investment Activities

In addition to developing factual information about investments in specialty hospitals, CMS is very interested in public comment on how best to support enforcement against inappropriate investment, which is an issue that is different from our usual mandate and capacities to promote quality care and to pay appropriately for care provided to our beneficiaries. In conjunction with the hospital survey, we also are assessing how we can best promote the availability of accurate and relevant information on physician investments in hospitals. In addition, we are continuing to assess the extent to which relevant State and other Federal agencies have jurisdiction over issues related to whether investments are bona fide and result in "appropriate" return on investment.

CMS has program responsibility for the physician self-referral statute under section 1877 of the Social Security Act. The HHS Office of Inspector General (OIG) has authority to impose civil monetary penalties for knowing violations of section 1877. The statute's "whole hospital exception" permits a physician to refer a patient to a hospital in which the physician has an investment or ownership interest, so long as the investment is in the whole hospital, and not just the department or subdivision of the hospital, provided that certain other conditions are satisfied. During the period of the MMA specialty hospital moratorium, the exception applied only if the physician's ownership interest was not in a specialty hospital as defined under the MMA. Now that the moratorium has expired, the exception applies without regard to whether the hospital is a specialty hospital or some

other type of hospital. Presently, there are no additional restrictions in the physician self-referral statute and regulations with respect to whether a physician's investment is "proportional" or "bona fide."

In some circumstances, physician investments in specialty hospitals may implicate the Federal anti-kickback statute, a criminal law enforced by the Department of Justice (DOJ) and the OIG. If we uncover evidence of possible violations of the anti-kickback statute, or evidence of potential knowing violations of the physician self-referral statute, we refer those cases to the OIG for appropriate action. Importantly, CMS works collaboratively with the OIG and DOJ to ensure that allegations of potential fraud and abuse, whether arising in the context of specialty hospitals or otherwise, are handled in an appropriate manner, using the full range of tools available to the government.

CMS recognizes that there are different opinions regarding physician-owned specialty hospitals. Physician-owned specialty hospitals are legal under the existing whole hospital exception to the physician self-referral law and elimination of the exception cannot be done administratively.

Conclusion

Mr. Chairman, thank you for this opportunity to discuss CMS' efforts to promote quality care in all hospitals. Regardless of the setting of care, CMS is committed to improving the quality of patient care and to increasing the efficiency of Medicare spending. CMS has proposed reforms to Medicare's payment systems that would improve quality, while at the same time more accurately reflect the cost of providing care. In addition, transparency of hospital pricing and quality data will help to allow consumers to make more informed choices on where they receive care, furthering our quality efforts by promoting competition. CMS also is considering ways to further patient safety and improve the Medicare payment system by addressing "never events." CMS looks forward to working with this Committee to ensure Medicare and Medicaid beneficiaries continue to have access to high quality care. I thank the Committee for its time and would welcome any questions you may have.

RESPONSES TO QUESTIONS FOR THE RECORD
FROM HON. MARK McCLELLAN

ANSWERS FOR THE RECORD
TO QUESTIONS
SUBMITTED BY SENATOR CHARLES E. GRASSLEY
FROM THE SENATE FINANCE COMMITTEE HEARING ON
PHYSICIAN-OWNED SPECIALTY HOSPITALS
May 17, 2006

Question 1:

In your May 16, 2006 response to an inquiry by Senator Baucus and I, you noted that "CMS is not aware of any physician-owned specialty hospitals (other than Physicians [sic] Hospital) that were subject to the MMA moratorium that have received provider agreements during the moratorium without requesting an advisory opinion." Accordingly, please provide the date of Medicare certification for the following facilities, along with the date the advisory opinion was requested and the date and outcome of each advisory opinion provided to the hospitals by CMS:

(1) Irving Coppell Surgical Hospital – Irving, TX
(2) New Albany Surgical Hospital – New Albany, OH
(3) Kansas Spine Hospital – Wichita, KS
(4) Physicians' Surgical Hospital at Quail Center – Amarillo, TX
(5) Lubbock Heart Hospital – Lubbock, TX
(6) Texans Heart Hospital of San Antonio – San Antonio, TX
(7) Carson Valley Medical Center – Gardnerville, NV
(8) Wisconsin Heart Hospital, LLC – Wauwatosa, WI
(9) Providence Hospital – Laredo, TX
(10) Edgewood Surgical Hospital – Transfer, PA
(11) Ouachita Surgical Hospital – West Monroe, LA
(12) Saint Francis Heart (Tulsa) – Tulsa, OK
(13) Nebraska Orthopedic Hospital – Omaha, NE
(14) Medical Centre Surgical Hospital – Fort Worth, TX
(15) Trophy Club Medical – Trophy Club, TX
(16) Mountain River Birthing & Surgical Center – Blackfoot, ID
(17) Arizona Orthopedic Surgical Hospital – Chandler, AZ
(18) Butler County Surgery Center – Hamilton, OH
(19) Neuromed Center Hospital – Baton Rouge, LA
(20) Southwest Surgical Hospital – Hurst, TX
(21) University Pointe Surgical Hospital – West Chester, OH
(22) Texas Institute for Surgery at Presbyterian – Dallas, TX
(23) Southlake Specialty Hospital – Southlake, TX
(24) Lafayette General Surgical Hospital – Lafayette, LA
(25) Animas Surgical Hospital – Durango, CO
(26) Fairway Medical Center – Covington, LA
(27) Presbyterian Plano Center for Diagnostics & Surgery – Plano, TX
(28) Indiana Orthopedic Hospital – Indianapolis, IN
(29) Hospital for Special Surgery – Oklahoma City, OK

(30) North Texas Hospital Rocky Mountain – Denton, TX
(31) Miracle Mile Medical Center – Los Angeles, CA
(32) Pine Creek Medical Center – Dallas, TX
(33) Thousand Oaks Surgical Hospital – Thousand Oaks, CA

Answer:

As you know, the moratorium established in the Medicare Modernization Act (MMA) did not provide a basis for the Centers for Medicare & Medicaid Services (CMS) to deny provider agreements to physician-owned specialty hospitals. The moratorium, which was effective from December 8, 2003 through June 8, 2005, prohibited billing Medicare for designated health services (DHS), such as hospital inpatient or outpatient services, furnished to beneficiaries who had been referred to the hospital by physician investors/owners. The moratorium did not prevent hospitals from billing Medicare for DHS furnished to Medicare beneficiaries who were not referred by physician investors/owners. Further, the moratorium did not prevent physician-owned specialty hospitals from opening and receiving a Medicare provider agreement during the moratorium.

It is also important to note that the statement you reference in your question—that "CMS is not aware of any physician-owned specialty hospitals (other than Physicians Hospital) that were subject to the MMA moratorium that have received provider agreements during the moratorium without requesting an advisory opinion"—also included an important caveat, i.e., that the statement was based on our preliminary analysis only.

As indicated in our earlier response, we attempted to ascertain whether there were other hospitals that did not seek an advisory opinion that were in fact subject to the MMA moratorium. We compiled a list of short term acute care hospitals that received Medicare provider agreements on or after November 17, 2003 and which had a bed capacity of less than 75 beds. From the resulting list of 78 hospitals, we disregarded those hospitals that had requested an advisory opinion or of which we were already aware, as well as those few hospitals that received provider agreements after the expiration of the MMA moratorium. We also disregarded hospitals that received their provider agreements prior to April 1, 2004, because we were confident that any specialty hospital that received its provider agreement prior to that date would have been "under development" as of November 18, 2003 and thus would have been excepted from the MMA moratorium.

To determine preliminarily whether any of the hospitals identified through the steps noted above were primarily engaged in the care and treatment of patients with a cardiac or orthopedic condition, or those receiving a surgical procedure, we conducted a review of inpatient claims data. That is, we examined MedPAR data to capture the percentage of the hospital's total discharges that fell within MDC 5, MDC 8, and the type of DRG within the MDC (that is, medical or surgical). Consistent with our earlier actions and the criteria used by the Medicare Payment Advisory Commission (MedPAC) and the Government Accountability Office (GAO), we established a threshold whereby, if 45 percent or more of the hospital's total discharges fell within MDC 5 or MDC 8, or 45 percent of its total discharges were surgical in nature, we

considered the hospital to be a specialty hospital. After performing the claims analysis we arrived at a final list of 10 hospitals.

In April 2006, we sent a letter to each of the 10 hospitals, requiring information concerning the ownership of the hospital and the nature of the services performed. Based on the information we received in response to the letter, we determined that two hospitals were likely to have been under development, and thus excepted from the MMA moratorium. The responses also indicated that two hospitals did not have physician-owners and two hospitals had not submitted bills to Medicare for the period during the moratorium. Information submitted by four hospitals indicated that they were subject to the MMA moratorium. Overpayment notices were sent in July 2006 to the four hospitals, demanding repayment of approximately $12.1 million in the aggregate. Each of the four hospitals submitted rebuttal statements and supporting documentation, which demonstrated that they were not subject to the MMA moratorium because each hospital was "under development" as of November 18, 2003.

As requested, please find attached a list of the selected hospitals, including the date of Medicare certification, the date the advisory opinion was requested (if applicable) and the date and outcome of each advisory opinion provided to the hospitals by CMS.

Medicare Participation Dates and Advisory Opinion Requests for Selected Hospitals

PROVIDER NUMBER	PROVIDER NAME	CITY	STATE	MEDICARE PARTICIPATION DATE	DATE ADVISORY OPINION REQUESTED	DATE ADVISORY OPINION ISSUED	OUTCOME OF ADVISORY OPINION (*)
450874	IRVING COPPELL SURGICAL HOSPITAL	Irving	TX	12/03/03	None Requested	N/A	N/A
360266	NEW ALBANY SURGICAL HOSPITAL	New Albany	OH	12/24/03	None Requested	N/A	N/A
170196	KANSAS SPINE HOSPITAL	Wichita	KS	12/29/03	7/9/2004	N/A	AO Request Withdrawn 12/14/2004
450875	PHYSICIANS' SURGICAL HOSPITAL AT QUAIL CENTER	Amarillo	TX	01/13/04	None Requested	N/A	N/A
450876	LUBBOCK HEART HOSPITAL	Lubbock	TX	01/22/04	9/23/2004		Pending with Office of General Counsel
450878	TEXANS HEART HOSPITAL OF SAN ANTONIO	San Antonio	TX	01/22/04	5/18/2004		AO Request Withdrawn 12/2/05
290048	CARSON VALLEY MEDICAL CENTER	Gardnerville	NV	02/26/04	None Requested	N/A	N/A
520199	WISCONSIN HEART HOSPITAL, LLC	Wauwatosa	WI	03/04/04	None Requested	N/A	N/A
450879	PROVIDENCE HOSPITAL	Laredo	TX	03/17/04	None Requested	N/A	N/A
390307	EDGEWOOD SURGICAL HOSPITAL	Transfer	PA	03/24/04	None Requested	N/A	N/A
190261	OUACHITA SURGICAL HOSPITAL	West Monroe	LA	04/08/04	5/14/2004	9/21/2004	Under Development
370218	ST. FRANCIS HEART (TULSA)	Tulsa	OK	04/13/04	5/18/2004	10/26/2005	Under Development
280129	NEBRASKA ORTHOPAEDIC HOSPITAL	Omaha	NE	04/22/04	None Requested	N/A	N/A
450880	MEDICAL CENTRE SURGICAL HOSP-FORT WORTH	Fort Worth	TX	04/29/04	4/12/2004	N/A	Placed on Inactive Status 10/28/05
450883	TROPHY CLUB MEDICAL	Trophy Club	TX	06/08/04	5/10/2004	N/A	Placed on Inactive Status 10/28/05
130067	MOUNTAIN RIVER BIRTHING & SURGICAL CENTER	Blackfoot	ID	07/19/04	None Requested	N/A	N/A
30112	ARIZONA ORTHOPEDIC SURGICAL HOSPITAL	Chandler	AZ	07/21/04	4/6/2004	7/29/2005	Under Development
360269	BUTLER COUNTY SURGERY CENTER	Hamilton	OH	08/13/04	None Requested	N/A	N/A
190266	NEUROMED CENTER HOSPITAL	Baton Rouge	LA	10/25/04	5/26/2004	12/7/2004	Under Development
450886	SOUTHWEST SURGICAL HOSPITAL	Hurst	TX	10/25/04	8/17/2004	2/10/2005	Under Development
360271	UNIVERSITY POINTE SURGICAL HOSPITAL	West Chester	OH	11/06/04	None Requested	N/A	N/A
450889	TEXAS INSTITUTE FOR SURGERY AT PRESB	Dallas	TX	11/16/04	None Requested	N/A	N/A
450888	SOUTHLAKE SPECIALTY HOSPITAL	Southlake	TX	11/19/04	6/23/2004	N/A	Violated Moratorium; Overpayment Letter Sent
190268	LAFAYETTE GENERAL SURGICAL HOSPITAL	Lafayette	LA	11/23/04	None Requested	N/A	N/A
60117	ANIMAS SURGICAL HOSPITAL	Durango	CO	12/14/04	8/17/2004	N/A	Placed on Inactive Status 1/19/06
190267	FAIRWAY MEDICAL	Covington	LA	02/09/05	8/12/2004		Pending with Office of General Counsel
450891	PRESBYT. PLANO CENTER FOR DIAG & SURG	Plano	TX	02/23/05	6/8/2004	3/31/2005	Under Development
150160	INDIANA ORTHOPAEDIC HOSPITAL	Indianapolis	IN	03/23/05	5/24/2004	12/29/2004	Under Development
370220	HOSPITAL FOR SPECIAL SURGERY	Oklahoma City	OK	03/31/05	7/20/2004	N/A	Placed on Inactive Status 1/19/06
450893	NORTH TEXAS HOSPITAL-ROCKY MOUNTAIN	Denton	TX	03/31/05	1/10/2005	8/15/2005	Under Development
50751	MIRACLE MILE MEDICAL CENTER	Los Angeles	CA	04/01/05	None Requested	N/A	N/A
450894	PINE CREEK MEDICAL CENTER	Dallas	TX	04/13/05	9/14/2004		Pending with Office of General Counsel
50749	THOUSAND OAKS SURGICAL HOSPITAL	Thousand Oaks	CA	05/13/05	6/10/2004	2/23/2005	Under Development

*** Outcome of Advisory Opinions**
Withdrawals - based upon requests from the hospital or its representative
Inactive - based upon failure of Requestor to respond to multiple requests for additional information
Under development - CMS concluded that hospitals are exempt from the moratorium

ANSWERS FOR THE RECORD
TO QUESTIONS
SUBMITTED BY SENATOR CHARLES E. GRASSLEY
FROM THE SENATE FINANCE COMMITTEE HEARING ON
PHYSICIAN-OWNED SPECIALTY HOSPITALS
May 17, 2006

Question 2:

In addition to the 33 specialty hospitals listed above, it appear that 9 additional specialty hospitals opened following CMS's administrative "suspension on enrollment" of new specialty hospitals announced on June 9, 2005. Accordingly, please provide the date of Medicare certification and the amount of money Medicare and Medicaid have reimbursed the following specialty hospitals since their respective certification dates:

(1) Greater Baton Rouge Surgical Hospital – Baton Rouge, LA
(2) Sierra Surgery & Imaging – Carson City, NV
(3) McBride Clinic Orthopedic Hospital – Oklahoma City, OK
(4) Living Hope New Boston Medical Center – New Boston, TX
(5) West Texas Hospital – Abilene, TX
(6) Kingwood Specialty – Kingwood, TX
(7) Hospital at Westlake Medical Center – Austin, TX
(8) Beaumont Bone & Joint Institute – Beaumont, TX
(9) Surgical Arts Center of Clear Lake, Webster, TX

Answer:

As you may know, the administrative suspension on processing enrollment applications of specialty hospitals was a limited mechanism that CMS put into place while we reviewed our enrollment procedures concerning specialty hospitals. Hospital applicants that had requested an advisory opinion were exempt from the temporary suspension.

Further, the suspension was dependent upon projections of inpatient cases from hospital applicants. More specifically, if a hospital applicant had not requested an advisory opinion, the fiscal intermediary would ask if the hospital would be primarily engaged in cardiac, orthopedic, or surgical care. If the applicant stated yes, the application would not be processed. However, if the applicant stated that it would not be primarily engaged in cardiac, orthopedic or surgical care, then a model letter explaining the six month enrollment suspension was mailed to the hospital applicant. This letter requested that the applicant submit a signed, written statement containing a projection, based upon DRG/MDC and type of DRG (medical/surgical), for all inpatient stays in the first year of operation. The letter also noted that a hospital that projected 45 percent or more cardiac, or orthopedic, or surgical inpatient cases would be considered a specialty hospital for purposes of the suspension. Upon receipt of the signed statement from the applicant, the fiscal intermediary would review the projection. If the applicant's projections indicated that fewer than 45 percent of inpatient cases would fall in cardiac, orthopedic, or surgical care, the hospital

would not be considered a specialty hospital and its application would be processed. If the projection was 45 percent or greater, the application would be suspended.

As requested, please find attached a list of the selected hospitals, including the date of Medicare certification, and the amount of Medicare payments the hospitals have received since their respective certification dates.

Medicare Payments to Selected Hospitals from Participation Date to Present

PROVIDER NUMBER	PROVIDER NAME	CITY	STATE	MEDICARE PARTICIPATION DATE	MEDICARE PAYMENTS FROM PARTICIPATION DATE - PRESENT (*)
190273	GREATER BATON ROUGE SURGICAL HOSPITAL	Baton Rouge	LA	10/26/05	$422,201
290051	SIERRA SURGERY & IMAGING	Carson City	NV	05/02/05	$4,883,196
370222	MCBRIDE CLINIC ORTHOPEDIC HOSPITAL	Oklahoma City	OK	09/20/05	$11,803,301
670001	LIVING HOPE NEW BOSTON MEDICAL CENTER	New Boston	TX	08/17/04	$111,439
670003	WEST TEXAS HOSPITAL	Abilene	TX	05/20/05	$4,193,702
670005	KINGWOOD SPECIALTY	Kingwood	TX	06/14/05	$632,936
670006	HOSPITAL AT WESTLAKE MEDICAL CENTER	Austin	TX	08/25/05	$3,540,942
670007	BEAUMONT BONE & JOINT INSTITUTE	Beaumont	TX	11/09/05	$513,827
670008	SURGICAL ARTS CENTER OF CLEAR LAKE	Webster	TX	02/14/06	$409,461

* Medicare payment data is from the hospital's participation date up to October 25, 2006.

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May 17, 2006

Question 3:

In your testimony you noted that CMS has taken enforcement action against two specialty hospitals for violating the Congressional moratorium outlined in Section 507 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The first, Physicians' Hospital in Portland, Oregon was brought to your attention by the Senate Finance Committee, the second, Southlake Specialty Hospital in Southlake, Texas, was brought to your attention after it requested an advisory opinion. Absent Congressional investigation, self-reporting, or application for an advisory opinion, what pro-active enforcement efforts does CMS plan on conducting following evidence that facilities may have violated section 507 of the MMA?

Answer:

We investigated and determined that two hospitals that did not receive advisory opinions were, in fact, specialty hospitals, and were subject to the moratorium. Based on information one hospital submitted with its request for an advisory opinion, we determined that the hospital increased the number of its physician-investors past the time allowed by the MMA. We investigated a second hospital after it was brought to our attention by the Senate Finance Committee, which had received information indicating that the hospital was a physician-owned specialty hospital. We requested and received information from the hospital that indicated that it was a physician-owned orthopedic specialty hospital that was not under development as of November 18, 2003.

We also attempted to ascertain whether there were other hospitals that did not seek an advisory opinion but which, in fact, were specialty hospitals and which may have violated the moratorium. We compiled a list of short term acute care hospitals that received Medicare provider agreements on or after November 17, 2003 and which had a bed capacity of less than 75 beds. From the resulting list, we disregarded hospitals that had requested an advisory opinion or of which we were already aware; hospitals that received their provider agreements prior to April 1, 2004 (because they would have been "under development" as of November 18, 2003); and hospitals that received provider agreements after the expiration of the MMA moratorium.

To determine if any of the hospitals identified were primarily engaged in the care and treatment of patients with a cardiac or orthopedic condition, or those receiving a surgical procedure, we reviewed inpatient claims data to capture the percentage of the hospital's total discharges that fell within MDC 5, MDC 8, and the type of DRG within the MDC (that is, medical or surgical). Consistent with our earlier actions, we established a threshold whereby, if 45 percent or more of

the hospital's total discharges fell within MDC 5 or MDC 8, or 45 percent of its total discharges were surgical in nature, we considered the hospital to be a specialty hospital.

In April 2006, CMS sent a letter to each of the 10 hospitals identified through the steps noted above, requiring information concerning the ownership of the hospital and the nature of the services performed. Based on the information we received in response to the letter, we determined that two hospitals were likely to have been under development, and thus excepted from the MMA moratorium; two hospitals did not have physician-owners; and two hospitals had not submitted bills to Medicare for the period during the moratorium. Information submitted by four hospitals indicated that they were subject to the MMA moratorium. Overpayment notices were sent in July 2006 to the four hospitals, demanding repayment of approximately $12.1 million in the aggregate. Each of the four hospitals submitted rebuttal statements and supporting documentation, which demonstrated that they were not subject to the MMA moratorium because each hospital was "under development" as of November 18, 2003.

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Question 4:

On May 9, 2006, CMS issued an interim report on specialty hospitals as required by the Deficit Reduction Act of 2005 (DRA). In the interim report CMS addresses the issue of EMTALA obligations and the impact their relationship to specialty hospitals. CMS states that in the proposed Inpatient Prospective Payment System (IPPS) rule, which was recently released, includes a provision that would require all hospitals (including specialty hospitals) with specialized capabilities, to accept appropriate transfers of unstable patients covered under EMTALA, without regard to whether the hospital has an emergency department. Given that this change in the IPPS rule would allow transfers of unstable patients to facilities absent an emergency department, could you please elaborate on what qualifies as "specialized capabilities" under CMS's new IPPS rule? Further, would specialty hospitals and other facilities with "specialized capabilities" be required to remain open or on call 24 hours a day 7 days a week?

Answer:

The EMTALA statute outlines the obligation of hospitals to receive appropriate transfers from other hospitals. Section 1867(g) of the Social Security Act states that a participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires these specialized capabilities or facilities if the hospital has the capacity to treat the individual.

We recognize that this list is not exhaustive and would include physician-owned limited service facilities with specialized capabilities. We also would note that the EMTALA Technical Advisory Group (TAG) is currently considering whether the definition of "specialized capabilities" should be further revised. However, no expansion of the list of specialized facilities or capabilities was specifically proposed in the proposed rule published on April 25, 2006. In view of this fact and in consideration of the fact that the EMTALA TAG may make recommendations relating to this issue, we have decided not to make any further revision to the list of examples noted above. However, we will consider carefully any recommendations made by the EMTALA TAG on the issue and may propose changes in the future.

We note that this revision does not reflect a change in current CMS policy. We further note that the revision will not require hospitals without dedicated emergency departments to open dedicated emergency departments nor will it impose any EMTALA obligation on these hospitals with respect to individuals who come to the hospital as their initial point of entry into the medical system seeking a medical screening examination or treatment for a medical condition.

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Question 5:

The final "strategic and implementing plan" regarding specialty hospitals is due from CMS to Congress in less than three months. In your testimony, as well as in private conversations, you have made a personal commitment to me that the final strategic and implementing plan will include meaningful disclosure requirements, in addition to regulations aimed at ensuring bona fide investments, and true enforcement efforts by CMS to curb shady backdoor deals. I expect that you will stay true to your word and produce a final plan implementing real reforms and not issue just another report. Following the hearing I remain concerned regarding a statement in the interim report that restricts the Office of the Inspector General (OIG) to a consulting role. More specifically, the report states that the OIG cannot play a direct role in developing the plan, but will be available to CMS for consultation. Could you please explain the consulting role that the OIG is playing in developing the strategic and implementing plan?

Answer:

Because of the protections Congress provided to the Department of Health and Human Services' (HHS) Office of the Inspector General (OIG), which insulate it from developing or administering the programs that it is asked to review, CMS assumed responsibility for developing the Strategic Plan. However, we recognized the HHS OIG's important role related to enforcement issues, especially with regard to physician self-referral and anti-kickback issues, and consulted with the HHS OIG on those issues. More specifically, since the civil monetary penalty and exclusion provisions for knowing violations of the physician self-referral statute are administered by the HHS OIG, we worked closely with the HHS OIG on the enforcement elements of the Strategic Plan.

Further, within the Strategic Plan itself, CMS reasserted its continued commitment to work closely with the HHS OIG. More specifically, consistent with current practice, the Plan reiterates our continuing commitment to refer to the HHS OIG credible allegations of a knowing violation of the physician self-referral statute (including, but not limited to, one involving disproportionate returns or non-bona fide investment) and of improper referral payments for potential investigation under the Federal anti-kickback statute. CMS also continues to work with the HHS OIG and other law enforcement agencies to support the investigation and prosecution of fraud and abuse cases, including without limitation, cases involving violations of the physician self-referral statute and the False Claims Act.

ANSWERS FOR THE RECORD
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May 17, 2006

Question 6:

The interim report noted that CMS currently did not have enough information on physician investment interests and provision of care to low income and charity patients. Accordingly, CMS sent a survey to 130 specialty hospitals and 270 general acute care hospitals. Please provide a list of the 130 specialty hospitals that received the survey along with a list of the 270 general acute care hospitals that also received the survey. Additionally, please provide a detailed response as to how CMS selected the relevant sample of hospitals.

Answer:

In the Interim Report, we stated that it was necessary to secure additional information on each component of the Strategic Plan based upon the analysis of information available to CMS at the time. We explored possible ways to obtain this information, including the development of a survey to supplement the data we already had. Our goal in collecting and analyzing data was to bring transparency to the investments of physician-owners in specialty hospitals and to present a picture of the Medicaid population served by, and the charity care practices of, specialty hospitals within the context of their primary competitors—community hospitals.

CMS sent a survey to all 130 specialty hospitals that met our definition of a specialty hospital. To identify these hospitals, we began with the universe of 76 specialty hospitals identified in the HHS MMA Study. The HHS study defined physician-owned specialty hospitals using, in part, MedPAC's criteria from its March 2005 MMA Study. MedPAC's requirements in turn were that at least 45 percent of the hospital's Medicare cases be cardiac, orthopedic, or surgical in nature, or that at least 66 percent of the hospital's Medicare cases be in two major diagnostic categories (MDCs), with the primary one being cardiac or orthopedic, or the primary type of cases within an MDC being surgical. Hospitals must have had a minimum volume of at least 25 total Medicare cases during 2002 and submitted Medicare cost reports and claims for 2002. HHS, in its study required under section 507 of the MMA, placed one additional requirement that cardiac and orthopedic hospitals must have performed at least five major procedures.

Building upon the number of specialty hospitals identified in the HHS MMA Study, we added the 49 specialty hospitals that had requested an advisory opinion. These facilities were added because they projected that they would be primarily engaged in the care and treatment of patients with a cardiac or orthopedic condition, or patients receiving a surgical procedure. The hospitals that had requested an advisory opinion did not have to meet any case volume criteria and did not have to meet the requirement of having filed a cost report. We also identified other hospitals as specialty hospitals based on Medicare claims data.

The survey was also sent to 320 competitor general acute care hospitals. In order to identify which acute care hospitals were competitors of specialty hospitals, we first identified the markets in which specialty hospitals are located. We identified the health referral regions (HRR) in which each of the cardiac specialty hospitals are located, by using the Dartmouth Atlas for Healthcare. Researchers at the Dartmouth Atlas Project (DAP) defined HRRs as health care markets for tertiary medical care where there was at least one hospital that performed major cardiovascular procedures and neurosurgery. We also identified the hospital service areas (HSAs) in which each of the orthopedic and surgical hospitals are located. As designated by researchers at DAP, HSAs represent local health care markets for hospital care. DAP defined HSAs by assigning zip codes to the hospital areas where the greatest proportion of their Medicare residents were hospitalized. We then identified competitor acute care hospitals for each of the HRRs and HSAs in which specialty hospitals are located by employing the same criteria used by the GAO in its report *Operational and Clinical Changes Largely Unaffected by Presence of Competing Specialty Hospitals*, GAO Report, GAO-06-520R, (April 2006). For purposes of that report, GAO identified those general hospitals in regional health care markets with a specialty hospital that opened since the start of 1998.

Please see the attached list of 130 specialty hospitals and 320 competitor general acute care hospitals that received the survey, as well as the list of 140 hospitals that responded to the survey.

Survey Respondents

PROVIDER NUMBER	NAME	CITY	STATE	ZIP CODE
	SPECIALTY HOSPITALS			
	Cardiac			
03-0100	MedCath of Tucson, LLC	Tucson	AZ	85704
03-0102	Arizona Heart Hospital, LLC	Phoenix	AZ	85006
04-0134	MedCath of Little Rock, LLC	Little Rock	AR	72118
05-0724	Heart Hospital of BK	Bakersfield	CA	93308
19-0250	Louisiana Heart Hospital, LLC	LaCombe	LA	70445
19-0263	Heart Hospital of Lafayette, LLC	Lafayette	LA	70508
32-0083	Heart Hospital of New Mexico, LLC	Albuqueque	NM	87102
37-0218	Tulsa Heart Hospital of Saint Francis,LLC	Tulsa	OK	74133
43-0095	Heart Hosptial of South Dakota, LLC	Sioux Falls	SD	57108
45-0824	Heart Hospital IV, LP	Austin	TX	78756
45-0876	Lubbock Heart Hospital, LP	Lubbock	TX	79416
52-0199	The Wisconsin Heart Hospital	Wauwatosa	WI	53226
	Orthopedic			
03-0107	Arizona Spine and Joint Hospital, LLC	Mesa	AZ	85206
15-0160	Indiana Orthopaedic Hospital, LLC	Indianapolis	IN	46278
17-0195	Heartland Surgical Specialty Hospital, LLC	Overland Park	KS	66211
28-0127	Lincoln Surgery Center LLC	Lincoln	NE	68506
28-0129	Nebraska Orthopaedic Hospital, LLC	Omaha	NE	68144
34-0049	North Carolina Specialty Hospital, LLC	Durham	NC	27701
36-0263	West Central Ohio Group, LTD	Lima	OH	45804
36-0266	New Albany Surgical Hospital, LLC	New Albany	OH	43054
37-0210	Orthopedic Hospital of Oklahoma	Oklahoma City	OK	73109
43-0091	Black Hills Surgery Center, LLP	Rapid City	SD	57703
45-0780	Methodist Healthcare System of San Antonio, Ltd , L L P	San Antonio	TX	78240
45-0804	Orthopedic Hospital, Ltd	Houston	TX	77030
45-0845	El Paso Specialty Hospital	El Paso	TX	79902
45-0856	Orthopedic & Spine Surgical Hospital of South Texas, LP	San Antonio	TX	78258
45-0864	Texas Spine & Joint Hospital, L T D	Tyler	TX	75701
46-0054	Cache Vallet Specialty Hospital, L L C	North Logan	UT	84341
52-0194	Orthopaedic Hospital of Wisconsin, LLC	Glendale	WI	53212
	Surgical			
04-0145	Surgical Hospital of Jonoboro, LLC	Jonesboro	AR	72401
05-0697	James D Tate/ Patients's Hospital of Redding	Redding	CA	96001
05-0708	Fresno Surgery Center, LP	Fresno	CA	93710
05-0749	Thousand Oaks Surgical Hospital, lp	Thousand Oaks	CA	91361
13-0063	Treasure Valley Hospital	Boise	ID	83704
17-0190	Manhattan Surgical Hospital LLC	Manhattan	KS	66502
17-0191	Surgical and Diagnostic Center of Great Bend, LLC	Great Bend	KS	67530
17-0193	Emporia Surgical Hospital, LLC	Emporia	KS	66801
17-0194	Doctors Hospital, LLC	Shawnee Mission	KS	66211
19-0246	P&S Surgery Center, LLC	Monroe	LA	71201
19-0251	SSH Management, LLC	Baton Rouge	LA	70810
19-0266	N M C Operating Company LLC	Baton Rouge	LA	70810
23-0264	Southeast Michigan Surgical Hopsital, LLC	Warren	MI	48091
27-0087	HealthCenter Northwest LLC	Kalispell	MT	59901
29-0051	Sierra Surgery & Imaging, LLC	Carson City	NV	89703
36-0261	Three Gables Surgery Center, LLC	Proctorville	OH	45669
36-0269	Prexus Health Partners	Hamilton	OH	45011
37-0212	Oklahoma Center for Orthopaedic and Multi-Specialty Surgery, LLC	Oklahoma City	OK	73139
43-0090	Sioux Falls Surgical Center, LLP	Sioux Falls	SD	57105
43-0096	Lewis and Clark Specialty Hospital, LLC	Yankton	SD	57078
45-0422	MSH Partners LLP	Dallas	TX	75204
45-0834	Brazos Valley Physicians Org -MSO,LLC	Bryan	TX	77802
45-0860	Sugar Land Surgical Hospital	Sugar Land	TX	77478
45-0872	USMD Hospital at Arlington, L P	Arlington	TX	76017

