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

HEARING

BEFORE THE

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

TUESDAY, MARCH 8, 2005

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

The hearing was convened, pursuant to notice, at 10:17 a.m., in room SD–628, Dirksen Senate Office Building, Hon. Charles E. Grassley (chairman of the committee) presiding.

Also present: Senators Kyl, Thomas, Baucus, Lincoln, and Wyden.

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

The CHAIRMAN. As you all know, Congress placed a moratorium on the development of physician-owned specialty hospitals for 18 months, and that ends June 8th this year.

This moratorium was for a number of reasons. First, there were concerns about the rapid growth of these facilities. Second, there were concerns about physician self-referral. Third, there were thoughts that these specialized hospitals might be an unfair form of competition to the existing system of hospitals. In all of this was a concern about the impact that these hospitals are having on the health care system as a whole.

Now, specialty hospitals have existed for quite some time. There are children's hospitals and there are psychiatric facilities. But these are not really what the moratorium is all about. We are talking about the emergence of a new type of hospital. These new facilities are mostly for-profit, they are mainly owned by physicians, and they only treat very specific conditions, like cardiac, orthopedic, or surgical care.

These physician-owned specialty hospitals have more than tripled in number in the past 5 or 6 years. While there are still only a small number of about 100, they are growing quickly.

They are also mainly located in certain pockets of the country. Basically, they are located in those States without certificate of need, or where hospitals do not need to get State approval to build new facilities.

Now, these specialty hospitals have certain advantages. Because they see one type of patient, they might be able to increase their efficiency, lower their costs, and improve quality of care.

Also, patients like to go there because the facilities are often new, with great amenities. This can be everything from easier parking to certain types of meals. And also, perhaps more importantly, physicians like to work there because they have a greater say in the hospital's operations. They have more control over patient scheduling and purchasing of equipment.

However, others have said that these new hospitals are problematic. This is because doctors who refer patients to these places have a financial conflict of interest.

Not only do the physicians get a fee through Medicare for performing surgery on the patients, but they also get a fee for use of hospitals which they might own, and they get a share of the hospital profit as well. So, the more profitable, the more money that they make.

There is concern that this interest in profit, the bottom line, may lead physicians to actually steer patients. That is, physicians choose where to send the patient based on his condition or based on insurance, or based on whether or not they think that the patient will profit their hospital.

The Government Accountability Office has found that specialty hospitals are less likely to have emergency rooms, and has found that they treat fewer Medicaid patients, and few, if any, uninsured patients. You know that there are now 45 million uninsured, and that is a concern if we have facilities that do not help take care of the needs of those who are uninsured.

Now Congress, with very few exceptions, does not allow physicians to refer Medicaid and Medicare patients to facilities in which they are owners. One of these exceptions is the whole-hospital exception, which I think we will hear about during this hearing.

Obviously, we are interested in what MedPAC has found and what those testifying here today have to say. I want to take a moment and thank MedPAC for their hard work on this report. I know that Congress threw a lot of work at them, and they have done a great job.

My colleague, Senator Baucus, and I are in the process of drafting bipartisan legislation on specialty hospitals. This hearing will provide us an opportunity to learn more about this very important issue, beyond the statements that we are making here.

I know a number of my colleagues are also engaged in this topic, and I anticipate there will be a number of questions. I look forward to hearing your thoughtful responses.

Now it is time for Senator Baucus.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Thank you very much, Mr. Chairman. I deeply appreciate you holding this hearing. It is a very important one. It has generated a lot of interest. In fact, it is kind of hard to believe that the Medicare Modernization Act, the so-called MMA, was signed into law just 15 months ago today.

It is also a little bit hard to believe—in fact, it is a little strange—that the specialty hospital issue, at that time, was the most difficult one to resolve in this 400-page bill, and here we are again today, still attempting to resolve it.

Some view specialty hospitals as innovative, as focused factories for high-quality, specialized care. Advocates say specialty hospitals add competition to the health care marketplace.

Others say specialty hospitals flourish because they exploit a Medicare loophole, allowing physician owners to select patients who are less sick, and therefore more profitable.

For my part, I do not want to stand in the way of innovation or competition. For example, I am glad that the Congress brought innovation to Medicare in the form of outpatient drug benefits. That was long overdue.

And hospitals and physicians should work together in innovative ways to improve efficiency in health care. The United States spends twice as much per capita on health care as the majority of advanced western countries, and yet our health outcomes are probably not twice as good. We should get a better bang for our buck.

That is why I want to encourage quality and accountability in health care. I am pushing to advance incentives for quality improvement in Medicare, so patients and taxpayers get the most for the money.

As for competition, I am all for it, as long as it is carried out on a level playing field. But when it comes to physician ownership of specialty hospitals, I am not so sure that the playing field is level. That is because physicians alone choose where patients go on the playing field, either to community hospitals or to specialty hospitals.

Some liken physician owners of specialty hospitals to coaches who choose the starting line-up for both teams, in this case, the specialty hospital team and the community hospital team.

And, for the third time, a Federal agency tells us that the healthiest team—that is, the most profitable patients—ends up at the physician-owned specialty hospitals.

In 1989, the HHS Inspector General reported that patients of referring physicians who owned or invested in independent clinical labs received 45 percent more lab services than Medicare patients in general. Forty-five percent.

In response to this study and others like it, Congress passed the Stark law. This legislation—that is, the Stark law—sought to restrict physician self-referral, first, in the area of clinical labs, and subsequently in 10 other areas, including physical therapy and certain imaging procedures.

But the Stark law did not address the issue we are here to discuss today: physician self-referral to specialty hospitals. In part, that is because there were not many specialty hospitals at the time. But as the nonpartisan GAO has pointed out, the number of specialty hospitals tripled between 1990 and March of 2003.

The Stark law does prohibit physicians with ownership interest in only a hospital department from referring patients to that department. For example, doctors cannot invest in just the orthopedics wing of a hospital and then refer patients to that wing.

But, notwithstanding the MMA moratorium, the law currently allows physicians to self-refer to specialty hospitals in which they have a financial interest.

This is the case even though specialty hospitals are typically smaller in size and scope than community hospitals. For example, the average surgical specialty hospital has just 14 beds.

In many ways, these specialty hospitals resemble hospital departments more than they do community hospitals. This loophole may well need closing, and I am interested to hear testimony on this.

Today we will hear about a report from the Medicare Payment Advisory Commission, MedPAC, which has heard public testimony over the last 15 months, surveyed 48 specialty hospitals, and visited several communities in which specialty hospitals exist. We will also hear what I understand are preliminary findings from the Department of Health and Human Services. HHS, for example, surveyed 11 specialty hospitals.

Starting with MedPAC, their report recommends a number of steps to improve the accuracy of the Medicare inpatient payment system. These recommendations should mitigate all hospitals' incentives to choose healthy patients over sick ones. All hospitals. Basically, it is a DRG refinement.

MedPAC also recommends several steps to better align physician/hospital incentives. On this point, many specialty hospital advocates argue that the growth in these facilities results from physician dissatisfaction with hospital management practices. MedPAC's recommendations for gain sharing stand to alleviate some of that concern by giving physicians more control over their workplace.

Finally, MedPAC recommends extending the MMA mandated moratorium on new specialty hospital construction. As I understand it, MedPAC made this recommendation, in part, to examine further the issue of physician self-referral and whether it is appropriate to allow such referrals in the specialty hospital setting.

As for the HHS report, we received word only recently that the Agency would be ready to testify today, albeit with preliminary findings. I understand, further, that many of those findings are not statistically significant. This suggests caution in using the HHS findings as a basis for policy changes.

After MedPAC and HHS, we will hear from witnesses who have experienced the impact of specialty hospitals firsthand, both pro and con. These witnesses, I think we will hear, have strongly held views formed by experience.

I am interested to hear their perspectives. We will be listening to the music, as well as the words, and read between the lines of what they are saying. I want to thank them for taking the time to come and be with us today. Thank you.

The CHAIRMAN. Thank you, Senator Baucus.

Now I am able to introduce the first panel. Glenn Hackbarth is Chairman of the Medicare Payment Advisory Commission, better known as MedPAC. Tom Gustafson is Deputy Director of the Center for Medicare Management at the Centers for Medicare and Medicaid Services.

Mr. Hackbarth and Mr. Gustafson and their teams of people that work with them have spent the last year or so researching specialty hospitals, and we are pleased that they are here with us today to give this report that is being released from MedPAC.

So, I will have you start, Mr. Hackbarth. Thank you very much.

STATEMENT OF GLENN HACKBARTH, CHAIRMAN, MEDICARE PAYMENT ADVISORY COMMISSION (MedPAC), WASHINGTON, DC

Mr. HACKBARTH. Thank you, Senator Grassley, Senator Baucus, Senators. You well summarized the basic issues in the debate for us, the pros and the cons of physician-owned specialty hospitals.

Our findings on the performance of physician-owned specialty hospitals are based on 2002 data from 48 hospitals, some of which are very small institutions, as Senator Baucus mentioned.

Only 48 hospitals in 2002 met our test for both specialization and Medicare volume, and that is why we used that number. 2002, incidentally, was the most recent data available when we began our study.

We also conducted site visits, three of them: Austin, TX, Wichita, KS, and Sioux Falls, SD. The data underlying our findings are limited in three respects. First, is the small number of institutions. Second, is 2002 was fairly early in the development of the specialty hospital phenomenon. Third, we did not look at the quality of care provided. That responsibility was given to the Department of Health and Human Services.

On the other hand, as was mentioned in the introduction, we do have a series of recommendations on refining the payment system for hospitals, and we will be clear that those recommendations are based not just on the analysis of 48 specialty hospitals, but on an analysis of the overall Medicare claims and cost report database. So, the foundation for those recommendations, we believe, is very strong.

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

Let me talk about our findings. First of all we found, in studying the 48 hospitals, that heart hospitals tend to focus on DRGs and types of patients with a greater-than-average expected profit. Orthopedic and surgical hospitals, on the other hand, tend to focus on DRGs where the expected profit is less than average.

However, all three types of hospitals—heart, orthopedic, and surgical hospitals—tend to treat patients within those categories that are less severely ill than average. So, there are two types of selection effects, the type of DRGs provided, and then the type of patients within each of those diagnostic categories.

This table summarizes our basic findings on these issues. So the column labeled "Across DRG" addresses the type of DRGs provided. You can see that the heart hospitals have a higher expected profitability based on the type of care they provide.

The "Within DRG" column is about the severity of illness for the patients within each of those categories. You can see that the numbers higher than one signify that the patients are healthier than average within the DRGs served.

In 2002, the specialty hospitals that we studied tended to draw their patients away from community hospitals as opposed to treating new patients, although we did find some indication of increased utilization that merits further study and watching.

In 2002, the year we studied, the community hospitals competing against physician-owned specialty hospitals seemed to recover relatively quickly from the loss of patients by lowering costs or adding new services, although it may be more difficult for that to be accomplished in the smallest communities.

We also found that the cost of physician-owned specialty hospitals are not lower than community hospitals, although the average length of stay is lower. In fact, what we found was that the cost of the care provided in specialty hospitals was higher than in community hospitals, but the differences were not statistically significant.

The difference in average length of stay, however, was statistically significant. Finally, we also found that specialty hospitals serve proportionately fewer Medicaid patients than community hospitals.

Based on this evidence, we have a series of recommendations. First of all, we recommend that the DRG payment system be refined so that payments better match the expected cost of caring for different types of patients.

There were several specific recommendations in this package that pertain to how the DRG weights are calculated. The weights are the factors that determine the relative payment rate for different types of cases.

We also recommend that a severity adjustment be added to the system so that patients who are more severely ill, and therefore more likely to cost more, bring with them higher payments.

The net effect of these recommendations is shown in this graph. The net effect is to significantly improve the accuracy of our payment system. Over at the far left, you see current law. What that says is that 35 percent of the payments in the Medicare system are for DRGs where the expected profitability is within plus or minus 5 percent of the average.

If you go to the far right set of columns labeled "Plus Suggested Outlier," that shows the cumulative impact of all of our recommendations on refining the payment system.

You can see there that 86 percent of the dollars would be in DRGs where the expected profitability is within plus or minus 5 percent of the average. So, we have a significant increase in the accuracy and fairness of the payment system.

We are better off adjusting for differences among the patients, so that the financial outcome for a hospital is more likely to be the result, not of the selection of patients they get, but their performance as an institution.

Let me emphasize again that this analysis and the recommendations on payment refinement are based on an extensive analysis of the Medicare claims and cost report database.

A second recommendation is that we have a transition period. These changes affect not just physician-owned specialty hospitals, but all hospitals in the Medicare system. There are significant shifts in the Medicare revenue received by different hospitals as a result of these recommendations.

You are familiar with analysis that we have done in the past. We talk about the impact of our proposals on urban hospitals, or rural hospitals, or teaching hospitals versus non-teaching hospitals. The

impact of these changes is interesting, in that it cuts across those different categories.

In other words, some urban hospitals would benefit from these changes, but some urban hospitals would lose Medicare revenue from these changes. Some teaching hospitals would benefit, some would lose; some rural hospitals would benefit, some would lose. Because it is shifting money around the system in the name of payment accuracy, we believe it would be important to have a transition.

Next, we recommend that Congress give the Secretary of HHS the authority to permit and regulate gain-sharing arrangements between hospitals and physicians. One part of the specialty hospital thesis that we find most appealing, is the notion that if physicians and hospital management work together, they can achieve improvements in efficiency and quality that may not otherwise be attainable.

Under current law, hospitals are not permitted to share gains with physicians. We think that ought to change in the name of better aligning physicians and hospitals, improving care for Medicare beneficiaries.