Survey Respondents

PROVIDER NUMBER	NAME	CITY	STATE	ZIP CODE
45-0874	Irving Coppell Surgical Hospital, L L P	Irving	TX	75063
45-0878	Heart Hospital of San Antonio, LP	San Antonio	TX	78201
45-0879	Providence Hospital, L P	Laredo	TX	78041
45-0880	Fort Worth Surgicare Partners LTD	Fort Worth	TX	76104
45-0883	Trophy Club Medical Center, LP	Trophy Club	TX	76262
45-0886	S W S C - Hurst, L P	Hurst	TX	76054
45-0889	Texas Institute for Surgery, LLP	Dallas	TX	75231
45-0891	Physicians Medical Center, LLP	Plano	TX	75093
45-0893	Rocky Mountain Medical Center L P	Denton	TX	76208
52-0196	Oak Leaf Surgical Hospital, LLC	Eau Claire	WI	54701
67-0005	Kingwood Specialty Hospital	Kingwood	TX	77339
	COMPETITOR HOSPITALS			
03-0014	John C Lincoln Hospital-North Mountain	PHOENIX	AZ	85020
03-0023	Flagstaff Medical Center, Inc	FLAGSTAFF	AZ	86001
03-0043	Sierra Vista Regional Health Center	SIERRA VISTA	AZ	85635
03-0092	John C Lincoln Hospital - Deer Valley	PHOENIX	AZ	85027
04-0021	Little Rock HMA, INC	LITTLE ROCK	AR	72209
04-0026	St Joseph Mercy Health Center	HOT SPRINGS	AR	71913
04-0084	Saline County Medical Center	BENTON	AR	72015
05-0179	Emanuel Medical Center	TURLOCK	CA	95380
05-0455	Adventist-San Joaquin Communioty Hospital	BAKERSFIELD	CA	93301
05-0528	Memorial Hospital Los Banos	LOS BANOS	CA	93635
13-0018	Eastern Idaho Health Services Inc	IDAHO FALLS	ID	83403
15-0007	Board of Trustees of Howard Community Hospital	KOKOMO	IN	46904
17-0020	Hutchinson Hospital Corporation	HUTCHINSON	KS	67502
17-0023	St Catherine's Hospital	GARDEN CITY	KS	67846
17-0027	Pratt Regional Medical Center Corporation	PRATT	KS	67124
17-0122	Via Christi Regional Medical Center, Inc	WICHITA	KS	67214
19-0003	Dauterive Hospital Corporation	NEW IBERIA	LA	70563
19-0017	Opelousas General Hospital Trust Authority	OPELOUSAS	LA	70570
19-0025	Rapides Healthcare System, LLC	MAMOU	LA	70554
19-0040	St Tammany Parish Hospital Service District No 2	SLIDELL	LA	70458
19-0205	Hamilton Medical Center	LAFAYETTE	LA	70506
36-0006	Ohio Health Corporation	COLUMBUS	OH	43214
36-0011	Marion General Hospital	MARION	OH	43302
36-0017	Ohio Health Corporation	COLUMBUS	OH	43215
36-0109	Coshocton County Memorial Hospital Association	COSHOCTON	OH	43812
36-0210	Grady Memorial Hospital	DELAWARE	OH	43015
37-0016	Integris Bass Baptist Health Center	ENID	OK	73701
37-0020	Valley View Hospital, Inc	ADA	OK	74820
37-0028	Integris Baptist Medical Center, Inc	OKLAHOMA CITY	OK	73112
37-0032	Deaconess Health System, LLC	OKLAHOMA CITY	OK	73112
37-0114	St John Medical Center, Inc	TULSA	OK	74104
37-0148	Edmond Regioal Medical Center, LLC	EDMOND	OK	73034
43-0016	Avera Mckennan	SIOUX FALLS	SD	57117
43-0027	Sioux Valley Hospital	SIOUX FALLS	SD	57117
45-0007	Sid Peterson Memorial Hospital	KERRVILLE	TX	78028
45-0010	United Regional Health Care System, Inc	WICHITA FALLS	TX	76301
45-0031	HMA Mesquite Hospital, Inc	MESQUITE	TX	75149
45-0097	Pasadena Bayshore Hospital Inc	PASADENA	TX	77504
45-0126	CHCA East Houston Regional Medical Center	HOUSTON	TX	77015
45-0128	Knapp Medical Center	WESLACO	TX	78596
45-0130	Accord Medical Management, L P	SAN ANTONIO	TX	78205
45-0132	Ector County Hospital District	ODESSA	TX	79761
45-0176	Mission Hospital, Inc	MISSION	TX	78572
45-0358	The Methodist Hospital	HOUSTON	TX	77030
45-0403	Columbia Medical Center of McKinney Subsidiary, LP	MCKINNEY	TX	75069
45-0424	San Jacinto Methodist Hospital	BAYTOWN	TX	77521

Survey Respondents

PROVIDER NUMBER	NAME	CITY	STATE	ZIP CODE
45-0431	St David's Healthcare Partnership L P , LLP	AUSTIN	TX	78705
45-0530	CHCA Mainland L P	TEXAS CITY	TX	77591
45-0604	Hill Country Memorial Hospital	FREDERICKSBURG	TX	78624
45-0617	CHCA Clear Lake, L P	WEBSTER	TX	77598
45-0630	Spring Branch Medical Center, Inc [A Texas Corporation]	HOUSTON	TX	77055
45-0634	Columbia Medical Center of Denton Subsidiary, L P	DENTON	TX	76205
45-0644	CHCA West Houston, LP	HOUSTON	TX	77082
45-0646	El Paso Healthcare System, ltd	EL PASO	TX	79925
45-0647	Columbia Hospital at Medical City Dallas Subsidiary	DALLAS	TX	75230
45-0651	Columbia Medical Center of Plano Subsidiary, LP	PLANO	TX	75075
45-0662	Columbia Valley Healthcare System, LP	BROWNSVILLE	TX	78521
45-0669	Columbia Medical Center of Lewisville Subsidiary, L P [a Texas limited partnership]	LEWISVILLE	TX	75057
45-0683	Terrell Healthcare, L P	TERRELL	TX	75160
45-0688	Lone Star HMA, LP	MESQUITE	TX	75150
45-0711	Columbia Rio Grande Healthcare, L P	MC ALLEN	TX	78503
45-0713	St David's Healthcare Partnership, L P , L L P	AUSTIN	TX	78704
45-0716	New Medical Horizons II, Ltd	HOUSTON	TX	77065
45-0771	Presbyterian Hospital of Plano	PLANO	TX	75093
46-0010	LDS Hospital	SALT LAKE CITY	UT	84143
46-0015	Logan Regional Hospital	LOGAN	UT	84341
52-0008	Wauesha Memorial Hospital	WAUKESHA	WI	53186
52-0040	St Michael Hospitalof Franciscan Sisters of Milwaukee Inc	MILWAUKEE	WI	53209
52-0051	Columbia St Mary's Hospital Milwaukee, Inc	MILWAUKEE	WI	53211
52-0062	Oconomowoc Memorial Hospital	OCONOMOWOC	WI	53066
52-0078	St Francis Hospital, Inc	MILWAUKEE	WI	53215
52-0096	All Saints Medical Center, Inc	RACINE	WI	53405
52-0103	Community Memorial Hospital of Menomonee Fall, Inc	MENOMONEE FALLS	WI	53051
52-0136	St Joseph Regional Medical Center, inc	MILWAUKEE	WI	53210
	Additional Respondents			
19-0086	Lincoln General Hospital	Ruston	LA	71273
36-0152	Ohio Health Corporation	Columbus	OH	43228
NOTE Lincoln General Hospital had received the survey from the AHA and the Ohio Health Corporation's survey was unsolicited				

Survey Participants

PROVIDER NUMBER	NAME	CITY	STATE	ZIP CODE
03-0100	Tucson Heart Hospital	Tucson	AZ	85704
03-0102	Arizona Heart Hospital	Phoenix	AZ	85006
03-0107	Arizona Spine & Joint Hospital	Mesa	AZ	85206
03-0112	Arizona Orthopedic Surgical Hospital	Chandler	AZ	85224
04-0134	Arkansas Heart Hospital	Little Rock	AR	72118
04-0142	Healthpark Hospital	Hot Springs Nat'l Park	AR	71913
04-0145	Surgical Hospital of Jonesboro	Jonesboro	AR	72401
05-0697	Patients' Hospital of Redding	Redding	CA	96001
05-0707	Menlo Park Surgical Hospital	Menlo Park	CA	94025
05-0708	Fresno Surgery Center	Fresno	CA	93710
05-0724	Bakersfield Heart Hospital	Bakersfield	CA	93308
05-0726	Stanislaus Surgical Hospital	Modesto	CA	95355
05-0732	Fresno Heart Hospital	Fresno	CA	93720
05-0749	Thousand Oaks Surgical Hospital	Thousand Oaks	CA	91361
05-0751	Miracle Mile Medical Center	Los Angeles	CA	90036
06-0117	Animas Surgical Hosp	Durango	CO	81301
13-0063	Treasure Valley Hospital	Boise	ID	83704
13-0065	Mountain View Hospital	Idaho Falls	ID	83404
13-0066	Northwest Specialty Hospital	Post Falls	ID	83854
13-0067	Mountain River Birthing & Surgery Center	Blackfoot	ID	83221
15-0147	Illiana Surgery & Medical Ctr, LLC	Munster	IN	46321
15-0153	Heart Center of Indiana	Indianapolis	IN	46290
15-0154	Indiana Heart Hospital	Indianapolis	IN	45250
15-0160	Indiana Orthopaedic Hospital	Indianapolis	IN	46278
17-0186	Kansas Heart Hospital	Wichita	KS	67226
17-0187	Salina Surgical Hospital	Salina	KS	67401
17-0188	Kansas City Orthopedic	Leawood	KS	66211
17-0190	Manhattan Surgical Hospital	Manhattan	KS	66502
17-0191	Surgical and Dianostic of Great Bend	Great Bend	KS	67530
17-0192	Galichia Heart Hospital	Wichita	KS	67220
17-0193	Emporia Surgical Hospital	Emporia	KS	66801
17-0194	Doctors Specialty Hospital	Shawnee Mission	KS	66211
17-0195	Heartland Surgical Specialty	Overland Park	KS	66211
17-0196	Kansas Spine Hospital	Wichita	KS	67226
19-0241	Physicians Surgical Specialty	Houma	LA	70360
19-0245	Monroe Surgical Hospital	Monroe	LA	71201
19-0246	P&S Surgical Hospital	Monroe	LA	71201
19-0250	Louisiana Heart Hospital	LaCombe	LA	70445
19-0251	Surgical Specialty Centre	Baton Rouge	LA	70810
19-0255	Park Place Surgery Ctr	Lafayette	LA	70503
19-0256	Doctors Hospital of Slidell	Slidell	LA	70458
19-0257	Green Clinic Surgical	Ruston	LA	71270
19-0259	Lafayette Surgical Specialty Hospital	Lafayette	LA	70505
19-0261	Ouachita Surgical Hospital	West Monroe	LA	71291
19-0263	Heart Hospital Lafayette	Lafayette	LA	70508
19-0266	Neuromed Ctr Hospital	Baton Rouge	LA	70810
19-0267	Fairway Medical Center	Covington	LA	70433
19-0268	Lafayette General Surgical Hospital	Lafayette	LA	70503
19-0273	Greater Baton Rouge Surgical Hosp	Baton Rouge	LA	70807
23-0264	Southeast Michigan Surgical Hosp	Warren	MI	48091
27-0086	Central Montana Surgical Hospital	Great Falls	MT	59405
27-0087	Health Center Northwest	Kalispell	MT	59901
28-0127	Lincoln Surgical Hospital	Lincoln	NE	68506
28-0128	Nebraska Heart Hospital	Lincoln	NE	76104
28-0129	Nebraska Orthopaedic Hosp	Omaha	NE	68144
29-0048	Carson Valley Medical Center	Gardnerville	NV	89410
29-0051	Sierra Surgery & Imaging	Carson City	NV	89703
32-0083	Heart Hospital of New Mexico	Albuqueque	NM	87102
34-0049	North Carolina Specialty Hospital	Durham	NC	27701
36-0056	Mercy Hospital Fairfield	Fairfield	OH	45014

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PROVIDER NUMBER	NAME	CITY	STATE	ZIP CODE
36-0253	Dayton Heart Hospital	Dayton	OH	45408
36-0258	Barix Care Center of Ohio	Groveport	OH	43125
36-0261	Three Gables Surgery Center, LLC	Proctorville	OH	45669
36-0263	Institute for Orthopedic Surgery	Lima	OH	45804
36-0266	New Albany Surgical Hospital	New Albany	OH	43054
36-0269	Butler County Surgery Center	Hamilton	OH	45011
36-0271	University Pointe Surgical Hospital	West Chester	OH	45069
37-0192	Northwest Surgical Hospital	Oklahoma City	OK	73120
37-0201	Surgical Hospital of Oklahoma LLC	Oklahoma City	OK	73129
37-0206	Oklahoma Spine Hospital	Oklahoma City	OK	73134
37-0210	Orthopedic Hospital of Oklahoma	Oklahoma City	OK	73109
37-0212	Oklahoma Ctr for Orthopaedic & Multi-Specialy	Oklahoma City	OK	73139
37-0215	Oklahoma Heart Hospital	Oklahoma City	OK	73120
37-0216	Tulsa Spine Hospital	Tulsa	OK	74132
37-0218	Saint Francis Heart (Tulsa)	Tulsa	OK	74133
37-0220	Hospital for Special Surgery	Oklahoma City	OK	73109
37-0222	McBride Clinic Orthopedic Hospital	Oklahoma City	OK	73114
38-0100	Physicians Hospital	Portland	OR	97220
39-0307	Edgewood Surgical Hospital	Transfer	PA	16154
43-0089	Siouxland Surgery Center LP	Dakota Dune	SD	57049
43-0090	Sioux Falls Surgical Center, LLP	Sioux Falls	SD	57105
43-0091	Black Hills Surgery Center, LLP	Rapid City	SD	57703
43-0092	Dakota Plains Surgical Center	Aberdeen	SD	57401
43-0093	Same Day Surgery Center, LLP	Rapid City	SD	57701
43-0094	Spearfish Surgery Center	Spearfish	SD	57783
43-0095	Avera Heart Hospital of South Dakota, LLC	Sioux Falls	SD	57108
43-0096	Lewis & Clark Specialty Hosp	Yankton	SD	57078
45-0315	Vista Hospital Of Dallas	Garland	TX	75042
45-0422	Mary Shiels Hospital	Dallas	TX	75204
45-0774	Tops Surgical Specialty Hospital	Houston	TX	77090
45-0780	Methodist Ambulatory Surgery Hosp NW	San Antonio	TX	78240
45-0796	Northwest Texas Surgery Center	Amarillo	TX	79119
45-0804	Texas Orthopedic Hospital	Houston	TX	77030
45-0824	Heart Hospital Of Austin	Austin	TX	78756
45-0831	Vista Medical Center Hospital	Pasadena	TX	77504
45-0834	Physicians Centre	Bryan	TX	77802
45-0841	Brownsville Surgical Hospital	Brownsville	TX	78526
45-0845	El Paso Specialty Hospital	El Paso	TX	79902
45-0849	Bariatric Care Center of Texas	Wylie	TX	75098
45-0851	Baylor Heart & Vascular Center	Dallas	TX	75226
45-0853	Frisco Medical Center	Frisco	TX	75034
45-0856	Spine Hospital of South Texas	San Antonio	TX	78258
45-0860	Sugar Land Surgical Hospital	Sugar Land	TX	77478
45-0864	Texas Spine & Joint Hospital	Tyler	TX	75701
45-0871	Austin Surgical Hospital	Austin	TX	78746
45-0872	USMD Hospital at Arlington	Arlington	TX	76017
45-0874	Irving Coppell Surgical Hospital	Irving	TX	75063
45-0875	Physicians Surgical Hospital at Quail Cr	Amarillo	TX	79124
45-0876	Lubbock Heart Hospital	Lubbock	TX	79416
45-0878	Texsan Heart Hospital Of San Antonio	San Antonio	TX	78201
45-0879	Providence Hospital	Laredo	TX	78041
45-0880	Medical Centre Surgical Hosp -Fort Worth	Fort Worth	TX	76104
45-0883	Trophy Club Medical	Trophy Club	TX	76262
45-0886	Southwest Surgical Hospital	Hurst	TX	76054
45-0888	Southlake Specialty Hospital	Southlake	TX	76092
45-0889	Texas Institute for Surgery at Presb	Dallas	TX	75231
45-0891	Presbyt Plano Center for Diag & Sur	Plano	TX	75093
45-0893	North Texas Hospital-Rocky Mountain	Denton	TX	76208
45-0894	Pine Creek Medical Center	Dallas	TX	75235
46-0049	Orthopedic Specialty Hospital	Murray	UT	84107

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PROVIDER NUMBER	NAME	CITY	STATE	ZIP CODE
46-0054	Cache Valley Specialty Hospital	North Logan	UT	84341
52-0194	Orthopaedic Hospital of Wisconsin	Glendale	WI	53212
52-0196	Oakleaf Surgical Hospital, LLC	Eau Claire	WI	54701
52-0199	Wisconsin Heart Hospital, LLC	Wauwatosa	WI	53226
67-0001	Living Hope New Boston Medical Center	New Boston	TX	75570
67-0003	West Texas Hospital	Abilene	TX	79605
67-0005	Kingwood Specialty	Kingwood	TX	77339
67-0006	Hospital at Westlake Medical Ctr	Austin	TX	78746
67-0007	Beaumont Bone & Joint Institute	Beaumont	TX	77707
67-0008	Surgical Arts Center of Clear Lake	Webster	TX	77598
	Total Specialty Hospitals above = 130			
	COMPETITOR HOSPITALS			
03-0001	MARYVALE HOSPITAL	PHOENIX	AZ	85031
03-0002	BANNER GOOD SAMARITAN MEDICAL CENTER	PHOENIX	AZ	85006
03-0006	TUCSON MEDICAL CENTER	TUCSON	AZ	85712
03-0007	VERDE VALLEY MEDICAL CENTER	COTTONWOOD	AZ	86326
03-0010	CARONDELET ST MARYS HOSPITAL & HEALTH CENTER	TUCSON	AZ	85745
03-0011	CARONDELET SAINT JOSEPHS HOSPITAL	TUCSON	AZ	85711
03-0013	YUMA REGIONAL MEDICAL CENTER	YUMA	AZ	85364
03-0014	JOHN C LINCOLN HOSP NORTH MOUNTAIN	PHOENIX	AZ	85020
03-0018	BANNER MESA MEDICAL CENTER	MESA	AZ	85201
03-0019	TEMPE ST LUKE'S HOSPITAL	TEMPE	AZ	85281
03-0022	MARICOPA MEDICAL CENTER	PHOENIX	AZ	85008
03-0023	FLAGSTAFF MEDICAL CENTER	FLAGSTAFF	AZ	86001
03-0024	ST JOSEPH'S HOSPITAL MEDICAL CENTER	PHOENIX	AZ	85013
03-0030	PHOENIX BAPTIST HOSP & MED CENTER	PHOENIX	AZ	85015
03-0036	CHANDLER REGIONAL HOSPITAL	CHANDLER	AZ	85224
03-0038	SCOTTSDALE HEALTHCARE-OSBORN	SCOTTSDALE	AZ	85251
03-0043	SIERRA VISTA REGIONAL HEALTH CENTER	SIERRA VISTA	AZ	85635
03-0055	KINGMAN REGIONAL MEDICAL CENTER	KINGMAN	AZ	86401
03-0060	COBRE VALLEY COMMUNITY HOSPITAL	GLOBE	AZ	85501
03-0062	NAVAPACHE HOSPITAL	SHOW LOW	AZ	85901
03-0064	UNIVERSITY MEDICAL CENTER	TUCSON	AZ	85724
03-0065	BANNER DESERT MEDICAL CENTER	MESA	AZ	85202
03-0069	HAVASU REGIONAL MEDICAL CENTER	LAKE HAVUSA	AZ	86403
03-0080	EL DORADO HOSPITAL	TUCSON	AZ	85712
03-0083	PARADISE VALLEY HOSPITAL	PHOENIX	AZ	85032
03-0085	NORTHWEST MEDICAL CENTER	TUCSON	AZ	85741
03-0087	SCOTTSDALE HEALTHCARE-SHEA	SCOTTSDALE	AZ	85261
03-0088	BANNER BAYWOOD MEDICAL CENTER	MESA	AZ	85206
03-0089	BANNER THUNDERBIRD MEDICAL CENTER	GLENDALE	AZ	85306
03-0092	JOHN C LINCOLN HOSPITAL-DEER VALLEY	PHOENIX	AZ	85027
03-0094	ARROWHEAD COMMUNITY HOSP/MED CENTER	GLENDALE	AZ	85312
03-0103	MAYO CLINIC HOSPITAL	PHOENIX	AZ	85054
03-0106	PHOENIX MEMORIAL HOSPITAL	PHOENIX	AZ	85007
03-0110	WEST VALLEY HOSPITAL MEDICAL CENTER	GOODYEAR	AZ	85338
04-0002	JOHNSON REGIONAL MEDICAL CENTER	CLARKSVILLE	AR	72830
04-0007	ST VINCENT INFIRMARY MEDICAL CENTER	LITTLE ROCK	AR	72205
04-0014	CENTRAL ARKANSAS HOSPITAL INC	SEARCY	AR	72143
04-0021	SOUTHWEST REGIONAL MEDICAL CENTER	LITTLE ROCK	AR	72209
04-0026	ST JOSEPHS MERCY HEALTH CENTER INC	HOT SPRINGS	AR	71913
04-0029	CONWAY REGIONAL MEDICAL CENTER	CONWAY	AR	72032
04-0036	BAPTIST HEALTH MEDICAL CENTER - NLR	NORTH LITTLE ROCK	AR	72117
04-0041	ST MARYS REGIONAL MEDICAL CENTER	RUSSELLVILLE	AR	72801
04-0050	OUACHITA COUNTY MEDICAL CENTER	CAMDEN	AR	71701
04-0071	JEFFERSON REGIONAL MEDICAL CENTER	PINE BLUFF	AR	71603
04-0072	STUTTGART REGIONAL MEDICAL CENTER	STUTTGART	AR	72160
04-0074	REBSAMEN MEDICAL CENTER INC	JACKSONVILLE	AR	72076
04-0078	NATIONAL PARK MEDICAL CENTER INC	HOT SPRINGS	AR	71901

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PROVIDER NUMBER	NAME	CITY	STATE	ZIP CODE
04-0084	SALINE MEMORIAL HOSPITAL	BENTON	AR	72015
04-0088	MEDICAL CENTER OF SOUTH ARKANSAS	EL DORADO	AR	71731
04-0100	WHITE COUNTY MEDICAL CENTER	SEARCY	AR	72143
04-0114	BAPTIST HEALTH MEDICAL CENTER	LITTLE ROCK	AR	72205
04-0119	WHITE RIVER MEDICAL CENTER	BATESVILLE	AR	72501
04-0137	ST VINCENT MEDICAL CENTER-NORTH	SHERWOOD	AR	72120
05-0057	KAWEAH DELTA DISTRICT HOSPITAL	VISALIA	CA	93291
05-0060	COMMUNITY MEDICAL CENTER FRESNO	FRESNO	CA	93721
05-0093	SAINT AGNES MEDICAL CENTER	FRESNO	CA	93720
05-0117	MERCY MED CTR MERCED DOMINICAN CAMPUS	MERCED	CA	95340
05-0179	EMANUEL MEDICAL CENTER INC	TURLOCK	CA	95380
05-0335	SONORA COMMUNITY HOSPITAL	SONORA	CA	95370
05-0455	SAN JOAQUIN COMMUNITY HOSPITAL	BAKERSFIELD	CA	93301
05-0464	DOCTORS MEDICAL CENTER	MODESTO	CA	95350
05-0492	COMMUNITY MEDICAL CENTER - CLOVIS	CLOVIS	CA	93611
05-0528	MEMORIAL HOSPITAL LOS BANOS	LOS BANOS	CA	93635
13-0018	EASTERN IDAHO REGIONAL MED CENTER	IDAHO FALLS	ID	83403
13-0026	CASSIA REGIONAL MEDICAL CENTER	BURLEY	ID	83318
14-0202	CONDELL MEMORIAL HOSPITAL	LIBERTYVILLE	IL	60048
15-0007	HOWARD REGIONAL HEALTH SYSTEM	KOKOMA	IN	46904
15-0048	REID HOSPITAL & HEALTH CARE SERVICES	RICHMOND	IN	47374
15-0056	CLARIAN HEALTH PARTNERS INC	INDIANAPOLIS	IN	46202
15-0059	RIVERVIEW HOSPITAL	NOBLESVILLE	IN	46060
17-0009	SAINT JOHN HOSPITAL	LEAVENWORTH	KS	66048
17-0010	MERCY HOSPITAL	INDEPENDENCE	KS	67301
17-0012	SALINA REGIONAL MEDICAL CENTER	SALINA	KS	67401
17-0013	HAYS MEDICAL CENTER	HAYS	KS	67601
17-0017	SUSAN B ALLEN MEMORIAL HOSPITAL	EL DORADO	KS	67042
17-0020	HUTCHINSON HOSPITAL CORPORATION	HUTCHINSON	KS	67502
17-0022	ATCHISON HOSPITAL	ATCHISON	KS	66002
17-0023	ST CATHERINE HOSPITAL	GARDEN CITY	KS	67846
17-0027	PRATT REGIONAL MEDICAL CENTER	PRATT	KS	67124
17-0033	CENTRAL KANSAS MEDICAL CENTER	GREAT BEND	KS	67530
17-0049	OLATHE MEDICAL CENTER	OLATHE	KS	66061
17-0104	SHAWNEE MISSION MEDICAL CENTER	SHAWNEE MISSION	KS	66201
17-0122	VIA CHRISTI REGIONAL MEDICAL CENTER	WICHITA	KS	67214
17-0123	WESLEY MEDICAL CENTER,LLC	WICHITA	KS	67214
17-0133	CUSHING MEMORIAL HOSPITAL	LEAVENWORTH	KS	66048
17-0146	PROVIDENCE MEDICAL CENTER	KANSAS CITY	KS	66112
17-0147	VIA CHRISTI RIVERSIDE MEDICAL CENTER	WICHITA	KS	67203
17-0176	OVERLAND PARK REGIONAL MEDICAL CENTER	OVERLAND PARK	KS	66215
17-0182	MENORAH MEDICAL CENTER	OVERLAND PARK	KS	66209
17-0185	SAINT LUKES SOUTH HOSPSITAL	OVERLAND PARK	KS	66213
19-0002	LAFAYETTE GENERAL MEDICAL CENTER	LAFAYETTE	LA	70505
19-0003	DAUTERINE HOSPITAL	NEW IBERIA	LA	70563
19-0017	OPELOUSAS GENERAL HOSPITAL SYSTEM	OPELOUSAS	LA	70570
19-0025	SAVOY MEDICAL CENTER	MAMOU	LA	70554
19-0040	SLIDELL MEMORIAL HOSPITAL	SLIDELL	LA	70458
19-0044	AMERICAN LEGION HOSPITAL	CROWLEY	LA	70526
19-0054	IBERIA GENERAL HOSPITAL & MEDICAL CTR	NEW IBERIA	LA	70560
19-0078	EUNICE COMMUNITY MEDICAL CENTER	EUNICE	LA	70535
19-0102	OUR LADY OF LOURDES REG MED CENTER	LAFAYETTE	LA	70506
19-0125	ST FRANCIS MEDICAL CENTER	MONROE	LA	71210
19-0160	GLENWOOD REGIONAL MEDICAL CENTER	WEST MONROE	LA	71291
19-0191	DOCTORS HOSPITAL OF OPELOUSAS	OPELOUSAS	LA	70570
19-0197	NORTH MONROE CENTER	MONROE	LA	71203
19-0204	NORTHSHORE REGIONAL MEDICAL CENTER	SLIDELL	LA	70461
19-0205	SOUTHERN MEDICAL CENTER - LAFAYETTE	LAFAYETTE	LA	70506
24-0037	QUEEN OF PEACE HOSPITAL	NEW PRAGUE	MN	56071
24-0057	ABBOTT - NORTHWESTERN HOSPITAL INC	MINNEAPOLIS	MN	55407

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PROVIDER NUMBER	NAME	CITY	STATE	ZIP CODE
24-0132	UNITY HOSPITAL	FRIDLEY	MN	55432
24-0141	FAIRVIEW NORTHLAND REGIONAL HOSPITAL	PRINCETON	MN	55371
24-0207	FAIRVIEW RIDGES HOSPITAL	BURNSVILLE	MN	55337
27-0014	ST PATRICK HOSPITAL CORP	MISSOULA	MT	59806
27-0023	COMMUNITY MEDICAL CENTER INC	MISSOULA	MT	59801
27-0040	NORTH VALLEY HOSPITAL	WHITEFISH	MT	59937
27-0051	KALISPELL REGIONAL HOSPITAL	KALISPELL	MT	59901
27-0084	ST JOSEPH HOSPITAL CORP	POLSON	MT	59860
32-0002	ST VINCENT HOSPITAL	SANTA FE	NM	87502
32-0003	NORTHEASTERN REGIONAL HOSPITAL	LAS VEGAS	NM	87701
32-0004	GERALD CHAMPION REGIONAL MEDICAL CENTE	ALAMOGORDO	NM	88310
32-0009	ALBUQUERQUE REGIONAL MEDICAL CTR	ALBUQUERQUE	NM	87102
32-0011	ESPANOLA HOSPITAL	ESPANOLA	NM	87532
32-0013	HOLY CROSS HOSPITAL	TAOS	NM	87571
32-0014	MIMBRES MEMORIAL HOSPITAL	DEMING	NM	88030
32-0017	NORTHEAST HEIGHTS MEDICAL CENTER	ALBUQUERQUE	NM	87109
32-0018	MEMORIAL MEDICAL CENTER INC	LAS CRUCES	NM	88001
32-0019	LOVELACE MEDICAL CENTER	ALBUQUERQUE	NM	87108
32-0021	PRESBYTERIAN HOSPITAL	ALBUQUERQUE	NM	87106
32-0033	LOS ALAMOS MEDICAL CENTER	LOS ALAMOS	NM	87544
32-0079	PRESBYTERIAN KASEMAN HOSPITAL	ALBUQUERQUE	NM	87110
32-0085	MOUNTAIN VIEW REGIONAL MEDICAL CENTER	LAS CRUCES	NM	88011
36-0002	SAMARITAN REGIONAL HEALTH SYSTEM	ASHLAND	OH	44805
36-0006	RIVERSIDE METHODIST HOSPITAL	COLUMBUS	OH	43214
36-0008	SOUTHERN OHIO MEDICAL CENTER	PORTSMOUTH	OH	45662
36-0009	LIMA MEMORIAL HOSPITAL	LIMA	OH	45804
36-0011	MARION GENERAL HOSPITAL	MARION	OH	43302
36-0012	ST ANNS HOSPITAL OF COLUMBUS	WESTERVILLE	OH	43081
36-0013	WILSON MEMORIAL HOSPITAL	SIDNEY	OH	45365
36-0014	O BLENESS MEMORIAL HOSPITAL	ATHENS	OH	45701
36-0017	GRANT MEDICAL CENTER	COLUMBUS	OH	43215
36-0035	MT CARMEL HEALTH	COLUMBUS	OH	43222
36-0039	GENESIS HEALTHCARE SYSTEM	ZANESVILLE	OH	43701
36-0044	WAYNE HOSPITAL	GREENVILLE	OH	45331
36-0051	MIAMI VALLEY HOSPITAL	DAYTON	OH	45409
36-0052	GOOD SAMARITAN HOSPITAL	DAYTON	OH	45406
36-0054	HOLZER MEDICAL CENTER	GALLIPOLIS	OH	45631
36-0062	OSUHE	COLUMBUS	OH	43205
36-0066	ST RITA'S MEDICAL CENTER	LIMA	OH	45801
36-0072	FAIRFIELD MEDICAL CENTER	LANCASTER	OH	43130
36-0109	COSHOCTON COUNTY MEMORIAL HOSPITAL	COSHOCTON	OH	43812
36-0118	MEDCENTRAL HEALTH SYSTEM	MANSFIELD	OH	44903
36-0147	MARIETTA MEMORIAL HOSPITAL	MARIETTA	OH	45750
36-0159	ADENA REGIONAL MEDICAL CENTER	CHILLICOTHE	OH	45601
36-0174	UPPER VALLEY MEDICAL CENTER	TROY	OH	45373
36-0197	MARY RUTAN HOSPITAL	BELLEFONTAINE	OH	43311
36-0203	SOUTHEASTERN OHIO REGIONAL MEDICAL CTR	CAMBRIDGE	OH	43725
36-0210	GRADY MEMORIAL HOSPITAL	DELAWARE	OH	43015
36-0218	LICKING MEMORIAL HOSPITAL	NEWARK	OH	43055
37-0002	WOODWARD HOSPITAL AND HEALTH CENTER	WOODWARD	OK	73801
37-0006	VIA CHRISTI OKLA REG MEDICAL CENTER	PONCA CITY	OK	74602
37-0013	MERCY HEALTH CENTER, INC	OKLAHOMA CITY	OK	73120
37-0014	MEDICAL CTR OF SOUTHEASTERN OKLAHOMA	DURANT	OK	74702
37-0016	INTEGRIS BASS BAPTIST HEALTH CENTER	ENID	OK	73701
37-0018	JANE PHILLIPS MEMORIAL MEDICAL CENTER	BARTLESVILLE	OK	74006
37-0019	GREAT PLAINS REGIONAL MEDICAL CENTER	ELK CITY	OK	73644
37-0020	VALLEY VIEW REGIONAL HOSPITAL	ADA	OK	74820
37-0026	ST MARY'S REGIONAL MEDICAL CENTER	ENID	OK	73702
37-0028	INTEGRIS BAPTIST MEDICAL CENTER	OKLAHOMA CITY	OK	73112
37-0032	DEACONESS HOSPITAL	OKLAHOMA CITY	OK	73112