Finally, to permit time for Congress to consider our recommendations and HHS to implement them, we recommend an extension of the moratorium until January 1, 2007.

We hope that Congress and HHS will move quickly to adopt these changes. I must say that, even after these changes assumedly are adopted and implemented, MedPAC does have concerns about the impact of physician ownership of hospitals on the clinical decision-making, specifically whether the financial incentives involved affect inappropriately decisions about where patients ought to receive care.

We are very eager to hear from CMS and the Department about their analysis, in particular, of the quality issue, in differences in referral patterns between physician owners and non-owners; and we think that that information will help us develop a better understanding of the issues. Thank you very much.

The CHAIRMAN. Thank you, Mr. Hackbarth.

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

The CHAIRMAN. Now we go to Mr. Gustafson.

STATEMENT OF TOM GUSTAFSON, DEPUTY DIRECTOR, CENTER FOR MEDICARE MANAGEMENT, CENTERS FOR MEDICARE AND MEDICAID SERVICES, WASHINGTON, DC

Mr. GUSTAFSON. Thank you, Senator, distinguished members of the committee. I appreciate very much being invited to testify today.

I am here to present preliminary results of the technical analysis that will underlie the report by CMS that we and the Secretary expect to be sending to you shortly.

I must emphasize that the quantitative findings I would discuss with you today are tentative. Our analysis is not yet complete—the researchers are doing final tweaks on the numbers—but I believe that the qualitative nature of the results will not change materi-

ally. We will develop our policy recommendations once we have completed the empirical analysis.

Our study collected a considerable amount of new data related to the performance and impact of specialty hospitals. We made site visits to six market areas around the country. They are listed in the testimony.

And I would like to apologize to the Chairman. I am now advised that Rapid City is in South Dakota and not in Iowa. There is an error there.

The CHAIRMAN. If you can move the mountain, we will take it. [Laughter.]

Mr. GUSTAFSON. We included 11 of the 59 cardiac surgery and orthopedic hospitals that were paid for by Medicare at the end of 2003. These market areas were selected very deliberately to represent a range of the circumstances in which these hospitals operate.

Within each market area, we sent in teams to interview. We interviewed the hospital managers of the specialty hospitals, their owners, the staff. We also interviewed members associated with the community hospitals in those areas.

And to assess patient satisfaction, which was one of the issues that Congress asked us to look at, the study used patient focus groups composed of beneficiaries treated in the specialty hospitals.

We also used Medicare claims data for 2003, a little bit more recent than the MedPAC data, to examine referral patterns, and drew on information from the hospitals and from tax files to look at financial information.

Major conclusions that we see coming out of our study are basically that cardiac hospitals differ very substantially from surgery and orthopedic hospitals; that cardiac hospitals are larger, they have a higher average daily census, about 40 individuals; they tend to have emergency rooms and other features that are usually associated with full-service hospitals, such as community outreach programs.

About two-thirds of the patients treated in these hospitals are Medicare beneficiaries, which is significantly higher than the average in other hospitals.

In the study of hospitals, ownership by physicians as a group averaged about 34 percent. Typically, a national corporation, or sometimes a nonprofit hospital in the area, owned the majority share of these hospitals. The average ownership share of the individual physicians was about 1 percent.

Surgery and orthopedic hospitals, on the other hand, more closely resemble ambulatory surgical centers. They focus primarily on outpatient services. They are much smaller. They have an average daily census of about five.

Physicians, however, in general, own a larger share: looking at physicians together, about 80 percent. The average ownership share is just over 2 percent. Medicare patients account for about 40 percent of the inpatient days in these facilities, which is more typical of what you see in other hospitals.

Now, unfortunately, the very small number of inpatient cases at the surgery and orthopedic hospitals precluded the development of many meaningful findings for this group on several of the dimen-

sions we were asked to look at, so our results will be qualified in that respect.

Turning now to the results we have been working up, we have discovered that the majority of Medicare patients in most specialty hospitals are referred by a physician owner of that hospital. The physicians in question do not refer their patients only to the specialty hospitals that they own, but also to hospitals in the area, to the local community hospitals. A similar, but slightly lower, proportion of their patients go to those hospitals.

Overall, the Medicare cardiac patients treated in community hospitals were more severely ill than those treated in cardiac specialty hospitals in most of the study sites, which I think conforms with what MedPAC discovered.

This result held generally for patients admitted both by those physicians that had ownership in specialty hospitals and by other physicians without such ownership interest.

We found, in short, no difference in referral patterns for physician owners and non-owners looked at in this way. There was some variation, but it looked like a fairly consistent pattern.

Looking at surgery in orthopedic hospitals, the number of cases there was too small to draw definitive conclusions, but the preliminary results are suggestive of a similar sort of pattern.

In order to examine quality, we looked at the patterns of claims using the AHRQ quality indicators and methodology. Our preliminary findings show that the measures of quality at cardiac hospitals were generally at least as good, and in some cases better, than local community hospitals.

Complication and mortality rates were lower at the cardiac specialty hospitals, even when we adjusted for the severity of the cases that these hospitals were serving. Because of the small number of discharges at the surgery and orthopedic hospitals, we could not make a statistically valid assessment in that area.

Patient satisfaction, one of the things we were asked to look for, was extremely high in both groups of hospitals. Medicare beneficiaries enjoyed large private rooms and other amenities, and they appreciated those features.

We used proprietary financial information from the specialty hospitals and, as I said earlier, some tax information to look at the taxes paid by these hospitals and the uncompensated care as a proportion of their net revenues.

Relative to the net revenues, the specialty hospitals provided only about 40 percent of the share of uncompensated care that the local community hospitals provided.

However, the specialty hospitals paid significant real estate and property taxes, as well as income and sales taxes, while the nonprofit community hospitals did not pay these taxes. In our study areas, virtually all of the community hospitals were nonprofit.

As a result, the total portion of net revenue that specialty hospitals devoted to both uncompensated care and taxes, those two items taken together, significantly exceeded the proportion of net revenues that community hospitals devoted to uncompensated care alone.

You have just heard from my colleague, Mr. Hackbarth, about the complementary MedPAC study. I think it would be fair to say

that we found nothing in our results that appears to contradict any of the MedPAC results. We are currently evaluating MedPAC's recommendations as we form our own.

Mr. Chairman, thank you for the opportunity to testify, and I look forward to your questions.

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

The CHAIRMAN. Yes. Thank you very much. We will have a 5-minute round of questioning.

Mr. Hackbarth, in a transcript from September of 2004, MedPAC staff said, "Physician-owned providers could have a competitive advantage over other facilities because physicians influence where patients receive care."

From your report, it also seems that physician-owned hospitals treat patients who are generally less severe, with shorter recovery times, and tend to concentrate on particular diagnosis-related groups that are more profitable.

Based on the data from your report, do you believe that physician-owned specialty hospitals, under current law, have a competitive advantage over other facilities?

Mr. HACKBARTH. Two types of comments about that, Senator. First of all, the reason that physician-owned specialty hospitals have a better selection of patients, defined as a more profitable selection of patients, could be due to a number of different factors.

One could be the physician's personal economic incentive, but other factors could deal with the type of services offered and referral patterns from other physicians in the community. It is not all necessarily directly due to the fact that the physician is an owner.

That does not mean that it is not a problem, however. So we think that the best thing to do is change the payment system, as I have described, so that a physician-owned specialty hospital does not benefit from patient selection.

If we adopt the sort of changes that I have talked about, then there will not be undue rewards for selecting patients in certain DRGs, or selecting patients that are less severely ill.

By the same token, the community hospital that is competing, and ends up with the more costly cases, will receive increased payment, which will help defray its added costs from those patients, unlike current law. So we can balance the system, in terms of patient selection, with the payment reforms that I have talked about.

The CHAIRMAN. Then let me follow up with this question. If this would be so, that there is some advantage to having a competitive advantage, is this competitive advantage based solely on a physician's ability to self-refer less severe patients for more lucrative procedures?

Mr. HACKBARTH. Well, the direct answer to that would be no. Again, I think there are multiple reasons why patients sort out the way they do, one of which could be the physician ownership incentive. Second, you can derive competitive advantage from the services that you provide.

As Tom was describing, if patients are more satisfied with the care received in a specialty hospital, they can want to go to the specialty hospital, which gives the hospital a competitive advantage.

The dynamics are fairly complicated, but we can largely fix the patient selection issue through payment reform.

The CHAIRMAN. All right.

Congress has repeatedly legislated—and this is for you, Mr. Hackbarth—to prohibit physical referrals in certain areas like clinical labs, radiological services, durable medical equipment, physical and occupational therapy, home health services, inpatient and outpatient services.

Based upon this expansive list, there seems to be a legitimate concern that self-referrals could be blocked in most instances. Is there a way to close the loophole so specialty hospitals that really function as off-site hospital departments are not considered whole hospitals?

Mr. HACKBARTH. Yes. It would be pretty straightforward to close the loophole legislatively and rewrite the exclusions to preclude physician-owned specialty hospitals. As I said in my testimony, we remain concerned about physician-owned specialty hospitals, even if our payment reforms are developed and implemented.

However, we are not quite prepared to reach the conclusion that they ought to be outlawed. We want to see all of the evidence on quality of care. We want to see as much evidence as possible on efficiency before reaching that judgment.

Frankly, the status quo, as Senator Baucus mentioned, in our health care is not great. We have got real quality and cost issues. If there is a type of institution that could provide better quality at a lower cost and higher patient satisfaction, we ought not rule it out.

Do physician-owned specialty hospitals fit that bill? We do not know the answer to that today, but I think it is knowable in the not-too-distant future. So, that is why we recommend an extension of the moratorium as opposed to moving to close the whole-hospital exception today.

The CHAIRMAN. All right.

Senator Baucus?

Senator BAUCUS. Thank you. Thank you, Dr. Hackbarth. First of all, I want to thank you and MedPAC. I mean, it means a lot to the Congress to have an independent, third-party group to look at these kinds of issues. You have got the expertise, you have also got the independence, and I just wanted to thank you for that very much. It means a lot to all of us here in the Congress.

Following up on the last question, what do you need to know, and by when do you think you will know it, in order to answer that basic question, namely whether or not there is a role for specialty hospitals or whether they should be outlawed?

Mr. HACKBARTH. Well, basically, what we want to know is the questions you asked us in the MMA: how does the cost compare; how does the quality compare; how does the patient satisfaction compare? Those are the basic measures of institutional performance.

Right now, what we are working from, in the case of the MedPAC analysis, is 2002 data. CMS, because they started a little bit later, had the benefit of 2003 data. That is a relatively small——

Senator BAUCUS. And you think you will have that data when?

Mr. HACKBARTH. Well, we have obviously now in hand 2002 and 2003, before the end of this calendar year we will have 2004 data, so we would have a 3-year database to analyze as opposed to just 1 year.

Senator BAUCUS. Now, some of those who advocate specialty hospitals say, well, gee, it is a very small percentage interest, 1 percent, 2 percent, in the facility, so that cannot be a huge incentive there. What are some of MedPAC's concerns with that analysis?

Mr. HACKBARTH. Well, we think that just looking at the 1 percent or 2 percent may understate the rewards that come to a physician owner from a decision to refer patients to the physician in the hospital, in two respects.

First of all, when a physician is an owner, he or she shares not just in the gains from his or her referral decisions, but from the physician partnership group. So, Tom indicated that, for heart hospitals, typically physicians will own, together, 30 percent. So, each member of the ownership group is sharing not just in his or her own additional referrals to the institution, but everybody else's as well.

The second factor to keep in mind is that, when you are thinking about this economically and the rewards from one additional patient—which you ought to be looking at as the marginal profit derived from that additional patient—the marginal profit is different from the average profits we usually talk about, because they don't include the fixed costs for the building, the equipment, and the like.

Senator BAUCUS. Right.

Mr. HACKBARTH. So the economic gains from one more patient are quite substantial. If you multiply that times 30 physician partners, the numbers can be much larger than 1 percent would suggest.

Senator BAUCUS. You said earlier, I think, that the recommended changes to the DRG system, the refinement, and so forth, will help a bit. But I also think I heard you say that may not sufficiently resolve some of the concerns surrounding specialty hospitals.

Mr. HACKBARTH. Yes.

Senator BAUCUS. To what degree will those changes, do you think, if used by both community hospitals and specialty hospitals, alleviate the specialty concern, and to what degree not? And where not, why?

Mr. HACKBARTH. Yes. First of all, we think that the reforms we recommend will improve the DRG system a lot, and not just as it affects specialty hospitals, but as it affects all hospitals.

There are important changes that we would like to see made. Frankly, even if specialty hospitals did not exist, we would be making these recommendations on refining the payment system.

What they will accomplish is that, if a specialty hospital does well only because of its selection of patients, those profits will go away.

In order to do well in the future as a specialty hospital, you will have to perform well, not just on patient selection, but on management of care, organizational management, and the like. In that sense, the playing field will be more level.

The remaining residual concern, however, that we have is the possibility that clinical decisions about appropriate care and site of care may still be unduly influenced by an ownership interest.

We do not want to reach a final decision on whether that risk is too great, however, until we know more about the potential benefits in terms of improved quality and lower cost. We want to weigh both items on the scale.

Senator BAUCUS. Thank you.

Mr. Gustafson, as I understand it, your study looked at 11 specialty hospitals in all. Is that correct?

Mr. GUSTAFSON. Yes. That is correct, Senator.

Senator BAUCUS. And four of these were cardiac, and seven were a mix of orthopedic and surgery.

Mr. GUSTAFSON. That is correct.

Senator BAUCUS. I also understand the data you collected from the orthopedic and surgery hospitals were not statistically significant.

Mr. GUSTAFSON. In many cases, that is true, Senator.

Senator BAUCUS. I would just like to know, were the sites that you visited randomly selected, according to standard statistical protocols?

Mr. GUSTAFSON. No, Senator. The number of hospitals involved here is very small, so the sample was chosen as a judgment sample in order to examine the range of different circumstances that specialty hospitals——

Senator BAUCUS. If you could explain, how were those four hospitals selected?

Mr. GUSTAFSON. I do not have the detail on that, Senator. I would have to get back to you on that.

Senator BAUCUS. You do not know how they are selected?

Mr. GUSTAFSON. Excuse me?

Senator BAUCUS. You do not know how they are selected?

Mr. GUSTAFSON. I do not know the detail. It was done in collaboration with our research office and the research contractor. I would be happy to provide you that information for the record.

Senator BAUCUS. And how did you measure quality? You said the quality data, as I understand it, were all right. Measured against what?

Mr. GUSTAFSON. Basically, we were looking at data that were derivable from our claims data. In that analysis, we were looking at a much broader set of hospitals. So, we were looking at all 15 cardiac hospitals and 56 orthopedic and surgical hospitals.

The measures were derived from the AHRQ measures, and looked at mortality, both during the hospital stay and within 30 days of discharge; complications associated with the case; and readmission within 30 days.

Senator BAUCUS. But the main point is, you looked at only 11, and the orthopedic are not statistically significant because there are so few of them, and the specialties you selected were not randomly selected, according to standard statistical protocols. We also do not know how they were selected, or why they were selected.

Mr. GUSTAFSON. Let me just be clear here, Senator. The 11 that we studied were ones where we went in and did intensive case studies and detailed interviews on the ground. The quality results

are based on a larger set, so it is based on all of the hospitals that were billing Medicare at the end of 2003 in these categories.

Senator BAUCUS. All right.

But, again, the selection is unclear as to why those particular—say, cardiacs—were selected. We do not know why, we do not know how.

Mr. GUSTAFSON. I do not have that information for you today, Senator. I would be happy to provide that.

Senator BAUCUS. Could you get that?

Most disturbing to me is the sample is not large enough, and it is not randomly selected according to correct protocols, so it raises questions as to why those four were selected.

It raises further questions as to whether there is an ulterior motive here, frankly, to get a biased result. You have such small data and you cannot answer the questions on how the hospitals were selected, at least one has to ask those questions. They may be satisfactory answers, but those questions have to be asked.

Mr. GUSTAFSON. I would be happy to provide that information for the record, Senator. I can assure you, as I previously described, the choices were made in order to reflect the diverse circumstances of specialty hospitals.

Senator BAUCUS. If you could provide whatever you could, we would sure appreciate it.

Mr. GUSTAFSON. Certainly, Senator.

Senator BAUCUS. Thank you very much.

Thank you, Mr. Chairman.

[The information appears in the appendix on page 43.]

The CHAIRMAN. Thank you.

Senator Kyl?

Senator KYL. Thank you. I appreciate both of you testifying.

Mr. Hackbarth, with respect to the net payment obligation of the United States, the revisions in the DRGs that you have recommended would have what effect?

Mr. HACKBARTH. They would be budget neutral.

Senator KYL. So it is budget neutral. Is that based on the recommendation of the market basket or the reduction in market basket that was recently recommended?

Mr. HACKBARTH. That is based on the basic dynamics of the system. What we are changing, is how the dollars are distributed——

Senator KYL. No. I understand that. But you say it is budget neutral. Budget neutral to what number, is what I am getting at.

Mr. HACKBARTH. Well, to wherever you decide to set the update factor, it would be budget neutral. That is a policy choice that the Congress makes, and this would be budget neutral to whatever target you set.

Senator KYL. So, in other words, the specific reimbursements for specific situations, procedures plus degree of difficulty or acuity, or whatever, would be adjusted upward or downward to match whatever Congress decided with respect to the market basket update. Is that right?

Mr. HACKBARTH. Yes. So the update decision that Congress makes influences the base amount and determines whether it goes up by 3 percent, 2.5 percent, or whatever the number is, and then this determines how those dollars are distributed among them.

Senator KYL. And your recommendations then are proportional within that.

Mr. HACKBARTH. Yes. Exactly.

Senator KYL. Yes. It just seems to me, and I would like to have both of you comment on what is a very general observation. If my observation is incorrect, please say so, but it is intended to be sort of a notional summary here.

As you have said, we do have quality and cost problems in our current system. There is some suggestion that specialty hospitals, at least in some situations, can help meet those challenges, especially with respect to patient satisfaction.

So, it seems to me that, maybe instead of trying to punish Group A specialty hospitals which seem to be providing a legitimate service and meeting a need that we have, if there are some results of that that impact negatively on Group B, the community hospitals, the answer is to ensure that we are reimbursing Group B—that is, the Federal Government's obligation—at a level adequate to cover the obligations we have imposed upon them, such as the EMTALA obligations with respect to emergency room care and all of the other things that we require or desire of our community hospitals.

Would you both please comment on that? In other words, instead of making it a zero sum game here, since Congress has to deal with this question of reimbursement each year, try to take the best of both worlds to ensure the continued adequacy of our community hospitals, while taking advantage of what specialty hospitals have to offer.

Mr. HACKBARTH. Right. Two reactions. One, as I indicated, the effect of our payment proposals, our refinement proposals, would be not only to reduce payment to a specialty hospital that is treating easier cases, but increase payment to the community hospital that has——

Senator KYL. Right. May I just interrupt and say, let me just assume for the sake of this question your recommendations, which have an inherent logic to them that I accept. So, let us assume that. I am getting, now, to the net number.

Mr. HACKBARTH. All right.

After that, in fact, the burden of providing services that society considers to be important is not equally distributed across hospitals. That was true even before specialty hospitals.

Senator KYL. Right.

Mr. HACKBARTH. So we find that some institutions that bear a disproportionate share of those burdens, whether it be trauma centers, or whatever the service is, are hurt by that. Rather than stopping competition from specialty hospitals or new community hospitals, we think a better approach is to adjust payment to properly pay for the services that society wants.

Senator KYL. Thank you. That is my thought as well.

Mr. Gustafson?

Mr. GUSTAFSON. I believe I would agree with Mr. Hackbarth on that, Senator.

Senator KYL. Would that then suggest that, instead of a recommendation to reduce by 0.4 the market basket update, that Congress should go back to the rough draft that was presented, that actually would allow us to compensate, on a net basis, the hospitals

more in line with the medical inflation and other costs that are associated with their care today?

Mr. HACKBARTH. No, I do not think that would follow, because the update goes to all hospitals uniformly, not just to the hospitals that are carrying those societal burdens.

So, spreading money across the whole system to try to help a few hospitals is a very inefficient way to try to accomplish the task. In a time where we face budget pressures from all around us, it may not be the best use of Federal dollars.

Our philosophy is, try to improve the accuracy of payment at the institutional level. If there are services that were weighed or under-paid for, let us adjust the payment for those institutions that provide them, not for every hospital in the country.

Senator KYL. Mr. Gustafson?

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

The CHAIRMAN. All right.

Senator Thomas, then Senator Lincoln, then Senator Wyden.

Senator THOMAS. Well, thank you, Mr. Chairman.

I am, I think, going to ask a little broader questions. For example, you said what else you need to know had to do with patients' comfort, and so on. It seems to me that one of the other things, particularly in small communities, is whether or not you can have both kinds of facilities exist, just simply from a volume standpoint and from an investment standpoint.

But is it not generally true that these special hospitals get more people who have an ability to pay? They do not get the emergencies, they do not get the Medicaids, they do not get as much of Medicare. They get the ones that are insured, generally.

Mr. HACKBARTH. Yes. Well, the piece that we looked at specifically was Medicaid. In fact, they serve proportionately fewer Medicaid patients. HHS looked at the uncompensated care issue.

Senator THOMAS. So that is generally the case.

You mentioned the specifics. But, again, in a small community, volume has something to do with the fixed costs. So, if you divide the amount of services between two, then some of the fixed costs become more difficult to meet. Is that not true?

Mr. HACKBARTH. Yes. As I indicated in my testimony, we found that, in general, looking across the full 48-hospital database, that the community hospitals, faced with competition, were able to recover from the loss of patients relatively quickly.

But in our site visits, we came across some concerns that the situation might be different in the smallest communities. Part of it is, you have fewer patients and, therefore, fewer opportunities to add new services, and the like.

Senator THOMAS. And the reason some of these recover quicker is because they get some public money, sometimes, local money.

Mr. HACKBARTH. We looked at the result as opposed to exactly how it was accomplished.

Senator THOMAS. I guess what I am saying is, it seems like, instead of measuring the questions of comfort and so on, one of the questions in a small community is, can both of these facilities exist? The answer often, it looks like, would be no.

Mr. HACKBARTH. Again, depending on the community, that may be the case. But the question *that* raises for me, then, is should we

make national policy that affects large and small communities alike based solely on the impact on small communities or——

Senator THOMAS. National policies do not have to fit everyone alike. As a matter of fact, that is one of the reasons that we often want more local input into national policies.

So I guess I am talking in more of a general term than you are. And I think we have to look at it that way because of communities—and we have some in Wyoming—where, really, there is a question whether you can support both. If the private ones take the best-paying jobs and the others have to pick up the rest, then you have a problem.

I was interested in your talk about, we are looking here at a problem that exists, apparently. But you are saying, why do we not just extend the moratorium? What is the moratorium doing if the problem exists to this extent?

Mr. HACKBARTH. Well, the idea behind an extension of the moratorium, from our perspective, would be to prevent the development of new hospitals, the flow of capital into the development of new physician-owned specialty hospitals, until we have more definitive data on their performance.

We do not think that we know the definitive answers to the questions about how they compare on cost, quality, and patient satisfaction.

Senator THOMAS. I see.

Mr. HACKBARTH. So rather than outlaw them based on uncertain information, we are basically saying, let us get some more time and we can more definitively answer those questions. In the meantime, we can also implement the payment reforms that help level out the playing field between specialty hospitals and community hospitals.

Senator THOMAS. I am not an expert in this. These were there before the moratorium?

Mr. HACKBARTH. Yes.

Senator THOMAS. It's not possible for that to start now? Is that right?

Mr. HACKBARTH. The 48 hospitals that we studied all pre-date the moratorium, so they continue to operate under the moratorium. The moratorium simply limits the development of new institutions.

Senator THOMAS. Well, as you know, we all know competition is a good thing, in services and in goods. But health care is a little different. Competition may, in a small community, not provide a better thing, but provide nothing, as a matter of fact. So, I hope we can look at it from the differences in the size of communities, because I think that can make a difference. Thank you.

The CHAIRMAN. Thank you.

Now we go to Senator Lincoln.

Senator LINCOLN. Thank you, Mr. Chairman. Thank you, gentlemen, for joining us.

I guess, to both of you all, one of the questions I had is, how do the State licensure laws and the certificate of need laws that regulate hospitals in some of our States affect or not affect the proliferation or, again, the nonproliferation of physician-owned specialty hospitals?

I think we will hear later on the testimony from Mr. Veitz that the surgical hospital near his hospital in South Dakota has only

four beds. I do not know, but that is just incredible to me that there would be a facility with four beds that was actually licensed. Do you all have comments on that?

Mr. HACKBARTH. State licensing and certificate of need laws seem to have a significant impact on where specialty hospitals develop. If you look at the map, they are not everywhere. If you look at the States in blue, the States with certificate of need, there are far fewer. For the most part, specialty hospitals have developed in non-CON States.

In addition, some of the States where there are specialty hospitals have adopted special licensing rules that facilitate the development of the institutions and alter the requirements.

It is my understanding that, in fact, in some cases States have done that to attract a certain type of care into less-developed areas. They have lowered the hurdle so they could get specialty care into less populated communities.

Mr. GUSTAFSON. I think he said it well.

Senator LINCOLN. Ditto, right?

Mr. GUSTAFSON. Yes.

Senator LINCOLN. All right.

Well, it just seems that some of this could maybe be solved through States, or at least the encouragement from us to States. I know we eliminated certificate of need, how long ago? Twenty years. Something like that, was it not?

Mr. HACKBARTH. Right. Well, I should also mention that there are some States that outright prohibit physician-owned specialty hospitals.

Senator LINCOLN. All right.

Mr. HACKBARTH. There are a variety of different types of restrictions in addition to certificate of need that some States use to limit the development.

Senator LINCOLN. I know that in touring both of these types of hospitals—and I have gone out to see and to tour them and to listen to the physicians, patients, hospital administrators, and everybody—some of the complaints from the physicians have been about their ability to work with the administration in the hospital in actually getting the kind of technologies and the advanced technologies they want.

I guess, Mr. Hackbarth, do you think your recommendation on the gain sharing, which kind of allows the physicians and the hospitals to share savings from more efficient practices, putting into place technologies and practices, would help doctors feel less frustrated with the community hospital environment or the environment that they do not have as much of a say? Would that maybe be an alternative to physician ownership?

Mr. HACKBARTH. Well, our hope is that gain sharing could change the relationship, improve the relationship between physicians and hospitals, get them pulling in the same direction to both improve efficiency and quality.

In a previous life, I ran a very large physician group in Boston and spent many hours listening to physicians—surgeons, in particular—frustrated with how the hospital was run and how they felt it made it more difficult for them to practice, not just effi-

ciently, but also provide the level of quality and patient satisfaction. We were blessed to work with an outstanding institution.