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PROVIDER NUMBER	NAME	CITY	STATE	ZIP CODE
37-0034	MCALESTER REGIONAL HEALTH CENTER	MCALESTER	OK	74501
37-0037	ST ANTHONY HOSPITAL	OKLAHOMA CITY	OK	73101
37-0039	CLAREMORE REGIONAL HOSPITAL	CLAREMORE	OK	74017
37-0047	MERCY MEMORIAL HEALTH CENTER	ARDMORE	OK	73401
37-0057	OKMULGEE MEMORIAL HOSPITAL	OKMULGEE	OK	74447
37-0091	SAINT FRANCIS HOSPITAL, INC	TULSA	OK	74136
37-0094	MIDWEST CITY REG MED CENTER	MIDWEST CITY	OK	73110
37-0106	INTEGRIS SOUTHWEST MEDICAL CENTER	OKLAHOMA CITY	OK	73109
37-0114	ST JOHN MEDICAL CENTER, INC	TULSA	OK	74104
37-0148	EDMOND MEDICAL CENTER	EDMOND	OK	73034
37-0149	UNITY HEALTH CENTER	SHAWNEE	OK	74801
37-0166	WAGONER COMMUNITY HOSPITAL	WAGONER	OK	74467
37-0176	SAINT FRANCIS HOSPITAL - BROKEN ARROW	BROKEN ARROW	OK	74012
37-0178	MEMORIAL HOSPITAL	STILWELL	OK	74960
37-0200	SEMINOLE MEDICAL CENTER	SEMINOLE	OK	74868
37-0202	SOUTHCREST HOSPITAL	TULSA	OK	74153
37-0211	INTEGRIS CANADIAN VALLEY	YUKON	OK	73099
43-0005	PRAIRIE LAKES HOSP & CARE CTR	WATERTOWN	SD	57201
43-0012	AVERA SACRED HEART HOSPITAL	YANKTON	SD	57078
43-0013	AVERA QUEEN OF PEACE	MITCHELL	SD	57301
43-0014	AVERA ST LUKES	ABERDEEN	SD	57401
43-0015	ST MARYS HOSPITAL	PIERRE	SD	57501
43-0016	AVERA MCKENNAN HOSP&UNIVERSITY HLTH CT	SIOUX FALLS	SD	57117
43-0027	SIOUX VALLEY HOSPITAL UNIVERSITY MEDICAL CENTER	SIOUX FALLS	SD	57117
45-0007	SID PETERSON MEMORIAL HOSPITAL	KERRVILLE	TX	78028
45-0010	UNITED REGIONAL HEALTH CARE SYSTEM	WICHITA FALLS	TX	76301
45-0021	BAYLOR UNIVERSITY MEDICAL CENTER	DALLAS	TX	75246
45-0028	VALLEY BAPTIST MEDICAL CENTER-BROWNSVILLE	BROWNSVILLE	TX	78520
45-0029	LAREDO MEDICAL CENTER	LAREDO	TX	78041
45-0031	MEDICAL CENTER OF MESQUITE,THE	MESQUITE	TX	75149
45-0033	VALLEY BAPTIST MEDICAL CENTER	HARLINGEN	TX	78550
45-0035	CHRISTUS ST JOSEPH HOSPITAL	HOUSTON	TX	77002
45-0040	COVENANT MEDICAL CENTER	LUBBOCK	TX	79410
45-0044	ST PAUL UNIVERSITY HOSPITAL	DALLAS	TX	75235
45-0047	DOLLY VINSANT MEMORIAL HOSPITAL	SAN BENITO	TX	78586
45-0051	METHODIST MEDICAL CENTER	DALLAS	TX	75203
45-0056	SETON MEDICAL CENTER	AUSTIN	TX	78705
45-0058	BAPTIST HEALTH SYSTEM	SAN ANTONIO	TX	78205
45-0059	MCKENNA MEMORIAL HOSPITAL	NEW BRAUNFELS	TX	78130
45-0072	BRAZOSPORT MEMORIAL HOSPITAL	LAKE JACKSON	TX	77566
45-0079	BAYLOR MEDICAL CENTER AT IRVING	IRVING	TX	75061
45-0083	EAST TEXAS MEDICAL CENTER	TYLER	TX	75701
45-0097	BAYSHORE MEDICAL CENTER	PASADENA	TX	77504
45-0098	EAST TEXAS MEDICAL CENTER PITTSBURG	PITTSBURG	TX	75686
45-0099	PAMPA REGIONAL MEDICAL CENTER	PAMPA	TX	79065
45-0102	MOTHER FRANCES HOSPITAL	TYLER	TX	75701
45-0124	BRACKENRIDGE HOSPITAL	AUSTIN	TX	78701
45-0126	COLUMBIA E HOUSTON MED CTR E LOOP CAMP	HOUSTON	TX	77015
45-0128	KNAPP MEDICAL CENTER	WESLACO	TX	78596
45-0130	NIX HEALTH CARE SYSTEM	SAN ANTONIO	TX	78205
45-0132	MEDICAL CENTER HOSPITAL ECTOR COUNTY HOSP DIS	ODESSA	TX	79761
45-0133	MIDLAND MEMORIAL HOSPITAL	MIDLAND	TX	79701
45-0165	SOUTH TEXAS REGIONAL MEDICAL CENTER	JOURDANTON	TX	78026
45-0176	MISSION HOSPITAL INC	MISSION	TX	78572
45-0184	MEMORIAL HOSPITAL SYSTEM	HOUSTON	TX	77074
45-0187	TRINITY COMMUNITY MED CENTER OF BREHAM	BRENHAM	TX	77833
45-0193	ST LUKES EPISCOPAL HOSPITAL	HOUSTON	TX	77030
45-0194	EAST TEXAS MEDICAL CENTER JACKSONVILLE	JACKSONVILLE	TX	75766
45-0196	PARIS REGIONAL MEDICAL CENTER	PARIS	TX	75460
45-0213	UNIVERSITY HEALTH SYSTEM	SAN ANTONIO	TX	78229

Survey Participants

PROVIDER NUMBER	NAME	CITY	STATE	ZIP CODE
45-0214	GULF COAST MEDICAL CENTER	WHARTON	TX	77488
45-0224	PRESBYTERIAN HOSPITAL OF WINNSBORO	WINNSBORO	TX	75494
45-0231	BAPTIST ST ANTHONYS HOSPITAL	AMARILLO	TX	79106
45-0237	CHRISTUS SANTA ROSA HOSPITAL	SAN ANTONIO	TX	78207
45-0272	CENTRAL TEXAS MEDICAL CENTER	SAN MARCOS	TX	78667
45-0280	BAYLOR MEDICAL CENTER AT GARLAND	GARLAND	TX	75042
45-0296	CLEVELAND REGIONAL MEDICAL CTR	CLEVELAND	TX	77327
45-0299	COLLEGE STATION MEDICAL CENTER	COLLEGE STATION	TX	77840
45-0324	TEXOMA MEDICAL CENTER	DENISON	TX	75020
45-0347	HUNTSVILLE MEMORIAL HOSPITAL	HUNTSVILLE	TX	77340
45-0358	METHODIST HOSPITAL,THE	HOUSTON	TX	77030
45-0370	COLUMBUS COMMUNITY HOSPITAL	COLUMBUS	TX	78934
45-0372	BAYLOR MEDICAL CENTER AT WAXAHACHIE	WAXAHACHIE	TX	75165
45-0378	TWELVE OAKS MEDICAL CENTER	HOUSTON	TX	77074
45-0388	METHODIST HOPSITAL	SAN ANTONIO	TX	78229
45-0389	EAST TEXAS MEDICAL CENTER ATHENS	ATHENS	TX	75751
45-0403	NORTH CENTRAL MEDICAL CENTER	MCKINNEY	TX	75069
45-0424	SAN JACINTO METHODIST HOSPITAL	BAYTOWN	TX	77521
45-0431	ST DAVIDS HOSPITAL	AUSTIN	TX	78705
45-0438	COLORADO FAYETTE MEDICAL CENTER	WEIMAR	TX	78962
45-0447	NAVARRO REGIONAL HOSPITAL	CORSICANA	TX	75110
45-0462	PRESBYTERIAN HOSPITAL OF DALLAS	DALLAS	TX	75231
45-0469	WILSON N JONES MEDICAL CENTER	SHERMAN	TX	75091
45-0475	HENDERSON MEMORIAL HOSPITAL	HENDERSON	TX	75652
45-0484	WOODLAND HEIGHTS MEDICAL CENTER	LUFKIN	TX	75904
45-0530	MAINLAND MEDICAL CENTER	TEXAS CITY	TX	77591
45-0563	BAYLOR REGIONAL MEDICAL CENTER AT GRAPEVINE	GRAPEVINE	TX	76051
45-0580	EAST TEXAS MEDICAL CENTER CROCKETT	CROCKETT	TX	75835
45-0604	HILL COUNTRY MEMORIAL HOSPITAL INC	FREDERICKSBURG	TX	78624
45-0610	MEMORIAL HOSPITAL MEMORIAL CITY	HOUSTON	TX	77024
45-0617	CLEAR LAKE REG MEDICAL CENTER	WEBSTER	TX	77598
45-0630	COLUMBIA SPRING BRANCH MEDICAL CENTER	HOUSTON	TX	77055
45-0634	DENTON REGIONAL MEDICAL CENTER	DENTON	TX	76205
45-0638	HOUSTON NORTHWEST MEDICAL CENTER	HOUSTON	TX	77090
45-0644	WEST HOUSTON MEDICAL CENTER	HOUSTON	TX	77082
45-0646	DEL SOL MEDICAL CENTER	EL PASO	TX	79925
45-0647	MEDICAL CITY DALLAS HOSPITAL	DALLAS	TX	75230
45-0651	MEDICAL CENTER OF PLANO	PLANO	TX	75075
45-0659	PARK PLAZA HOSPITAL	HOUSTON	TX	77004
45-0662	VALLEY REGIONAL MEDICAL CENTER	BROWNSVILLE	TX	78521
45-0669	MEDICAL CENTER OF LEWISVILLE	LEWISVILLE	TX	75057
45-0683	MEDICAL CENTER AT TERRELL	TERRELL	TX	75160
45-0688	MESQUITE COMMUNITY HOSPITAL	MESQUITE	TX	75150
45-0694	EL CAMPO MEMORIAL HOSPITAL	EL CAMPO	TX	77437
45-0709	CHRISTUS ST JOHN HOSPITAL	NASSAU BAY	TX	77058
45-0711	RIO GRANDE REGIONAL HOSPITAL	MC ALLEN	TX	78503
45-0713	SOUTH AUSTIN HOSPITAL	AUSTIN	TX	78704
45-0715	MEDICAL CENTER AT LANCASTER	LANCASTER	TX	75146
45-0716	CYPRESS FAIRBANKS MED CTR HOSPITAL	HOUSTON	TX	77065
45-0718	ROUND ROCK MEDICAL CENTER	ROUND ROCK	TX	78681
45-0730	TRINITY MEDICAL CENTER	CARROLLTON	TX	75010
45-0742	LAKE POINTE MEDICAL CENTER	ROWLETT	TX	75088
45-0743	DENTON COMMUNITY HOSPITAL	DENTON	TX	76201
45-0747	PALESTINE REGIONAL MEDICAL CENTER	PALESTINE	TX	75801
45-0759	HEALTHSOUTH MEDICAL CENTER	DALLAS	TX	75235
45-0766	ZALE LIPSHY UNIV HOSP	DALLAS	TX	75235
45-0771	PRESBYTERIAN HOSP OF PLANO	PLANO	TX	75093
45-0803	DOCTORS HOSPITAL TIDWELL	HOUSTON	TX	77091
45-0820	METHODIST SUGAR LAND HOSPITAL	SUGAR LAND	TX	77479
45-0822	LAS COLINAS MEDICAL CENTER	IRVING	TX	75039

Survey Participants

PROVIDER NUMBER	NAME	CITY	STATE	ZIP CODE
45-0832	CHRISTUS ST CATHERINE HEALTH & WELLNES	KATY	TX	77450
45-0833	ENNIS REGIONAL MEDICAL CENTER	ENNIS	TX	75119
45-0840	PRESBYTERIAN HOSPITAL OF ALLEN	ALLEN	TX	75013
45-0844	METHODIST WILLOWBROOK HOSPITAL	HOUSTON	TX	77070
45-0847	MEMORIAL HERMANN KATY HOSPITAL	KATY	TX	77494
45-0848	MEMORIAL HERMANN FORT BEND HOSPITAL	MISSOURI CITY	TX	77459
45-0862	ST LUKES COMMUNITY MEDICAL CENTER THE WOODLANDS	THE WOODLANDS	TX	77384
45-0867	SETON NORTHWEST HOSPITAL	AUSTIN	TX	78759
46-0003	SALT LAKE REGIONAL MEDICAL CENTER	SALT LAKE CITY	UT	84102
46-0006	COTTONWOOD HOSPITAL	MURRAY	UT	84107
46-0010	LDS HOSPITAL	SALT LAKE CITY	UT	84143
46-0015	LOGAN REGIONAL HOSPITAL	LOGAN	UT	84341
46-0042	LAKEVIEW HOSPITAL	BOUNTIFUL	UT	84010
46-0044	ALTA VIEW HOSPITAL	SANDY	UT	84070
46-0051	JORDAN VALLEY HOSPITAL	WEST JORDAN	UT	84088
52-0008	WAUKESHA MEMORIAL HSPTL	WAUKESHA	WI	53186
52-0027	ST MARYS HSPTL OZAUKEE	MEQUON	WI	53097
52-0035	AURORA SHEBOYGAN MEM MED CTR	SHEBOYGAN	WI	53081
52-0038	AURORA MED CTR OF WASHINGTON CTY	HARTFORD	WI	53027
52-0040	ST MICHAEL HSPTL	MILWAUKEE	WI	53209
52-0044	ST NICHOLAS HOSPITAL	SHEBOYGAN	WI	53081
52-0051	COLUMBIA ST MARYS MILW CAMPUS	MILWAUKEE	WI	53211
52-0062	OCONOMOWOC MEM HSPTL	OCONOMOWOC	WI	53066
52-0063	ST JOSEPHS COMM HSPTL WEST BEND	WEST BEND	WI	53095
52-0070	LUTHER HSPTL	EAU CLAIRE	WI	54702
52-0078	ST FRANCIS HOSPITAL INC	MILWAUKEE	WI	53215
52-0096	ALL SAINTS MED CTR INC	RACINE	WI	53405
52-0102	AURORA LAKELAND MED CTR	ELKHORN	WI	53121
52-0103	COMMUNITY MEMORIAL HSPTL	MENOMONEE FALLS	WI	53051
52-0136	ST JOSEPH REG MED CTR	MILWAUKEE	WI	53210
52-0138	ST LUKES MED CTR	MILWAUKEE	WI	53215
52-0140	COLUMBIA HSPTL	MILWAUKEE	WI	53211
52-0177	FROEDTERT MEMORIAL LUTHERAN HSPTL	MILWAUKEE	WI	53226
	Total Competitor Hospitals above = 320			
	Additional Competitor Hospitals identified by the American Hospital Association =			
43-0077	RAPID CITY REGIONAL HOSPITAL	RAPID CITY	SD	57701
43-0048	LOOKOUT MEMORIAL HOSPITAL	SPEARFISH	SD	57783
19-0066	LINCOLN GENERAL HOSPITAL	RUSTON	LA	71273
28-0003	BRYAN LGH HOSPITAL	LINCOLN	NE	68506
28-0020	ST ELIZABETH HOSPITAL	LINCOLN	NE	68510
16-0153	MERCY MEDICAL CENTER	SIOUX CITY	IA	51101
16-0146	ST LUKE'S REGIONAL MEDICAL CENTER	SIOUX CITY	IA	51104
37-0093	OKLAHOMA UNIVERSITY MEDICAL CENTER	OKLAHOMA CITY	OK	73104
	NOTE The American Hospital Association was invited to ask these hospitals to submit a survey These hospitals are not included in the total number of competitor hospitals to which CMS sent surveys that is cited in the Report to Congress			
	Additional hospital self-identified as a Competitor Hospital =			
36-0152	Ohio Health Corporation	Columbus	OH	43228
	NOTE This hospital identified itself as a competitor hospital Although we did not send a survey to this hospital, the hospital submitted a survey response			

ANSWERS FOR THE RECORD
TO QUESTIONS
SUBMITTED BY SENATOR CHARLES E. GRASSLEY
FROM THE SENATE FINANCE COMMITTEE HEARING ON
PHYSICIAN-OWNED SPECIALTY HOSPITALS
May 17, 2006

Question 7:

The Centers for Medicare and Medicaid Services (CMS) have jurisdiction over the Medicaid program which is jointly administered by the various state governments in addition to the federal government. Last June, the Committee held a hearing entitled "Medicaid Fraud, Waste and Abuse: Threatening the Healthcare Safety Net," which addressed the vulnerabilities that exist in the Medicaid program. At that hearing, a representative from CMS stated that there was no way to calculate an overall error rate for the Medicaid program and, subsequently, no way to accurately determine how much money is lost to fraud, waste, or abuse in the Medicaid program.

At a recent hearing before the Senate Homeland Security and Government Affairs Committee, Subcommittee on Federal Financial Management officials from CMS stated a guess at Medicaid losses between 5-8% of total outlays in the Medicaid program. As Chairman of the Committee of jurisdiction over the Medicaid program, I would like to know where this estimate came from and what the total breakdown in fraud, waste and abuse to the Medicaid program is. Accordingly, please provide a written response detailing any estimates for losses to the Medicaid program for fraud, waste, or abuse, including losses attributed to both providers and state governments.

Answer:

There have been many "guesstimates" of what the fraud rate might be. One figure frequently used comes from a then-General Accounting Office (GAO) report to the House Committee on Government Operations in 1992 which stated, in part, "Estimates vary widely on the losses resulting from fraud and abuse, but the most common is 10 percent...of our total health care spending." In 1994, a GAO representative testifying before the same Committee said, specifically in reference to fraud in the Medicaid program, "The ensuing drain on program funds is difficult to gauge, but state officials believe it can be as high as 10 percent of program expenditures."

The range of 5-8 percent that Dennis Smith used in his testimony is rough but a reasonable approximation based on formal and informal estimates that have been put forward over the years. However, with the implementation of the new Medicaid Integrity Program and its attendant resources, it is safe to say that this is something that CMS will be looking at much more closely over the next couple of years.

Error rate measurement has been employed by a number of government agencies for some time. For example, in CMS, Medicare measures error rates through a program called Comprehensive Error Rate Testing, or CERT. The Medicare error rate is published annually. The following

error rates have been published for the last three years: 10.8 percent in FY 2003; 10.1 percent in FY 2004; and, 5.2 percent in FY 2005. Other government agencies conduct error rate measurement in their programs. For example, the Department of Labor's Unemployment Insurance program registered error rates of 10.3 percent and 10.1 percent for the past two years, the Department of Education's Pell Grant program published error rates of 4.9 percent and 4.5 percent. There are many other examples.

In Medicaid, a number of states have conducted error rate studies. For example: Illinois conducted such a study in SFY 1998 and posted a 4.72 percent error rate; the Texas Controller's Office published error rates of 13.7 percent in the fee-for-service part of the program and 2.2 percent in managed care in SFY 2005; North Carolina's SFY 2004 error rate was 3.3 percent; Oklahoma's SFY 2005 error rate was 9.58 percent.

Partly because there was no consistency across states either in methodology or frequency, Congress passed the Improper Payments Information Act of 2002 (IPIA). In response to that law, CMS developed the Payment Error Rate Measurement Program (PERM) to estimate the amount of improper payments made by the states in Medicaid and the State Children's Health Insurance Program (SCHIP). After conducting pilots for a few years, CMS implemented a national contracting strategy to implement IPIA nationwide. Beginning in FY 2006, CMS will measure improper payments in the fee-for-service component of Medicaid. In FY 2007, CMS will publish the fee-for-service error rate; in FY 2008, published error rates will incorporate the fee-for-service, managed care and eligibility aspects of both the Medicaid and SCHIP programs. State-specific error rates will be calculated, upon which a national Medicaid error rate can be estimated.

ANSWERS FOR THE RECORD
TO QUESTIONS
SUBMITTED BY SENATOR MAX BAUCUS
FROM THE SENATE FINANCE COMMITTEE HEARING ON
PHYSICIAN-OWNED SPECIALTY HOSPITALS
May 17, 2006

Question 1(a):

Why was your response delayed until the evening before the hearing on physician-owned specialty hospitals?

Answer:

Please be assured that responses to the February 16, 2006 and March 29, 2006 inquiries received from Senators Baucus and Grassley were prioritized by the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS). As indicated in communications with your staff, we made every effort to expedite our responses to ensure that you would have them prior to the Senate Finance Committee's May 17 hearing on physician-owned specialty hospitals. The questions submitted were multifaceted and complex, requiring further elaboration from your staff as evident in a March 8, 2006 conference call. As discussed during this call, we indicated that some of the information requested would take time to compile as it required specific data runs. Due to the complexity associated with the various data runs, the difficulty in displaying the data in a clear manner, and the difficulty identifying the limitations of the data, the responses were subject to extensive review prior to release. This review was critically important to ensure the responses were accurate and understandable. As a result of this review, questions were identified and points were raised that required additional work and clarity. Despite this somewhat lengthy process, we met our commitment of sending the responses prior to the May 17 hearing.

ANSWERS FOR THE RECORD
TO QUESTIONS
SUBMITTED BY SENATOR MAX BAUCUS
FROM THE SENATE FINANCE COMMITTEE HEARING ON
PHYSICIAN-OWNED SPECIALTY HOSPITALS
May 17, 2006

Question 1(b):

In our February 14 letter, we asked how many physician-owned specialty hospitals have policies, either written or verbal, that do not require a physician to be on duty or on call when patients are present. You responded that Medicare hospital Conditions of Participation require a physician to be on duty or on call at all times. Given that Physicians' Hospital did not meet this standard, how does CMS monitor whether hospitals are abiding by this standard?

Answer:

The Medicare program requires at 42 CFR 482.12(c)(3) that the hospital's governing body must ensure that a doctor of medicine or osteopathy is on duty or on call at all times. The expectation is that hospitals meet this (and all) requirements at all times. CMS evaluates compliance with this regulation during onsite hospital surveys. The survey process affords a 'snap shot' of compliance at the time of the survey. CMS provides Interpretive Guidelines to determine compliance with the regulation that direct the surveyor to—

- Verify the governing body has established and monitors the enforcement of policies that ensure a doctor of medicine or osteopathy is on duty or on call at all times to provide medical care and onsite supervision when necessary;

- Review the "call" register and documents that assure that a doctor of medicine or osteopathy is on duty or on call at all times; and

- Interview nursing staff to see if they know (1) who is on call, (2) if they are able to call the on-call doctor and speak with him/her at all times, and (3) when appropriate, confirm whether on-call doctors come to the hospital to provide needed care.

If we receive a complaint of noncompliance with any regulatory provision, we investigate. Such investigation includes an onsite hospital survey.

ANSWERS FOR THE RECORD
TO QUESTIONS
SUBMITTED BY SENATOR MAX BAUCUS
FROM THE SENATE FINANCE COMMITTEE HEARING ON
PHYSICIAN-OWNED SPECIALTY HOSPITALS
May 17, 2006

Question 1(c):

In our February 14 letter, we asked how many physician-owned specialty hospitals have policies directing hospital staff to call 911 in case of a patient emergency. You responded that 'CMS does not collect or track such information.' Is it CMS' position that tracking such information is unimportant? Is CMS planning to track such information in the future?

Answer:

The collection or tracking of the number of physician-owned specialty hospitals that have policies directing hospital staff to call 911 in case of a patient emergency may have importance. However, for a hospital to call 911 is not a substitute for having a physician on call or on duty, and thereby having its own capacity to respond to emergency situations.

More specifically, the Medicare program requires at 42 CFR 482.12(f) that all Medicare-participating hospitals must be able to appropriately address the emergency needs of their patients. However, Medicare participating hospitals are not required to offer emergency services.

For hospitals offering emergency services, the hospital must be in compliance with the Emergency Services Condition of Participation at 42 CFR 482.55. Specifically 482.55(b)(1) states, "The emergency services must be supervised by a qualified member of the medical staff." The Interpretive Guidelines (used by surveyors to determine compliance with the regulation) state—

- A qualified member of the medical staff must be on premises and available to supervise the provision of emergency services at all times the hospital offers emergency services.

- A qualified member of the medical staff must be physically present in the emergency department and available to directly supervise the provision of emergency care to a patient.

Furthermore, there must be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility. As part of the survey process, surveyors verify that there are "sufficient medical and nursing personnel qualified in the needs anticipated by the facility and that there are specific assigned duties for emergency care personnel and a clear chain of command."

For those hospitals that do not offer emergency services, 42 CFR 482.12(f)(2) states—

"If emergency services are not provided at the hospital, the governing body must assure that the medical staff has written policies and procedures for appraisal of emergencies, initial treatment, and referral when appropriate."

If a hospital does not offer emergency services, CMS' expectation is that it be able to evaluate the patient's emergency condition, provide appropriate initial treatment, and refer the patient to another hospital when appropriate. This referral could include calling 911.

ANSWERS FOR THE RECORD
TO QUESTIONS
SUBMITTED BY SENATOR MAX BAUCUS
FROM THE SENATE FINANCE COMMITTEE HEARING ON
PHYSICIAN-OWNED SPECIALTY HOSPITALS
May 17, 2006

Question 1(d):

In response to our March 29 letter, you stated that CMS has no method of tracking the number of physician investors in physician-owned specialty hospitals. Yet you also stated that during the advisory opinion process for a particular specialty hospital, you discovered that this hospital increased its number of physician investors during the MMA-mandated moratorium. Please describe how you discovered this increase, and the steps you took to determine whether other specialty hospitals had similarly increased their number of physician-investors. Finally, is CMS planning to create a method by which it could track the number of physician investors in hospitals?

Answer:

We preliminarily determined that a specialty hospital had increased the number of its physician-investors past the time permitted by the MMA using information the hospital submitted with its request for an advisory opinion. After requesting and receiving additional information from the hospital, we confirmed our preliminary determination and sent an overpayment notice for Medicare claims totaling approximately $118,000 for services rendered to patients who were referred to the hospital by physician-investors during the period of the MMA moratorium.

We also attempted to ascertain whether there were other hospitals that did not seek an advisory opinion that were in fact subject to the MMA moratorium. We compiled a list of short term acute care hospitals that received Medicare provider agreements on or after November 17, 2003 and which had a bed capacity of less than 75 beds. From the resulting list of 78 hospitals, we disregarded those hospitals that had requested an advisory opinion or of which we were already aware, as well as those few hospitals that received provider agreements after the expiration of the MMA moratorium. We also disregarded hospitals that received their provider agreements prior to April 1, 2004, because we were confident that any specialty hospital that received its provider agreement prior to that date would have been "under development" as of November 18, 2003 and thus would have been excepted from the MMA moratorium.

To determine preliminarily whether any of the hospitals identified through the steps noted above were primarily engaged in the care and treatment of patients with a cardiac or orthopedic condition, or those receiving a surgical procedure, we conducted a review of inpatient claims data. That is, we examined MedPAR data to capture the percentage of the hospital's total discharges that fell within MDC 5, MDC 8, and the type of DRG within the MDC (that is, medical or surgical). Consistent with our earlier actions and the criteria used by the Medicare Payment Advisory Commission (MedPAC) and the Government Accountability Office (GAO),

we established a threshold whereby, if 45 percent or more of the hospital's total discharges fell within MDC 5 or MDC 8, or 45 percent of its total discharges were surgical in nature, we considered the hospital to be a specialty hospital. After performing the claims analysis we arrived at a final list of 10 hospitals.

In April 2006, we sent a letter to each of the 10 hospitals, requiring information concerning the ownership of the hospital and the nature of the services performed. Based on the information we received in response to the letter, we determined that two hospitals were likely to have been under development, and thus excepted from the MMA moratorium. The responses also indicated that two hospitals did not have physician-owners and two hospitals had not submitted bills to Medicare for the period during the moratorium. Information submitted by four hospitals indicated that they were subject to the MMA moratorium. Overpayment notices were sent in July 2006 to the four hospitals, demanding repayment of approximately $12.1 million in the aggregate. Each of the four hospitals submitted rebuttal statements and supporting documentation, which demonstrated that they were not subject to the MMA moratorium because each hospital was "under development" as of November 18, 2003.

With regard to creating a method by which we can track the number of physician investors in hospitals, section 1877(f) of the Social Security Act allows the Secretary to collect, in such form, manner, and at such times as the Secretary shall specify, "information concerning [an] entity's ownership, investment and compensation arrangements, including" (1) the covered items and services furnished by the provider or supplier; and (2) the names and unique physician identification numbers (UPINs) of all physicians (or their immediate family members) with an ownership or investment interest, or compensation arrangement. The implementing regulation, 42 CFR § 411.361, states that CMS and the HHS Office of Inspector General (OIG) may require entities to submit information concerning their financial arrangements (ownership, investment, or compensation) with a physician (or his or her immediate family member), including the name and UPIN of each physician-owner or investor, and the extent and/or value of the ownership or investment interest or compensation arrangement. Therefore, we believe the statute and the regulation provide the necessary authority for requiring hospitals to disclose the names of physician-owners or investors, the nature and extent of their interests, and information concerning any possible compensation arrangements such as loans, or profit distributions, dividends, or other payments made by the hospital to the physicians.

CMS will require hospitals to provide information on a periodic basis concerning their investment and compensation relationships with physicians through a regular disclosure process. We have not yet designed the process, but will consider such issues as whether we should (1) survey all hospitals annually, (2) stagger our survey so that all hospitals are queried but not all in the same year, and/or (3) focus our inquiry on certain types of relationships or certain hospitals. We will also consider whether, having once provided information, hospitals need submit only updated information on a yearly or other periodic basis. Failure to disclose the information sought in a timely manner can result in civil monetary penalties of up to $10,000 for each day beyond the deadline established for disclosure (which in all cases must be at least 30 days).

ANSWERS FOR THE RECORD
TO QUESTIONS
SUBMITTED BY SENATOR MAX BAUCUS
FROM THE SENATE FINANCE COMMITTEE HEARING ON
PHYSICIAN-OWNED SPECIALTY HOSPITALS
May 17, 2006

Question 1(e):

In response to our March 29 letter, you stated that CMS has no mechanism in place to track the number of beds for which a hospital is licensed. Is it CMS' position that tracking such information is unimportant? Is CMS planning to add a mechanism by which it could track such information in the future?

Answer:

Tracking the number of beds for which a hospital is licensed may have importance. CMS has periodically captured the number of hospital licensed beds. However, there have been data challenges, e.g., some states count all licensed beds whether from the general hospital or from the distinct part of the hospital. For example, a hospital may have a higher number of licensed beds than are actually operational or certified. In addition, hospitals often adjust beds that are actually in use based on staffing or retention of highly specialized medical personnel. As a result, this snapshot of a hospital's licensed beds may have limited usefulness.

ANSWERS FOR THE RECORD
TO QUESTIONS
SUBMITTED BY SENATOR MAX BAUCUS
FROM THE SENATE FINANCE COMMITTEE HEARING ON
PHYSICIAN-OWNED SPECIALTY HOSPITALS
May 17, 2006

Question 2:

The "whole hospital" exception for physician self-referrals seems to have different application for physician-owned specialty hospitals than it does for general hospitals. Do you believe that the whole hospital exception should apply the same to a 400-bed full service hospital as it does to a 4-bed surgical hospital? As CMS is responsible for enforcing the ban on physician self-referrals, do you apply the whole hospital exception differently depending on the type of hospital? If so, what are the differences in application? If not, why not?

Answer:

Although some have argued that physician ownership in specialty hospitals, because of their limited size, is more akin to ownership of a department of a hospital and, thus, is inconsistent with the whole hospital exception, the Congress did not enact an absolute bar to physician ownership of small facilities. The physician self-referral statute allows physician ownership of any hospital regardless of its size, including ownership in small community hospitals, and also allows physician ownership of rural facilities (including, but not limited to, hospitals), regardless of their size. Ultimately, the Congress must decide whether physician investment in specialty hospitals should be treated like ownership in these other hospitals and facilities or whether it calls for different treatment.

ANSWERS FOR THE RECORD
TO QUESTIONS
SUBMITTED BY SENATOR MAX BAUCUS
FROM THE SENATE FINANCE COMMITTEE HEARING ON
PHYSICIAN-OWNED SPECIALTY HOSPITALS
May 17, 2006

Question 3:

CMS began a suspension on enrollment for specialty hospitals while it considered the correct definition of hospital. Please describe in detail the current definition and the changes CMS is considering to account for physician-owned specialty hospitals.

Answer:

Section 1861(e) of the Social Security Act provides that, in order to be a "hospital," an institution must be primarily engaged in providing care to inpatients. Some entities providing specialty care may concentrate primarily on outpatient care and consequently do not meet the definition of "hospital" in section 1861(e) of the Social Security Act. Specialty hospitals could be denied a provider agreement if it were determined that they did not meet the definition of a "hospital," and specialty hospitals operating under an existing Medicare provider agreement could have such agreement terminated if they did not satisfy the definition of a "hospital."

At the time we began the enrollment suspension, we were concerned that some specialty hospitals may not meet the definition of a "hospital." Therefore, we wanted to be assured that, given their limited focus, specialty hospitals meet such core requirements that we determine are necessary for the health and safety of Medicare beneficiaries. To address these concerns, we reviewed Medicare's current standards for approval for participation and payment to determine whether additional or different standards should apply to specialty hospitals in light of the focused nature of their services. In doing so, we conferred with State survey and certification units, and the organizations that accredit hospitals (that is, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and the American Osteopathic Association (AOA)); and we assessed whether revisions to our standards for enrolling specialty hospitals would be appropriate based on the requirements of the Emergency Medical Treatment and Labor Act (EMTALA).