So, personally I have some sympathy for physicians who are frustrated that they cannot always get over barriers that exist within hospitals. We are hoping that gain sharing could help change those relationships where they are not working and get benefits for Medicare beneficiaries.

Senator LINCOLN. Well, they are limited in terms of the number of arrangements that are out there. But the ones that we do have to look at, are they——

Mr. HACKBARTH. Well, the ones that we have, I think they are all very new.

Senator LINCOLN. Yes.

Mr. HACKBARTH. There has been a spate of recently issued advisory opinions by the Inspector General saying that we can permit relationships, gain-sharing type relationships, with these characteristics, but they are all too new to have yielded results.

CMS was going to do a demonstration of gain sharing to test the hypothesis, but that was actually prohibited by a Federal court on the grounds that it violated Federal law. What we are asking is that law be changed to permit gain sharing.

Senator LINCOLN. It would be interesting to see. I know, as we have had others that have come to testify, we talk about the improvements in efficiency in health care delivery. We keep hearing all of this technology, IT, records, and blah, blah, blah, all of which cost a tremendous amount of dollars in terms of the programs we are dealing with.

Just one last one, I guess. The emergency care. As you all well know, one of the criticisms of specialty hospitals is that they do not really shoulder their share of emergency care or indigent patients. We have talked about that.

I guess, in its site visits, did MedPAC find that specialty hospitals typically staff emergency departments? I know one of the specialty hospitals I visited had a very active one, and the statistics were good on their emergency room, but others did not have such good statistics.

Mr. HACKBARTH. Right. We found—and I think this was also found by CMS—a significant difference among the types of specialty hospitals.

Senator LINCOLN. The heart ones.

Mr. HACKBARTH. The heart hospitals are much more likely to have a functioning emergency room and——

Senator LINCOLN. Yes. That is the one I visited.

Mr. HACKBARTH [continuing]. Be part of the emergency medical service network in the community. On the other hand, we found in our visits that orthopedic and surgical hospitals were unlikely to have a functioning emergency room.

Senator LINCOLN. Mr. Chairman, can I ask Mr. Gustafson just one quick question? It is a yes or no.

The CHAIRMAN. Better than having you offer an amendment. [Laughter.] Quickly, so we can go to Senator Wyden.

Senator LINCOLN. All right.

Mr. Gustafson, I just wanted to know what you used, I guess, in your research. Do you feel like seven hospitals is enough to bring any meaningful findings?

Mr. GUSTAFSON. Yes. We were able to uncover some results we regard as meaningful. We studied 11 hospitals in a case study methodology. We also looked at a set of 59 hospitals, basically a national sample, of all of the cardiac, surgical, and orthopedic hospitals that were billing Medicare at the end of 2003.

These results have to be described as preliminary, for a couple of reasons. One, as I think Mr. Hackbarth has stressed, this industry is maturing. It is an infant industry, in economic terms, and it is a little hard to discern what is going on.

We have done as good a job as we thought we were able to do, given the time involved, and given the small number of people to look at in trying to track down what was going on here.

The CHAIRMAN. Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman.

Gentlemen, based on what is known now, how do poor people fare in communities where these specialty hospitals are? Mr. Hackbarth?

Mr. HACKBARTH. Senator, I am not sure that we developed any evidence directly on that issue. As I said, we did find that specialty hospitals were much less likely to have a lot of Medicaid patients.

But in terms of the impact of the specialty hospital on Medicaid patients' access to care or uncompensated care patients' access to care, I do not have any direct information on that.

Senator WYDEN. The reason I ask is, as I look at this, this is another step towards two-tier medicine in America. The system of funding health care—and I know Senator Kyl asked about it—is a zero sum game. I mean, we are spending $1.8 trillion today on health care. Most Americans say we are spending plenty. So I think if you take it out of community hospitals and move it to these other hospitals, that is that. I want to know how the poor are going to be affected.

It strikes me, as I look at the health care landscape, if you have a lot of these, those who are affluent are going to go off and use these kinds of facilities, and poor people are going to go to community facilities where, if they just do not have the revenue, at some point they are just going to be sacrifice zones.

Now, tell me your reaction to that kind of concern.

Mr. HACKBARTH. Well, as I said in the discussion with Senator Thomas, it is my belief that assuring access to care for all Americans is critically important. The best way to do that, is that we properly pay for the services.

Senator WYDEN. No. But is the concern that I raise a valid one? Because I do believe that this is a zero sum game. I mean, it is fine to talk about more revenue and changing the reimbursement systems. But you have a lot of these in the health care landscape right now, and it seems to me we are going to be taking dollars out of programs that serve the poor. Do you disagree with that?

Mr. HACKBARTH. I do disagree, in the sense that what I want to do is assure access to care for the poor and all other Americans, and I want to assure the best possible care for Medicare beneficiaries and all other Americans.

To say that the way we protect the core is to deny access to better care for other people, that is a policy that I do not prefer. I would say, let us protect access for the poor by choosing to pay for the services that the poor people need, not preventing competition—but constructive and helpful.

Senator WYDEN. I am for competition, too. But based on what I hear you saying, pay for the services that the poor need, that means extra money. I think it is a zero sum game, and I think you are ducking the question unless you respond to, what do we do with respect to that $1.8 trillion?

I mean, it comes to $24,000 for a family of four. At this point in the United States, we could go out and hire an internist for every four or five families in the country for the amount of money we are spending.

Mr. HACKBARTH. Well, that is precisely my point. I think there is plenty of money in the U.S. health care system to provide quality care for all Americans. The problem is *not* enough money.

The problem is, the system does not perform well. If we have a type of institution—if, because we do not know this yet—a specialty hospital that can improve system performance, we ought not be outlawing them, we ought to be encouraging them.

We ought to be improving the performance of the existing system—set aside specialty hospitals, which are tiny—by linking payment to performance. There are a lot of things that we can do, must do, to assure access to care for all Americans.

Senator WYDEN. I have actually introduced legislation to link payment to performance as it relates to nursing home facilities, so I am totally on board on that one. But how are we doing that with what is being considered today with these specialty hospitals? Specialty hospitals are not making a commitment to take a certain number of poor people.

They are not talking about how they want to do what you are talking about, which I support. They are saying, look, we want this moratorium lifted. We are going to go out and find the areas where we want to go, and poor people will be off on their own.

Mr. HACKBARTH. Let us look within the Medicare program alone. Within the Medicare program alone we have large payments going to teaching hospitals and so-called disproportionate share hospitals that may not be well-targeted to the goals that you and I share—billions of dollars a year.

Rather than saying what we need to do is protect hospitals from competition from institutions that may be better, let us talk about how we redirect the dollars that we have already got in the game to achieve our social objectives.

Senator WYDEN. My time is up. I am fine on redirecting those dollars to places that have quality, as long as those places are willing to say that they have got a commitment to the poor and they are not going to leave the poor behind. I do not see those specialty facilities making that pledge right now. In fact, quite the opposite. If you read all the little charts and phone banks they are running, they just say, oh, communities are going to be fine where we have specialty hospitals. The poor are going to get taken care of.

If we do what you are talking about, which is, we pay for quality but those facilities are required to do their fair share for the poor,

then I think we are off to the races. But I think it ought to be understood, the specialty facilities are not making that commitment as of now.

Mr. HACKBARTH. Nor do all community hospitals.

Senator WYDEN. Fair enough. Thank you.

The CHAIRMAN. Thank you. Thank you.

To this panel, you may expect some questions in writing from those who could not be here. Other than that, thank you very much for your kind testimony and answers to our questions.

I now move to our second panel. Dr. Alan Pierrott is past president of the American Surgical Hospital Association and chief executive officer of PSC Health, Inc., Fresno, CA; Mr. Larry Veitz, the chief executive officer for Lookout Memorial Hospital in Spearfish, SD; and Dr. Andy Sullivan, chairman of the Department of Orthopedics, Oklahoma University College of Medicine, and chief medical officer at the Oklahoma University Medical Center in Oklahoma City, OK.

We are going to go with Dr. Pierrott, then Mr. Veitz, then Dr. Sullivan.

Dr. Pierrott?

STATEMENT OF DR. ALAN H. PIERROTT, PAST PRESIDENT, AMERICAN SURGICAL HOSPITAL ASSOCIATION, AND CHIEF EXECUTIVE OFFICER, PSC HEALTH, INC., FRESNO, CA

Dr. PIERROTT. Thank you, Mr. Chairman and members of the committee. My name is Alan Pierrott. I am an orthopedic surgeon from Fresno, CA and a founding member of the Fresno Surgery Center, a multi-specialty physician-owned surgical hospital.

I am here today on behalf of the American Surgical Hospital Association, and we appreciate the opportunity to testify.

In 2003, Congress expressed concern that specialty hospitals were harming general hospitals. A moratorium on new specialty facilities was imposed while MedPAC and CMS studied these concerns.

MedPAC found that general hospitals have effectively responded to the competition posed by specialty hospitals. No proof of harm to general hospitals, risks to patients, or abuse of the Medicare program because of excessive or unnecessary surgery has been presented.

Therefore, ASHA urges the committee and Congress to let the moratorium expire in June as scheduled and take no other action that would limit the ability of physicians to own or invest in specialized hospitals.

We oppose MedPAC's recommendation to extend the moratorium. The idea that large numbers of specialty hospitals will open as soon as the current moratorium expires is not realistic.

I also think there is a widespread view that it is benign, allowing existing specialty hospitals to proceed unhindered, while only limiting new development. This leads to the mistaken conclusion that extension of the moratorium would not harm existing facilities.

In fact, the moratorium is not benign and has hurt many well-established specialty hospitals because it limits the expansion of facilities and the introduction of new services in response to changing needs and circumstances in our communities.

Another moratorium would only exacerbate this condition. MedPAC's analysis of specialty hospitals did show that Medicare's inpatient hospital payment system needs substantial revision. ASHA agrees with MedPAC's recommendations to correct the problems that were found and urges Congress and CMS to act on them this year. We also support adoption of MedPAC's recommendations on gain sharing and the proposals on pay-for-performance measures in the hospital setting.

The Fresno Surgery Center and other members of ASHA provide cost-effective, high-quality surgical care in a very efficient manner. Specialty hospitals offer a choice of surgical site for patients and physicians. We get high marks from our patients, our staff, and our physicians, whether or not they are investors.

Physician investment in these facilities is a key ingredient to our success. It means that the people whose names are on the door are responsible for setting the quality standards, the operational requirements, and directing all facets of the hospital activities.

It is this group of investors who are fundamentally responsible for the existence of the hospital and the maintenance of its standards. Because these hospitals provide a focused set of surgical services, the staff is able to develop a high degree of skills in these specialized areas.

This skill makes possible the efficiency of operation and the high quality of patient outcome. We succeed because we are focused factories designed to provide elective surgical care to otherwise healthy patients.

The interest in a specialty hospital usually begins after physicians have failed to persuade the general hospitals at which they practice to make changes that will improve physician efficiency and patient care.

For example, the Stanislaus Surgical Center in Modesto was established first as an ambulatory surgery center, and later as a hospital, by surgeons who could not get reasonable access to the operating rooms at the other two major hospitals in that community.

Fresno is a similar case. My colleagues and I believed we could provide a better model for elective surgical care, and we have. We continue to care for patients at the other hospitals in Fresno, as do our colleagues in Modesto.

In fact, we require our physicians to maintain privileges at one of the other general hospitals in town. That means, of course, that we are all subject to the on-call emergency room responsibilities of those hospitals.

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

Clearly, not all general hospitals are hostile to specialty hospitals or joint ventures with their physicians. For example, Baylor Hospital in Dallas has a variety of joint ventures with physicians, including specialized hospitals and ambulatory surgery centers. Integris Health System in Oklahoma City has a joint venture with an ASHA member hospital specializing in orthopedic services.

HCA partners with physicians in numerous ambulatory surgery centers and an orthopedic hospital in Texas. Avra McKenna in Sioux Falls, SD has a joint venture with MedCath and the cardiovascular physicians who practice there.

In my community, the Fresno Heart Hospital is a joint venture between our largest not-for-profit hospital, the one with the higher indigent care load, and local physicians.

Our opponents say that specialty hospitals engage in unfair competition because they have physician owners. This ignores the reality identified by GAO that approximately 73 percent of physicians with admitting privileges to specialty hospitals were not investors in those hospitals.

Clearly, these physicians find something very attractive about the specialty hospital model, even without an investment interest. They have no motivation to engage in unfair competition.

General hospitals also have many tools they can use to respond to competition from specialty hospitals, including revoking or limiting medical staff privileges to any physician who invests in a competing facility, exclusive contracting with health plans to exclude specialty hospitals, and requiring primary care physicians employed by hospitals to refer patients to their facilities to specialists closely affiliated with the hospital.

Specialty hospitals have been accused of not taking Medicare or Medicaid patients. This is simply not true. According to a recent survey, the average specialty hospital earns 32.4 percent of its revenue from Medicare, 3.7 percent from Medicaid, 46.4 percent from commercial payors, and so forth, and provides charity care equal to 2.1 percent of total volume.

In addition, the average specialty hospital paid nearly $2 million in Federal, State, and local taxes. CMS testified as to this point.

We are also accused of taking only the easiest cases. When GAO looked at this issue, its analysis revealed little real difference in acuity of admissions. For example, among admissions to surgical hospitals, 2 percent of the cases were in the highest acuity groups, while general hospitals had 4 percent of their admissions for the same surgery fall into the most severe classification.

In other words, 98 percent of admissions to surgical hospitals were healthy, and 96 percent of admissions to general hospitals were in the same category.

The allegations that physician ownership of hospitals is a conflict of interest and gives specialty hospitals a competitive edge over general hospitals in their communities is baseless.

That issue was thoroughly debated when Congress considered the Stark laws and Congress chose to allow physician ownership of hospitals, ambulatory surgery centers, lithotripsy facilities, and a number of other sites where the physician provided the service in question. The AMA has also addressed the potential conflict of interest at length and concluded that no conflict exists in these circumstances.

AMA also raises the potential for conflict of interest that can arise with hospital ownership of physician practices, their employment of physicians—particularly specialists—and the ownership of health insurance plans by hospital systems.

If one is to argue that physician ownership of hospitals is a conflict of interest, then one is surely bound to agree that hospital ownership of physicians' practices or employment of physicians raises the same concerns.

There is one other resource I urge you to look at as you consider the issue of physician-owned specialty hospitals, and that is the more than 20 years of experience that Medicare has with ambulatory surgery centers.

Nearly every ASC has some physician owners, yet there is virtually no evidence that physicians have performed unnecessary surgery or engaged in behavior that placed patients at risk, nor is there any evidence that an ASC forced the hospital to close or curtail essential community services.

Medicare's ASC experience should be a strong predictor to Congress that physician-owned specialty hospitals also pose no risk to Medicare, to patients, or to general hospitals.

In summary, after thorough study, the allegations against specialty hospitals have not been proven. Therefore, ASHA urges the committee to allow the moratorium to expire as scheduled in June.

The reforms to Medicare's inpatient payment system and the hospital pay-for-performance recommendations suggested by MedPAC would greatly benefit the Medicare program and should be adopted.

However, there is no evidence to justify putting specialty hospitals under another moratorium during a period these changes are implemented, or imposing any other limit on physician ownership of hospitals.

Mr. Chairman, ASHA appreciates the opportunity to present this testimony, and I would be pleased to answer any questions members of the committee might have.

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

The CHAIRMAN. Mr. Veitz?

STATEMENT OF LARRY VEITZ, CHIEF EXECUTIVE OFFICER, LOOKOUT MEMORIAL HOSPITAL, SPEARFISH, SD

Mr. VEITZ. Mr. Chairman, members of the committee, good morning. I am Larry Veitz, CEO of Lookout Memorial Hospital in rural Spearfish, SD, a town of 9,300 people. Our 40-bed community hospital serves 35,000 people across three States: Wyoming, Montana, and South Dakota.

I am here today to share my concerns about the impact that physician-owned limited-service hospitals are having on patient access to care in communities across this country.

In many communities, certain physicians are exploiting a loophole in Federal law to own limited-service hospitals, where they then refer their carefully selected patients to perform highly reimbursed procedures.

This raises serious concerns about conflict of interest, fair competition, and whether the best interests of patients and communities are being served. To protect patients and ensure health care services for everyone, Congress should close the loophole permanently, prohibiting physicians from referring patients to limited hospitals they own.

My community has experienced, first-hand, the negative effect of this loophole. In the 1990s, Lookout Memorial Hospital was recognized as one of the top 100 hospitals in the country. Now we are struggling just to keep our doors open.

Our patients have lost access to important services, all because of a physician-owned four-bed surgical hospital that began operating in 2000 just a few blocks from our hospital.

The physician-owned Spearfish Surgery Center focuses on general and orthopedic surgery. It does not take on the responsibility of providing daily, round-the-clock emergency services like our hospital does.

In fact, the physician-owned surgery center did not add a single new program of benefit to the community, it merely duplicated services already available in the community.

The center's physician owners have created a profitable business by targeting patients that are healthier and have good health insurance, and by targeting highly reimbursed surgical procedures.

Their business practices have siphoned off resources critical to Lookout Memorial Hospital's continued ability to meet the needs of our broader community, including the poor, the uninsured, and the sicker patients.

The financial impact of the physician-owned surgery center on our rural hospital has directly affected access to health care services, especially for our Wyoming patients.

We have eliminated our hospice program in Wyoming because we no longer have the financial means to support it. Home health services such as nursing and physical therapy have been curtailed.

Congress has previously passed laws designed to prevent conflict of interest related to physician referrals. It is time for Congress to act again to preserve access to health care services for all patients by closing this loophole.

Both the Government Accountability Office and MedPAC have found troubling evidence surrounding the business practices of physician-owned limited service hospitals. Physician owners refer only healthier, well-insured patients, are less likely to offer emergency room services, and do not have lower costs in treating Medicare patients than full-service community hospitals.

Mr. Chairman, the issue is not that full-service community hospitals do not want to compete based on quality, cost or efficiency. We do that everyday in a market-driven economy.

But full-service community hospitals cannot compete in a system riddled with conflict of interest, where some physician owners reward themselves for referring healthier, well-insured patients to the facilities they own.

Full-service community hospitals must rely on physicians for their referrals, but cannot pay for them for those referrals. Instead of promoting fair competition, specialty hospitals actually stifle it.

Physician self-referral breeds conflict of interest. When physicians own limited-service hospitals to which they refer patients, their decisions about when to provide care and where to send patients are subject to competing interests.

Mr. Chairman, community hospitals were created and sustained by the community to serve all patients, regardless of their health status or ability to pay. A conflict of interest inherent when physi-

cians refer patients to limited service hospitals that they own is robbing us of our ability to meet that mission and is risking patient access to essential medical services.

Enough data has been compiled, the studies have been completed, and the case is compelling. It is time to take action. I urge Congress to close the loophole in the Federal law by permanently prohibiting physicians from referring patients to limited-service hospitals they own.

Thank you. I am happy to respond to your questions.

The CHAIRMAN. Thank you very much.

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

The CHAIRMAN. Now, Dr. Sullivan?

STATEMENT OF DR. J. ANDY SULLIVAN, CHIEF MEDICAL OFFICER, OKLAHOMA UNIVERSITY MEDICAL CENTER, OKLAHOMA CITY, OK

Dr. SULLIVAN. Good morning, Mr. Chairman.

As chief medical officer of the Oklahoma University Medical Center and chairman of the Department of Orthopedic Surgery at OU, I have witnessed first-hand the adverse effect that limited-service hospitals can impose on community hospitals, and I appreciate the opportunity to share my experience.

As a physician practicing for 36 years, I know the frustrations, complaints and constraints that affect our practices nationwide. Increasing medical malpractice premiums, uncertain Medicare and Medicaid reimbursement, the bureaucracy of managed care, and demanding on-call schedules all cause physicians to retire early or to limit their practice, therefore limiting patient access.

Any solution to these problems must be comprehensive and aimed to reform a fractured health care system. This is not about the existence of specialty hospitals. Rather, it is physician ownership and self-referral to these facilities that creates an uneven playing field and directly harms full-service community hospitals. This ownership creates the potential for conflict of interest and over-utilization of facilities.

These facilities drain essential resources from community hospitals, particularly harming their capacity to provide vital health services. They do so by taking advantage of a loophole in the whole-hospital exception to the Anti-Referral and Ethics in Medicine law.

Specialty hospitals are merely subdivisions of full-service hospitals. They specialize in services that offer the highest profit margin and reimbursement rates. Self-referral allows the physician to profit not only from the fee for his service, but also from the facility fee to the hospital. If a community hospital were to pay physicians to refer patients to such units, they would be committing a felony. Some individuals have been imprisoned for just such acts.

Physicians do not invest in trauma units, burn centers, or children's hospitals because these represent the least profitable practice area. Removal of the most profitable services removes the ability of the full-service hospital to offset the provision of critical health care needs that generate only low margins of revenue, or even losses.

American hospital emergency rooms have become the de facto public health care system for the Nation's uninsured. These emergency rooms are required to provide medical evaluation and treatment to everyone, regardless of ability to pay.

From what I have witnessed in Oklahoma City, specialty hospitals do not share in this commitment to our community. In Oklahoma, despite a requirement that all licensed hospitals provide emergency service, a significant number of the State's specialty hospitals provide little or no emergency care. They treat the most profitable patients, leaving the full-service hospitals, the uninsured, and the high-risk patients.

OU Medical Center presently operates the only Level 1 trauma center in the State of Oklahoma. We are credentialed by the American College of Surgeons and must be capable of treating the most severely injured patients.

It has been shown repeatedly that these centers save lives and reduce mortality. Typically, these patients arrive with multiple broken bones, along with other injuries to vital organ systems, such as head and chest wounds. There was no Level 1 trauma center to serve 3.2 million residents of Oklahoma prior to our designation in 2001. Wichita, KS, with a population of 350,000, was the closest, followed by Dallas and Arkansas.

Studies by the American College of Surgeons suggest that, under optimal circumstances, a Level 1 center should treat 80 percent of the most serious victims and only 20 percent of the less seriously injured. The less seriously injured need to be treated at Level 2 trauma centers.

This was not the case in Oklahoma. OU Medical Center was treating 80 percent of all trauma patients across the entire metropolitan area of Oklahoma City, along with transports from across the State.

This over-loading of our Level 1 trauma center with less seriously injured patients created a crisis, taxed our capacity, and jeopardized the Level 1 certification. Like police and fire, a full-service hospital must remain in a complete state of readiness 24/7, 365 days a year. Trauma centers rely upon six surgical subspecialties, including anesthesiology, to take care of the patients.

Before the advent of physician ownership of specialty hospitals and ambulatory centers, physicians typically maintained an affiliation with multiple hospitals, assuring a sufficient number of doctors for the on-call roster.

As physicians in specialty hospitals dropped out of the call, a vicious cycle was formed. Those remaining had an increasing load, an escalation in their work hours, and an inability to get their elective patients in.

This caused a crisis in the Oklahoma City area. At the inception of our Level 1 trauma center, we had six neurosurgeons at OU. We now struggle to maintain two to sustain our emergency coverage for head trauma. The hospital recently committed $1 million annually in temporary staffing and local attendants for neurosurgery coverage.

We were forced to resort to a voluntary stop-gap on-call system for trauma. Under this plan, OU Medical Center, along with the

other full-service hospitals and the Oklahoma County Medical Society, developed a voluntary Level 2 trauma rotation.

A group of neurosurgeons, orthopedists, and other critical specialists who had dropped out of call agreed, on a voluntary basis, to provide coverage at at least one other Oklahoma City hospital each night, lessening our load and providing an additional avenue for Level 2 patients.

This voluntary system is very fragile. The State has agreed to give us a $5.7 million subsidy to support the Level 1 trauma center. These are short-term, temporary measures and they are costly, but they have at least insured the temporary survival of our Level 1 center.

We risk the possibility of losing our neurosurgery residence training program. This loss would be devastating. It would result in fewer specialists in the State of Oklahoma and would threaten other residency programs within our center. It would also jeopardize our Level 1 trauma center certification.

When the Oklahoma Heart Hospital opened in 2002, we suffered $11.6 million in cardiovascular loss between 2002 and 2004. We terminated programs to the uninsured and under-insured. We had an outpatient pharmacy that provided drugs to patients who had no money at greatly reduced costs that was eliminated.

We planned a facility renovation. We had to curtail that. The part that got curtailed was services to women and children. We lost 56 staff members who joined the Heart Hospital, most of whom were registered nurses.

Regular hours with no responsibility for call are great incentives to take a different job. The estimated cost of turnover was $2.6 million. We narrowly avoided the closure of our intensive care unit by an infusion of $500,000 in retention bonuses.

Specialty hospitals offer an alternative to traditional hospitals, and some patients certainly prefer these. Nevertheless, these facilities create both a conflict of interest for the physicians and an unfair competitive advantage with no evidence that they have increased in quality.

It is my hope that Congress will protect community hospitals like OU Medical Center by removing the opportunity for self-referral. I understand that Congress, as we have heard today, is weighing recommendations by the Medicare Payment Advisory Committee that would seek to level the playing field through Medicare payment adjustments.

Valid studies of past experience with this tactic demonstrate that Medicare payment adjustments alone will not solve the self-referral program.

So, Mr. Chairman, in conclusion, I would say that any of my faculty could leave today and double their income at a specialty hospital where the value of their investment, even if it is a small percentage, increases as a direct result of self-referral.

Two of my most critical faculty are being recruited as I speak. There is also, despite the moratorium, a new specialty hospital being built in our area, scheduled to open later this year.

As long as any financial gain can be generated through self-referral, competition will be neither fair, free, or equal between community hospitals and specialty hospitals.

Improper financial motives simply do not serve the best interests of our patients and threaten to undermine the vital health care services that communities expect from the cornerstone of American medicine, the full-service hospital.

I ask this committee to eliminate these concerns by ensuring the current moratorium does not lapse, and by supporting legislation to prohibit physician self-referral before the network of full-service hospitals becomes completely impaired.

I fear that we are facing a house of cards. For 29 years, I have had the joy of taking care of all comers, regardless of ability to pay, and to teach other young physicians how to become orthopedic surgeons. It alarms me that the hospitals in which this teaching occurs are being threatened at this time.

I also fear that members of my family or yours are going to arrive at what they perceive to be a full-service hospital, only to find that the specialists needed to provide their care are no longer on call.

I thank you for your time. I would be happy to answer any questions.

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

The CHAIRMAN. Thank you very much.

I am going to ask Senator Lincoln if, after I get done and Senator Baucus gets done, if you would finish up with your questioning. And you can have all afternoon, if you want to take it. [Laughter.]

Senator LINCOLN. He says that because he knows there is a vote at 12:50.

The CHAIRMAN. Would you do that for me?

Senator LINCOLN. Yes.

The CHAIRMAN. Thank you very much.