The issue of how to determine whether a facility was primarily engaged in furnishing services to inpatients was discussed during a September 30, 2005 Special Open Door Forum. Representatives of both community and specialty hospital associations opposed the adoption of a fixed definition of "primarily engaged in furnishing services to inpatients." Some associations recognized that, given advances and improvements in medical technology, many procedures that previously could only be performed on an inpatient basis can now be safely performed on an outpatient basis. In addition, community hospital associations opposed a fixed standard because some small rural hospitals might not meet new requirements.

We have not yet identified any quantitative method, such as percentage of services, or ratio of inpatient-to-outpatient services, that could be used without disqualifying both community hospitals and specialty hospitals. Therefore, we currently do not intend to define by regulation the statutory requirement that a hospital is an entity that is "primarily engaged" in furnishing services to hospital inpatients for the purpose of differentiating specialty hospitals from community hospitals. Instead, we will continue to interpret "primarily engaged" on a case-by-case basis as we continue to explore other options for addressing this issue.

Currently, the provider enrollment form—the CMS-855A—does not distinguish between specialty hospitals and other types of hospitals. We will propose changing the CMS-855A to capture whether the applicant hospital is, or is projected to be, a specialty hospital. We will need to define specialty hospital (for example, the definition could be limited to cardiac, orthopedic and surgical hospitals or could include other types of specialty hospitals, such as women's hospitals) and establish criteria for determining the area of focus (for example, a certain percentage of discharges occurring or projected to occur within certain MDCs). In advance of any change to the CMS-855A, we will instruct the fiscal intermediaries to begin capturing data through contacting those hospitals that check the hospital box on the CMS-855A, and inquire whether they are, or plan to be, a specialty hospital.

ANSWERS FOR THE RECORD
TO QUESTIONS
SUBMITTED BY SENATOR MAX BAUCUS
FROM THE SENATE FINANCE COMMITTEE HEARING ON
PHYSICIAN-OWNED SPECIALTY HOSPITALS
May 17, 2006

Question 4:

You said at the hearing that CMS lacked the authority to extend the enrollment suspension currently in effect. Please provide a detailed explanation for that statement, including an analysis of the basis for CMS' authority to enact the enrollment suspension initially in June 2005, as well as the limitations on that authority you believe prevent you from extending the moratorium when it expires later this year.

Answer:

On May 12, 2005, Mark B. McClellan, M.D., Ph.D., the Administrator of CMS, testified before the House Committee on Energy and Commerce and presented four key recommendations regarding specialty hospitals. First, Dr. McClellan stated that CMS would analyze MedPAC's recommendations to improve the accuracy of the payment rates for inpatient hospital services. Second, CMS would reform payment rates for ambulatory surgical centers to reduce incentives to form a specialty hospital simply to take advantage of higher payment rates under the Medicare outpatient prospective payment system. Third, CMS would engage in closer scrutiny of whether specialty hospitals meet the definition of a hospital in section 1861(e) of the Social Security Act. Fourth, CMS would carefully review its criteria for enrolling new specialty hospitals into the Medicare program.

We stated that, while we were looking at the procedures for enrolling new specialty hospitals, we would instruct the CMS regional offices not to issue new specialty hospital provider agreements or authorize an initial survey by the State survey agency for new specialty hospitals. Medicare fiscal intermediaries would be instructed to refrain from processing further new provider enrollment applications for specialty hospitals during a six-month period.

Section 5006 of the Deficit Reduction Act (DRA) directed CMS to continue the suspension on enrollment that we instituted on June 9, 2005 until the earlier of the date that the Secretary submits the final report, or the date that is six months after the date of enactment of the DRA (August 8, 2006), and that, if the final report is not issued by August 8, 2006, the suspension is to be continued for an additional two months. Thus, because the Congress provided for definite end dates for the suspension, including an end date in the event that the final report was not issued by August 8, 2006, we question whether we would have the authority to continue the suspension beyond the time specifically provided for in section 5006 of the DRA. That is, we believe that the end dates specified by the Congress may not be simply an end to the mandate for the suspension, but may be an end to the authorization for the suspension.

ANSWERS FOR THE RECORD
TO QUESTIONS
SUBMITTED BY SENATOR MAX BAUCUS
FROM THE SENATE FINANCE COMMITTEE HEARING ON
PHYSICIAN-OWNED SPECIALTY HOSPITALS
May 17, 2006

Question 5:

In response to question 5 from our February 14 letter, you noted that Physicians' Hospital was certified to participate in the Medicare program effective January 26, 2005, having met all participation requirements. Please explain how CMS determined that Physicians' met Medicare's Condition of Participation requiring that a hospital always have a physician either on duty or on call (42 CFR 482.12(c)(3)).

Answer:

In January 2005, Physicians' Hospital requested an initial certification survey from the Oregon State Survey Agency. When the Oregon State Survey Agency completed the initial certification survey, Physicians' Hospital was found in compliance with all applicable hospital Conditions of Participation related to physician services, specifically, that physicians be on duty or on-call with coverage 24 hours per day. Deficient practices were limited to Life Safety Code findings. Physicians' Hospital submitted an acceptable Plan of Correction, and received approval of certification from the Oregon State Survey Agency, effective January 26, 2005.

ANSWERS FOR THE RECORD
TO QUESTIONS
SUBMITTED BY SENATOR MAX BAUCUS
FROM THE SENATE FINANCE COMMITTEE HEARING ON
PHYSICIAN-OWNED SPECIALTY HOSPITALS
May 17, 2006

Question 6:

As was discussed at the hearing, physicians are not required to disclose their ownership interest in a specialty hospital. Does CMS support instituting such a requirement? Could such a requirement be incorporated into the Medicare provider agreement?

Answer:

Section 5006 of the DRA requires CMS to consider the issue of annual disclosure of investment information. Accordingly, we first considered whether we have existing authority to require specialty or other hospitals to provide us with investment information on a routine basis. Such information could include the names of investors, the percentage of their shares, and the returns on their investments, as well as other information that would pertain to whether the return was proportional to the capital invested or whether the investments were bona fide.

Section 1877(f) of the Social Security Act allows the Secretary to collect, in such form, manner, and at such times as the Secretary shall specify, "information concerning [an] entity's ownership, investment and compensation arrangements, including" (1) the covered items and services furnished by the provider or supplier; and (2) the names and unique physician identification numbers (UPINs) of all physicians (or their immediate family members) with an ownership or investment interest, or compensation arrangement. The implementing regulation, 42 CFR § 411.361, states that CMS and the HHS OIG may require entities to submit information concerning their financial arrangements (ownership, investment, or compensation) with a physician (or his or her immediate family member), including the name and UPIN of each physician-owner or investor, and the extent and/or value of the ownership or investment interest or compensation arrangement. Therefore, we believe the statute and the regulation provide the necessary authority for requiring hospitals to disclose the names of physician-owners or investors, the nature and extent of their interest, and information concerning any possible compensation arrangement, such as a loan, or profit distributions, dividends, or other payments made by the hospital to the physicians. We note that failure to disclose the information sought in a timely manner can result in civil monetary penalties of up to $10,000 for each day beyond the deadline established for disclosure (which in all cases must be at least 30 days).

We will require hospitals to provide us information on a periodic basis concerning their investment and compensation relationships with physicians through a regular disclosure process. We have not yet designed the process, but will consider such issues as whether we should (1) survey all hospitals annually, (2) stagger our survey so that all hospitals are queried but not all in the same year, and/or (3) focus our inquiry on certain types of relationships or certain hospitals.

We will also consider whether, having once provided information, hospitals need only submit updated information on a yearly or other periodic basis.

We believe that a well-crafted disclosure requirement, which, at a minimum, would require hospitals to disclose to patients whether they are physician-owned and, if so, the names of the physician-owners, is consistent with our approach that hospitals should be transparent as to their pricing and their quality outcomes. A well-educated consumer is essential to improving the quality and efficiency of our healthcare system. Accordingly, we are exploring a change to our regulations, either related to hospital Conditions of Participation or provider agreement requirements, to require hospitals to disclose to patients investment interests, and possibly certain compensation arrangements, with physicians who refer to the hospital.

ANSWERS FOR THE RECORD
TO QUESTIONS
SUBMITTED BY SENATOR MAX BAUCUS
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PHYSICIAN-OWNED SPECIALTY HOSPITALS
May 17, 2006

Question 7:

Your May 16 response noted that many of your findings on specialty hospitals were incomplete, based on preliminary analysis. Please provide updated answers to questions 4, 6, 7 and 8 from our February 14 letter, and question 5 and 7 from our March 29 letter.

Answer:

Updated Responses to February 14, 2006 Letter
(1) Question 4 asked for a list of payments, including the type of procedure, to Physicians' Hospital by Medicare or Medicaid for any services rendered during or after the physician-owned specialty hospital moratorium (November 18, 2003 – Present).

Physicians' Hospital was certified to participate in the Medicare program as a hospital, effective January 26, 2005. Please find attached a list of Medicare payments to Physicians' Hospital for 2005 and 2006.

(2) Question 6 asked if CMS was aware of any other physician-owned specialty hospitals that received provider agreements during the moratorium without applying for the requested advisory opinion, and if so, to provide a list of the hospitals and a reason why CMS granted a provider agreement.

CMS attempted to ascertain whether there were other hospitals that did not seek an advisory opinion as to whether they were subject to the MMA moratorium but which, in fact, were specialty hospitals and which may have violated the moratorium. We identified 10 hospitals that potentially could be specialty hospitals and we requested information from them to determine whether they were subject to the moratorium and, if so, whether they complied with the moratorium. In July 2006, CMS sent overpayment notices to four hospitals that, based upon a review of Medicare data, were found to be specialty hospitals. Each of the four hospitals submitted rebuttal statements and supporting documentation which demonstrated that they were not subject to the MMA moratorium because each hospital was "under development" as of November 18, 2003.

(3) Question 7 asked if CMS knew of any other physician-owned specialty hospital similar to Physicians' that may have opened during the moratorium utilizing a provider agreement from a facility that existed prior to the moratorium, and if so, provide a list of such facilities and provide a detailed explanation as to why CMS approved them during the moratorium.

CMS is not aware of any other physician-owned specialty hospitals (other than Physicians' Hospital) that may have opened during the moratorium utilizing a provider agreement from a facility that existed prior to the moratorium. If a physician-owned hospital opened during the moratorium and wished to utilize a provider agreement from a facility that existed prior to the moratorium, a new enrollment application (CMS-855-A) would have been submitted to the fiscal intermediary regarding a change of ownership and the application would have been processed.

(4) Question 8 asked for a list of all specialty hospitals that received any payment from Medicare and Medicaid from November 18, 2003, through June 8, 2005, including the name of the facility, the location, contact information for the facility, and the total amount of Medicare and Medicaid funds received by the facility.

Please find attached a list of hospitals that qualify as specialty hospitals or potentially could qualify as specialty hospitals (including hospitals that requested advisory opinions) under section 507 of the MMA that received any payment from Medicare from November 18, 2003 through June 8, 2005. This document replaces the document you received earlier (referred to as Attachment 2), which only listed hospitals that received Medicare payments during calendar year 2004.

Updates to Responses to March 29, 2006 Letter

(1) Question 5 asked for a list of all hospitals that qualify as a "specialty hospital" under section 507 of the MMA (codified at 42 U.S.C. 1395nn(h)), including the name of the facility, the Medicare provider number of the facility, the geographic location of the facility, and the date that the Medicare provider number was granted to the facility.

As noted in the updated response to Question 8 from the February 14 letter, please find attached a list of hospitals that qualify as specialty hospitals or potentially could qualify as specialty hospitals (including hospitals that requested advisory opinions) under section 507 of the MMA that received any payment from Medicare from November 18, 2003 through June 8, 2005.

(2) Question 7 asked for a detailed response outlining how many specialty hospitals CMS is currently investigating as potentially violating the moratorium, including the name of the facility, why CMS is examining a certain facility, and the current status of any investigation.

CMS attempted to ascertain whether there were other hospitals that did not seek an advisory opinion as to whether they were subject to the MMA moratorium but which, in fact, were specialty hospitals and which may have violated the moratorium. CMS identified 10 hospitals that potentially could be specialty hospitals and we requested information from them to determine whether they were subject to the moratorium and, if so, whether they complied with the moratorium. In July 2006, CMS sent overpayment notices to four hospitals that, based upon a review of Medicare data, were found to be specialty hospitals. Each of the four hospitals submitted rebuttal statements and supporting documentation which demonstrated that they were not subject to the MMA moratorium because each hospital was "under development" as of November 18, 2003.

Medicare Payments to Hospitals that Qualify as Specialty Hospitals Under Section 507 of the MMA*

PROVIDER NUMBER	PROVIDER NAME	CITY	STATE	ZIP CODE	PHONE NUMBER	Medicare Payments from 11/18/2003 - 6/7/2005	MEDICARE PARTICIPATION DATE
30100	TUCSON HEART HOSPITAL	Tucson	AZ	85704	520-696-2328	$38,973,797	10/16/97
30102	ARIZONA HEART HOSPITAL	Phoenix	AZ	85016	602-532-1000	$72,958,576	06/10/98
30107	ARIZONA SPINE & JOINT HOSPITAL	Mesa	AZ	85206	480-832-4770	$7,519,889	01/28/03
30112	ARIZONA ORTHOPEDIC SURGICAL HOSPITAL	Chandler	AZ	85224	480-603-9000	$858,319	07/21/04
40134	ARKANSAS HEART HOSPITAL	Little Rock	AR	72211-4335	501-219-7000	$78,195,482	03/03/97
40142	HEALTHPARK HOSPITAL	Hot Springs National Park	AR	71913	501-520-2000	$10,312,038	02/22/02
40145	SURGICAL HOSPITAL OF JONESBORO	Jonesboro	AR	72401	870-336-1100	$4,983,224	10/10/03
50697	PATIENTS' HOSPITAL OF REDDING	Redding	CA	96001	330-225-8700	$1,345,800	04/08/92
50707	MENLO PARK SURGICAL HOSPITAL	Menlo Park	CA	94025-2617	650-324-8500	$845,762	03/23/93
50708	FRESNO SURGERY CENTER	Fresno	CA	93710-5207	559-431-8000	$6,544,243	04/09/93
50724	BAKERSFIELD HEART HOSPITAL	Bakersfield	CA	93308-6337	661-316-6000	$38,192,961	10/06/99
50726	STANISLAUS SURGICAL HOSPITAL	Modesto	CA	95355-3359	209-572-2700	$5,052,785	04/10/00
50732	FRESNO HEART HOSPITAL	Fresno	CA	93720	559-433-8000	$29,101,781	10/22/03
50749	THOUSAND OAKS SURGICAL HOSPITAL	Thousand Oaks	CA	91361	805-777-7750	$43,104	05/13/05
60117	ANIMAS SURGICAL HOSPITAL	Durango	CO	81301	970-247-3537	$603,193	12/14/04
130063	TREASURE VALLEY HOSPITAL	Boise	ID	83704	208-373-5000	$2,343,666	11/11/96
130065	MOUNTAIN VIEW HOSPITAL	Idaho Falls	ID	83404	208-557-2700	$5,169,953	01/21/03
130066	NORTHWEST SPECIALTY HOSPITAL	Post Falls	ID	83854	208-262-2300	$2,972,668	10/16/03
150147	ILLIANA SURGERY & MEDICAL CENTER, LLC	Munster	IN	46321-4029	219-924-1300	$6,272,152	08/04/00
150153	HEART CENTER OF INDIANA	Indianapolis	IN	46290	317-583-5000	$61,940,330	12/05/02
150154	INDIANA HEART HOSPITAL	Indianapolis	IN	46256	317-621-8000	$44,357,362	02/25/03
150160	INDIANA ORTHOPAEDIC HOSPITAL	Indianapolis	IN	46278	371-956-1180	$757,267	03/23/05
170186	KANSAS HEART HOSPITAL	Wichita	KS	67226	316-630-5000	$37,817,238	02/17/99
170187	SALINA SURGICAL HOSPITAL	Salina	KS	67401-2697	785-827-0610	$4,078,438	12/09/99
170188	KANSAS CITY ORTHOPEDIC	Shawnee Mission	KS	66211	913-319-7586	$4,288,550	01/21/00
170190	MANHATTAN SURGICAL HOSPITAL	Manhattan	KS	66502	785-776-5100	$1,389,277	02/07/01
170191	SURGICAL AND DIAGNOSTIC OF GREAT BEND	Great Bend	KS	67530	620-792-8833	$1,730,695	04/19/01
170192	GALICHIA HEART HOSPITAL	Wichita	KS	67220	316-858-2610	$38,925,132	12/21/01
170193	EMPORIA SURGICAL HOSPITAL	Emporia	KS	66801	620-342-8822	$1,196,270	03/26/02
170194	DOCTORS SPECIALTY HOSPITAL	Shawnee Mission	KS	66211	913-529-1801	$2,143,445	09/18/02
170195	HEARTLAND SURGICAL SPECIALTY	Overland Park	KS	66211	913-754-5000	$6,518,455	09/18/03
170196	KANSAS SPINE HOSPITAL	Wichita	KS	67226	316-462-5338	$8,613,045	12/29/03
190241	PHYSICIANS SURGICAL SPECIALTY	Houma	LA	70360-2764	985-853-1390	$2,148,808	07/27/00
190245	MONROE SURGICAL HOSPITAL	Monroe	LA	71201	318-410-0002	$6,692,368	06/10/02
190246	P&S SURGICAL HOSPITAL	Monroe	LA	71201	318-338-4040	$3,831,848	12/16/02
190250	LOUISIANA HEART HOSPITAL	Lacombe	LA	70445	985-690-7500	$23,625,301	03/27/03
190251	SURGICAL SPECIALTY CENTRE	Baton Rouge	LA	70810	225-408-8080	$2,541,933	04/04/03
190255	PARK PLACE SURGERY CENTER	Lafayette	LA	70503	337-237-8119	$1,345,501	08/26/03
190256	DOCTORS HOSPITAL OF SLIDELL	Slidell	LA	70458	985-690-8200	$734,731	08/28/03
190257	GREEN CLINIC SURGICAL	Ruston	LA	71270	318-232-7700	$4,542,749	09/29/03
190259	LAFAYETTE SURGICAL SPECIALTY HOSPITAL	Lafayette	LA	70508	337-769-4100	$2,722,593	04/17/04
190261	OUACHITA SURGICAL HOSPITAL	West Monroe	LA	71291	318-322-1339	$456,504	04/08/04
190263	HEART HOSPITAL LAFAYETTE	Lafayette	LA	70508	337-521-1000	$34,378,655	07/16/96
190266	NEUROMED CENTER HOSPITAL	Baton Rouge	LA	70810	225-763-9900	$1,003,424	10/25/04
190267	FAIRWAY MEDICAL	Covington	LA	70433	985-809-9888	$476,129	02/09/05

Medicare Payments to Hospitals that Qualify as Specialty Hospitals Under Section 507 of the MMA*

PROVIDER NUMBER	PROVIDER NAME	CITY	STATE	ZIP CODE	PHONE NUMBER	Medicare Payments from 11/18/2003 - 6/7/2005	MEDICARE PARTICIPATION DATE
230264	SOUTHEAST MICHIGAN SURGICAL HOSPITAL	Warren	MI	48091-2287	586-427-1000	$1,516,419	09/24/73
270086	CENTRAL MONTANA SURGICAL HOSPITAL	Great Falls	MT	59405	406-727-5577	$551,078	01/09/03
270087	HEALTH CENTER NORTHWEST	Kalispell	MT	59901	406-751-7500	$5,227,359	09/17/03
280127	LINCOLN SURGICAL HOSPITAL	Lincoln	NE	68506	402-484-9090	$4,890,746	04/01/03
280128	NEBRASKA HEART HOSPITAL	Omaha	NE	68198-7400	402-552-2000	$55,855,004	05/12/03
280129	NEBRASKA ORTHOPAEDIC HOSPITAL	Omaha	NE	68144	402-637-0600	$3,036,083	04/22/04
290048	CARSON VALLEY MEDICAL CENTER	Gardnerville	NV	89410	775-782-1600	$439,360	02/26/04
320083	HEART HOSPITAL OF NEW MEXICO	Albuquerque	NM	87102	505-724-2000	$48,285,179	10/26/99
340049	NORTH CAROLINA SPECIALTY HOSPITAL	Durham	NC	27701-2000	919-956-9300	$6,346,425	07/01/66
360056	MERCY HOSPITAL FAIRFIELD	Fairfield	OH	45014	513-870-7000	$52,449,144	07/01/66
360253	DAYTON HEART HOSPITAL	Dayton	OH	45408	937-221-8000	$47,803,502	09/16/99
360258	BARIX CARE CENTER OF OHIO	Groveport	OH	43125-9119	614-834-6800	$6,919	05/03/01
360261	THREE GABLES SURGERY CENTER, LLC	Proctorville	OH	45669	740-886-9911	$1,533,851	05/23/02
360263	INSTITUTE FOR ORTHOPEDIC SURGERY	Lima	OH	45804	419-224-7586	$1,698,922	07/26/02
360266	NEW ALBANY SURGICAL HOSPITAL	New Albany	OH	43054	614-775-6600	$10,482,879	12/24/03
370192	NORTHWEST SURGICAL HOSPITAL	Oklahoma City	OK	73120-4419	405-848-1918	$2,159,644	01/25/94
370201	SURGICAL HOSPITAL OF OKLAHOMA, LLC	Oklahoma City	OK	73129	405-634-9300	$2,666,187	01/15/99
370206	OKLAHOMA SPINE HOSPITAL	Oklahoma City	OK	73134	405-749-2700	$4,409,466	12/14/99
370210	ORTHOPEDIC HOSPITAL OF OKLAHOMA	Tulsa	OK	74137	918-477-5000	$9,932,153	07/24/01
370212	OKLAHOMA CENTER FOR ORTHOPEDIC & MULTI-SPECIALTY	Oklahoma City	OK	73139	405-602-6500	$2,295,750	04/08/02
370215	OKLAHOMA HEART HOSPITAL	Oklahoma City	OK	73120	405-608-3200	$83,870,312	10/25/02
370216	TULSA SPINE HOSPITAL	Tulsa	OK	74132	918-388-5701	$8,378,409	01/29/03
370218	ST. FRANCIS HEART (TULSA)	Tulsa	OK	74133	918-307-6000	$19,207,709	04/13/04
370220	HOSPITAL FOR SPECIAL SURGERY	Oklahoma City	OK			$5,211	03/31/05
380100	PHYSICIANS HOSPITAL	Portland	OR	97220-3831	503-257-5500	$598,038	01/26/05
430089	SIOUXLAND SURGERY CTR LTD PARTNERSHIP	Dakota Dunes	SD	57049-5000	605-232-3332	$4,348,654	12/06/95
430090	SIOUX FALLS SURGICAL CENTER LLP	Sioux Falls	SD	57105	605-334-6730	$4,195,642	11/07/96
430091	BLACK HILLS SURGERY CENTER LLP	Rapid City	SD	57701	605-721-4900	$12,429,524	02/20/97
430092	DAKOTA PLAINS SURGICAL CENTER LLP	Aberdeen	SD	57402-4450	605-622-5000	$3,090,085	06/10/98
430093	SAME DAY SURGERY CENTER LLC	Rapid City	SD	57701	605-719-5000	$928,920	12/09/97
430094	SPEARFISH SURGERY CENTER	Spearfish	SD	57783	605-642-3113	$1,371,620	02/09/00
430095	AVERA HEART HOSPITAL OF SOUTH DAKOTA, LLC	Sioux Falls	SD	57108-8148	605-977-7000	$46,280,914	03/22/01
430096	LEWIS & CLARK SPECIALTY HOSPITAL	Yankton	SD	57078-3899	605-668-8000	$2,204,553	05/09/02
450315	VISTA HOSPITAL OF DALLAS	Garland	TX	75042-6499	972-487-2401	$31,393	09/01/72
450422	MARY SHIELS HOSPITAL	Dallas	TX	75204-2895	214-443-3000	$2,092,554	07/01/66
450774	TOPS SURGICAL SPECIALTY HOSPITAL	Houston	TX	77090	281-539-2900	$3,588,742	04/23/91
450780	METHODIST AMBULATORY SURGERY HOSP NW	San Antonio	TX	78240-1545	210-691-8000	$3,976,508	01/24/92
450796	NORTHWEST TEXAS SURGERY CENTER	Amarillo	TX	79109	805-359-7999	$3,215,544	05/13/94
450804	TEXAS ORTHOPEDIC HOSPITAL	Houston	TX	77030-4509	713-799-8600	$10,862,909	02/14/95
450824	HEART HOSPITAL OF AUSTIN	Austin	TX	78756	512-407-7000	$59,824,636	01/08/99
450831	VISTA MEDICAL CENTER HOSPITAL	Pasadena	TX	77504	713-378-3000	$790,188	11/10/99
450834	PHYSICIANS CENTRE	Bryan	TX	77802	979-731-3100	$4,802,920	06/05/00
450841	BROWNSVILLE SURGICAL HOSPITAL	Brownsville	TX	78521	956-544-2000	$4,931,079	02/08/01
450845	EL PASO SPECIALTY HOSPITAL	El Paso	TX	79902	915-533-7465	$9,358,349	05/30/01

Medicare Payments to Hospitals that Qualify as Specialty Hospitals Under Section 507 of the MMA*

PROVIDER NUMBER	PROVIDER NAME	CITY	STATE	ZIP CODE	PHONE NUMBER	Medicare Payments from 11/18/2003 - 6/7/2005	MEDICARE PARTICIPATION DATE
450849	BARIATRIC CARE CENTER OF TEXAS	Wylie	TX	75098	972-429-8000	$0	02/20/02
450851	BAYLOR HEART & VASCULAR CENTER	Dallas	TX	75226-1337	214-820-0600	$37,736,207	05/16/02
450853	FRISCO MEDICAL CENTER	Frisco	TX	75034	214-618-2000	$2,613,905	10/15/02
450856	SPINE HOSPITAL OF SOUTH TEXAS	San Antonio	TX	78258	210-404-0800	$4,393,232	10/25/02
450860	SUGAR LAND SURGICAL HOSPITAL	Sugar Land	TX	77478	281-243-1000	$2,132,832	02/27/03
450864	TEXAS SPINE & JOINT HOSPITAL	Tyler	TX	75701	903-526-8754	$13,720,208	04/10/03
450871	AUSTIN SURGICAL HOSPITAL	Austin	TX	78746	512-314-3800	$7,444,573	10/08/03
450872	USMD HOSPITAL AT ARLINGTON	Arlington	TX	76017	817-472-3400	$5,539,727	10/30/03
450874	IRVING COPPELL SURGICAL HOSPITAL	Irving	TX	75063	972-868-4000	$1,431,941	12/03/03
450876	LUBBOCK HEART HOSPITAL	Lubbock	TX	79416	806-687-7777	$42,199,971	01/22/04
450878	HEART HOSPITAL OF SAN ANTONIO	San Antonio	TX	78201	210-736-6700	$27,624,726	01/22/04
450880	MEDICAL CENTRE SURGICAL HOSP-FORT WORTH	Fort Worth	TX	76104	817-334-5050	$3,102,785	04/29/04
450883	TROPHY CLUB MEDICAL	Trophy Club	TX	76262	817-837-4600	$568,652	06/08/04
450886	SOUTHWEST SURGICAL HOSPITAL	Hurst	TX	76054	817-345-4100	$272,547	10/25/04
450888	SOUTHLAKE SPECIALTY HOSPITAL	Southlake	TX	76092	817-748-8700	$204,396	11/19/04
450889	TEXAS INSTITUTE FOR SURGERY AT PRESB	Dallas	TX	75231	214-647-5300	$771,082	11/16/04
450891	PRESBYT. PLANO CENTER FOR DIAG & SURG	Plano	TX	75093	972-403-2700	$181,513	02/23/05
450893	NORTH TEXAS HOSPITAL-ROCKY MOUNTAIN	Denton	TX	76208	940-220-0600	$193,883	03/31/05
450894	PINE CREEK MEDICAL CENTER	Dallas	TX	75235	214-231-2273	$8,826	04/13/05
460049	ORTHOPEDIC SPECIALTY HOSPITAL, THE	Murray	UT	84107	801-314-4100	$8,521,404	10/22/91
460054	CACHE VALLEY SPECIALTY HOSPITAL	North Logan	UT	84341	435-713-9700	$5,235,717	10/17/00
520194	ORTHOPEDIC HOSPITAL OF WISCONSIN	Glendale	WI	53212	414-961-6800	$1,526,011	10/12/01
520196	OAKLEAF SURGICAL HOSPITAL, LLC	Eau Claire	WI	54701	715-831-8130	$3,790,113	01/12/02
520199	WISCONSIN HEART HOSPITAL, LLC	Wauwatosa	WI	53226	414-778-7800	$14,800,548	03/04/04

NOTE 1: This list includes hospitals that meet the definition of "specialty hospital" under section 507 of the MMA, including hospitals that requested an advisory opinion as to their status as being "under development" as of November 18, 2003.

* This list also includes hospitals that are currently under review to determine whether they are specialty hospitals.