So, in advance, I thank all of your for your participation. Usually the Chairman is the last one to leave the committee meeting, but we have such good cooperation on this committee, that we try to help each other out.

Mr. Veitz, you have told us about the impact of these specialty hospitals on your hospital, like cutting such services as home care and hospice. Could you please expand on which services were limited and to what extent, and did cutting of such services negatively impact beneficiaries who received services at Lookout Memorial?

Mr. VEITZ. We eliminated the entire program in Wyoming for our hospice patients. We eliminated our services for home health care services in Wyoming. We had a negative bottom line and needed to look at services that were not supporting themselves financially, and those were two areas that we had to look at.

It was a very difficult decision for us because those were services that we cared dearly about. But, again, we had to shore up our financial bottom line so that we could continue to provide emergency room services.

In addition to that, we have worked, in the past, cooperatively with the county to provide public health services. We gave them notice that we could no longer afford to subsidize that program, and over a year and a half period we ceased to subsidize that program, and that program is no longer in existence with the county.

We also curtailed a number of capital investments in cardiac rehabilitation, which is a very popular program. But it is not a self-sustaining program. We have curtailed our capital investment in that program.

We have delayed some programs, like incontinent care and wound care, because we did not have the funds and they were not self-supporting programs, as well as diabetic education.

The CHAIRMAN. All right.

We had a statement from a physician in Spearfish: "There used to be a collegial medical community in Spearfish. We used to work together, even cover each other's vacations. But no more. The establishment of Spearfish Surgery Center has torn our medical community apart."

From your testimony, it is clear, Mr. Veitz, that the entry of this specialty hospital has had significant impact on community relations. The medical community in Spearfish does not get along like it used to. Is that an accurate description?

Mr. VEITZ. Yes, it is.

The CHAIRMAN. All right.

Dr. Pierrott, in the MedPAC staff presentation last month, MedPAC found that "specialty hospitals do not have lower Medicare costs per case." Additionally, "average cost in orthopedic and surgical hospitals are higher at 117 percent and 133 percent of the national average."

My question to you, Dr. Pierrott, you and the American Surgical Hospital Association claim that surgical hospitals are efficient. What criteria do you use to base that claim on?

Dr. PIERROTT. The efficiency that physicians refer to generally has to do with the way the schedule works. For example, when I was in practice, I could do four operations at the big hospital or do six at the surgery center in the same length of time. So, it has to do with productivity.

Then you get into a quality issue. When physicians are in charge, we have, since 1988, have had one nurse for every three patients. In California last year, the nurses struck to get a 1 per 6 as a State-wide standard.

So, I do not know all the reasons for the cost, but the biggest single cost in a hospital is labor. We do not have a 1 to 6 or 1 to 8 nurse-to-patient ratio, we have 1 to 3. That is one of the reasons that I believe strongly that any investigation about quality is going to show superior quality at the specialty hospital level.

If you talk to the front-line people, physicians and nurses, who have experienced specialty hospitals, you will find an overwhelming majority believe that the model provides superior care.

The CHAIRMAN. All right.

Dr. Sullivan, we have heard from MedPAC today that specialty hospitals tend to concentrate on particular types of cases or diagnosis-related groups. In your testimony, you state that fixing the Medicare payment structure or diagnosis-related groups is not the ultimate solution to the problem that we face today from specialty hospitals. Why do you believe that closing the loophole in self-referral laws is so important, then?

Dr. SULLIVAN. There have been studies that show that when they adjusted the rate that ophthalmologists were paid for cataracts,

they merely did other procedures and did not end up saving any money.

I think closing the loophole is important because it represents a conflict of interest. So long as physicians are able to profit on that, and sometimes exceed the amount of income they make for the facility fee over the amount that they make from the fee-for-service, it represents a conflict of interest. I think this loophole needs to be closed.

Senator BAUCUS. Gentlemen, I have one question for Dr. Pierrott. I understand that Senator Lincoln will be back very soon, because I have got to leave.

I would like you, Dr. Pierrott, just to tell me what you think is motivated by this statement. This was made, and I am sure you have heard of it, by a physician investor named Dr. Larry Tuber. He owns part of Black Hills Surgery Center, one of our association's founding members.

This is what he said in his speech a few years ago to a neurosurgery conference: "The last thing, and the easiest thing, is money. There will be a lot of money out there. Why go to a surgical facility? Profit, profit, profit. You have got to get market share. You want to take from them," hospitals, "and it will be so easy. You can't believe how easy it is."

What is your response to that?

Dr. PIERROTT. I think that one of the challenges for the committee is that there are huge market differences. All I can speak for is from my own experience in Fresno.

In Fresno, there are not anywhere near the high profits available to anybody. Sixty-five percent of the hospitals in California are losing money from operations, and we are among them. So, markets are very different.

The motivation that I find when I talk to physicians around the country, is their fundamental drive is to improve their working conditions. That is, to improve patient care and improve the efficiency with which they can accomplish the work that they do.

Senator BAUCUS. On that point, though I understand that is a noble value, a noble goal, I do not understand how, frankly, doctors can leave a hospital where they can go get a "more efficient operation" and not have to perform a lot of the services that the community hospitals have to perform, and do perform.

I am talking about—you know what I am going to say—emergency care, and all the full range of services, which are costly. I would think that doctors, because they do like to serve people, like to help people, would want to help and serve the community in a broader, general sense and want to stay with the hospital and figure out how to be part of the team on the hospital, to make sure the hospital is running efficiently, better patient-to-staff ratios, the right equipment, and so forth, and not just skim the cream off the top.

If I were a doctor, it would be very easy to think, gee, this really sounds neat. I can just go ahead, whether it be cardiac, orthopedic, or whatnot, because that is kind of where the money is, so I will take the money and not have to share with others in the hospital.

It is interesting to me, for example, that there are not pneumonia care specialty hospitals, there are not AIDS specialty hos-

pitals. There are not specialty hospitals in the areas where it is tough, it is rough, where reimbursement is not quite so high.

Just help me get over this problem I have, the problem being, why should we all not stay together here, doctors working with the other doctors, the pneumonia doctors, the AIDS doctors, and the emergency care doctors, and so forth?

Dr. PIERROTT. Senator, your comments sound absolutely reasonable until you try to change the behavior of a hospital. It is very, very difficult to change and make more efficient a 400-, 500-, 600-bed hospital where you are a very small part of the total equation. That is the first comment.

The second one, this notion about emergency rooms is an interesting one. There was a study that was published last year by the California Healthcare Foundation, a not-for-profit, independent entity looking at California emergency rooms.

They found that emergency rooms actually are profitable for hospitals. That is, they lost, on average, $84 per patient seen, but one patient in seven was admitted and they made a profit of approximately $1,200 per patient admitted.

So, taken altogether, inpatient/outpatient, emergency rooms were actually profitable. So the notion that specialty hospitals do not have an emergency room and that it is somehow detrimental, to me does not hold up under analysis.

The final point I would like to make is, if you look at the research of Harvard Professor Nancy Kane, you will find that hospitals receive more in benefits—that is, tax relief, property tax, State income tax, Federal income tax, and a whole host of other benefits—that, for 75 percent of American hospitals, exceeds the charity care that they provide.

Senator BAUCUS. Just one final question, just trying to get some facts out here. I asked about profit, profit, profit, and you said, well, gee, that is not my hospital, that is not Fresno.

Dr. PIERROTT. Yes.

Senator BAUCUS. But, on the other hand, I understand, what, in Fresno, this information is correct. A 600-bed hospital is treated on the same footing as one that reports no Medicaid, has no discharges for the county indigent program, no charity care, bad debt less than 1 percent of total gross patient revenue, and no emergency room. So, what is the point? This is your hospital. Is that your hospital?

Dr. PIERROTT. I have no idea. We are a 20-bed facility.

Senator BAUCUS. You are a 20-bed facility, but you have no discharges for the county indigent program at your hospital. You have no charity care at your hospital. You have bad debt at less than 1 percent of total gross patient revenue, and you have no emergency room at your hospital.

Dr. PIERROTT. We are not required to have an emergency room at our hospital. We cannot get access to the Medi-CAL program. It is a managed care program that channels all of its patients to a small number of providers through contracts. So, we are criticized for not having patients that we cannot get access to.

My final point is the point that was made by CMS, which is, if you add the taxes that our facility pays to the charity care, it ex-

ceeds, on a percentage of revenue, the charity care provided by not-for-profit hospitals.

Senator BAUCUS. Well, I have no further questions. Thank you.

Senator Lincoln?

Senator LINCOLN. Thank you.

Dr. Pierrott, you talked about the efficiency of specialty hospitals. I think MedPAC found that the specialty hospitals do not have lower costs than the community hospitals. So I guess my question is, how are you measuring efficiency? Can you get those efficiencies without your physician self-referral?

Dr. PIERROTT. Physicians primarily measure efficiency—that is, surgeons—in terms of the turnover of the operating rooms. It is much quicker in surgery centers and it is much quicker in specialty hospitals. That is why surgeons are the drivers behind these models, because they make that more efficient.

In addition, we clearly have, in my experience, better quality. I have performed surgery on over 1,000 patients in the big hospital setting. I have performed surgery on over 1,000 patients in the small hospital setting.

I was a big-hospital physician. I was the president of the medical staff of the largest hospital between San Francisco and Los Angeles. I am a convert. You have the zeal of the convert in front of you. I found that our facility did a better job of taking care of our patients, and I would welcome any evaluation of our quality. We have won awards for quality.

Senator LINCOLN. Well, we are talking about efficiency, which is probably a combination of quality as well as other things.

Dr. PIERROTT. Yes. Exactly. So I think if we were to look at costs plus quality, I think we are the winner.

Senator LINCOLN. But you do not have a lower cost.

Dr. PIERROTT. Well, not according to MedPAC. But MedPAC is talking about an average. I do not know if they are talking about my facility, and I do not have an absolute comparison of our facility.

Senator LINCOLN. It kind of gets back to what Senator Baucus was asking, and that is really that you are talking about apples and oranges.

If we compare your facility, which you said was a 20-bed facility, compared to a 600-bed facility where there are no discharges in that indigent program, there is no charity care, the bad debt that is less than 1 percent, which my hospitals would scream to have that, no emergency room, I mean, I guess the question I would say is, when you talk about a definition of a whole hospital, how can you truly look at that issue and use this apple and orange comparison to say that they are comparable in the definition of a whole hospital? I mean, do you not see anything in terms of a little bit of a stretch to consider your hospital in the same terms as the other facility, the 600-bed facility?

Dr. PIERROTT. We are clearly different models, but we are licensed by the State and we carry a hospital license like the other hospitals. If you look at the scope of services of the 400 or 500 hospitals in California, you will find a significant variation.

From the smallest to the largest, there will be huge differences in the services that they offer. I think one of the challenges for

health policy is to try to match the facility to the needs of the patient.

I think one of the greatest successes of my lifetime is the development of this surgery center, which is very limited in terms of the services provided, matches the need of the patient to that facility, and offers significant benefits to payors and the patients and their families.

So, we are talking about trying to develop a model that matches the needs of the patient appropriately and out-performs a model that was developed for a different purpose.

Senator LINCOLN. I do not think anybody wants to feel like they are asking anybody to diminish the service or diminish the quality or the technology that you are able to develop there.

I think what we are asking is the consideration of those that get left behind because you peel off, obviously, those that are helping to support the facilities that provide the other types of services, OB care, and other things like that.

Have you ever been in a teaching hospital? Have you ever been in medical academics?

Dr. PIERROTT. No, I have not ever been in academics. I obviously had my training in a teaching hospital.

Senator LINCOLN. Right. But, I mean, when you were out of your training.

Dr. PIERROTT. No.

Senator LINCOLN. No. I have a little bit of history with that. That is why I was concerned, certainly, with our teaching facilities and others where they do catch an awful lot of the care that is necessary for making sure that our communities are whole. If we want to talk about whole hospitals, we have got to have whole communities.

Dr. PIERROTT. You bet. I have great respect for the teaching hospitals and Dr. Sullivan's work, and others', and they are very important. I just do not want to sacrifice a model that I have come to find to be superior in the mix as we try to figure out how to sort out priorities.

Senator LINCOLN. Do you have suggestions of how we deal with those that are left behind by the institutions that you favor so strongly?

Dr. PIERROTT. Well, first of all, from the reading that I have done, this argument about being left behind, that there is somehow inadequate compensation, I think, is going to be difficult to prove based on the benefits that we already provide our big hospitals to take care of those patients in terms of the tax relief and other benefits. There is a whole host of those that could be listed. People who have looked into that, like Professor Kane, argue that the big hospitals are compensated for their charity care.

Senator LINCOLN. And so you feel like those that are left behind to be cared for, those institutions that care for them are adequately provided for to do the kind of quality of work that you profess you are able to do in a for-profit physician-owned facility?

Dr. PIERROTT. The statistics are that 75 percent of not-for-profit hospitals receive more in tax benefits than they provide in charity care.

Senator LINCOLN. We are not just talking about charity care. We are also talking about volumes in terms of Medicare and Medicaid, and others that obviously present a disproportionate share of one group of individuals that need care. I think that is really important.

One of the things that Senator Baucus mentioned, and you mentioned many reasons, I think, why physicians establish specialty hospitals. And I have visited with some of them, and I have toured some of those facilities. I want to make sure I get all sides of that.

But you did not list profit, which I was a little bit amazed at. I mean, it seems like, if we are going to lay everything out on the table here, is this not something that is considered by physicians as they enter into this agreement? We have seen some of the quotes from, I guess, some of your founding members. The biggest one—and I do not know if Senator Baucus said this, I was out—but Dr. Tuber, who is one of your founders——

Dr. PIERROTT. Yes.

Senator LINCOLN. His quote said, a couple of years ago from a neurosurgery conference was, "And the last thing, and the easiest thing, is money. There will be a lot of money out there. Why go to a surgical facility? Profit, profit, profit. You have got to get the market share. You want to take from them," meaning those hospitals, "and it will be so easy, you just can't believe how easy it will be."

If we are going to be realistic, we have got to be realistic about what we are dealing with.

Dr. PIERROTT. In California, you cannot make that kind of statement. The marketplace does not allow any facility that I know of in California—with a couple of exceptions, but they are not specialty hospitals—to make huge profits.

Senator LINCOLN. I do not know what Dr. Tuber was talking about then.

Dr. PIERROTT. But, absolutely, there does have to be a return on investment or you cannot attract the capital needed to build these facilities.

Senator LINCOLN. Well, when we look at what MedPAC does present us, it is that the distribution at some of the specialty hospitals frequently has exceeded 20 percent of the physicians in national investment, and the specialty hospitals in their study had an average all-payor margin, I think, of 13 percent in 2002, which was pretty much well above the 3- to 6-percent average for community hospitals in those same markets, or in their markets.

Dr. PIERROTT. Yes. And then if you tax those profits and put those into the system for delivering health services, you have a significant benefit to the community as well.

Senator LINCOLN. You mean, at the corporate yes?

Dr. PIERROTT. Yes. Or, no, at the personal rate.

Senator LINCOLN. Those guys have just got a big cut, just looking at what we are going to be providing, and certainly what the incentives are there.

Dr. Sullivan and Mr. Veitz, and certainly, Dr. Pierrott, jump in here, in terms of MedPAC's recommendations on improving the accuracy of Medicare's inpatient PPS and its recommendations on

gain sharing. You have supported the gain sharing, and in your testimony, I believe, said that you felt like it would have——

Dr. PIERROTT. Absolutely.

Senator LINCOLN. I mean, I would like to investigate where we need to go there, or if there is something there that is helpful.

Dr. SULLIVAN. I am on record. I will defer to Mr. Veitz.

Mr. VEITZ. As far as the gain sharing, I think that that is something I personally have interest in pursuing. Any time that you can create an environment in which the physicians and the hospitals work together, I would be in full support of that.

As far as the payment adjustments, that is always an option to consider. But I do not think that it, in itself, is an adequate solution. First of all, it does nothing to address the issue of conflict of interest, and second, it does not do anything to help the uninsured, the under-insured, and the poor.

Senator LINCOLN. My last two questions. One, is to Mr. Veitz, particularly. How do you think that MedPAC's recommendation on improving the accuracy of Medicare's inpatient PPS would impact small and rural hospitals? I have a vested interest there. The majority of my hospitals are rural. We are out there trying to serve those rural communities, which is very difficult.

Mr. VEITZ. I do not have the answer to that. I would really have to know specifically what they are talking about, and then take a look at that. Just with my limited knowledge in that area, I would agree with their comments that it probably will cut across all types of hospitals. Our own concern is that it might hurt some hospitals in very rural communities that are already struggling.

Senator LINCOLN. Right.

Mr. VEITZ. But I do not have any data to support that.

Senator LINCOLN. Well, I think it is important to make sure that our point is well taken. That is, we do not want to diminish the advancements in technology, the abilities to provide increased quality care to all people in this country. There are many advancements that are out there, but there is no doubt that we have got to, in some way, make the playing field as level as possible.

Representing a State that is, one, disproportionately elderly—we are in the top 10 States for the percentage of our population that is over 65—we also are disproportionately low income, which means the majority of our hospitals, if not all of them, are high Medicare and high Medicaid.

The critical issue of meeting all of these needs and using all of these new technologies, but making sure that we can still provide the basic needs and the basic services that our hospitals and our medical professionals have been able to do, is something that is really critical.

So, I think the playing field has got to be level if these people are going to be able to continue to keep their doors open. It certainly is quality of care and quality of life, but it is also jobs.

We almost lost one of our rural hospitals that covered a 90-mile radius. Not only were we going to lose the hospital, which was the second-largest employer in that county, but we were going to lose the two biggest manufacturing facilities because their liability went up when they lost the emergency room and the hospital care. So when we disproportionately put these people at a disadvantage, it

just means a tremendous amount to people in these under-served areas.

Dr. PIERROTT. Well, Senator, MedPAC conducted the study at the request of Congress and did not find that specialty hospitals had a negative financial impact on community hospitals. So, that must be reassuring in this——

Senator LINCOLN. I think Mr. Veitz has a comment on that.

Mr. VEITZ. I believe that was qualified, except in small communities.

Senator LINCOLN. Well, this is certainly a conversation that I hope will not end here. There are a lot of things that we still need to address, and there are many of us that do feel very passionate about making sure that that service remains there for our constituency. It just about broke my heart when Dr. Sullivan told me that they had to cancel the hospice care.

Those are the kinds of services that are absolutely vital to people living in these areas that will help us bring down, ultimately, the cost of health care. Because when you have got a good program like hospice that allows you the dignity, the home health, and all of the other things that you can do, then you do not end up spending the tremendous dollars in the end-of-life care in these hospitals.

Dr. PIERROTT. If I might describe my community. The eight-county area around Fresno, if it were a State, would be the 23rd largest State in the United States. It would have the lowest per capita income. It would have the highest indigent care load. It would have the highest rate of unemployment in the United States. It would have statistics far worse than Appalachia.

So if there is a model to test the impact of a specialty hospital on the ability of the not-for-profits to meet the needs of the uninsured and the under-insured, come to the Central Valley of California.

Senator LINCOLN. This is the same place where the 600-bed hospital sits beside your 20-bed hospital?

Dr. PIERROTT. We have a 400-bed hospital in our community, and a 300-bed hospital that just expanded as well. But, yes. There is no better place, I think, no better laboratory.

And if you look at this, and we all report our financial information to the State, you will find the most profitable hospital in our community in, I think, 2002, was the biggest one with the highest charity care load, and the least profitable was our specialty hospital.

So, these generalizations that are being made do not absolutely hold up. We have a long history of demonstrating that specialty hospitals do not harm community hospitals, and it has been confirmed by MedPAC.

Senator LINCOLN. Well, it would be important to look at the financial structure of both of those institutions to see where those gains were made.

Thank you all very much. As I said, I hope this discussion does not end here. I think I officially will adjourn the committee.

[Whereupon, at 12:25 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF TOM GUSTAFSON

Senators Grassley and Baucus, distinguished committee members, thank you for inviting me to testify today about physician-owned specialty hospitals. At the Centers for Medicare & Medicaid Services (CMS), we remain deeply committed to improving the quality of patient care and to increasing the efficiency of Medicare spending. As you know, how Medicare pays for medical services can have important impacts on quality and medical costs, for our beneficiaries and for our overall health care system. By carefully examining interactions between physicians and hospitals, we can consider how the financial incentives created by the Medicare program might be redirected to improve quality. To that end, Section 507 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires HHS to study a set of important quality and cost issues related to specialty hospitals, and to report to Congress on our findings. I am here today to present the preliminary results from the technical analysis that will underlie the CMS report for Section 507.

CMS STUDY

Specifically, MMA required HHS to study referral patterns of specialty hospital physician owners, to assess quality of care and patient satisfaction, and to examine the differences in uncompensated care and tax payments between specialty hospitals and community hospitals. CMS contracted with RTI International to conduct the technical analysis. At this time, we are reporting on the factual findings of the RTI analysis. Any policy recommendations on this issue will have to be developed once the report on the analysis is finalized.

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

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

CARDIAC HOSPITALS DIFFER FROM SURGERY AND ORTHOPEDIC HOSPITALS

The empirical evidence clearly shows that cardiac hospitals differ substantially from surgery and orthopedic hospitals. Compared to surgery and orthopedic hospitals, cardiac hospitals tend to have a higher average daily census, an emergency room, and other features, such as community outreach programs. The average daily census of the 16 cardiac hospitals nationwide was 40 patients. All the cardiac hospitals that were operational in 2003 reported that they were built exclusively for cardiac care. Cardiac hospitals treated 34,000 Medicare cases in 2003, and Medicare beneficiaries account for a very high proportion (about two-thirds) of inpatient days in those hospitals nationwide. In aggregate, within our sample, physicians own about a 49-percent share in cardiac hospitals; typically, a corporation, such as MedCath or a non-profit hospital, owns the majority share. In the study hospitals, the aggregate physician ownership averaged approximately 34 percent for the cardiac hospitals in the study. The average ownership share per physician in those hospitals was 0.9 percent, with individual ownership share per physician ranging from .1 percent to 9.8 percent, with a median of 0.6 percent and an average per physician share of 0.9 percent.

Surgery and orthopedic hospitals more closely resemble ambulatory surgical centers, focusing primarily on outpatient services. Their aggregate average daily census of inpatients is only about 5 patients. Physicians generally own a large share of the interest, averaging 80 percent in aggregate for the surgery and orthopedic hospitals in the study. The average ownership share per physician is 2.2 percent, with individual ownership shares per physician ranging from 0.1 percent to 22.5 percent, with a median of 0.9 percent. The balance is typically owned by a non-profit hospital or national corporation. Medicare patients account for about 40 percent of the inpatient days in these facilities. The small number of inpatient cases at surgery and orthopedic hospitals precluded the development of meaningful findings for this group on several of the dimensions of performance that we examined.

PRELIMINARY RESULTS

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

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

Overall, the Medicare cardiac patients treated in community hospitals were more severely ill than those treated in cardiac specialty hospitals in most of the study sites. This generally was true for patients admitted both by physicians with ownership in specialty hospitals and by other physicians without such ownership, indicating no difference in referral patterns for physician owners and non-owners. However, there was some variation, with cardiac hospitals in some areas having higher average severity than in the community hospitals. Although the number of cases was too small to draw definitive conclusions for surgery and orthopedic patients, the difference in the proportion of severely ill patients treated in community hospitals was greater for the surgery and orthopedic patients than for the cardiac patients.

The analysis of patients transferred out of cardiac hospitals did not suggest any particular pattern. The proportion of patients transferred from cardiac hospitals to community hospitals is about the same, around 1 percent, as the proportion of patients transferred between community hospitals. The proportion of patients transferred from cardiac hospitals to community hospitals who were severely ill was similar to patients in the same diagnosis-related group (DRG) who were transferred between community hospitals. The number of cases transferred from surgery and orthopedic hospitals was too small to derive meaningful results on this type of analysis.

Based on claims analysis using the AHRQ quality indicators and methodology, preliminary findings show that measures of quality at cardiac hospitals were generally at least as good and in some cases were better than the local community hospitals. Complication and mortality rates were lower at cardiac specialty hospitals even when adjusted for severity. Because of the small number of discharges, a statistically valid assessment could not be made for surgery and orthopedic hospitals. Patient satisfaction was extremely high in both cardiac hospitals and surgery and orthopedic hospitals, as Medicare beneficiaries enjoyed large private rooms, quiet surroundings, adjacent sleeping rooms for family members if needed, easy parking,

and good food. Patients also had very favorable perceptions of the clinical quality of care they received at the specialty hospitals.

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

MEDICARE PAYMENT ADVISORY COMMISSION (MedPAC) REPORT

The MMA also required a complementary MedPAC study of certain issues related to the payments, costs, and patient severity at specialty hospitals. Based on our initial review of their report, there are several preliminary findings in our analysis that are consistent with their results:

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

CONCLUSION

Mr. Chairman, thank you for this opportunity to discuss the technical findings that will be incorporated into our report on physician-owned specialty hospitals. We have been thoroughly studying this important topic, with extensive collection and analysis of new data, as part of our ongoing efforts to provide a strong factual foundation for implementing policy decisions that help patients get the high quality health care possible at the lowest cost. We will act expediently to incorporate these findings to complete our study and prepare our final results and recommendations for your review. As part of our careful evaluation of this multi-dimensional issue, we are also assessing what authority we have in this area to assure the best possible alignment of Medicare's financial incentives with our goal of improving quality of care provided to our beneficiaries while avoiding unnecessary costs. CMS looks forward to continuing to work with you closely on this issue. I thank the committee for its time and would welcome any questions you may have.

RESPONSES TO QUESTIONS FROM SENATOR GRASSLEY

Question: Your testimony indicates that your findings are based on 11 specialty hospitals in six market areas across the country. Of these 11 hospitals in your study, how many were heart hospitals? How many were orthopedic? And how many were surgical?

Answer: Where possible, we used the entire population of physician-owned specialty hospitals to answer the study questions. The quality study and the analysis of severity levels use the entire population of physician-owned specialty hospitals. The analysis of physician referral patterns, patient satisfaction, and uncompensated care required data beyond the Medicare claims could only be done with the sample of 11 facilities in the six market areas we visited: in those six areas, our research team visited four cardiac specialty hospitals (25 percent of the universe in 2003) and seven orthopedic and surgery hospitals (16 percent of the orthopedic/surgical universe in 2003).

Question: In your testimony you present findings about quality care, patient severity, transfers and physician referral patterns, but you often state you only have enough data to draw meaningful results on heart hospitals. To what extent do your findings apply to orthopedic and surgical hospitals?

Answer: Surgery and orthopedic hospitals more closely resemble ambulatory surgical centers, focusing primarily on outpatient services. In 2003, these physician-owned hospitals treated only 8,400 Medicare cases, and their aggregate average daily inpatient census was about 5 patients. The measures of quality used in the study, *e.g.,* mortality, complications, and readmissions, are rare events within any hospital population. Using all Medicare cases treated in these hospitals, there were very few deaths, no complications for most patient safety indicators, and lower readmissions rates than in community hospitals. However, the very small number of these events precluded a statistically meaningful comparison to community hospitals for similar cases.