Physicians' Hospital - Medicare Payments During Calendar Year 2005

Provider Number	Claim Thru Date	Payment Am unt (*)	Date of S rvice	Procedure Name
380100	2005-02-03	$4,161.93	2005-02-03	OPEN RED-INT FIX HUMERUS
380100	2005-02-04	$3,786.02	2005-02-01	SPINAL CANAL EXPLOR NEC
380100	2005-02-04	$3,057.12	2005-02-03	ROTATOR CUFF REPAIR
380100	2005-02-06	$5,035.21	2005-01-31	VENTRICL SHUNT-ABDOMEN
380100	2005-02-10	$16,601.41	2005-02-03	OTHER BRAIN EXCISION
380100	2005-02-10	$16,601.41	2005-02-04	PACKED CELL TRANSFUSION
380100	2005-02-11	$9,210.96	2005-02-07	TOTAL KNEE REPLACEMENT
380100	2005-02-12	$18,740.44	2005-02-10	TOTAL KNEE REPLACEMENT
380100	2005-02-14	$9,210.96	2005-02-09	TOTAL KNEE REPLACEMENT
380100	2005-02-16	$2,748.93	2005-02-15	HAND JOINT STRUCT DIVIS
380100	2005-02-16	$2,748.93	2005-02-15	TENOTOMY OF HAND
380100	2005-02-16	$2,748.93	2005-02-15	CHNG HND MUS/TEN LNG NEC
380100	2005-02-21	$9,210.96	2005-02-17	PARTIAL HIP REPLACEMENT
380100	2005-02-22	$16,638.87	2005-02-16	EXCISE BONE FOR GFT NEC
380100	2005-02-22	$16,638.87	2005-02-16	LUMBAR/LUMBOSAC FUS POST
380100	2005-02-22	$16,638.87	2005-02-16	PACKED CELL TRANSFUSION
380100	2005-03-01	$9,210.96	2005-02-25	TOTAL KNEE REPLACEMENT
380100	2005-03-05	$6,262.00	2005-03-02	SPINAL CANAL EXPLOR NEC
380100	2005-03-05	$6,262.00	2005-03-02	DESTRUCT JOINT LES NEC
380100	2005-03-05	$9,210.96	2005-03-02	TOTAL HIP REPLACEMENT
380100	2005-03-07	$7,565.95	2005-03-04	LOC EXC BONE LES HUMERUS
380100	2005-03-07	$7,565.95	2005-03-04	TOTAL SHOULDER REPLACE
380100	2005-03-07	$6,708.60	2005-03-05	TENDON TRNSFR/TRANSPLANT
380100	2005-03-11	$3,786.02	2005-03-10	SPINAL CANAL EXPLOR NEC
380100	2005-03-11	$6,394.93	2005-03-10	SPINAL CANAL EXPLOR NEC
380100	2005-03-11	$6,394.93	2005-03-10	EXCIS SPINAL CORD LESION
380100	2005-03-11	$8,456.66	2005-03-07	OPEN REDUC-INT FIX FEMUR
380100	2005-03-11	$3,786.02	2005-03-10	EXCISION INTERVERT DISC
380100	2005-03-12	$3,179.60	2005-03-12	HIP JOINT BIOPSY
380100	2005-03-12	$3,179.60	2005-03-12	CONTRAST ARTHROGRAM
380100	2005-03-19	$16,638.87	2005-03-17	REMOVE IMPL DEVICE NEC
380100	2005-03-19	$16,638.87	2005-03-17	DORSAL/DORSOLUM FUS POST
380100	2005-03-19	$8,857.82	2005-03-16	TOTAL HIP REPLACEMENT
380100	2005-03-19	$16,638.87	2005-03-17	FUS/REFUS 4-8 VERTEBRAE
380100	2005-03-19	$16,638.87	2005-03-17	PERIOP AUT TRANS HOL BLD
380100	2005-03-20	$9,210.96	2005-03-16	TOTAL HIP REPLACEMENT
380100	2005-03-20	$9,210.96	2005-03-16	EXC LES SOFT TISSUE NEC

Physicians' Hospital - Medicare Payments During Calendar Year 2005

Provider Number	Claim Thru Date	Payment Amount (*)	Date of Service	Procedur Name
380100	2005-03-21	$8,530.85	2005-03-18	BONE BIOPSY NEC
380100	2005-03-31	$3,786.02	2005-03-29	REOPEN LAMINECTOMY SITE
380100	2005-03-31	$3,786.02	2005-03-29	SPINAL CANAL EXPLOR NEC
380100	2005-03-31	$3,340.92	2005-03-29	OTHER SUPRAPU CYSTOSTOMY
380100	2005-03-31	$3,340.92	2005-03-29	OTH TRANSURETH PROSTATEC
380100	2005-03-31	$3,786.02	2005-03-29	EXCISION INTERVERT DISC
380100	2005-04-03	$6,262.00	2005-03-31	SPINAL CANAL EXPLOR NEC
380100	2005-04-06	$3,786.02	2005-04-06	EXCISION INTERVERT DISC
380100	2005-04-11	$6,262.00	2005-04-07	REOPEN LAMINECTOMY SITE
380100	2005-04-11	$3,786.02	2005-04-09	SPINAL CANAL EXPLOR NEC
380100	2005-04-11	$6,262.00	2005-04-07	SPINAL CANAL EXPLOR NEC
380100	2005-04-11	$6,262.00	2005-04-07	VERTEBRAL FX REPAIR
380100	2005-04-15	$2,791.75	2005-04-11	ARTERIAL CATHETERIZATION
380100	2005-04-17	$6,935.63	2005-04-15	OPEN RED-INT FIX HUMERUS
380100	2005-04-20	$16,863.80	2005-04-14	PART SM BOWEL RESECT NEC
380100	2005-04-20	$16,863.80	2005-04-14	SM-TO-SM BOWEL ANASTOM
380100	2005-04-20	$16,863.80	2005-04-14	PERITONEAL SUTURE
380100	2005-04-20	$6,262.00	2005-04-19	EXCISION INTERVERT DISC
380100	2005-04-22	$3,786.02	2005-04-20	SPINAL CANAL EXPLOR NEC
380100	2005-04-22	$3,786.02	2005-04-20	EXCISION INTERVERT DISC
380100	2005-04-22	$2,927.67	2005-04-21	CONTRAST MYELOGRAM
380100	2005-04-23	$6,262.00	2005-04-22	SPINAL CANAL EXPLOR NEC
380100	2005-04-23	$4,274.95	2005-04-22	ASPIRATION OF BREAST
380100	2005-04-25	$12,295.34	2005-04-25	SPINAL CANAL EXPLOR NEC
380100	2005-04-25	$12,295.34	2005-04-25	EXCISE BONE FOR GFT NEC
380100	2005-04-25	$12,295.34	2005-04-25	REFUSION OF LUMBAR POST
380100	2005-04-25	$12,295.34	2005-04-25	FUS/REFUS 2-3 VERTEBRAE
380100	2005-04-28	$12,295.34	2005-04-25	EXCISION INTERVERT DISC
380100	2005-04-28	$12,295.34	2005-04-25	LUMBAR/LUMBOSAC FUS POST
380100	2005-04-28	$12,295.34	2005-04-25	REFUSION OF LUMBAR POST
380100	2005-04-28	$12,295.34	2005-04-25	INS SPINAL FUSION DEVICE
380100	2005-05-02	$7,611.94	2005-04-28	OPEN REDUC-INT FIX FEMUR
380100	2005-05-06	$3,786.02	2005-05-04	SPINAL CANAL EXPLOR NEC
380100	2005-05-07	$12,295.34	2005-05-05	SPINAL CANAL EXPLOR NEC
380100	2005-05-07	$13,148.22	2005-05-07	DESTRUCT CHEST WALL LES
380100	2005-05-07	$12,295.34	2005-05-05	EXCISE BONE FOR GFT NEC
380100	2005-05-07	$12,295.34	2005-05-05	REFUSION OF LUMBAR POST

Physicians' Hospital - Medicare Payments During Calendar Year 2005

Provid r Number	Claim Thru Date	Payment Amount (*)	Date of Service	Proc dure Name
380100	2005-05-07	$12,295.34	2005-05-05	FUS/REFUS 2-3 VERTEBRAE
380100	2005-05-08	$7,565.95	2005-05-06	TOTAL SHOULDER REPLACE
380100	2005-05-11	$3,786.02	2005-05-09	SPINAL CANAL EXPLOR NEC
380100	2005-05-12	$3,786.02	2005-05-11	EXCISION INTERVERT DISC
380100	2005-05-20	$9,210.96	2005-05-16	TOTAL KNEE REPLACEMENT
380100	2005-05-21	$625.47	2005-05-20	EXCISION INTERVERT DISC
380100	2005-05-21	$7,203.49	2005-05-20	EXCISION INTERVERT DISC
380100	2005-05-21	$625.47	2005-05-20	OTHER CERVICAL FUS ANT
380100	2005-05-21	$7,203.49	2005-05-20	OTHER CERVICAL FUS ANT
380100	2005-05-21	$625.47	2005-05-20	FUS/REFUS 2-3 VERTEBRAE
380100	2005-05-21	$7,203.49	2005-05-20	FUS/REFUS 2-3 VERTEBRAE
380100	2005-05-21	$7,203.49	2005-05-20	INS SPINAL FUSION DEVICE
380100	2005-05-28	$3,786.02	2005-05-26	SPINAL CANAL EXPLOR NEC
380100	2005-05-29	$17,550.87	2005-05-25	SPINAL CANAL EXPLOR NEC
380100	2005-05-29	$17,550.87	2005-05-25	EXCISE BONE FOR GFT NEC
380100	2005-05-29	$17,550.87	2005-05-25	REFUSION OF LUMBAR POST
380100	2005-05-29	$17,550.87	2005-05-25	FUS/REFUS 4-8 VERTEBRAE
380100	2005-05-30	$16,638.87	2005-05-27	SPINAL CANAL EXPLOR NEC
380100	2005-05-30	$16,638.87	2005-05-27	EXCISE BONE FOR GFT NEC
380100	2005-05-30	$16,638.87	2005-05-27	LUMBAR/LUMBOSAC FUS POST
380100	2005-05-30	$16,638.87	2005-05-27	FUS/REFUS 2-3 VERTEBRAE
380100	2005-05-30	$16,638.87	2005-05-27	PACKED CELL TRANSFUSION
380100	2005-06-02	$7,918.83	2005-05-31	OTHER SUPRAPU CYSTOSTOMY
380100	2005-06-02	$7,918.83	2005-05-31	RETROGRADE PYELOGRAM
380100	2005-06-05	$12,295.34	2005-05-31	SPINAL CANAL EXPLOR NEC
380100	2005-06-05	$12,295.34	2005-05-31	REFUSION OF LUMBAR POST
380100	2005-06-05	$12,295.34	2005-05-31	FUS/REFUS 2-3 VERTEBRAE
380100	2005-06-05	$12,295.34	2005-05-31	INS SPINAL FUSION DEVICE
380100	2005-06-12	$6,262.00	2005-06-09	SPINAL CANAL EXPLOR NEC
380100	2005-06-13	$12,295.34	2005-06-09	SPINAL CANAL EXPLOR NEC
380100	2005-06-13	$12,295.34	2005-06-09	EXCISE BONE FOR GFT NEC
380100	2005-06-13	$12,295.34	2005-06-09	LUMBAR/LUMBOSAC FUS POST
380100	2005-06-13	$12,295.34	2005-06-09	FUS/REFUS 2-3 VERTEBRAE
380100	2005-06-18	$3,786.02	2005-06-16	SPINAL CANAL EXPLOR NEC
380100	2005-06-18	$9,210.96	2005-06-15	TOTAL HIP REPLACEMENT
380100	2005-06-19	$8,780.29	2005-06-16	OTHER BRAIN DX PROCEDURE
380100	2005-06-19	$8,780.29	2005-06-16	OTHER BRAIN EXCISION

Physicians' Hospital - Medicare Payments During Calendar Year 2005

Provide: Number	Claim Thru Date	Payment Amount (*)	Date of Servic	Procedure Name
380100	2005-06-20	$12,295.34	2005-06-17	SPINAL CANAL EXPLOR NEC
380100	2005-06-20	$12,295.34	2005-06-17	EXCISE BONE FOR GFT NEC
380100	2005-06-20	$12,295.34	2005-06-17	LUMBAR/LUMBOSAC FUS POST
380100	2005-06-20	$9,210.96	2005-06-13	TOTAL KNEE REPLACEMENT
380100	2005-06-20	$12,295.34	2005-06-17	FUS/REFUS 2-3 VERTEBRAE
380100	2005-06-23	$9,210.96	2005-06-20	TOTAL KNEE REPLACEMENT
380100	2005-06-24	$3,786.02	2005-06-22	SPINAL CANAL EXPLOR NEC
380100	2005-06-25	$12,295.34	2005-06-22	SPINAL CANAL EXPLOR NEC
380100	2005-06-25	$12,295.34	2005-06-22	LUMBAR/LUMBOSAC FUS POST
380100	2005-06-25	$12,295.34	2005-06-22	FUS/REFUS 4-8 VERTEBRAE
380100	2005-06-26	$4,161.93	2005-06-25	CLOS RED-INT FIX HUMERUS
380100	2005-06-27	$3,786.02	2005-06-25	EXCISION INTERVERT DISC
380100	2005-06-29	$3,786.02	2005-06-27	SPINAL CANAL EXPLOR NEC
380100	2005-06-30	$12,295.34	2005-06-27	SPINAL CANAL EXPLOR NEC
380100	2005-06-30	$12,295.34	2005-06-27	EXCISE BONE FOR GFT NEC
380100	2005-06-30	$12,295.34	2005-06-27	LUMBAR/LUMBOSAC FUS POST
380100	2005-06-30	$12,295.34	2005-06-27	FUS/REFUS 2-3 VERTEBRAE
380100	2005-07-01	$3,057.12	2005-06-29	BONE GRAFT-RADIUS/ULNA
380100	2005-07-01	$3,057.12	2005-06-29	APPL EXT FIX-RADIUS/ULNA
380100	2005-07-01	$3,057.12	2005-06-29	CL FX REDUC-RADIUS/ULNA
380100	2005-07-02	$8,817.63	2005-06-30	KYPHOPLASTY
380100	2005-07-03	$12,295.34	2005-06-30	EXCISION INTERVERT DISC
380100	2005-07-03	$12,295.34	2005-06-30	LUMBAR/LUMBOSAC FUS POST
380100	2005-07-03	$9,210.96	2005-06-30	TOTAL KNEE REPLACEMENT
380100	2005-07-03	$12,295.34	2005-06-30	FUS/REFUS 2-3 VERTEBRAE
380100	2005-07-03	$12,295.34	2005-06-30	INJECTION INTO JOINT
380100	2005-07-03	$12,295.34	2005-06-30	INJECT/INFUSE NEC
380100	2005-07-06	$4,161.93	2005-07-05	OPEN RED-INT FIX HUMERUS
380100	2005-07-09	$3,786.02	2005-07-06	SPINAL CANAL EXPLOR NEC
380100	2005-07-12	$7,203.49	2005-07-11	EXCISION INTERVERT DISC
380100	2005-07-12	$7,203.49	2005-07-11	REFUSION OF OTH CERV ANT
380100	2005-07-12	$7,203.49	2005-07-11	FUS/REFUS 2-3 VERTEBRAE
380100	2005-07-12	$7,203.49	2005-07-11	INS SPINAL FUSION DEVICE
380100	2005-07-15	$6,262.00	2005-07-13	SPINAL CANAL EXPLOR NEC
380100	2005-07-15	$6,262.00	2005-07-13	BONE GRAFT NEC
380100	2005-07-15	$4,161.93	2005-07-13	ANKLE FUSION
380100	2005-07-24	$3,786.02	2005-07-22	SPINAL CANAL EXPLOR NEC

Physicians' Hospital - Medicare Payments During Calendar Year 2005

Provider Number	Claim Thru Date	Payment Amount (*)	Date of S rvic	Procedur Name
380100	2005-07-25	$3,786.02	2005-07-22	SPINAL CANAL EXPLOR NEC
380100	2005-07-27	$4,483.75	2005-07-27	SPINAL CANAL EXPLOR NEC
380100	2005-07-27	$4,483.75	2005-07-27	INSERT ENDOTRACHEAL TUBE
380100	2005-07-27	$4,483.75	2005-07-27	CONT MECH VENT < 96 HRS
380100	2005-07-29	$6,262.00	2005-07-28	EXCISION INTERVERT DISC
380100	2005-07-29	$6,262.00	2005-07-28	FUS/REFUS 2-3 VERTEBRAE
380100	2005-07-29	$6,262.00	2005-07-28	INS SPINAL FUSION DEVICE
380100	2005-07-30	$3,786.02	2005-07-28	SPINAL CANAL EXPLOR NEC
380100	2005-07-30	$9,210.96	2005-07-27	TOTAL HIP REPLACEMENT
380100	2005-07-30	$9,210.96	2005-07-27	PACKED CELL TRANSFUSION
380100	2005-08-02	$7,203.49	2005-08-01	EXCISION INTERVERT DISC
380100	2005-08-02	$7,203.49	2005-08-01	OTHER CERVICAL FUS ANT
380100	2005-08-02	$7,203.49	2005-08-01	FUS/REFUS 2-3 VERTEBRAE
380100	2005-08-03	$3,786.02	2005-08-02	EXCISION INTERVERT DISC
380100	2005-08-04	$9,210.96	2005-08-01	TOTAL KNEE REPLACEMENT
380100	2005-08-06	$4,447.21	2005-08-04	SHOULDER ARTHROPLAST NEC
380100	2005-08-06	$4,447.21	2005-08-04	ROTATOR CUFF REPAIR
380100	2005-08-10	$3,157.20	2005-08-08	ABOVE KNEE AMPUTATION
380100	2005-08-12	$4,161.93	2005-08-10	OP RED-INT FIX TIB/FIBUL
380100	2005-08-13	$6,262.00	2005-08-11	SPINAL CANAL EXPLOR NEC
380100	2005-08-13	$6,262.00	2005-08-11	DESTRUCT JOINT LES NEC
380100	2005-08-24	$10,122.96	2005-08-22	REVISE HIP REPLACEMT NOS
380100	2005-08-24	$10,122.96	2005-08-23	PACKED CELL TRANSFUSION
380100	2005-08-31	$4,318.64	2005-08-31	TU BLADDER CLEARANCE
380100	2005-08-31	$4,318.64	2005-08-31	OTHER SUPRAPU CYSTOSTOMY
380100	2005-08-31	$4,318.64	2005-08-31	CLOS TRANSURETH BLADD BX
380100	2005-08-31	$4,318.64	2005-08-31	TU DESTRUC BLADD LES NEC
380100	2005-08-31	$3,786.02	2005-08-31	EXCISION INTERVERT DISC
380100	2005-08-31	$4,318.64	2005-08-31	CYSTOGRAM NEC
380100	2005-09-02	$6,262.00	2005-09-01	REOPEN LAMINECTOMY SITE
380100	2005-09-02	$9,210.96	2005-08-29	TOTAL HIP REPLACEMENT
380100	2005-09-05	$3,786.02	2005-09-01	SPINAL CANAL EXPLOR NEC
380100	2005-09-05	$9,210.96	2005-08-31	REVISE KNEE REPLACE NOS
380100	2005-09-07	$3,786.02	2005-09-06	SPINAL CANAL EXPLOR NEC
380100	2005-09-09	$16,638.87	2005-09-08	EXCISE BONE FOR GFT NEC
380100	2005-09-09	$45.21	2005-09-08	EXCISION INTERVERT DISC
380100	2005-09-09	$16,638.87	2005-09-08	REFUSION OF LUMBAR POST

Physicians' Hospital - Medicare Payments During Calendar Year 2005

Provider Number	Claim Thru Date	Payment Amount (*)	Dat f Service	Procedure Nam
380100	2005-09-09	$16,638.87	2005-09-08	FUS/REFUS 2-3 VERTEBRAE
380100	2005-09-10	$12,295.34	2005-09-06	ANESTH INJECT-SPIN CANAL
380100	2005-09-10	$12,295.34	2005-09-06	EXCISION INTERVERT DISC
380100	2005-09-10	$12,295.34	2005-09-06	REFUSION OF LUMBAR POST
380100	2005-09-10	$12,295.34	2005-09-06	FUS/REFUS 2-3 VERTEBRAE
380100	2005-09-10	$12,295.34	2005-09-06	PERIOP AUT TRANS HOL BLD
380100	2005-09-10	$12,295.34	2005-09-06	INJECT/INFUSE NEC
380100	2005-09-13	$16,638.87	2005-09-08	SPINAL CANAL EXPLOR NEC
380100	2005-09-13	$16,638.87	2005-09-08	EXCISE BONE FOR GFT NEC
380100	2005-09-13	$16,638.87	2005-09-08	LUMBAR/LUMBOSAC FUS POST
380100	2005-09-13	$16,638.87	2005-09-08	FUS/REFUS 2-3 VERTEBRAE
380100	2005-09-13	$16,638.87	2005-09-10	PACKED CELL TRANSFUSION
380100	2005-09-14	$3,786.02	2005-09-12	SPINAL CANAL EXPLOR NEC
380100	2005-09-14	$3,786.02	2005-09-12	EXCIS SPINAL CORD LESION
380100	2005-09-15	$9,210.96	2005-09-12	TOTAL KNEE REPLACEMENT
380100	2005-09-17	$12,588.66	2005-09-14	SPINAL CANAL EXPLOR NEC
380100	2005-09-17	$12,588.66	2005-09-14	LUMBAR/LUMBOSAC FUS POST
380100	2005-09-17	$12,588.66	2005-09-14	FUS/REFUS 4-8 VERTEBRAE
380100	2005-09-17	$12,588.66	2005-09-14	INS SPINAL FUSION DEVICE
380100	2005-09-18	$16,638.87	2005-09-15	SPINAL CANAL EXPLOR NEC
380100	2005-09-18	$16,638.87	2005-09-15	LUMBAR/LUMBOSAC FUS POST
380100	2005-09-18	$16,638.87	2005-09-15	FUS/REFUS 4-8 VERTEBRAE
380100	2005-09-18	$16,638.87	2005-09-15	INS SPINAL FUSION DEVICE
380100	2005-09-23	$8,530.85	2005-09-21	SPINAL CANAL EXPLOR NEC
380100	2005-09-23	$8,530.85	2005-09-21	BONE BIOPSY NEC
380100	2005-09-23	$8,530.85	2005-09-21	REMOVE IMPL DEVICE NEC
380100	2005-09-23	$9,210.96	2005-09-19	TOTAL KNEE REPLACEMENT
380100	2005-09-26	$7,565.95	2005-09-22	TOTAL ELBOW REPLACEMENT
380100	2005-09-28	$6,262.00	2005-09-26	SPINAL CANAL EXPLOR NEC
380100	2005-09-29	$2,378.01	2005-09-19	VENOUS CATH NEC
380100	2005-09-29	$27,648.85	2005-09-13	ILEOSTOMY NOS
380100	2005-09-29	$27,648.85	2005-09-22	POLYPECTOMY OF RECTUM
380100	2005-09-29	$27,648.85	2005-09-13	FORM CUTAN ILEOURETEROST
380100	2005-09-29	$27,648.85	2005-09-13	PELVIC EVISCERATION
380100	2005-09-29	$2,378.01	2005-09-15	ELECTROSHOCK THERAPY NEC
380100	2005-09-29	$2,378.01	2005-09-19	ELECTROSHOCK THERAPY NEC
380100	2005-09-29	$2,378.01	2005-09-21	ELECTROSHOCK THERAPY NEC

Physicians' Hospital - Medicare Payments During Calendar Year 2005

Provider Number	Claim Thru Date	Payment Amount (*)	Date of Service	Procedure Name
380100	2005-09-29	$2,378.01	2005-09-23	ELECTROSHOCK THERAPY NEC
380100	2005-09-29	$2,378.01	2005-09-26	ELECTROSHOCK THERAPY NEC
380100	2005-09-29	$4,192.17	2005-09-13	ELECTROSHOCK THERAPY NEC
380100	2005-09-29	$4,192.17	2005-09-15	ELECTROSHOCK THERAPY NEC
380100	2005-09-29	$4,192.17	2005-09-17	ELECTROSHOCK THERAPY NEC
380100	2005-09-29	$4,192.17	2005-09-19	ELECTROSHOCK THERAPY NEC
380100	2005-09-29	$4,192.17	2005-09-21	ELECTROSHOCK THERAPY NEC
380100	2005-09-29	$4,192.17	2005-09-23	ELECTROSHOCK THERAPY NEC
380100	2005-09-29	$27,648.85	2005-09-14	CONT MECH VENT < 96 HRS
380100	2005-09-29	$27,648.85	2005-09-13	PACKED CELL TRANSFUSION
380100	2005-10-01	$3,718.59	2005-09-29	EXCISION INTERVERT DISC
380100	2005-10-05	$6,168.00	2005-10-04	SPINAL CANAL EXPLOR NEC
380100	2005-10-06	$6,168.00	2005-10-05	SPINAL CANAL EXPLOR NEC
380100	2005-10-06	$13,314.02	2005-10-03	EXCISE BONE FOR GFT NEC
380100	2005-10-06	$6,168.00	2005-10-05	EXCISION INTERVERT DISC
380100	2005-10-06	$13,314.02	2005-10-03	LUMBAR/LUMBOSAC FUS POST
380100	2005-10-06	$13,314.02	2005-10-03	FUS/REFUS 2-3 VERTEBRAE
380100	2005-10-06	$13,314.02	2005-10-05	PACKED CELL TRANSFUSION
380100	2005-10-12	$6,168.00	2005-10-10	EXCISION INTERVERT DISC
380100	2005-10-13	$3,718.59	2005-10-12	SPINAL CANAL EXPLOR NEC
380100	2005-10-13	$3,718.59	2005-10-12	EXC LES SOFT TISSUE NEC
380100	2005-10-15	$3,718.59	2005-10-12	REOPEN LAMINECTOMY SITE
380100	2005-10-15	$3,718.59	2005-10-12	EXCISION INTERVERT DISC
380100	2005-10-20	$4,802.78	2005-10-19	ANESTH INJEC PERIPH NERV
380100	2005-10-20	$4,802.78	2005-10-19	OTH CHEST CAGE OSTECTOMY
380100	2005-10-20	$4,802.78	2005-10-19	SHOULDER ARTHROPLAST NEC
380100	2005-10-20	$4,802.78	2005-10-19	ROTATOR CUFF REPAIR
380100	2005-10-21	$3,718.59	2005-10-21	EXCISION INTERVERT DISC
380100	2005-10-24	$6,168.00	2005-10-21	SPINAL CANAL EXPLOR NEC
380100	2005-10-27	$13,314.02	2005-10-24	EXCISE BONE FOR GFT NEC
380100	2005-10-27	$13,314.02	2005-10-24	REFUSION OF LUMBAR POST
380100	2005-10-27	$13,314.02	2005-10-24	FUS/REFUS 4-8 VERTEBRAE
380100	2005-10-27	$13,314.02	2005-10-24	INS SPINAL FUSION DEVICE
380100	2005-10-28	$3,718.59	2005-10-27	SPINAL CANAL EXPLOR NEC
380100	2005-10-28	$3,718.59	2005-10-27	EXCISION INTERVERT DISC
380100	2005-10-30	$3,718.59	2005-10-28	SPINAL CANAL EXPLOR NEC
380100	2005-11-02	$3,718.59	2005-10-31	SPINAL CANAL EXPLOR NEC

Physicians' Hospital - Medicare Payments During Calendar Year 2005

Provide Number	Claim Thru Date	Payment Amount (*)	Date of Service	Procedure Name
380100	2005-11-04	$6,168.00	2005-11-03	SPINAL CANAL EXPLOR NEC
380100	2005-11-04	$17,630.82	2005-11-01	SPINAL CANAL EXPLOR NEC
380100	2005-11-04	$6,168.00	2005-11-03	EXCISION INTERVERT DISC
380100	2005-11-04	$17,630.82	2005-11-01	LUMBAR/LUMBOSAC FUS POST
380100	2005-11-04	$17,630.82	2005-11-01	FUS/REFUS 4-8 VERTEBRAE
380100	2005-11-04	$17,630.82	2005-11-01	INS SPINAL FUSION DEVICE
380100	2005-11-08	$9,143.12	2005-11-04	HIP REP SURF-METAL/METAL
380100	2005-11-08	$9,143.12	2005-11-04	TOTAL HIP REPLACEMENT
380100	2005-11-08	$9,143.12	2005-11-04	BURSECTOMY
380100	2005-11-09	$12,560.64	2005-11-09	REV HIP REPL-FEM COMP
380100	2005-11-09	$12,560.64	2005-11-09	HIP REP SURF-METAL/METAL
380100	2005-11-09	$12,560.64	2005-11-09	REMOVE IMP DEVICE-FEMUR
380100	2005-11-09	$12,560.64	2005-11-09	OPEN REDUC-INT FIX FEMUR
380100	2005-11-09	$12,560.64	2005-11-09	PERIOP AUT TRANS HOL BLD
380100	2005-11-09	$12,560.64	2005-11-09	PACKED CELL TRANSFUSION
380100	2005-11-10	$9,143.12	2005-11-07	TOTAL KNEE REPLACEMENT
380100	2005-11-14	$9,143.12	2005-11-10	HIP REPL SURF-METAL/POLY
380100	2005-11-14	$10,055.12	2005-11-10	HIP REPL SURF-METAL/POLY
380100	2005-11-14	$9,143.12	2005-11-10	TOTAL HIP REPLACEMENT
380100	2005-11-14	$10,055.12	2005-11-10	TOTAL HIP REPLACEMENT
380100	2005-11-16	$3,277.85	2005-11-15	ROTATOR CUFF REPAIR
380100	2005-11-18	$12,708.77	2005-11-09	REV HIP REPL-FEM COMP
380100	2005-11-18	$12,708.77	2005-11-09	HIP REP SURF-METAL/METAL
380100	2005-11-18	$12,708.77	2005-11-09	REMOVE IMP DEVICE-FEMUR
380100	2005-11-18	$12,708.77	2005-11-09	OPEN REDUC-INT FIX FEMUR
380100	2005-11-18	$12,708.77	2005-11-09	PERIOP AUT TRANS HOL BLD
380100	2005-11-18	$12,708.77	2005-11-09	PACKED CELL TRANSFUSION
380100	2005-11-19	$3,718.59	2005-11-17	SPINAL CANAL EXPLOR NEC
380100	2005-11-20	$3,718.59	2005-11-18	SPINAL CANAL EXPLOR NEC
380100	2005-12-06	$6,168.00	2005-12-05	EXCISION INTERVERT DISC
380100	2005-12-12	$9,143.12	2005-12-07	HIP REPL SURF-METAL/POLY
380100	2005-12-12	$9,143.12	2005-12-07	TOTAL HIP REPLACEMENT
380100	2005-12-13	$8,908.16	2005-12-12	KYPHOPLASTY
380100	2005-12-14	$6,168.00	2005-12-13	SPINAL CANAL EXPLOR NEC
380100	2005-12-16	$6,168.00	2005-12-14	REOPEN LAMINECTOMY SITE
380100	2005-12-16	$6,168.00	2005-12-14	SPINAL CANAL EXPLOR NEC
380100	2005-12-16	$6,168.00	2005-12-14	EXCISION INTERVERT DISC

Physicians' Hospital - Medicare Payments During Calendar Year 2005

Provider Number	Claim Thru Date	Payment Amount (*)	Date of Service	Procedure Name
380100	2005-12-18	$6,168.00	2005-12-16	SPINAL CANAL EXPLOR NEC
380100	2005-12-18	$6,168.00	2005-12-16	KYPHOPLASTY

Total Payments **$2,711,125.57**

*** The payment amounts represent ONLY Medicare Data**

Physicians' Hospital - Medicare Payments During Calendar Year 2006

Provid r Number	Claim Thru Date	Claim Payment Am unt(*)	Dat of Service	Procedur Name
380100	2006-01-06	$6,155.41	2006-01-04	REOPEN LAMINECTOMY SITE
380100	2006-01-06	$6,155.41	2006-01-04	EXCISION INTERVERT DISC
380100	2006-01-10	$3,696.52	2006-01-09	REOPEN LAMINECTOMY SITE
380100	2006-01-10	$3,696.52	2006-01-09	SPINAL CANAL EXPLOR NEC
380100	2006-01-10	$11,805.98	2006-01-05	REV HIP REPL-ACETAB/FEM
380100	2006-01-10	$11,805.98	2006-01-05	HIP REPL SURF-METAL/POLY
380100	2006-01-15	$6,155.41	2006-01-11	SPINAL CANAL EXPLOR NEC
380100	2006-01-15	$6,155.41	2006-01-11	EXCISION INTERVERT DISC
380100	2006-01-16	$3,268.97	2006-01-12	URETERAL CATHETERIZATION
380100	2006-01-16	$3,268.97	2006-01-12	REPLACE CYSTOSTOMY TUBE
380100	2006-01-16	$3,268.97	2006-01-12	ULTRASON FRAGMENT-STONE
380100	2006-01-20	$4,784.90	2006-01-19	ROTATOR CUFF REPAIR
380100	2006-01-20	$9,018.96	2006-01-17	HIP REPL SURF-METAL/POLY
380100	2006-01-20	$9,018.96	2006-01-17	TOTAL HIP REPLACEMENT
380100	2006-01-27	$7,674.94	2006-01-23	EXCISION INTERVERT DISC
380100	2006-01-27	$7,674.94	2006-01-23	OTHER CERVICAL FUS ANT
380100	2006-01-27	$7,674.94	2006-01-23	FUS/REFUS 4-8 VERTEBRAE
380100	2006-01-27	$7,674.94	2006-01-23	INS SPINAL FUSION DEVICE
380100	2006-01-28	$5,574.22	2006-01-27	TU DESTRUC BLADD LES NEC
380100	2006-01-28	$5,574.22	2006-01-27	OTH TRANSURETH PROSTATEC
380100	2006-01-28	$5,574.22	2006-01-27	RETROGRADE PYELOGRAM
380100	2006-01-28	$6,155.41	2006-01-26	REOPEN LAMINECTOMY SITE
380100	2006-01-28	$6,155.41	2006-01-26	SPINAL CANAL EXPLOR NEC
380100	2006-01-28	$6,155.41	2006-01-26	SPINAL STRUCT REPAIR NEC
380100	2006-01-28	$6,155.41	2006-01-26	KYPHOPLASTY
380100	2006-01-29	$12,049.21	2006-01-26	REV HIP REPL-FEM COMP
380100	2006-01-29	$12,049.21	2006-01-26	HIP REPL SURF-METAL/POLY
380100	2006-01-29	$12,049.21	2006-01-26	TRANSFUS PREV AUTO BLOOD
380100	2006-01-29	$12,049.21	2006-01-26	PACKED CELL TRANSFUSION
380100	2006-01-30	$11,805.98	2006-01-26	REV HIP REPL-ACETAB/FEM
380100	2006-01-30	$11,805.98	2006-01-26	HIP REPL SURF-METAL/POLY
380100	2006-01-30	$11,805.98	2006-01-27	PACKED CELL TRANSFUSION
380100	2006-02-01	$17,682.97	2006-01-27	VENOUS CATH NEC
380100	2006-02-01	$17,682.97	2006-01-24	SOFT TISSUE INCISION NEC
380100	2006-02-01	$17,682.97	2006-01-27	SOFT TISSUE INCISION NEC
380100	2006-02-02	$7,670.83	2006-01-31	TOTAL SHOULDER REPLACE
380100	2006-02-02	$18,614.62	2006-01-31	EXCISION INTERVERT DISC

Physicians' Hospital · Medicare Payments During Calendar Year 2006

Provider Number	Claim Thru Date	Claim Payment Amount(*)	Date of S rvice	Proc dur Nam
380100	2006-02-02	$18,614.62	2006-01-31	LUMBAR/LUMBOSAC FUS POST
380100	2006-02-02	$18,614.62	2006-01-31	FUS/REFUS 2-3 VERTEBRAE
380100	2006-02-02	$18,614.62	2006-01-31	INS SPINAL FUSION DEVICE
380100	2006-02-03	$3,696.52	2006-02-01	SPINAL CANAL EXPLOR NEC
380100	2006-02-04	$3,254.07	2006-02-02	OTH CHEST CAGE OSTECTOMY
380100	2006-02-04	$3,254.07	2006-02-02	ROTATOR CUFF REPAIR
380100	2006-02-07	$17,662.62	2006-02-03	REMOVE IMPL DEVICE NEC
380100	2006-02-07	$17,662.62	2006-02-03	REFUSION OF LUMBAR POST
380100	2006-02-07	$17,662.62	2006-02-03	FUS/REFUS 2-3 VERTEBRAE
380100	2006-02-07	$17,662.62	2006-02-03	INS SPINAL FUSION DEVICE
380100	2006-02-10	$3,696.52	2006-02-08	SPINAL CANAL EXPLOR NEC
380100	2006-02-13	$9,142.05	2006-02-10	HIP REPL SURF-METAL/POLY
380100	2006-02-13	$9,142.05	2006-02-10	TOTAL HIP REPLACEMENT
380100	2006-02-13	$25,121.52	2006-02-10	SPINAL CANAL EXPLOR NEC
380100	2006-02-13	$25,121.52	2006-02-10	EXCISE BONE FOR GFT NEC
380100	2006-02-13	$25,121.52	2006-02-10	LUMBAR/LUMBOSAC FUS POST
380100	2006-02-13	$25,121.52	2006-02-10	FUS/REFUS 2-3 VERTEBRAE
380100	2006-02-13	$25,121.52	2006-02-11	PACKED CELL TRANSFUSION
380100	2006-02-15	$6,155.41	2006-02-09	REMOVE IMPL DEVICE NEC
380100	2006-02-15	$6,155.41	2006-02-09	EXCISION INTERVERT DISC
380100	2006-02-15	$6,155.41	2006-02-09	FUS/REFUS 4-8 VERTEBRAE
380100	2006-02-15	$6,155.41	2006-02-09	INS SPINAL FUSION DEVICE
380100	2006-02-18	$3,716.56	2006-02-15	TU BLADDER CLEARANCE
380100	2006-02-18	$3,716.56	2006-02-15	BLADDER SPHINCTEROTOMY
380100	2006-02-18	$3,716.56	2006-02-15	OTH TRANSURETH PROSTATEC
380100	2006-02-18	$9,142.05	2006-02-15	HIP REPL SURF-METAL/POLY
380100	2006-02-18	$9,142.05	2006-02-15	PARTIAL HIP REPLACEMENT
380100	2006-02-24	$3,817.07	2006-02-22	URIN INCONTIN REPAIR NEC
380100	2006-02-24	$3,817.07	2006-02-22	CYSTOCELE REPAIR
380100	2006-04-21	$3,696.52	2006-04-20	SPINAL CANAL EXPLOR NEC
380100	2006-05-10	$3,696.52	2006-05-08	SPINAL CANAL EXPLOR NEC

Total Payments **$676,619.39**

*** Th payment amounts r pr s nt ONLY M dicar Data**

PHYSICAN-OWNED HOSPITALS
AND THEIR IMPACT ON COMMUNITY HOSPITALS
Testimony Submitted to the Senate Finance Committee by
Cindy Morrison
May 17, 2006

Good Morning. Mr. Chairman, Senator Baucus and members of the Committee, my name is Cindy Morrison and I am Vice President of Public Policy at Sioux Valley Health System in Sioux Falls, South Dakota. Located in the southeast corner of South Dakota, Sioux Valley is an integrated health system made of up 24 hospitals and over 300 physicians located in 4 States including South Dakota, Minnesota, Iowa and Nebraska. It is the largest health system between Minneapolis and Denver. South Dakota is a small state with a total population of roughly 750,000 but has 8 physician-owned specialty hospitals, some of which have been in operation for over 10 years.

I am here today on behalf of the Coalition of Full Service Hospitals, a grassroots organization that Sioux Valley founded in June of 2003 to raise awareness about problems associated with physician ownership of specialty hospitals, and attendant physician self-referral practices. The Coalition represents 20 states and its membership includes over 150 community full-service hospitals many of which have been directly affected by physician self-referral.

As a result of my personal experiences both in South Dakota and in 17 similarly affected States through the Coalition, I have been asked to testify before policy makers in states across the country regarding the effects of physician self-referral on community hospitals.

As I begin I would like to express my sincere appreciation to Chairman Grassley and Senator Baucus for their work on this issue and for allowing me to be here today to share the experiences of community hospitals. Community hospitals play a special role in both urban and rural communities as "equal opportunity" caregivers that provide full acute and sub-acute services with out discrimination based on insurance status or seriousness of condition. Specialty hospitals, by contrast, choose to provide only limited, high-revenue

services to select, usually well-insured, patients. Where community hospitals provide trauma, 24-hour emergency, surgical, obstetrics and other services, specialty hospitals usually perform only select services within specified subset of classes of care, i.e. cardiology, and orthopedics, etc.

Overview

In my testimony, I discuss the central issue in the debate over the appropriateness of physician-owned specialty hospitals---physician self-referral practices--- and how those practices impact community hospitals ability to provide high quality patient care and services. I also discuss the growth of physician-owned specialty hospitals; government proposals to reduce reimbursement for some procedures commonly performed in specialty hospitals; and conclude by calling for the elimination of one exception to federal law prohibiting physician self-referral that has allowed physician ownership of specialty hospitals to flourish.

Physician Admitting Power

Physicians alone are the only persons with the authority to admit a patient to a hospital. Hospitals cannot admit patients and neither can patients. This unique responsibility and trust is placed solely with the physician; and as a result puts the physician-owners of specialty hospitals in a position to "self-refer" patients away from community hospitals to be admitted to the specialty hospital they own. Physicians have a clear financial incentive to refer patients to facilities they own, like specialty hospitals, because while typical physicians get paid once for their professional services, physician-owners get paid twice, once for their professional fee and once for the technical fees traditionally paid to hospitals. Because hospitals cannot admit patients, physician self-referral practices put the community hospital at a tremendous competitive disadvantage. This unusual competitive set-up puts the hospital in a box. The hospital becomes in effect, a competitor whose mix of business (the patients) is controlled by its competitive rival (the physician-owned facility) through the incentives of those who make the referral (the physician investors who wear two hats).[1]

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[1] William J. Lynk and Carina S. Longley, July/August 2002, Health Affairs "The Effect of Physician-Owned Surgicenters on Hospital Outpatient Surgery"

Community Hospitals and Competition

Some have claimed that community hospitals need competition. In fact, community hospitals and non physician-owned specialty hospitals such as children's hospitals and women's hospitals have been competing with each other since their inception and they welcome the competition and recognize that it has been a great catalyst for producing efficiencies and innovations. Although advocates for physician-owned specialty hospitals have hypothesized that the entrance of specialty hospitals into a market encourages the area's existing general hospitals to adopt changes and make them more efficient and better able to compete, the survey responses generated by the Government Accountability Office (GAO) largely did not favor this view.[2]

We know that in a functional free market, informed consumers make choices that force efficiency. When patients are faced with medical challenges however, they place their complete trust in their physician to prescribe and direct their care and when their physician directs or refers them to hospitals the physician owns, the patient's "free market" choice is eliminated and patients unknowingly forfeit their opportunity to weigh their options. In the community hospital setting, the financial incentive is lacking for a physician to direct the patients other than to the most capable provider is and the "free" market is retained.

Who are the Community Hospitals They Impact?

The effects of self-referral and the presence of physician-owned specialty hospitals can affect community hospitals of all types and sizes; non-profit, for-profit, in rural and urban communities ranging from Spearfish, South Dakota – Population 8,800 to Oklahoma City, Oklahoma – Population 500,000.

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[2] GAO, April 2006, Operational and Clinical Changes Largely Unaffected by Presence of Competing Specialty Hospitals

A 2003 GAO report determined that physician-owned facilities, like specialty hospitals are concentrated in States where Certificate of Need (CON) regulation does not exist.[3] State CON regulations typically require health care facilities to apply for and obtain a certificate that evidences a community need for the designated health service. Such laws are intended to avoid "costly duplication of services" but not all states retain CON laws.[4] Locating in specific regions of the country allows the physician-owners to skirt the scrutiny that a CON process would present. But some community hospitals located in CON states have not been protected because border cities find themselves affected as physician-owners locate their facilities across the border in neighboring non-CON states. An example of this can be found in Sioux City, Iowa, a CON state. Physician-owners that traditionally practiced at the community hospitals in Sioux City, Iowa built a specialty hospital just over the border (less than six miles) into South Dakota, a non-CON state and steer patients away from the community hospital in Iowa to their facility located in Dakota Dunes, South Dakota.

Community Hospital Impact

Staff Reductions, Weakened Financial Condition

Ruston, Louisiana

Lincoln General Hospital, located in Ruston, Louisiana was a financially strong community hospital with historical operating margins in the 3-4 percent range according to Tom Stone, CEO. In 2003, a physician-owned specialty hospital, Green Clinic Surgical opened. The owners of this physician-owned specialty hospital, which is located directly adjacent to Lincoln General, represent 65 percent of Lincoln's active medical staff.

Lincoln General recognized the potential impact of the loss of their profitable surgical business. In an attempt to return some of their profitable procedures, they added two general surgeons. Despite the addition of these two new surgeons, Lincoln General saw their surgical patient volume drop by 35 percent. This was the result of physician steering

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[3] GAO-04-167 (October 22, 2003), pg. 15 "Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance."

[4] Ellen Jan Schneiter, Trish Riley, Jill Rosenthal, Rising Health Care Costs: State Health Cost Containment Approaches, National Academy for State Health Policy, June 2002

of surgical business away from the community hospital to the physician-owned specialty hospital.

In their last fiscal year, Lincoln General has lost over $8 million in operating margins as a result of the physician-owned specialty hospital. This rapid decline in operating margins impacted the community hospital negatively in several ways:

Lincoln General is having difficult meeting debt service and bond covenant ratios
In April 2006, Moody's Investor Services downgraded Lincoln General's bond rating citing "increased competitive pressure, primarily from a large physician group."[5]

In response to the downgrade and covenant requirement, Lincoln General faces difficult decisions ahead. Drastic expense reductions are being made, including a 20 percent staff reduction, in an attempt to improve financial performance.

West Bend, Kansas

Great Bend, Kansas is a small rural community located in Central, Kansas with approximately 15,000 people and one community hospital. Prior to the opening of the physician-owned Surgical and Diagnostic Center, the community hospital, Central Kansas Medical Center performed approximately 3,300 outpatient surgeries. After the opening of the physician-owned facility, the community hospital lost 60 percent of their outpatient surgeries and was forced to downsize their workforce by over 100 full-time equivalents. The community hospital is operating at a -0.2 percent margin while the physician-owned specialty hospital is enjoying a 17 percent margin according to cost reports filed in 2005 and 2004, respectively.

Emergency Room Crises and Recruitment Challenges

Rapid City, South Dakota

The entrance of physician-owned specialty hospitals has placed some trauma and emergency services in the community hospital at risk.[6] Across the country, physician

[5] Moody's, April 24, 2006, New York, "Moody's downgrades to Ba1 from Baa3 Lincoln Health System's Bond Rating"

specialists such as neurosurgeons, cardiac surgeons and orthopedic surgeons are increasingly unwilling to participate in community hospital's "on call" lists.[7] This problem is further intensified by the entrance of physician-owned specialty hospitals because physician-owners are less apt to care for emergency patients in the community hospitals and often rely on the resources of the community hospital's emergency room when a patient in their facility experiences complications that they are not equipped to handle. An example of this happened in the Black Hills of South Dakota with disturbing consequences for patients and for the community hospital. Before the physician owners built their own specialty hospital, they provided emergency room neurosurgical coverage for the community hospital. When the neurosurgeon-owners of the Black Hills Surgery Center abandoned taking ER call at Rapid City Regional, the local full-service community hospital, the community hospital was left with insufficient neurosurgery coverage. Community hospital officials attempted to remedy the situation by using locum tenens physicians (physicians who practice intermittently within the State but reside outside elsewhere) and two hospital-employed physicians to provide coverage, but this situation proved difficult to maintain and was very costly with expenses reaching nearly a million dollars. Recruitment of permanent neurosurgeons was also a challenge because there were already six neurosurgeons in the community. Because the Black Hills region is home to only one tertiary medical center ER, patients with immediate neurosurgical needs were transferred hundreds of miles away when gaps in neurosurgical coverage occurred. Ironically, this all occurred during the time of the annual Sturgis Motorcycle Rally when over 500,000 motorcycle enthusiasts converge in the Black Hills. South Dakota does not have a helmet law and the incidence of head injuries and trauma typically increases during this time making adequate neurosurgical coverage in the emergency room even more critical. This South Dakota experience demonstrates the access, recruitment, and emergency room challenges that physician-owned specialty hospitals exacerbate.

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[6] February 2005, McManis Study, "The Impact of Physician-owned Limited-Service Hospitals: A summary of Four Case Studies

[7] November 2001, Maguire, Phyllis, "Wanted: Doctors Willing to Take ER Call", ACP-SIM Observer, American College of Physicians-American Society of Internal Medicine

Checks and Balances in a Community Hospital vs. a Physician-Owned Hospital

Certain checks and balances present in the community hospital are not present in a physician-owned specialty hospital. Since the physicians own the hospital and are therefore the employers, nurses, other employees and even other physicians are reluctant, fearful or do not have a mechanism to report or deal with disruptive conduct or clinical incompetence on the part of physician-owners. Further, in most communities where physician-owned facilities exist, the physician-owners remain on the staff of the community hospital. The conflicted interests of the physician-owners causes them to disrupt operations of the community hospital, some examples of which include "insider recruiting" of key staff, disparaging the community hospital leadership and their management decisions to employees, and encouraging other non-physicians to become investors and pull their business from the community hospital. Physician-owners who continue to practice at the community hospital also have access to key inside information that may be helpful to their hospital at the expense of the community hospital.

Growth of Physician-Owned Specialty Hospitals

In November of 2003, Congress approved the Medicare Prescription Drug Improvement and Modernization Act which included an 18-month moratorium on new physician-owned facilities along with a number of limits on grandfathered facilities. The moratorium effectively prevented the expansion of physician-investors and/or additional beds to existing physician-owned specialty hospitals. The grandfathering exception also permitted referrals to physician-owned, limited service facilities determined by the Secretary to be in operation or "under development" as of November 18, 2003. Congress also directed the Medicare Payment Advisory Commission (MedPAC) and the Department of Health and Human Services to conduct studies during the moratorium and to recommend legislative and administrative changes. [8]

A number of activities occurred during the moratorium. The moratorium slowed the growth of physician-owned specialty hospitals but almost immediately, prospective

[8] Medicare Prescription Drug, Improvement, and Modernization Act of 2003

physician-owners, consultants and attorneys began looking at ways around the moratorium. The federal Centers for Medicare and Medicaid (CMS) received claims for payment from some specialty hospitals who believed they met the guidelines for "under development" as of November 18, 2003. Clearly, at least one physician-owned specialty hospital, Northeast Portland Physician's Hospital was operating in violation of the moratorium.

The moratorium expired on June 8, 2005. Although CMS announced that they would not approve any new physician-owned specialty hospitals until February 2006, existing facilities began recruiting new investors, expanding services, and adding additional beds.[9]

Payment Changes Alone Will Not Address Physician Self-Referral

Although inpatient payment changes have been recommended that would remove some of the financial incentives associated with physician-owned specialty hospitals, coding and payment changes alone will not address the problem. In particular, CMS has proposed reducing reimbursement for select high-cost procedures commonly performed in specialty hospitals. But, physician-owners could compensate for lower procedure payments by recommending the patient undergo more outpatient procedures and ancillary tests that are paid separately from the procedure.[10] Further, physicians have the ability to react to payment changes that community hospitals do not because of their singular and unique role in prescribing treatment. This is evidenced in a recent report by an investment analysis company, Raymond James, discussing the proposed coding and payment changes' impact on MedCath, a for-profit surgical hospital company that focuses on cardiac procedures. It stated:

> We believe that in response to a severe cut to cardiovascular reimbursement, the company could temper its mix of procedures that utilize high-cost devices and are most vulnerable to payment pressure, effectively reducing supply expense (note,

[9] Sioux City Journal, Jenny Welp, February 26, 2006, "Health Care Business Blooming in the Dunes"
[10] Jean Mitchell, October 2005, Health Affairs "The Effects of Physician-Owned Limited-Service Hospitals"

procedures that use high-cost drug-eluting stents or implantable defibrillators would face the largest reimbursement cuts under the proposals).[11]

Beyond MedCath, a comparison of the proposal's impact, based on filed cost reports, with the publicly-reported margins of one specialty hospital company with facilities in South Dakota is noteworthy. The three specialty hospitals are owned by Medical Facilities Corporation, a publicly-traded Canadian company that reports its earnings in periodic filings accessible via the world-wide web.

- Sioux Falls Surgical Center, Sioux Falls, South Dakota
  - Impact of proposed changes -2.3%
  - Reported EBITDA margin 49.4%

- Dakota Plains Surgical Center, Aberdeen, South Dakota
  - Impact of proposed changes -2.8%
  - Reported EBITDA margin 38.0%

- Black Hills Surgery Center, Rapid City South Dakota
  - Impact of proposed changes -5.9%
  - Reported EBITDA Margin 45.6%[12]

While CMS promotes that their DRG payment proposals would make a significant impact on physician-owned specialty hospitals and therefore alter physician referral patterns, it is clear from these numbers that the nick of a small percent in terms of payments, does not come close to neutralizing the 35-50 percent margins that some physician-owned specialty hospitals enjoy. The financial realization that comes from self-referral is too powerful to be overcome by DRG changes along.

[11] Raymond James, April 19, 2006 MDTH: (MedCath): Preliminary Medicare Impact Assessment Suggests Manageable Downside Risk
[12] Medical Facilities Corporation (MFC), March 2004 – Initial Public Offering

Finally, payment changes do not address physician-owner's ability to continue to select and steer the most well insured patients to their hospitals, leaving the poor and under and uninsured patients for the community hospital to care for.

The Root of the Problem – Physician Self-Referral

Physicians are the gatekeepers to healthcare services. Only physicians have the unique ability to admit patients to hospitals, to prescribe treatment, and to order services. Physician-owned facilities by themselves are not the problem; the problem lies in physician self-referral practices that create conflicts of interest with disturbing results for both patients and community hospitals.

Congress has enacted prohibitions on physician self-referral laws, with certain exceptions and "safe harbors," in part to prevent such conflicts of interest and to ensure that patient needs are never compromised. Also, these laws were in part the result of Congressional concern over noted increases in service utilization, which generally result in higher costs, both to government insurance programs and to patients. Current self-referral prohibitions set a sound precedent by plainly prohibiting physicians from self-referring to facilities they own such as laboratories, pharmacies, etc.

Physicians self-referring to hospitals they own is no different than physicians self-referring to a laboratory they own. We believe Congress should enforce the letter and spirit of the current self-referral laws by eliminating a broad exception in the law known as the "whole hospital" exception, which has historically allowed physician investment in, and referral to, entities that qualify as "whole hospitals", i.e. not a specified hospital department or unit.

I would like to extend my sincere appreciation to the Committee for bringing these issues to light and for their continued efforts to address the problem of self-referral.

STRUCTURE AND COMPETITIVE BEHAVIOR
OF PHYSICIAN-OWNED HOSPITALS
Testimony Submitted to the Senate Finance Committee by
Dan Mulholland[1]
May 17, 2006

Good morning. Mr. Chairman, Senator Baucus and Members of the Committee, my name is Dan Mulholland. I am an attorney based in Pittsburgh, Pennsylvania. Both my firm and I practice exclusively in the area of health care law. Among other things, I provide advice and counseling on federal laws governing financial relationships between health care facilities and physicians, and their many exceptions, "safe harbors" and loopholes. I also often litigate issues arising under these laws, and speak and write on the same topics. It is an honor to be here today and to provide this testimony, which I hope will assist the Committee in its own analysis and policy development on issues and concerns created by physician ownership of health care facilities.

Overview

In my testimony, I set out some examples of unfair economic incentives that promote physician investment in health care facilities; discuss that investment's impact on service utilization, patient care, competition, and on full-service community hospitals; and discuss how the policy goals of both the federal Medicare Anti-kickback statute and the Physician Self-referral law are subverted by the same. Finally, I recommend that this Committee and the larger Congress consider repealing the broadly abused "whole hospital" exception to the Physician Self-referral law in order to promote level competition in health care, fair and reasonable utilization, and high quality patient care.

Brief History of Physician-Hospital Relations

Traditionally, physicians and hospitals have peacefully co-existed with one another and have enjoyed a mutually beneficial relationship. Physicians derived most of their income from providing professional services, while hospitals relied on "technical revenue" to be reimbursed for the space, equipment, supplies and personnel used by the physicians to treat their patients in the facility. In the traditional setting, most physicians are not

employed by a hospital, but instead are appointed to the hospital's medical staff and granted clinical privileges to treat patients at the hospital. Unless the physician performs some other unique service for the hospital, no money changes hands and both the doctor and the hospital look to their own separate revenue streams for reimbursement.

In recent years, however, a variety of factors and trends have blurred this traditional relationship. In some situations, in order to assure adequate access to medical services in the community, hospitals have provided physicians recruited to their service area with income guarantees. In other instances, hospitals or related organizations have employed physicians to provide medical services to patients. But doctors too have begun to offer services that were historically only offered by hospitals. As a result of payment policies and technological advances, there has been a significant increase in investment by physicians in health care facilities, including imaging facilities, ambulatory surgery centers and even hospitals. This allows the physician-investor to supplement his or her professional income with revenue from the facility services that he or she orders. Many of these opportunities are quite lucrative for physician-investors and their joint venture partners.

Impact on Full-Service Community Hospitals

While this trend has provided an attractive supplemental revenue stream to the physician-investors, sometimes bordering on a windfall,[2] it has had a significant negative impact on their full-service community hospital competitors that are not physician-owned. Aside from reduced revenue resulting from the shift in referrals to the physician-owned hospital by the investors, community hospitals also experience considerable turmoil resulting from physician competitors remaining on the community hospital's medical staff. There have been numerous instances where physicians who compete with hospitals fail to properly handle conflicts that stem from their investment interest, refuse to accept community service obligations such as indigent care and emergency room call coverage, and "free ride" on the community hospital by cherry-picking more profitable patients while admitting or transferring uninsured, Medicaid or more acutely ill patients to the

community hospital. These trends have been especially dramatic when the physician-owned hospital is a specialty hospital.[3]

Many of these problems flow from the fact that when physicians have an ownership interest in a hospital or other health care facility, they have a financial incentive to refer patients to that facility and will, absent extraordinary circumstances, do so.[4]

The Federal Fraud and Abuse Laws and Medical Ethical Standards

Such an incentive has consistently been recognized as suspect from a public policy and ethical perspective. On two occasions, Congress has significantly restricted physician ownership in certain kinds of health care facilities and services. One is a criminal statute, while the other is civil. These laws carry penalties ranging from prison time, fines, civil money penalties and exclusion from participation in Medicare and Medicaid. Physician investment and ownership in limited-service or specialty hospitals, can, through creative lawyering and financial arrangements, navigate around these legal restrictions. In other cases, physician-investors and their equity partners employ outright secrecy and nondisclosure to strain Congress's intent.

The Medicare Anti-kickback statute,[5] which prohibits the payment, receipt, offering or solicitation of remuneration in return for the referral of Medicare or Medicaid patients, was enacted to address three fundamental concerns with economic incentives to refer patients: (1) overutilization; (2) potential harm to patients that can flow from not being referred to the facility that provides the best care; and (3) the undercutting of fair competition that occurs when competition is based on paying for referrals, and not price or quality.[6] All three of these concerns are present when physicians have an ownership or investment interest in hospitals.

Congress also recognized this fact when it enacted the Physician Self-referral law.[7] That statute renders any financial relationship, including ownership and investment interests by physicians in hospitals to which they refer presumptively illegal, unless they fit within a number of statutory or regulatory exceptions. There is an exception allowing physician

ownership in a "whole hospital."[8] That exception states that, in the case of designated health services provided by a hospital, a financial relationship shall not be considered to be an ownership or investment interest if: "the referring physician is authorized to perform services at the hospital;... and the ownership or investment interest is in the hospital itself (and not merely in a subdivision of the hospital)."

In its final regulation implementing the Physician Self-referral statute, the Centers for Medicare & Medicaid Services ("CMS") specifically acknowledged that physician-owned hospitals could possess a competitive advantage over those with no physician ownership.[9] CMS also recognized that notwithstanding the whole hospital exception in the statute, physician ownership of hospitals, particularly specialty hospitals, could implicate the Anti-kickback statute.[10]

The American Medical Association has also recognized that physician referrals to facilities in which they have an ownership interest can create conflicts of interest, and thus should be allowed only in limited circumstances. Among other things, the AMA's Council on Ethical and Judicial Affairs has stated that: "Physicians may invest in and refer to an outside facility, whether or not they provide direct care or services at the facility, if there is a demonstrated need in the community for the facility and alternative financing is not available."[11] Unfortunately, this ethical rule is honored more in the breach rather than the observance where many physician-owned specialty hospitals compete head-to-head with existing community hospitals which provide more than adequate services to the community.

Recent Developments Affecting Physician-Owned Hospitals

As part of the Medicare Modernization Act of 2003, Congress amended the Physician Self-referral law to enact an 18-month moratorium on physician ownership of specialty hospitals pending further study of this issue by CMS and the Medicare Payment Advisory Commission (MedPAC).[12] The moratorium has since expired, but pursuant to the Deficit Reduction Act of 2005, CMS has been directed to prepare a Strategic and Implementing Plan relative to physician-owned specialty hospitals and, in the interim, refrain from

enrolling any physician-owned specialty hospitals in Medicare.[13] There is also legislation pending to permanently reinstate the moratorium's prohibition on physician ownership of hospitals.

Regardless of the outcome of the CMS plan or proposed legislation, the structure and activities of physician-owned hospitals bear witness to the concerns that were voiced by CMS and others that physician ownership of hospitals can lead to exactly the kinds of abuses that the Anti-kickback statute, Physician Self-referral law and AMA Code of Ethics were designed to address.

Analysis of Physician Investing Patterns

A close analysis of how these hospitals are set up, what they represent to potential investors, and how they often try to conceal the identities of the physician-investors bears this out.

In a number of cases, physician-owned hospitals have been quite bold in touting the value of the investment as being tied to the fact that physician ownership will drive and improve the financial performance of the hospital. For example, in the Prospectus for the Canadian securities offering for three South Dakota surgical hospitals, the following statement appeared:

> Physician loyalty is a key to the success of the MFC Hospitals. Physician ownership and operation of each MFC Hospital has been a key factor in attracting physicians to the medical staffs of the MFC Hospitals. Physicians prefer practicing at the MFC Hospitals because they are able to increase the number of procedures they perform in a given period relative to the traditional hospital setting, thereby maximizing their efficiency and increasing professional fee potential. Managerial control of the MFC Hospitals and ownership interests therein, also provide participating physicians with operational freedom and administrative control over their practices.[14]

That offering statement went on to admit that physician ownership could possibly be found to violate the Anti-kickback statute.[15] A more recent newspaper article about a proposed physician-owned hospital in Lancaster, Pennsylvania was even more explicit.

According to the article: "Doctors buy into a hospital, becoming part owners. Doctors direct their patients to the hospital. Hospital thrives."[16] Individuals connected to this venture who were quoted in the article made no attempt to refute this premise.

Maximizing Referrals

The way in which physician-owned hospitals are organized also suggests that the sole reason for investment is the physicians' incentive to refer patients to the hospital and maximize revenue by maximizing referrals. In many cases, physicians are given more favorable investment positions than non-physician investors and/or enter into other arrangements with their investment partners that effectively underwrite the cost of the physicians' investment. For example, investment companies not controlled by physicians or occasionally full-service hospitals which are looking to joint venture with the physicians will occasionally purchase real estate or services from the physicians at amounts that appear to be above market value as a way of providing funds for the physicians to invest in the operating entity that will run the hospital. In other situations, physicians are not required to guarantee the debt of the hospital-operating entity even though their investment company and hospital joint venture partners provide guarantees. Some physician-investors also are given the right to sell their shares back to the joint venture at any time for a pre-determined price that may or may not reflect the true fair market value of those shares.

It is important to understand that when parties to a transaction such as a physician-owned hospital are in a position to refer to one another, the concept of "fair market value" – that is, what a willing buyer and willing seller in an arms-length transaction where both are free from compulsion – takes on a different dimension. Both the Physician Self-referral law and regulations and the Anti-kickback statute state that fair market value in such situations may not take into account the volume or value of services that one party may refer to the other.[17]

Limited Capital Investment

The effect of these "sweetheart" deals is that physicians often have to put very little of their own capital at risk. The only plausible explanation for such arrangements is that they are designed to induce the physicians to invest in a facility to which they will refer and thus provide a sufficient revenue stream to guarantee high returns for all the investors. The Office of Inspector General for the Department of Health and Human Services ("OIG") recently warned that providing physicians who are expected to make a large number of referrals with more favorable investment opportunities in joint ventures suggests that there may be an improper nexus between selection of joint venture participants and the volume or value of their referrals.[18]

Many physician-owned facilities are highly leveraged, with large debt-to-equity ratios. This allows physicians to have little up front capital at risk. But financing can come from still other sources. In one instance, $15,000,000 in bonds issued by a Louisiana economic development authority on behalf of a physician-owned specialty hospital were purchased by GE Commercial Finance Business Property Corporation, an affiliate of General Electric, a major vendor of medical equipment.[19]

Masquerading Act: General Hospital or Specialty Hospital?

Physician-owned specialty facilities have on occasion attempted to disguise themselves as general hospitals, either to avoid the prior moratorium or for other purposes. In one case, the Louisiana State Bond Commission approved the issuance of bonds for a proposed hospital project while the moratorium was in place, in spite of the fact that the facility clearly met the MedPAC definition of a specialty heart hospital. The promoters refused to concede that the facility was a specialty hospital. The matter is now being litigated in the state courts.[20] In another, one of the parties to a dispute over a non-compete covenant involving physician-investors in a heart hospital in Kansas (who happens to be one of the promoters in the Louisiana transaction mentioned above) tried to claim that a new facility in which he and others were going to invest was a general hospital despite the fact that 66% of the revenue from the new hospital was projected to come from the performance of heart procedures.[21] It is quite possible that a number of

new facilities which opened during the specialty moratorium took a similar position to avoid compliance with the moratorium.

Secrecy and Nondisclosure

The physician-owners of specialty hospitals have been especially reluctant to reveal their identity as well. For example, in the Louisiana litigation mentioned above, the Economic Development District refused to answer an interrogatory asking for the identities of all persons having an ownership interest in the proposed hospital, ostensibly because they feared retaliation by the community hospital with which they are planning to compete.[22] This consistent lack of transparency on the part of physician-owned facilities suggests that they may be unwilling to allow their patients to make a fully informed choice of where they would like to have their procedures performed.[23]

Impact on Full-Service Community Hospitals

Far from being in a position to "retaliate" against physicians who invest in facilities that compete with them, full-service community hospitals are often hampered in their ability to effectively compete when physicians have an economic incentive to direct patients to another facility. An uneven competitive playing field results. To the extent that such physicians are also on the medical staff of the community hospital, they are in a position to "cherry pick" the most favorably insured patients and the most profitable procedures and refer them to their own facility, while continuing to send Medicaid, underinsured and uninsured patients, and low-margin procedures to the community hospital. Hospitals that attempt to rein in this egregious "free-riding" by the physician-owners of their competitors by restricting their clinical privileges or establishing conflict of interest rules that prevent their competitors from serving in leadership positions are accused of "economic credentialing," which is a pejorative term coined by certain medical trade associations. A significant amount of litigation involving this issue has arisen in recent years, and courts throughout the country are split on whether hospitals can restrict or deny medical staff appointment to physicians who are direct competitors.[24]

The challenges associated with taking on competing physicians on an uneven playing field, and the prospect of having large amounts of revenue diverted as a result of that competition, have led many community hospitals to pursue joint ventures with physicians on their medical staffs to construct and operate specialty hospitals. In such cases, the majority of the financing, usually in the form of debt, is borne by the community hospital, and, as stated above, the physician-investors have relatively little at risk. The community hospital in this situation will suffer since most of its revenue will be diverted to the joint venture facility, while less financially attractive patients are still treated at the community hospital. To recover the lost revenue that is now shared with the physician-investors (as well as to protect the community hospital's investment, be it debt or equity), the volume and revenue at the joint venture facility must double, which is difficult to do without questionable utilization practices on the part of the physicians.

Conclusions and Recommendations

To address these issues of improper financial incentives, nondisclosure and deception, and free-riding on community hospitals, and the mischief that can result from them, the following public policy suggestions are offered.

First, Congress should consider repealing the whole hospital exception in the Physician Self-referral law, not just for specialty facilities, but for all hospitals, since the same effects can be seen regardless of whether the facility in which physicians invest offers full or limited services.

Second, if the whole hospital exception is not repealed, Congress should require full disclosure of any direct or indirect ownership interests held by physicians in hospitals, both to their patients and to CMS (and thus the public) on the hospital's Medicare cost report and 855 enrollment form. This concept of what constitutes an "indirect" ownership or investment interest is already sufficiently described in the Physician Self-referral regulations,[25] so implementation of such a requirement should be relatively simple.

Third, full-service community hospitals should be fully empowered to effectively compete with physician-owned facilities, by allowing revocation of medical staff appointment and proper handling of conflicts of interest on the part of physicians who have an ownership interest in their competitors.

Thank you again for the opportunity to share this information with the Committee.

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[1] Mr. Mulholland is a senior partner in the health care law firm of Horty, Springer & Mattern, P.C. in Pittsburgh, Pennsylvania. The firm represents and advises hospitals and health systems throughout the country. Information about the firm can be found on its website, www.hortyspringer.com. In providing testimony to the Committee, Mr. Mulholland is not acting on behalf of any client. Special thanks to Ian Donaldson, third-year law student at the University of Pittsburgh, who assisted with the research for this testimony.

[2] In one instance, three physician-owned surgical hospitals in South Dakota were the subject of a public stock offering in Canada, raising $150,000,000 for a 51% share of their operations. "S.D. Surgical Centers Plan Expansion with Merger" Sioux Falls Argus Leader (April 11, 2004). The 2005 Annual Report for this company, Medical Facilities Corporation, as published on the website of the Canadian Securities Commission, revealed that EBITDA income from one of the facilities equaled 49.3% for the last three months of the calendar year.

[3] The term "specialty hospital" has been defined as a hospital primarily or exclusively engaged in the care or treatment of patients with either cardiac or orthopedic conditions or receiving a surgical procedure. 42 U.S.C. § 1395nn(h)(7). For the purposes of specifically identifying specialty hospitals, CMS requires that at least 45% of a hospital's Medicare cases be in the relevant Major Diagnostic Categories for cardiac, orthopedic or surgical procedures. Testimony of CMS Administrator Mark B. McClellan to the House Committee on Energy and Commerce, May 12, 2005.

[4] For an empirical analysis of this phenomena, see Lynk, William J. and Longley, Carina S, "The Effect of Physician-Owned Surgicenters on Hospital Outpatient Surgery," 21 Health Affairs 215 (July/August 2002). With respect to the relationship between physician ownership of hospitals and overutilization, see Mitchell, Jean M., "Effects of Physician-Owned Limited Service Hospitals," Georgetown University Public Policy Institute (2005).

[5] 42 U.S.C. §1320a-7b(b).

[6] 135 Cong. Rec. H240-01.

[7] 42 U.S.C. §1395nn.

[8] 42 U.S.C. §1395nn(d)(3).

[9] 69 Fed. Reg. 16084 (March 26, 2004).

[10] Id.

[11] AMA Ethical Opinion E-8.032. www.ama-assn.org.

[12] Pub. L. 108-173, §507 (2003).

[13] Pub. L. 109-171, §5006 (2006).

[14] Medical Facilities Corporation Prospectus, p. 30 (March 17, 2004).

[15] Id. at p. 39.

[16] "A New Kind of Hospital Here?" Lancaster New Era (April 27, 2006).

[17] See 66 Fed. Reg. 944; 56 Fed. Reg. 35, 952 et seq.

[18] OIG Supplemental Compliance Program Guidance for Hospitals, 70 Fed. Reg. 4865 (Jan. 31, 2005).

[19] Hammond Area Economic and Industrial Development District Taxable Revenue Bond (Louisiana Hospital Center, L.L.C. Project, (February 2, 2006).

[20] Board of Commissioners of the Hammond Economic and Industrial Development District v. Taxpayers, No. 2005-001527 (21st Judicial District, Tangipahoa Parish, Louisiana 2005)

[21] Kansas Heart Hospital, L.L.C. v. Idbeis, No. 04 CV 4230 (18th Judicial District, Sedgwick County, Kansas 2005).

[22] Answers to Interrogatories by Board of Commissioners of the Hammond Economic and Industrial Development District, June 2, 2005.

[23] AMA Ethical Opinion E-8.032, *supra*, requires disclosure to patients whenever a physician refers to a facility in which he or she has an ownership interest.

[24] Compare Mahan v. Avera St. Lukes, 621 N.W.2d 150 (S.D. 2001) to Murphy v. Baptist Medical Center, No. 04-430 (Ark. 2006).

[25] See 42 C.F.R. § 411.354, stating "An indirect ownership or investment interest exists if – (A) Between the referring physician (or immediate family member) and the entity furnishing DHS there exists an unbroken chain of any number (but no fewer than one) of persons or entities having ownership interests; and (B) The entity furnishing DHS has actual knowledge of, or acts in reckless disregard or deliberate ignorance of, the fact that the referring physician (or immediate family member) has some ownership or investment interest (through any number of intermediary ownership or investment interests) in the entity furnishing the DHS."

STATEMENT OF SENATOR GORDON H. SMITH

U.S. Senate Finance Committee Hearing
"Physician-Owned Specialty Hospitals: Profits before Patients?"
May 17, 2006

Good morning.

Chairman Grassley, I appreciate being here today to discuss the ongoing debate regarding physician-owned specialty hospitals. I also appreciate Pastor Wilson's attendance today to discuss a very tragic incident that happened in my home state of Oregon.

We will hear today about Pastor Wilson's mom, Helen Wilson, who on July 27, 2005, was admitted to Physicians' Hospital in Portland for elective back surgery. While in recovery at the physician-owned hospital, Ms. Wilson was given an injection of pain medication, suddenly went into cardiac arrest, and later passed away after a call was made to 911 to transfer Helen to an emergency room. The rest of the details will be fleshed out by Pastor Wilson; however, we are here to discuss the fact that this incident happened at a physician-owned specialty hospital that was opened during a time when it was not legal to start physician-owned hospitals.

As we examine the issue of physician ownership of specialty hospitals, I urge the Committee to remain mindful that we have two responsibilities. The first is to ensure the health and safety of all patients. I am not certain whether the tragic events at Physicians' Hospital happened because it was a specialty hospital or whether numerous breakdowns in the system – starting with the rushed approval of this facility by the state – are to blame, but it is our responsibility to make sure this tragedy isn't repeated.

The other issue is to explore the financial arrangements of specialty hospitals. I am concerned that physician-owned hospitals may be skimming the healthiest and most profitable patients. If this is true it will undermine the community hospital infrastructure and potentially threaten the health and safety of our nation.

Today, it is my hope that we approach these topics in a thoughtful manner to determine what is the best course for Congress to take on physician-owned hospitals as we hear testimony regarding patient safety, quality of care, financial arrangements used to finance and operate specialty hospitals, as well as oversight by CMS in enforcing the congressionally mandated moratorium prohibiting new specialty hospitals.

I thank all of you for coming to share your expertise and look forward to your comments.

Thank you, Mr. Chairman.

Testimony by Michael W. Wilson

Pastor, Sellwood Baptist Church
Chaplain, Portland Police Bureau

Before the
United States Senate's
Committee on Finance

Hearing on
"Physician-Owned Specialty Hospitals: Profits Before Patients?"

Wednesday, May 17, 2006

Chairman Grassley, Ranking Member Baucus, and distinguished members of this committee, thank you for allowing us the privilege of being here to address you today and to share our family's story. I count it an honor to have been asked to come to Washington to testify before this committee. My name is Michael Wilson and I am from Portland, Oregon. Accompanying me is my wife, Ramel. I have also brought with me a photograph of my parents, Doyle and Helen Wilson. This picture was taken shortly before my mother's death on August 1st, 2005. They had been married for 69 years.

I believe you have heard my mother's name, because her case has already come before you several times in your discussions of physician-owned, for-profit, specialty hospitals. I am here today to give you the details of her death, in the hope that you can help make certain that no one else dies the way she did.

My mother, Helen Wilson, checked in at Physicians' Hospital in Portland, Oregon a little before 8:00 AM on Wednesday, July 27th, 2005. Physicians' was a new hospital, in business only since December 2004, its owners having purchased and remodeled the old Woodland Park Hospital that had operated in Portland for forty-three years.

My mother was 88 years old, but was in good health for her age. She had gone through a heart surgery 15 years earlier, but had had no serious coronary issues since then. She was also diagnosed with age-related type II diabetes, but kept that well under control with diet and medication. Her surgeon stated that he was confident that she was a good candidate for the relatively simple procedure and that he was certain that she would make a quick and full recovery.

The reason she was at Physicians' Hospital was to correct a problem in her lower spine. For quite some time she had suffered from a constriction of the spinal nerve in her lower back, which was causing back and leg pain and reducing motor function in her legs, making it difficult for her to walk. Her primary care physician referred her to an orthopedic surgeon named Dr. Mark Metzger.

After examining her, Dr. Metzger scheduled her for a lamenectomy to correct the problem. The surgery was scheduled for Physicians' Hospital where he had privileges. He planned to make a 1½-2 inch incision to free up pressure on the nerve bundle that controlled her legs and lower back. He told my parents that he estimated that the procedure would last 1-2 hours, and he told my mother to plan for one overnight stay in the hospital.

They finally wheeled Mom out to surgery at about 11:00 AM, an hour later than the scheduled time. Dad and I went down to the surgical waiting area where we sat and visited. Finally one of the nurses came and told us that the surgery was over and that my mother was in the recovery room. She reported that Mom was experiencing quite a bit of pain, however, and that her blood pressure was somewhat high, but they told us that she was doing well and not to worry.

The surgeon, Dr. Metzger, came out to the waiting area and told Dad and me that the surgery had been a complete success. He explained that the only problem he had encountered was a slight tear in the *dura*, the tough outer covering of the spinal cord, which he was able to suture and correct with no more leakage of spinal fluid. He said that she would need to spend one night in the hospital, and possibly two, depending on how well she

was feeling and how well she recovered from the effects of the anesthesia and surgery. He said that if we wanted to we could go upstairs to await her arrival from the recovery area.

The nurses wheeled Mom into her room at approximately 4:30 PM. They quickly got her settled in and connected to a blood pressure monitor. They also checked her oxygen levels. They did not, however, connect her to any kind of heart monitor, in spite of the fact that she was elderly and had gone through heart surgery years earlier, putting her at somewhat higher risk. We thought this odd at the time, but assumed that the heart monitor would be hooked up soon. However, it never was.

My mother was groggy but responsive. She perked up as soon as she saw us and began speaking, though with difficulty because of the effects of the anesthetics. At first only Dad and I were there with her. I questioned her about her pain level. She responded by saying that she had experienced severe pain in the recovery room but that it was subsiding now, and as long as she didn't try to move she was able to handle it. She had a dry mouth so I began feeding her ice chips, one at a time. At about 4:35 PM, approximately 5 minutes after Mom was wheeled into the room one of the elders from their church, Bem Walker, came to visit her. The three of us men stood around Mom's bed talking and laughing with her, trying to cheer her up and take her mind off the pain. She was alert and aware of her surroundings. She was not complaining of pain and none of the staff questioned her about her pain level.

After leaving work at Portland Police Bureau's Northeast Precinct my wife, Ramel, arrived in the room about 5:30 PM, approximately 15 minutes after Bem had left. Dad, Ramel, and I stood by Mom's bedside and continued to visit with her. She was doing well, was alert and laughing at our jokes and coming back to normal as the anesthetics gradually wore off.

Just minutes after Ramel got to the room, a nurse came in and prepared to inject medication into Mom's I/V line. The nurse used a large syringe to slowly inject a clear liquid into the line. We found out later that the drug used was Dilaudid, a powerful hydromorphone hydrocloride. We thought it odd at the time for them to give her more pain meds even though Mom had not asked for anything. And all three of us who were there are certain that none of the staff, including the nurse that administered the last dose, ever asked Mom about her level of pain after she was brought into the room from the recovery area. Moreover, that is the only injection she received while we were in the room with her so we are certain that there was a direct connection between the medicine and the almost immediate effect that it produced.

Once the pain medicine was fully dispensed (having taken not more than a minute), the nurse left and we continued to stand there by Mom's bedside. However, she quickly became droopy and obviously began having trouble keeping her eyes open. We were still talking with her, but she seemed to be falling asleep. Just then, a young nurse stepped into the room. At that moment Mom's eyes closed and she went clear out. We were a little concerned because it happened so quickly—less than 2 minutes after the medicine was put into her I/V. We asked the nurse if this was normal and she said, oh yes, that many times patients fall asleep quickly with pain medicine. She then walked out of the room. Mom seemed to be sleeping peacefully. Ramel and Dad and I continued to visit about various things, not alarmed in the least.

Suddenly, my mother made a strange little choking cough. All three of us immediately looked at her but we could see no signs of crisis at that time. Her arms and legs were still and she seemed to be breathing normally. We went back to our conversation. Approximately 30 seconds later, she once again made a strange, choking sound, but this time her mouth was hanging open and I could see and hear that she was gurgling in her throat. From the time the nurse finished injecting the Dilaudid into Mom's I/V line until she was into full respiratory arrest could not have been more than two, or two and a half minutes. I stepped immediately to the head of Mom's bed and observed that she was not breathing. I quickly checked her carotid artery for a pulse but could detect none. Seeing that she was in arrest I yelled for help, telling the nurses to come quickly, that my mother had stopped breathing.

The first nurse to arrive on the scene acted as though she had all the time in the world, and gave off the distinct impression that she thought we were being over-reactive in calling for help. After a tense minute of the nurse checking Mom's vitals, Ramel stepped out of the room into the hallway, across from the nurse's station, and hollered that we needed help quickly because Helen had stopped breathing and didn't have a pulse. I could not understand why no Code Blue was being called over the hospital PA system, and why the staff people were acting with such lack of speed, teamwork, and expertise. The next few minutes were some of the worst of my whole life. The three of us stood there and watched the most egregious example of gross incompetence and negligence that I have ever witnessed or heard of. We could not believe what was happening.

I yelled for help a second time and nurses finally began to show up. One took her place at the head of Mom's bed and began to use a resuscitation bag on her, trying to get air into her lungs. However, her tongue had fallen back into her throat and no air was getting past. Her cheeks were inflating and the air was escaping around the outside of the mask. I quickly told the nurse she needed to clear Mom's airway—that her chest was not rising. The nurse looked up at me panic stricken. About that time Ramel yelled, "Get the paddles on her, NOW!" The first nurse on the scene called for the Crash Cart. But they had to go down the hall, back behind the nurses' station to get the Cart. Then when they finally got it into the room the nurse began furiously searching through the drawers to find the various things she needed to prepare the defibrillation unit. She kept yelling, "Where are the paddle covers?" Someone went running to find some. The rummaging continued. Eventually they managed to get the paddles on Mom and shocked her three times, but to no avail. They tried chest compressions but that wasn't working because my mother was still in her bed, without a backboard. Both Ramel and I asked the nurses several times, "Has a doctor been called?" We just got stares and mumbles. Finally, several minutes later, one of them said, "We've called someone." Of course, we assumed that she was talking about a doctor.

As it turned out, they had called 911. The fire department quickly dispatched the paramedics who rushed into the room some 10-11 minutes after the start of the crisis. The contrast between them and the hospital staff was striking. They quickly were able to get Mom breathing and her heart stabilized enough to transport her. **However, by that time the damage had already all been done.** Through gross professional incompetence my mother was left without oxygen for so long that she was already brain-dead. The paramedics transported her by ambulance to Adventist Hospital's CCU, where she remained for the next five days, never regaining consciousness.

On July 31st, after twice running diagnostic tests to determine her level of brain function, the specialists at Adventist told us that there was absolutely no upper brain function remaining due to oxygen starvation. They advised us that it was time to wean her off the respirator and entrust her into God's hands. She was removed from the ventilator on Sunday, July 31st at 3:00 PM. To our surprise and amazement Mom's body responded and she began breathing on her own. She was transferred out of CCU to a room on one of the regular nursing floors. We maintained our constant vigil by her side until she slipped quietly away from us on Monday, August 1st at 3:12 PM. There with her at the time of her death was my father, Doyle, my sister, Janis, her daughter, Mona, and myself.

This was a tragic, needless death. Had my mother received the quality of care at Physicians' that she later received at Adventist she would still be with us today. **No hospital should ever have to call 911 to come and save one of their patients!!** Hospitals, doctors, and nurses are paid to know how to resuscitate a person who goes into post-surgical respiratory or cardiac arrest. Moreover, as patients and family members of patients we have a right to this assurance. What happened to my mother on July 27, 2005 was unconscionable and inexcusable. As a result of their blundering my father lost his wife of 69 years, my mother's 4 remaining siblings lost their beloved sister, my sister and I lost our wonderful mother, our 11 children lost their "Grammy," and our children's children lost a wonderful great-grandmother. My daughter, Simoni, gave birth to Mom's newest great-grandbaby, Billy, on August 25th, weeks after Mom's death, but Billy will never have the joy of knowing her because her life was cut short. That breaks my heart.

My mother was a wonderful, godly woman. Many years ago she placed her total faith in Jesus Christ as her Savior and Lord, and she was ready to go to be with Him at any time. And it has been our relationship with the Lord and the comfort of the Scriptures that have brought my father and the rest of our family through this difficult experience. We know that God, in His sovereign plan, allowed this to happen, and my mother was ready to go. However, that does not take away the fact that the immediate cause of her death was the negligence of a hospital that has a moral obligation to do everything possible to save lives.

In summary,

- The nursing staff at Physicians' evidently did not know how to intubate my mother with an endotracheal tube to get her breathing again.
- They did not administer the antidote, naloxone hydrochloride, which is the specific published treatment for an overdose of Dilaudid.
- They did not have a properly supplied "Crash Cart."
- The Cart they did have was not stationed close by, as it should have been.
- No Code Blue was called to summon help.
- There was not a Code Team trained for this type of emergency.
- The nurses were obviously unskilled in handling a respiratory arrest such as this.
- There was no doctor in the hospital available to respond to this emergency.

My mother is the poster child for what can happen when the foxes own and operate the hen house for their own benefit. We did not know until after my mother's death that the doctor who performed her surgery was one of the owners of the hospital. We did not discover until later that Physicians' Hospital was only marginally prepared to do this kind of surgery. We did not know that no emergency physician would be on the premises. We did not know that it was the hospital's policy to call 911 in case of a post-op medical emergency.

Patients trust their doctors. We never guessed that my mother was in such grave danger from the incompetence of the very people who took an oath to protect and heal, and above all, to do no harm.

One of the most troubling things that occurred was that when we got my mother's records we discovered that her med chart had been "doctored" to make it look like she had received that last dose of Dilaudid 40-minutes prior to her going into respiratory arrest, to make it seem like the two events were unrelated. You could see where the time had been erased with the new numbers written over the top. Moreover, the nurse wrote that my mother was sleeping when she administered the medicine. At another place in the nurses' report it said that my mother had reported a pain level of six out of ten. There were three of us with her the whole time and she was never asleep, and no nurse ever came in and asked about her pain level. Those were pure fabrications.

One of the hurtful attitudes that we have encountered in the process of trying to hold Physicians' Hospital legally accountable is the idea that my mother's death was a result of her age. That is simply not true. Even if she had been 40 years younger the same irresponsible treatment she received could have killed her. Her death was preventable!

- A review of her charts shows that she had already received multiple doses of pain medication while still in the recovery area, pushing her to the edge of her physical tolerance. That had nothing to do with her age.
- The dose administered in our presence, unsolicited and unneeded, pushed her over the edge into full respiratory failure and cardiac arrest, exactly as described in the drug literature. This reaction was not age related but triggered by an overdose.

It appears that Physicians' Hospital may be going out of business, now that their Medicare/Medicaid funding has been cut. For us that is good news. The four primary owners, plus the thirty-five other physicians who own stock are in the process of trying to sell the corporation. Our concern is that there are still 99 other hospitals similar to Physicians' operating across this country.

It is our opinion that when the doctors own the hospital and operate it to their benefit, when the almighty dollar rather than quality patient care is the bottom line, when physicians can pick and choose who they will treat, and when the hospital has no one holding everyone's feet to the fire, then patients will not be well-served. My mother is an example of what can happen if no one is looking over the doctors' shoulders.

If my mother's death results in raising public awareness of this problem, and results in this Senate committee closing some of the existing loopholes, and in so doing perhaps saves someone else's life, I'm certain that she would say that it was worth it. Please, make it so. Thank you for this opportunity to address the committee. I will be happy to take your questions.

COMMUNICATIONS

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Statement
of the
American Hospital Association
before the
United States Senate
Committee on Finance
on
Physician-owned Specialty Hospitals: Profits before Patients?

May 17, 2006

On behalf of the American Hospital Association (AHA), our 4,800 member hospitals and health care systems, and our 35,000 individual members, we are pleased to present our views on the critically important issue of physician-owned, limited-service hospitals and their impact on health care in our society.

A loophole in federal law allows physicians to own limited-service hospitals, such as cardiac, orthopedic and surgical facilities, where they then refer patients – a practice known as self-referral. Self-referral raises serious concerns about conflict of interest, fair competition and whether the best interests of patients and communities are being served.

Physician conflict of interest is a serious problem. When physicians own, even in part, the facilities to which they refer patients, their decisions are subject to competing interests. The AHA commends the committee for focusing squarely on the conflict of interest caused by self-referral.

Risks of Conflict of Interest vs. Benefits of "Competition"
The question facing lawmakers is: Do the risks posed by self-referral outweigh the benefits of adding physician-owned, limited-service hospitals to the competitive landscape? The risk of self-referral is that the financial incentives inherent in a self-referral model will influence physician behavior in ways that may not be in the best interests of patients and the system as a whole. Potential benefits touted by the physician-owned, limited-service hospital community include enhanced quality and greater efficiency.

This question can be answered by an examination of the evidence. The research to date has found strong evidence that financial incentives are influencing physician behavior. Behaviors documented include patient selection and steering, service selection and increased utilization. On the other hand, two benefits of competition claimed by these facilities have not been borne out – they are not more efficient and quality results have been mixed.

Patient selection and steering. Evidence shows that physician-owners respond to financial incentives by "cherry picking" patients in three ways. First, they simply avoid treating uninsured, Medicaid and other patients for whom reimbursement is low. Second, they selectively refer patients to different facilities, sending well-insured patients to the facilities they own and poorly-insured or uninsured patients elsewhere, often to the local full-service community hospital. Third, they selectively refer healthier, lower-cost, lower-risk patients to facilities they own, leaving more severely ill patients to be treated by local full-service community hospitals. Central to this concern is whether the patient's best interest is being served by the physician's selection of where the procedure will be provided.

These behaviors were documented by the Medicare Payment Advisory Commission's (MedPAC) March 2005 report to Congress. MedPAC found that physician-owned hospitals treat, on average, a lower share of Medicaid patients. Since Medicaid pays less than the cost of care – in 2004, Medicaid paid less than 90 cents for every dollar spent treating Medicaid patients – the financial burden of treating more than 57 million Medicaid beneficiaries falls to the full-service community hospital. MedPAC also found that physician-owned, limited-service facilities treat relatively low severity patients within profitable diagnoses-related groups. Government Accountability Office (GAO) reports and other peer review literature also support these findings.

A March 2005 Centers for Medicare & Medicaid Services' (CMS) report to Congress studied physician-owned, limited-service facilities and also found that all but one hospital treated patients with a lower severity of illness than full-service community hospitals. In addition to this evidence of patient selection, CMS documented patient steering: In two out of three cardiac facilities, owners had a clear preference for referring inpatients to their owned facility. CMS also found that surgical and orthopedic hospitals resemble ambulatory surgery centers, lack active emergency departments and focus on outpatient services.

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

Increased utilization. Even more troubling, growth in these facilities leads to increased use of health care services. MedPAC found in its April 2006 study that when physician-owned heart hospitals entered a community, cardiac surgeries per 1,000 Medicare beneficiaries increased by about 6 percent. As one commissioner stated, "That's not a sustainable rate of growth." These results represent an update of the prior report, including data from 43 additional physician-owned, limited-service hospitals – nearly double the number with available data in the original study. The finding of increased utilization is statistically significant based on two additional years of experience with physician-owned cardiac hospitals.

Meanwhile, the research to date does not support claims that these facilities provide the desired benefits of competition, efficiency and quality.

Efficiency claims unfounded. The April 2006 MedPAC data found that physician-owned surgical and orthopedic hospitals have costs that are 20 to 30 percent **higher** than competing community hospitals, while physician-owned heart hospitals have about the same cost per case as competing community hospitals. This finding refutes the claim from physician-owned, limited-service hospitals that they are more efficient – no competitive benefits were found. A recent GAO report, which questioned whether physician-owned, limited-service hospitals enhance the competitive landscape, instead found that hospitals in markets with and without limited-service hospitals already face a high level of competition. The study found no evidence that physician-owned, limited-service hospitals enhance competition.

Improved quality claims unproven. The March 2005 CMS report to Congress also found that when physician-owned cardiac hospitals were compared to full-service hospitals for quality, readmission rates were higher for physician-owned hospitals while mortality rates were lower.

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

Moratorium Recognized Congressional Concerns

Because of concerns with the rapid increase in physician-owned, limited-service hospitals, the Medicare Modernization Act of 2003 (MMA) imposed a temporary moratorium on physician self-referrals under Medicare to new limited-service hospitals. After the moratorium expired June 8, 2005, CMS put in place a "defacto" moratorium – barring self-referral under Medicare to new limited-service facilities while they

undertook a careful review of Medicare policies related to these entities. In the Deficit Reduction Act of 2005 (DRA), enacted in early 2006, Congress required that CMS continue its prohibition against self-referral in new limited-service hospitals entering Medicare until the agency develops and submits to Congress a strategic implementation plan that includes legislative and regulatory recommendations for regulating physician investment in limited-service hospitals, participation in Medicaid and provision of uncompensated care.

In the DRA, Congress again signaled its concern with these facilities – which the AHA shares – by requesting a study of investment structures of physician-owned, limited-service hospitals. On May 9, CMS submitted its interim report to Congress. The report provided lawmakers with an update on CMS' development of a plan to determine whether physician investments in limited-service hospitals are bona fide and proportional to their investment returns, and whether physician-owned, limited-service hospitals should be required to annually furnish investment information. The AHA supports the collection of new data in order to conduct a rigorous examination of these issues.

The report also includes a summary of steps CMS has taken since June 2005 to respond to recommendations from MedPAC and the Department of Health and Human Services (HHS). Many of these recommendations fall short of dealing with the real issue – physician self-referral and conflict of interest.

Troubling Recent Events

Some physicians who have a financial interest in and practice medicine at physician-owned, limited-service hospitals focus on well-paying elective procedures, increase the number of these procedures they perform per day, and avoid emergency department coverage. For these physicians, profit – and not patient care – has become a strong motive for practicing medicine.

The AHA also is concerned that more than 40 physician-owned, limited-service hospitals opened and participated in Medicare during the moratorium and subsequent suspensions, even though 13 appear to have been grandfathered under the MMA. We are concerned that self-referral may have occurred in these facilities and that CMS has not scrutinized such arrangements. In a November 21, 2005 Freedom of Information Act request to CMS, the AHA asked for information on specialty hospitals which had requested advisory opinions as to the validity of their operation as a limited-service hospital during the moratorium, information on those entities that requested Medicare provider numbers and other related documentation and information. As of May 17, 2006, we are still waiting for CMS to provide the documentation.

According to local news reports from Willamette, Ore., one hospital which opened during the moratorium, Northeast Portland's Physicians' Hospital, was unable to provide critical medical attention to a post-operative patient. No physicians were present at the hospital when an 88-year old patient who had undergone back surgery that day went into cardiac and respiratory distress. Hospital staff instead called 911 – emergency services – and requested an ambulance to transport the patient to a local community hospital.

Unfortunately, the patient died as a result of delayed medical treatment for her complications. Was the patient or her family aware of just how limited the capabilities were at this hospital and that complications would require being transported to a full-service community hospital?

No matter how routine a surgical procedure may be, complications can – and do – arise. Physicians have a professional obligation to be available to their patients when these situations occur, whether it is at 3:00 p.m. or 3:00 a.m. In the case of the Oregon woman, she went into cardiac and respiratory distress just before 6 p.m. on Wednesday, July 27, 2005, yet no physicians were on site at the specialty surgery facility and none responded to pages.

Impact on Care

Mr. Chairman, the AHA and its members are concerned about the impact that these limited-service facilities will have on community health care services. The behavior of physician owners in response to financial incentives puts at risk a community hospital's ability to fully serve their communities. You and Senator Baucus recently requested examinations of these facilities and their practices from the HHS Office of Inspector General and the GAO, and how these practices affect our communities and health care system.

Through studies and evidence that the AHA has conducted and collected in communities in which a number of physician-owned, limited-service hospitals operate, we can tell you they do affect the community health care infrastructure. In general, as these facilities pull out from the community hospitals profitable services and healthier elective procedures, full-service community hospitals are challenged to:

- Continue supporting essential services that are seldom self-supporting, such as EDs, burn units, trauma care, and care for uninsured patients.
- Maintain specialty "on-call" coverage in the ED, as physician-owners of limited-service hospitals may no longer want to participate in this broader community commitment. Lack of specialty coverage in our nation's EDs can jeopardize a hospital's trauma level status and cause emergency patients to be transported much farther to access needed specialty care.
- Overcome growing inefficiencies, such as more downtime and less predictable staffing needs, that result from a higher proportion of emergency admissions at full-service hospitals. These result as physician-owners move elective admissions to their own limited-service hospitals.
- Coordinate care for patients in their community when increasing numbers are being treated for a single condition by a limited-service hospital.

So far most community hospitals have been able to sustain services, despite the financial impact of physician-owned, limited-service hospitals, but at what cost and for how long? Given full rein, physician-ownership and self-referral will erode the ability of community hospitals to recover and maintain access to essential – and for some unprofitable – services for their communities.

The solution – ban self-referral to new limited-service hospitals. Self-referral is a federal issue and Congress has acted since 1989 to limit self-referral at the federal level.

Payment changes alone are not enough. MedPAC has recommended a number of changes to the Medicare hospital inpatient prospective payment system designed to rebalance payments and remove financial incentives for physicians to target certain, more financially rewarding Medicare services. But these changes alone will not solve the problem. Even if Medicare inpatient payments were revised, it would do nothing to address non-Medicare patients, incentives for physician-owners of limited-service hospitals to steer patients to their owned facilities, to increase utilization and select the most well-insured patients and avoid Medicaid and uninsured patients.

Self-referral and conflict of interest are serious threats to our nation's health care system, and endanger the overall health of communities. We strongly urge Congress to close the loophole in the federal law by permanently banning physician self-referral to new limited-service hospitals. By doing so, Congress can help prevent conflict of interest between physician financial incentives and patient need, preserve care for everyone's emergent and urgent health care needs, and promote fair competition in today's marketplace.

Statement

For the Record

of the

American Medical Association

to the

Committee on Finance
United States Senate

Re: Physician-Owned Specialty Hospitals: Profits before Patients?

May 17, 2006

Chairman Grassley, Ranking Member Baucus, and Members of the Finance Committee, the American Medical Association (AMA) appreciates the opportunity to provide our views regarding physician-owned specialty hospitals. We commend the Committee for holding a hearing on this important issue.

Specialty hospitals offer improved, cost-effective care. They have lower infection rates, fewer medical errors, shorter turnover times, and increased cost efficiencies. Moreover, specialty hospitals encourage competition between and among health facilities, which has led to the delivery of higher quality, more efficient, and innovative health care in the communities where they are located.

The AMA strongly supports and encourages competition between and among health facilities as a means of promoting the delivery of high quality, cost-effective health care. Consistent with AMA Council on Ethical and Judicial Affairs Opinion E-8.032, we support health facility ownership and referral by physicians if they directly provide care or services at the facility. The growth in specialty hospitals is an appropriate market-based response to a mature health care delivery system and a logical response to incentives in the payment structure for certain services.

Numerous market and environmental factors have led to the increase in physicians' desire to own and operate specialty hospitals. This growth has led to concern among general hospitals that must compete with these facilities. This concern, however, is unfounded. The impact of specialty hospitals has not proven to be harmful to patients or to general hospitals. In fact, the financial impact on community hospitals in the markets where

physician-owned specialty hospitals are located has been limited. These hospitals have managed to compensate for any losses of patients and revenues and demonstrate financial performance comparable to other community hospitals.

BACKGROUND

As the Committee is aware, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) imposed an 18-month moratorium on referrals of Medicare and Medicaid patients by physician-investors in certain specialty hospitals not already in operation or under development as of November 18, 2003.[1] The MMA further required that during the moratorium, the Secretary of the Department of Health and Human Services (HHS) should develop a study of investment and referral patterns and quality of care provided by specialty hospitals, while the Medicare Payment Advisory Commission (MedPAC) should study payment issues. MedPAC, in consultation with the Government Accountability Office (GAO), and HHS submitted their findings in reports to Congress last year.[2] The reports confirmed the myriad benefits of specialty hospitals for physicians, nurses, patients, and the health care system as a whole.

Following the release of the reports, the Centers for Medicare and Medicaid Services (CMS) announced that while it was studying additional issues related to specialty hospitals, it was suspending the enrollment for specialty hospitals into Medicare. The suspension was to end on February 15, 2006. The Deficit Reduction Act, however, which was signed into law before the end of the CMS-imposed suspension, extended the suspension for an additional six months in order to allow CMS to develop a Strategic Plan relating to specialty hospitals.

SPECIALTY HOSPITAL REPORTS

The intent of Congress in enacting the initial moratorium was to determine, within a prescribed amount of time, whether additional legislative or administrative restrictions on specialty hospitals were necessary pending review of the issues by MedPAC and HHS. The studies have been overwhelmingly positive for the continued development of physician-owned specialty hospitals.

MEDPAC/GAO

MedPAC's report, which focused on the financial implications of specialty hospitals, concluded that while the majority of specialty hospitals have some physician owners, the individual physicians who have a financial interest in a specialty hospital are small investors, and that the majority of physicians who work in specialty hospitals do not have

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[1] The MMA defined specialty hospitals as those primarily or exclusively engaged in cardiac, orthopedic, surgical procedures, and any other specialized category of services designated by the Secretary.

[2] *See* U.S. General Accounting Office, *Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served*, GAO-03-683R (April 18, 2003); U.S. General Accounting Office, *Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance*, GAO-4-167 (October 22, 2003); *see also*, Medicare Payment Advisory Commission, *Physician-Owned Specialty Hospitals* (March 2005).

any ownership interest in the facility.[3] The vast majority of physicians who admit patients to specialty hospitals, therefore, receive no financial incentive whatsoever to do so. In addition, MedPAC reported that Medicare inpatient margins averaged 9.4 percent at specialty hospitals, and 8.9 percent at general hospitals—a number that hardly substantiates opponents' claim that specialized facilities "cherry pick" the most profitable patients.[4]

In addition, the MedPAC report found no conclusive data indicating financial harm to community hospitals resulting from the operation of specialty hospitals. The report states, "[t]he financial impact on community hospitals in the markets in which physician-owned specialty hospitals are located has been limited, thus far. Those community hospitals competing with specialty hospitals have demonstrated financial performance comparable to other community hospitals."[5] The report underscored this in noting that there has been "little impact on community-hospital profitability."[6] Moreover, the report states, "specialty hospitals may be an important competitive force that promotes innovation."[7]

Updates of these studies confirm that specialty hospitals have had a limited impact on competing community hospitals. The most recent GAO report, released May 8, 2006, builds upon the previous Reports from MedPAC and HHS, and confirms that general hospitals are largely unaffected by competition from specialty hospitals.[8] Specifically, the GAO report, which compared general hospitals in regional markets with a specialty hospital, to general hospitals in regional markets where there were no specialty hospitals, found that general hospitals face competition from many types of facilities, not just specialty hospitals.[9] And, there was little evidence to suggest that general hospitals made substantially more or fewer operational or service changes, or different types of changes, if some of their competition came from a specialty hospital.[10] Similarly, MedPAC's updated evaluation of specialty hospitals found that specialty hospitals do not have a statistically significant effect on the total revenue or total margins of community hospitals in their markets.[11] MedPAC's evaluation also confirmed that physician-owned specialty hospitals had shorter than expected lengths of stay for Medicare patients.[12]

HHS REPORTS

Applying criteria similar to that used by MedPAC, CMS produced a report to Congress using a study sample of 11 specialty hospitals in six markets to review patient quality-of-

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[3] GAO, *supra* note 2
[4] *See id.*
[5] MedPAC, *supra* note 2, at p. vii.
[6] *Id.* at p. 23.
[7] *Id.* at p. 43.
[8] *See* U.S. General Accounting Office, *General Hospitals: Operational and Clinical Changes Largely Unaffected by Present of Competing Specialty Hospitals*, GAO-06-50 (April 2006)
[9] *See id.*
[10] *See id.*
[11] *See* MedPAC, J. Stensland and J. Pettengill, *Physician-Owned Specialty Hospitals Revisited* (Presentation Slides), (April 19, 2006).
[12] *See id.*

care issues.[13] Rather than finding harm, CMS Administrator Dr. Mark McClellan testified to findings of high quality of care at specialty hospitals when he presented his agency's report. Specifically, he noted, "specialty hospitals generally provide a more uniform set of services and have fewer competing pressures than community hospitals and thus are able to provide more predictable scheduling and patient care."[14] The CMS report also found fewer complications and lower mortality rates at cardiac hospitals, even when adjusted for severity, and noted that, "cardiac hospitals delivered high quality of care that was as good as or better than their competitor hospitals."[15] As for surgical and orthopaedic hospitals, CMS found that patient satisfaction was extremely high.[16]

In addition, pursuant to a contract with CMS, RTI International produced a comprehensive report published in the journal, *Health Affairs,* which dealt with four policy issues related to specialty hospitals.[17] RTI focused on the following issues: whether specialty hospitals enjoy an "unfair" competitive advantage in their markets driven by the incentive of physician-ownership; whether physician-ownership results in favorable referral patterns to specialty hospitals; how specialty hospital care and patient satisfaction compare to local community hospitals; and whether specialty hospitals bear an equal burden in providing community benefits compared with community hospitals.[18]

The researchers found that specialty hospitals stimulate a competitive environment in many markets, which could have positive effects on quality of care. With regard to referral patterns, they found that while physician owners often refer patients to their own facilities, many do so for reasons not related to profits. Concerning hospital care and patient satisfaction, the study found that specialty hospitals generally provide high-quality care "to satisfied patients." Finally, the study concluded that while specialty facilities provide less uncompensated care, they contribute substantial tax revenues, contrary to the notion that these facilities are simply a drain on community resources. In fact, they reported that the "total proportion of net revenue that specialty hospitals devoted to uncompensated care and taxes combined exceeded the proportion of net revenues that community hospitals devoted to uncompensated care."[19]

Finally, CMS, in its May 8, 2006, report to Congress, found that physician investors in specialty hospitals typically refer patients to community hospitals and specialty hospitals accept referrals from non-investor physicians.[20] In addition, CMS noted that by focusing

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[13] CMS, *Centers for Medicare & Medicaid Services Study of Physician-owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003*, (May 2005).

[14] Mark McClellan, M.D., Administrator, Centers for Medicare & Medicaid Services (CMS), in testimony before the House Committee on Energy and Commerce, May 12, 2005 – http://www.cms.hhs.gov/media/press/testimony.asp?Counter+1459.

[15] CMS, *supra* note 13, at p.5.

[16] CMS, *supra* note 13.

[17] RTI International, Specialty *Versus Community Hospitals: Referrals, Quality, and Community Benefits*, Health Affairs 25, no. 1 (2006): 106-118 (January/February 2006).

[18] *See id.*

[19] *See id.*

[20] CMS, *Strategic Plan Regarding Physician Investment in Specialty Hospitals Section 5006 of the Deficit Reduction Act Interim Report*, (May 8, 2006).

on certain types of cases, specialty hospitals have the potential to increase the quality of care and to provide care (including surgical procedures) in a more efficient manner.[21] All of the recent studies regarding specialty hospitals have consistently found that specialty hospitals represent a desirable, alternative form of care for many Medicare patients and are in many respects an asset to the communities they serve.

THERE IS NO EVIDENCE THAT PHYSICIAN REFERRALS TO SPECIALTY HOSPITALS ARE FINANCIALLY MOTIVATED

The studies completed by MedPAC and HHS provide no support for claims that physician referrals to specialty hospitals are financially motivated or inappropriate. The comprehensive studies performed to date demonstrate that the majority of physicians who admit patients to specialty hospitals have no ownership interest and thus receive no financial incentives to refer patients to them. In fact, the GAO found that while almost 70 percent of specialty hospitals have some physician owners, individual physicians who have financial interests in specialty hospitals are small investors—the average investment amounting to less than two percent. In addition, overall, approximately 73 percent of physicians with admitting privileges at specialty hospitals were not investors in these hospitals.[22]

The congressionally mandated studies also found that physicians refer patients to specialty hospitals for myriad reasons unrelated to financial gain. The RTI International study found that physicians refer to specialty hospitals for reasons such as insurance contracts, patient preferences, scheduling of procedures, and the location of the hospital relative to physician offices.

Finally, there is no evidence that physician ownership and referrals to specialty hospitals leads to inappropriate utilization. MedPAC found no evidence that overall utilization rates in communities with specialty hospitals rose more rapidly than utilization in other communities.[23] In addition, HHS found no evidence that physicians who have an ownership interest in a specialty hospital inappropriately refer patients to that hospital or have increased utilization.[24] In fact, data shows no difference in referral patterns between physician owners and non-owners.[25] Thus, physicians are not improperly referring patients to specialty hospitals for financial gain.

SPECIALTY HOSPITALS ARE NOT HARMFUL TO COMMUNITY HOSPITALS AND THEY CONTRIBUTE SIGNIFICANTLY TO THE COSTS OF CHARITY CARE

The cumulative evidence garnered from the studies performed by MedPAC and CMS prove that general hospitals are not suffering financially as a result of the growth of physician-owned specialty hospitals. In fact, MedPAC found that the financial impact on

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[21] *See id.*
[22] *See id.*
[23] MedPAC, *supra* note 2.
[24] CMS, *supra* note 13.
[25] *See id.*

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. MedPAC also found that specialty hospitals are an attractive alternative for patients and their families. [26]

Previous analysis has indicated that specialty hospitals may treat fewer Medicaid patients than general hospitals. This is due in large part, however, to the fact that specialty hospitals typically do not provide the services most often utilized by Medicaid patients. A significant proportion of Medicaid spending is budgeted to services such as perinatal, neonatal, pediatric, and primary care. Almost three-quarters of the recipients of Medicaid are low-income women and children, and Medicaid covers more than 40 percent of all childbirths in the United States. These services, however, are generally not provided by surgical and cardiac hospitals. Rather than simply comparing specialty hospitals and community hospitals based upon the shear number of Medicaid patients treated or the amount of Medicaid revenue collected, any review of Medicaid services provided by specialty hospitals should consider this critical distinction.

In addition, the number of Medicaid patients receiving care at specialty hospitals is significantly impacted by the states' increasing tendency to utilize managed care plans and selective contracting for the provision of health care services for the Medicaid population. In fact, between 1991 and 2003, the percentage of Medicaid enrollees covered by managed care programs increased from 10 percent to 59 percent, and according to CMS, the number continues to grow. As states have gained experience with managed care for Medicaid beneficiaries, they have also increasingly turned to selective contracting and competitive bidding. In selective contracting, states contract with a limited number of providers to supply certain agreed upon services for Medicaid beneficiaries at prospectively agreed upon rates. Rates are typically set through a competitive bidding process, whereby states require providers or plans to submit bids and compete with one another to offer services. States then award contracts to those hospitals that offer the lowest priced service arrangements, and Medicaid beneficiaries are required to seek treatment only at those facilities.

Both of these practices significantly restrict the ability of specialty hospitals to provide services to the Medicaid population. Unlike general hospitals, specialty hospitals typically are not involved in the bidding process for Medicaid service contracts, and are therefore prohibited from treating Medicaid patients covered under a selective contract. Likewise, Medicaid Health Maintenance Organizations (HMOs) typically do not contract with specialty hospitals, often because HMOs are owned by general hospitals or general hospitals refuse to participate in managed care plans that contract with specialty hospitals. Failure to recognize and consider the effect of these contractual relationships on specialty hospitals' ability to provide services to the Medicaid population paints an incomplete and skewed picture.

Furthermore, specialty hospitals benefit their communities through charity care and tax expenditures. As noted above, the CMS study concluded that the total proportion of net

[26] MedPAC, *supra* note 2.

revenue that specialty hospitals devote to both uncompensated care and taxes "significantly exceeds" the proportion of net revenues general hospitals devote to uncompensated care.27 Nonprofit hospitals, on the other hand, are exempt from federal and state income taxes, local property taxes, and have access to tax-exempt financing. In addition, most nonprofit hospitals receive Medicare and Medicaid Disproportionate Share Hospital (DSH) payments to help defray the costs of uncompensated care.

PHYSICIAN INVESTMENT IN SPECIALTY HOSPITALS IS ETHICAL, LEGAL, AND APPROPRIATE

It is ethically and legally permissible 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 whereby 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 when 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 physician has 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.[28]

In addition to ethical policy, physician self-referral laws permit physician ownership of treatment facilities and referrals to such facilities under various circumstances.[29] The physician self-referral law, the "Stark law," permits physician ownership of a hospital, and referral of patients to that 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." Although this whole hospital exception has been referred to as a "loophole," such allegations are unsupportable and misleading.

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 the beginning to the end of a course of treatment including specialty and sub-specialty physician services. In fact, a significant number of specialty hospitals also provide primary care, intensive care, and emergency services.

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[27] CMS, *supra* note 13.

[28] The hospital associations have distorted AMA ethical opinion E-8.032 by claming that it prohibits physicians' referrals to facilities in which they have an ownership interest unless there is a demonstrated need in the community. 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.

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

The protection of referrals to an entire hospital, and not just a "subdivision of a hospital," originally included in Stark I, was intended to prevent circumvention of the ban on referrals of laboratory services. When Stark II was enacted, Congress expanded the ban on physician referrals from clinical laboratory services to an entire list of ancillary services referred to as "designated health services." These designated health services are ancillary services, not physician services. Thus, Congress clearly intended the Stark laws to prevent referrals for ancillary services, not professional services performed by a physician.

In addition to addressing alleged problems related to the referral of ancillary services, the Stark laws also prohibit referrals to locations where the referring physician is not directly involved in the care of the patient. Under the Stark laws, referrals to physician-owned facilities are permissible only when the referring physician personally performs the service, or when the service is performed or supervised by another physician in the referring physician's group practice, in the same building where the referring physician regularly practices, or in a centralized building used by the referring physician for some or all of the designated health services performed by the group practice. The Stark laws provide adequate restrictions on physician investment in specialty hospitals prohibiting physicians from making referrals to facilities where they do not practice and at which only ancillary services are provided.

The Stark laws were intended to prohibit referrals only where studies demonstrated increased or inappropriate utilization of such services by physician-owners. There is no evidence of increased utilization of hospital services resulting from physician referrals. Similarly, HHS found no evidence that physicians who have an ownership interest in a specialty hospital inappropriately refer patients to that hospital or have increased utilization. Thus, there is no rationale, other than to stifle competition, for enacting additional enforcement measures aimed at specialty hospitals.

Permitting physicians to own specialty hospitals and refer patients to them is consistent with Congress' intent—to permit physician investments in facilities where the physician-investors provide care. Specialty hospitals are entire hospitals; they do not provide only ancillary services, and physicians who invest in them not only refer their patients to them, but also treat their patients there.

The AMA believes that any additional enforcement efforts should be focused on prohibiting general hospitals from engaging in inappropriate self-referral practices. Such practices include 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 physicians or other licensed independent practitioners that have an indirect or direct financial investment in a competing entity, thereby requiring referrals and channeling patients to their facilities. Such actions restrict a physician's ability to provide health care based on his or her professional judgment and the patient's best interest. This harms not only individual patients, but federal health care programs and the health care marketplace as a whole.

CONCLUSION

There is substantial and conclusive evidence that physicians are not inappropriately referring patients to specialty hospitals and that general hospitals are not suffering as a result of the growth of physician-owned specialty hospitals. The studies completed to date conclusively establish that specialty hospitals increase competition in the hospital industry and provide patients with higher satisfaction and more choice—forcing existing hospitals to innovate to stay competitive. Thus, the AMA believes that patients will be better served if Congress does not act to extend the moratorium on physician referrals to specialty hospitals in which they have an ownership interest.

We urge the Committee and Senate to consider the recommendations we have discussed today. We are happy to work with the Committee as it considers these important matters.

Statement for the Record

Physician-Owned Specialty Hospitals: Profits before Patients?

May 17, 2006

The Council of State Governments
2760 Research Park Drive
P.O. Box 11910
Lexington, KY 40578

THE COUNCIL OF STATE GOVERNMENTS RESOLUTION ON SPECIALTY HOSPITALS

Resolution Summary

The Medicare Payment Advisory Commission (MedPAC) is an independent federal body established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program. The Commission's statutory mandate is to advise the Congress on payments to private health plans participating in Medicare and providers in Medicare's traditional fee-for-service program, and to analyze access to care, quality of care and other issues affecting Medicare.

The Congress, in the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) 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, also known as specialty hospitals. Specifically, the law imposed an 18-month moratorium, which expired on June 8, 2005, during which physician-investors in new specialty hospitals could not refer Medicare or Medicaid patients to those hospitals, thereby effectively halting the development of new specialty hospitals. MedPAC was charged with analyzing the possible fiscal consequences of physician-owned specialty hospitals for existing community hospitals, Medicare beneficiaries, and Medicare payments.

Last summer, CMS again temporarily suspended enrollment of new specialty hospitals while the agency reviewed its procedures for enrollment. On February 8, 2006, President Bush signed the Deficit Reduction Act of 2005 (DRA) into law. A number of DRA provisions were effective January 1, 2006. The DRA continues that suspension until the earlier of six months after enactment or CMS's release of a final report on specialty hospitals required by the DRA. The DRA directs CMS to develop a strategic and implementation plan addressing these hospitals' proportionality of investment return; whether the investment is a bona fide investment; and whether the Secretary should require annual disclosure of investment information. In addition, the DRA requires the Secretary to consider the provision by specialty hospitals of care to: (a) Medicaid patients; (b) patients receiving medical assistance under a State demonstration project

approved under title XI of the Act; and (c) patients receiving charity care. The DRA also requires the strategic and implementing plan to address the issue of appropriate enforcement. The DRA requires an interim report within three months and a final report within six months.

Additional Resource Information

The Medicare Payment Advisory Commission – www.medpac.gov

Centers for Medicare and Medicaid Services – www.cms.hhs.gov

Management Directives

- **Management Directive #1:** Support the extension of the moratorium on the expansion of specialty hospitals so that state legislatures can study the issue in more detail and explore possible legislative initiatives to address the specialty hospital concerns such as state licensure laws and the definition of a hospital.

- **Management Directive #2:** CSG staff will post approved resolution on CSG's web site and make available through its regular communication venues at the state and local level to ensure its distribution to the state government and policy community.

THE COUNCIL OF STATE GOVERNMENTS
Resolution on Specialty Hospitals

WHEREAS, the issue of physician ownership of specialty hospitals continues to be an issue of interest and concern in many states across the country;

WHEREAS, many states continue to see increasing growth in the number of these facilities even though numerous independent studies indicate that specialty hospitals encourage over utilization of medical services and treat limited numbers of Medicaid and uninsured patients and thereby threatening the safety net provided by community hospitals;

WHEREAS, many states considered the issue of specialty hospitals during the 2005 and 2006 legislative sessions and concluded that state legislatures need to study the issue in more detail, including possible changes to state licensure laws and to the definition of a hospital;

WHEREAS, Congress has recognized these concerns and included provisions in the recently passed Deficit Reduction Act of 2005 (DRA), requiring the Secretary of the Department of Health and Human Services (HHS) to develop a "strategic and implementing plan" to address physician ownership of specialty hospitals as defined under the physician self referral law;

WHEREAS, the DRA also instructs CMS to temporarily suspended enrollment of new specialty hospitals for a period of six months effective January 1, 2006, while HHS completes it's strategic and implementing plan;

BE IT THEREFORE RESOLVED, that The Council of State Governments encourages the Department of Health and Human Services to conduct a thorough and complete analysis of the physician owned specialty hospital issue and to provide appropriate rules, regulations, and legislative guidance to eliminate any unfair competitive advantage that physician referrals may have and ensure that all health care providers provide appropriate support to State Medicaid programs and participate in appropriate emergency services networks.

Adopted this 10th Day of May, 2006 at the
CSG Spring National Committee and Task Force Meetings
In White Sulphur Springs, West Virginia

Governor Jim Douglas
2006 CSG President

Senate President Earl Ray Tomblin
2006 CSG Chair

UNITED STATES SENATE

COMMITTEE ON FINANCE

"PHYSICIAN-OWNED SPECIALTY HOSPITALS: PROFITS BEFORE PATIENTS?"
MAY 17, 2006

STATEMENT FOR THE RECORD OF

O. EDWIN FRENCH
PRESIDENT AND CHIEF EXECUTIVE OFFICER

MEDCATH CORPORATION
1720 SIKES PLACE, SUITE 300
CHARLOTTE, NORTH CAROLINA 28277

MAY 31, 2006

INTRODUCTION

My name is Ed French. I currently serve as President and Chief Executive Officer for MedCath Corporation (MedCath). Thank you for the opportunity to submit this statement on behalf of our company, our physician partners, our nurses, our professional staff, and the patients who have utilized MedCath's hospitals.

Based in Charlotte, North Carolina, MedCath is a national provider of cardiovascular services. We build and operate fully-licensed acute care hospitals, and other clinics and centers focusing on cardiovascular care. All of our 12 hospitals are owned in partnership with physicians and, in certain instances, local community hospitals. We also have entered into alliances with community hospitals to enhance the provision of cardiovascular services in their communities.

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

THE BENEFITS OF PHYSICIAN-OWNED SPECIALTY HOSPITALS HAVE BEEN CONFIRMED BY SEVERAL COMPREHENSIVE STUDIES

A wide array of federal agencies and related entities have examined physician-owned specialty hospitals including the Federal Trade Commission (FTC), Department of Justice (DOJ), the Medicare Payment Advisory Commission (MedPAC), and the Centers for Medicare & Medicaid Services (CMS). While the reports and studies produced by these entities have noted certain differences between physician-owned specialty hospitals and community hospitals, each has concluded that specialty hospitals offer considerable benefits to the communities they serve. These benefits include: (1) spurring competition in the hospital industry resulting in lower costs, improved quality, and increased efficiency; (2) better patient outcomes; (3) increased patient satisfaction; and (4) providing a greater level of "net community benefits" than competitor hospitals.

FTC and DOJ Report

In July 2004, the FTJ and DOJ antitrust division released its report on improving health care in the United States.[1] Hardly a rush to judgment, the report was developed over a two-year period from 6,000 pages of transcripts, over 27 days of joint hearings and workshops, and from the testimony of more than 250 panelists – including many hospital and health system executives, and association leaders. The report calls for vigorous competition in the health-care marketplace and elimination of protectionist policies that prevent consumers from gaining access to high-quality health care. Specifically, the report found that "[e]ntry by single specialty hospitals [into the marketplace] has had a number of beneficial consequences for consumers who receive care from these providers."[2] Competitive pressure from specialty hospitals encourages community

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[1] FTC & DOJ, *Improving Health Care: A Dose of Competition* (July 2004).

[2] *Id.* p.27.

hospitals to lower costs, improve quality, and operate more efficiently – all benefits to health care consumers and the entire community.

MedPAC Report and Update

While competition is not always welcomed, regardless of the industry, the communities where MedCath hospitals are located have benefited significantly from our competitive presence. In March 2005, MedPAC released its report on physician-owned specialty hospitals as mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).[3] In its report, MedPAC found that specialty hospitals often serve as a "wake-up call" for the traditional acute care hospitals in a community to improve services and efficiencies.

Specifically, MedPAC found that specialty hospitals focus community hospitals on the issues of hospital operations and physician relations. Community hospitals in these markets have made constructive improvements, including extended service hours, improved operating room scheduling, standardization of supplies in the operating room, and upgraded equipment. All this is evidence that community hospitals are responding to the new competitive pressures from specialty hospitals in a way that benefits doctors, patients, and the entire community.

Importantly, the MedPAC report found that the financial impact on community hospitals in the markets where physician-owned specialty hospitals are located has been minimal. One reason for this is that community hospitals have been able to either increase efficiency and reduce cost, or expand into other revenue sources. MedPAC found, for example, that community hospitals with a heart hospital in their market actually had a higher profit margin (3.4 percent) in 2002 than community hospitals without a heart hospital (2.7 percent) in their market. This is a critical point that we think is important for Congress to recognize.

In April 2006, during a public meeting, MedPAC provided updated results of its continuing study of physician-owned specialty hospitals.[4] First, MedPAC confirmed the results of its 2005 report and stated that the introduction of physician-owned specialty hospitals has had a minimal impact upon community hospitals. Further, MedPAC's chairman noted his personal bias for greater competition. The chairman then argued that there should be a "really convincing"[5] case that specialty hospitals are harmful before there is any outright specialty hospital prohibition, and that such a case has net yet been made.

Second, MedPAC noted that any increases in cardiac surgeries likely were attributable to the greater surgical capacity provided by a new specialty heart hospital in a market, rather than any financial incentives inherent with physician-owned specialty hospitals.

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[3] MedPAC, *Report to the Congress: Physician-Owned Specialty Hospitals* (Mar. 2005).

[4] MedPAC, *Public Meeting Transcript* pp. 104-53 (Apr. 19, 2006).

[5] *Id.* p.134.

CMS Study

In May 2005, CMS released its study of physician-owned specialty hospitals as required by the MMA.[6] As part of its study, CMS was required to compare physician-owned specialty hospitals with local full-service community hospitals in terms of both the quality of care furnished and patient satisfaction with such care. In both of these categories, specialty hospitals out-performed community hospitals.

Generally, CMS found that because of their small size and focused-services, specialty hospitals (1) are better able to plan admissions and needed staffing as compared to competitor hospitals and (2) rarely face overworked staff handling emergency admissions. "As a result, the atmosphere in specialty hospitals tends to be 'calmer' and 'more friendly' to patients."

In terms of quality of care, CMS examined several areas including mortality, complications during hospitalization, and readmissions. In each of these areas, specialty hospitals performed better, and in some cases markedly better, than community hospitals. The CMS study cited several unique features of physician-owned specialty hospitals which influence their delivery of high-quality care including: (1) specialization; (2) high nurse staffing ratios and expertise; (3) patient amenities; (4) focused patient communication and education; (5) emphasis on quality monitoring; and (6) involvement of physician-owners.

Additionally, CMS found that specialty hospital patients were extremely satisfied with their experience in terms of both the hospital environment and clinical care. With respect to clinical care in particular, specialty hospital patients noted that nurses in these hospitals were more attentive, available, and experienced as compared to community hospitals.

Lastly, specialty hospitals are organized as for-profit entities and, therefore, pay sales tax, personal property tax, and real estate/real property taxes, whereas not-for-profit hospitals do not. Moreover, owners of specialty hospitals pay state and federal income tax on their share of income, if any. The study concluded that even including the uncompensated care provided by competitor hospitals, physician-owned specialty hospitals still provide a greater level of net benefit to the communities they serve.

PHYSICIAN OWNERSHIP AND INVOLVEMENT IN MEDCATH'S HOSPITALS IS A KEY CONTRIBUTOR TO HIGHER QUALITY OUTCOMES, IMPROVED EFFICIENCY, AND PHYSICIAN RECRUITMENT AND RETENTION

The findings of the MedPAC and CMS reports have been confirmed by MedCath's experience in its physician-owned specialty hospitals. Specifically, MedCath's physician partnership model has resulted in lower costs, improved quality, increased efficiency, better patient outcomes, and increased patient satisfaction.

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[6] CMS, *Study of Physician-Owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (May 2005).

MedCath Recruits and Partners With Highly Regarded Physicians

MedCath partners with local physicians who have established reputations for clinical excellence. These physicians become owners in MedCath hospitals because of dissatisfaction with the quality of care, efficiency, and bureaucracy of their local hospitals, and to have any opportunity to make dramatic improvements in the delivery of health care. With ownership in the MedCath facility and a significant role in the governance and operation of the hospital, our physician partners are motivated to design and operate highly efficient care delivery systems that have a direct, positive impact on patient care. This increased control over clinical protocols and the quality of care process naturally motivates physicians to send their patients to these facilities – where they have confidence in the care provided.

The involvement of our physician partners in the governance and operations of our hospitals is a critical factor that contributes to quality patient care and is a logical by-product of their status as owners and board members. Through private placements or confidential offerings, MedCath only recruits physicians committed to the Company's objective of being a quality, cost-efficient provider of cardiovascular services.

All our physician-investors must assume substantial financial risk, and accountability for the hospital and the care provided. Our physician partners typically invest, on average, approximately $50,000, and in many instances invest more than $100,000. Importantly, these contributions are not financed by either MedCath or the hospital.

The hospitals are high-risk ventures where it usually takes 18-24 months to build a hospital. As startup businesses, all of our hospitals experience significant early stage losses, and there is no assurance they will subsequently be able to turn profitable.

For some of our physicians, this has led to a financial return on their investment. For others, it has led to no financial benefit and in the case of one of our hospitals, which we had to close due to the anti-competitive tactics of the surrounding general hospitals, a loss of almost all of their investment. We also believe that ownership causes physicians to have a greater incentive to self-police their peers – ensuring their use of the facility is appropriate.

MedCath's Physician Partners Maintain Their Ownership Because of Our Quality Outcomes and Improved Efficiency

We believe this alignment of interest between the physicians and the hospital operator is a primary reason MedCath hospitals have been able to improve the quality of care, reduce the average length of stay, save money to government payors, and achieve high levels of patient satisfaction.[7] MedCath has found that the economic commitment of physicians, under a physician ownership model, is in the best interest of the communities served and has resulted in the provision of a higher level of care and cost efficiencies.

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

The independent Lewin Group has confirmed that:

- MedCath hospitals provided **better care on average** (as measured by lower in-hospital mortality rates and lower rates of complications) **in a shorter period of time** than the peer community hospitals.

- After adjusting for risk of mortality, MedCath heart hospitals on average exhibited a **16 percent lower in-hospital mortality rate** for Medicare cardiac cases compared to the peer community hospitals, including major teaching facilities.

- MedCath heart hospitals also had **shorter average lengths of stay** for cardiac cases (3.81 days) than the peer community hospitals (4.88 days) after adjusting for severity.

- **Approximately 90% of our patients are discharged home** instead of being discharged to a subacute care facility, home health agency, or skilled nursing facility. Not only is this better for the patient, the Lewin Group also estimates it saves Medicare approximately $1.5 million per facility per year.

Indeed, the Lewin Group reported that MedCath's eight hospitals that were open in 2002 on average saved Medicare between $12.2 million and $15.2 million per year. This is an average of $1.5 million to $1.9 million per hospital, a result from our hospitals' ability to discharge more patients to their homes versus to sub-acute care facilities or skilled nursing facilities.[8] Imagine the billions of dollars that the national healthcare system could save if the higher quality of care and lower cost structure that our hospitals have achieved could be replicated by other hospitals.

Given the above, our physician-partners typically retain their interest in our hospitals. Importantly, under our model, there is no absolute restriction on the transferability of ownership interest. While we seek to retain all our physician partners, we do not create a mechanism whereby physicians are obligated to remain owners in our hospitals.

MedCath's Experience Confirms that Specialty Hospitals do not Adversely Impact Profitability and Utilization

Our own independent studies confirm MedPAC's significant finding that specialty hospitals have "little impact" on the profitability of community hospitals. Indeed, there is no statistically significant increase in utilization after the entry of a specialty heart hospital into a market.[9] In our opinion, many of the markets where we have hospitals were significantly under served prior to our entry into the community and that we met a much-needed demand, thus bringing the market up to parity with other markets. We believe that this unfulfilled need that our hospitals have met has had a very positive impact in the communities where we are located.

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

[9] The Lewin Group, *Impact of MedCath Heart Hospitals on MSA Cardiology Inpatient Utilization Rates* (Aug. 2001).

MEDCATH'S HOSPITALS ARE ACCREDITED, AND DEDICATED TO MAINTAINING PATIENT SAFETY AND QUALITY OF CARE TO ALL PATIENTS

All but one of our 12 hospitals (because of unique state licensure requirements) are licensed as general acute care facilities in the states where they operate. Our hospitals hold all federal, state, and local licenses, and all accreditations (including accreditation from the Joint Commission on Accreditation of Healthcare Organizations) and certifications required of or beneficial to institutional providers of health care services.

Moreover, MedCath maintains a Code of Ethics and vigorous compliance program. MedCath has designated compliance officers in the parent corporation and individual hospitals, established a toll-free compliance line, implemented various compliance training programs, and developed a process for screening all employees through applicable federal and state databases. There is an established reporting system, auditing and monitoring programs, and a disciplinary system to enforce the Code of Ethics and other compliance policies. Auditing and monitoring activities include claims preparation and submission, coding, billing, cost reporting, and financial arrangements with physicians and other referral sources.

It is important to note that given their licensure as general acute care facilities, our hospitals are required by law to treat patients regardless of their ability to pay.[10] While this is the law, MedCath also believes it is a community responsibility to treat anyone who walks in our doors and requires medical care.

In fact, a Lewin Group study found that in all four markets where comparable data was available, MedCath hospitals ranked in the top half of area hospitals for the volume of cardiac care provided to indigent patients.[11] Approximately 75-85% of the self-pay/uninsured care is provided without compensation. Despite this large amount of uncompensated care, our hospitals and their services are available to all patients in need of cardiovascular care.

JOINT VENTURES WITH SPECIALTY HOSPITALS ARE BEING EMBRACED BY NOT-FOR-PROFIT HEALTH SYSTEMS AND COMMUNITY HOSPITALS

A growing number of not-for-profit healthcare systems and community hospitals around the country have embraced the concept of physician ownership and/or MedCath's expertise as a means to improve the quality of care and cost effectiveness within their own health systems. Indeed, community hospitals seeking to improve their cardiac care programs have actively engaged MedCath in several different ways.

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

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

Partnerships Among Community Hospitals/Health Systems, MedCath, and Physicians

First, two of MedCath's most successful hospitals are three-way partnerships among a community hospital or health system, MedCath, and local physicians. In March 2001, Avera McKennan, MedCath, and local physicians built and opened the Avera Heart Hospital of South Dakota (Avera Hospital). This hospital is currently delivering high-quality cardiovascular care to patients of South Dakota and surrounding states.

In fact, in October 2005, MedCath's Avera Hospital was ranked among the top 5 percent of hospitals nationally for overall cardiac care, cardiac interventions, and cardiology according to a study release by HealthGrades, the nation's leading providing of independent hospital ratings. The same study also ranked Avera Hospital as first in South Dakota for overall cardiac care, cardiac interventions, and cardiology.

In January 2006, Avera Hospital received HealthGrades' "Cardiac Care Excellence Award." Avera Hospital was the only hospital in the tri-state region of South Dakota, Iowa, and Nebraska to receive the award. This recognition is based upon HealthGrades' annual analysis of more than 37 million Medicare patient discharges at nearly every hospital in the country.

Second, our Tucson Heart Hospital is a joint venture among Carondelet Health Network, MedCath, and local physicians in Tucson, Arizona. Much the same as Avera Hospital, this hospital is currently delivering high-quality cardiovascular care to patients of Arizona and surrounding states.

Alliances Between Community Hospitals/Health Systems and MedCath

In other instances, community hospitals have sought out MedCath's expertise by entering into management agreements whereby MedCath provides sophisticated management and consulting services focused on the cardiac programs of the community hospitals. MedCath also assists in the design and development of new cardiac facilities, such as new heart institutes. These community hospitals desire to obtain the benefit of the "best practices" MedCath and it physician partners have developed in their specialty heart hospitals.

For example, in June 2005, MedCath and Benefis Healthcare of Great Falls, Montana (Benefis) entered into a strategic alliance to grow and enhance Benefis' cardiovascular services. Under the agreement, MedCath manages Benefis' existing cardiovascular services and coordinates recruiting activities to increase the number of cardiologists in the Great Falls market to better meet the need for cardiovascular services in the region. MedCath and Benefis also have begun work on the design and development of a new tower that will include a new heart hospital to be managed by MedCath. The President and Chief Executive Officer of Benefis has stated that "[o]ur new partnership with MedCath will help us to further improve heart services for our community and region. MedCath has demonstrated that it knows how to provide superior clinical results in cardiovascular care."

In another example, MedCath and Methodist Medical Center of Illinois, a 353-bed hospital system in Peoria, Illinois (Methodist) have entered into a business alliance. Under the terms of this alliance, MedCath manages Methodist's existing cardiovascular program. Additionally, MedCath and Methodist are jointly working to identify, develop, and implement specific

strategies to expand and enhance Methodist's cardiovascular services. These strategies may include various joint venture and clinical initiatives. The parties also intend to explore the development of a heart tower that will be a dedicated heart facility to be managed by MedCath.

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

CONCLUSION

In conclusion, the advantages of competition to the health care sector provided by specialty hospitals are both undeniable and essential to meeting the growing demand for cardiovascular services as a result of the aging Baby Boomer population. As reported by FTC, DOJ, MedPAC and CMS, and confirmed by MedCath's experience, specialty hospital provide a benefit to the communities they serve. From improving quality and improving efficiency, to increasing patient satisfaction and making significant tax contributions, specialty hospitals are a valuable part of the health care delivery system. We believe the MedCath hospital model is a innovative model that is consistent with these goals.

In fact, not-for-profit health systems have embraced the concept of physician ownership. Moreover, community hospitals have recognized the expertise of MedCath and have entered into alliances to enhance the provision of cardiovascular services in their communities. As stated by former Secretary of Health and Human Services, Tommy G. Thompson, in a letter for the groundbreaking of the Heart Hospital of Milwaukee:

> This is the sort of public-private partnership, combining the resources of government with the innovation of the business world, that makes America great. In teaming together to find new ways to serve your fellow Americans, you truly have shown yourselves to be foot soldiers in what our President called "the armies of compassion." It's something to be proud of.

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