The number of cases of the entire population was large enough to assess the relative severity levels in the physician-owned orthopedic/surgery hospitals. Staff from the seven hospitals visited stated that they did not accept patients that required an intensive care unit level of care, since their hospitals did not have this level of service. Consequently, our severity analysis corroborated their statements by finding that the Medicare cases were less severe than comparable cases in community hospitals. The severity levels in the cardiac hospitals were much closer to community competitor hospitals and, in some cases, exceeded the competitor hospitals in a market area.

Question: Based on national data, you indicate that cardiac hospitals differ pretty significantly from orthopedic and surgical hospitals. Heart hospitals have more beds and more patients. They operate emergency rooms and community outreach programs. And, physicians own much less of these facilities—34 percent versus 80 percent. With heart hospitals differing from other types of specialty hospitals, do you believe that conclusions regarding heart hospitals can be applied equally to orthopedic and surgical hospitals?

Answer: We observed many similar patterns among the cardiac and the surgery and orthopedic group in relation to the local community hospitals for level of uncompensated care and patient satisfaction. On other issues (*e.g.,* quality of care, severity of illness), however, the number of cases in the surgery and orthopedic group was too small to derive statistically significant results.

Question: HHS found that quality in specialty hospitals was "generally at least as good and in some cases better than the local community hospitals." Does this then mean that in some cases the quality at full service community hospitals is better? Is it then also accurate to say that the quality at community hospitals is "at least as good and sometimes better" than at cardiac hospitals?

Answer: We examined quality on several dimensions. For some of these dimensions—such as readmissions—the community hospitals marginally outperformed the specialty hospitals. On measures such as in-hospital or 30-day post-admission mortality rates, the specialty hospitals performed better. The cardiac hospitals also had lower complication rates compared to community hospitals.

Question: Some say that a patient's ability to assess clinical quality is challenging. For example, I'm not sure I could really judge the skill of one surgeon over another. I might only know, for example, that my appendix has been removed and I'm feeling better. This especially gets tricky when these same doctors and surgeons are practicing at both community hospitals and specialty hospitals. It might be easier for patients to judge their satisfaction with things like food and parking. Given this, can you explain what information you used to assess quality? Can you assess the accuracy of this information? And, are there other measures out there that you could have employed?

Answer: In our assessment of patient satisfaction with focus groups of specialty hospital patients, we also asked about quality, but our major findings on the relative performance of specialty and community hospitals with regard to quality were based on our analysis of clinical measures using claims data.

Question: Your testimony didn't make any qualifications regarding limitations of this analysis. What are these limitations?

Answer: While national data could be used for some aspects of our analysis, the questions related to referral patterns by physician owners, patient satisfaction, and tax payments, as mandated by the MMA, required data that are not generally available. In order to obtain such data, we conducted site visits in a limited number of areas, with a small number of hospitals. Although the study areas were chosen to represent the diversity of conditions in which specialty hospitals operate, they are not necessarily statistically representative of the entire group of specialty hospitals nationwide.

However, it must be pointed out that there also are wide variations in operations, performance, and impact among community hospitals across the country, even within specific market areas. The analyses in the CMS report are intended to provide information that is broadly indicative of the range of situations we observed.

Question: When do you expect Congress will receive HHS's final report and recommendations?

Answer: We will act expediently to incorporate these findings to complete our study and prepare our final results and recommendations for your review. Additionally, as part of our careful evaluation of this multi-dimensional issue, we are assessing what authority we have in this area to assure that the financial incentives created by the Medicare program might be aligned to improve quality.

RESPONSES TO QUESTIONS FROM SENATOR BAUCUS

Question: Mr. Gustafson, as I understand it, your study looked at 11 specialty hospitals in all. Is that correct? And four of these were cardiac, and seven were a mix of orthopedic and surgery.

I also understand the data you collected from the orthopedic and surgery hospitals were not statistically significant.

I would just like to know, were the sites that you visited randomly selected, according to standard statistical protocols? And how did you measure quality? You said the quality data, as I understand it, were all right. Measured against what?

Answer: The number of specialty hospitals is not large, and we chose the hospitals for site visits to represent the diversity of experience within this small group—as is discussed more fully below—and thus to provide the best information we could to address the questions articulated by Congress. The case studies allowed us to delve in some depth into the situations of the selected hospitals and to gather information that CMS does not routinely collect. For instance, CMS does not usually obtain data on ownership, physician referral, uncompensated care, or patient satisfaction.

We also examined the quality of all specialty hospitals nationwide by using claims data. For hospitals in the sites visited, interviews with clinicians and management and patient focus groups were used to corroborate the findings on quality that were derived from the claims data.

CRITERIA FOR SELECTION OF SITES FOR VISITS

Site visits were made to six market areas: Dayton, OH; Fresno, CA; Rapid City, SD; Hot Springs, AR; Oklahoma City, OK; and Tucson, AZ. Our research team visited four of the 16 cardiac specialty hospitals (25 percent of the universe) and seven of the 43 orthopedic and surgery hospitals (13 percent of the universe). A randomized approach could not be used to choose facilities because of (1) the disproportionate number of cardiac hospital cases (80 percent of the specialty hospital cases, but only 25 percent of the facilities), (2) the inadequate number of cases for analysis in the orthopedic/surgery hospitals, and (3) the need to visit sites that could represent a range of circumstances. Consequently, we developed the following site selection criteria based on what we needed to learn.

For all specialty hospitals:

- Have as much geographic diversity (both urban and rural) as visits to six market areas would allow.
- Visit both mature hospitals and recent start-ups in order to understand the evolution of the industry.
- Visit hospitals that had an adequate level of cases to analyze and include in patient focus groups.
- Not repeat visits in the three areas visited by MedPAC.

Additional factors relevant for cardiac hospitals:

- Limit the cardiac hospital visits to no more than two of the nine hospitals in which MedCath is a majority owner, since these use similar operating protocols and ownership arrangements.
- Visit some cardiac hospitals that had non-profit hospital owners.

With the population of these hospitals so small and so diversified, random selection would not have given us the information necessary for the report. There was no indication that the hospitals were developed as a result of a random process, but rather developed as a result of the conditions in each State and area. During and after our site visits, we confirmed that each specialty hospital had its own unique set of circumstances.

QUALITY AND CLAIMS DATA

Three measures of quality were used to assess differences between specialty hospitals and competitor hospitals:

- Mortality, both during hospitalization and within 30 days of discharge from the hospital.

- Complications during hospitalization.
- Readmission within 30 days of discharge; and discharge disposition.

These measures were analyzed using the 2003 Medicare claims data from both the entire population of specialty hospitals and their area competitors. The site visit and patient interviews were used to corroborate the results of the claims analysis.

The mortality data were adjusted for severity for comparison purposes. Complications during hospitalization were assessed using the inpatient hospital indicators developed by the Agency for Health Research and Quality (AHRQ). The AHRQ measures, expressed as rates, that were used to compare specialty hospitals to competitor hospitals were:

- Complications of anesthesia.
- Death in low-mortality diagnosis-related groups.
- Decubitus ulcer.
- Failure to rescue.
- Foreign body left during procedure.
- Iatrogenic pneumothorax.
- Selected infections due to medical care.
- Post-operative hip fracture.
- Post-operative hemorrhage or hematoma.
- Post-operative physiologic and metabolic derangements.
- Post-operative pulmonary embolism or deep venous thrombosis.
- Post-operative sepsis.
- Accidental puncture or laceration.

RESPONSES TO QUESTIONS FROM SENATOR KYL

Question: Part of the confusion around specialty hospitals centers on the lack of a clear definition. According to the GAO and MedPAC definitions, two criteria must be met:

(a) Primarily cardiac, orthopedic, surgical or other specialty services, and

(b) Two-thirds or more of its inpatient claims from one or two major DRGs.

It is interesting that after the moratorium was implemented, some facilities that were considered specialty hospitals were anxious to claim that they were not specialty hospitals.

When will CMS issue a clear definition for a specialty hospital?

Answer: Section 507 of the Medicare Modernization Act defined a specialty hospital for the purposes of the moratorium. For the moratorium only, a "specialty hospital" is a hospital in one of the 50 States or the District of Columbia that is primarily or exclusively engaged in the care and treatment of one of the following:

- Patients with a cardiac condition;
- Patients with an orthopedic condition;
- Patients receiving a surgical procedure; or
- Patients receiving any other specialized category of services designated by the Secretary.

The Secretary has not designated any additional specialized services that would cause an institution to be considered a specialty hospital within the meaning of Section 507 of MMA. We note that we have not issued any definition that differs from or expands on the statutory definition because specialty hospitals under the moratorium are not a category used for any other Medicare program purposes.

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

Question: If the DRG changes are implemented before January 1, 2007 and an extension of the moratorium is passed, should the moratorium be lifted once the changes are completed?

Answer: The MMA required MedPAC and the Secretary to study various issues concerning physician-owned specialty hospitals and report to the Congress. The reports to Congress must include any recommendations for legislation or administrative changes. The MedPAC study addressed issues of cost differences, payment equity, and impacts on local community hospitals. The HHS study will address issues involving referral patterns, quality, patient satisfaction, and uncompensated care differences. We believe that Congress should consider all of these issues when evalu-

ating any potential legislative change, including the duration of any extension of the moratorium.

MedPAC's Report to Congress on the MMA-mandated study recommended certain DRG refinements, statutory changes to permit certain gain-sharing arrangements, and an extension of the moratorium until January 1, 2007. We note that CMS is currently analyzing MedPAC's DRG refinement recommendations. These recommendations are complex and have the potential to result in significant changes to hospital payments. We expect to present our analysis of the MedPAC recommendations in the IPPS proposed rule that will be published this spring.

Question: If the implementation of the DRG changes extends after January 1, 2007, would it follow logically that the moratorium should be extended?

Answer: The MMA required MedPAC and the Secretary to study various issues concerning physician-owned specialty hospitals and report to the Congress. The reports to Congress must include any recommendations for legislation or administrative changes. The MedPAC study addressed issues of cost differences, payment equity, and impacts on local community hospitals. The HHS study will address issues involving referral patterns, quality, patient satisfaction, and uncompensated care differences. We believe that Congress should consider all of these issues when evaluating any potential legislative change, including the duration of any extension of the moratorium.

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PREPARED STATEMENT OF GLENN HACKBARTH

Chairman Grassley, Senator Baucus, distinguished Committee members. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this afternoon to discuss physician-owned specialty hospitals.

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

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

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

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

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

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

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

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

How many and where

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

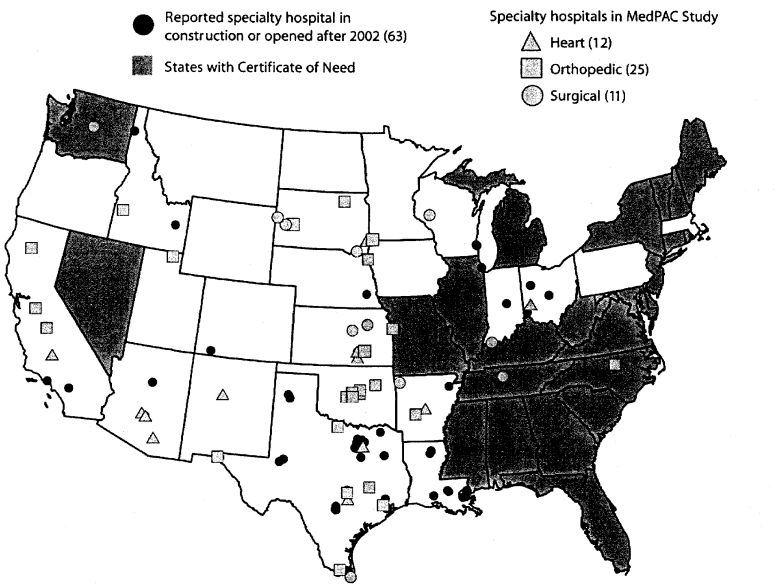
Many specialty hospitals do not have emergency departments (EDs), in contrast to community hospitals where the large majority (93 percent) do. Those that have EDs differ in how they are used, and that may influence how much control the hospital has over its schedule and patient mix. For example, 8 of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

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

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

FIGURE 1

Specialty hospitals are geographically concentrated



Motivations for forming physician–owned specialty hospitals and critics objections

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

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

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

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

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

Do physician-owned specialty hospitals have lower costs?

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

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

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

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

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

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

- Physician-owned heart, orthopedic, and surgical hospitals that did not focus on obstetrics tended to treat fewer Medicaid patients than peer hospitals and community hospitals in the same market. Heart hospitals treated primarily Medicare patients, while orthopedic and surgical hospitals treated primarily privately insured patients.
- The increases in cardiac surgery rates associated with the opening of physician-owned heart hospitals were small enough to be statistically insignificant for most types of cardiac surgery. It appears that specialty hospitals obtained most of their patients by capturing market share from community hospitals.
- Though the opening of heart hospitals was associated with slower growth in Medicare inpatient revenue at community hospitals, on average, community hospitals competing with physician-owned heart hospitals did not experience unusual declines in their all-payer profit margin.

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

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

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

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

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

Reflecting their similar concentration in surgical cardiac cases, peer heart hospitals also benefit from favorable selection across DRGs, though not as much as specialty heart hospitals. However, peer heart hospitals receive no additional benefit from selection

among more- or less-severe cases within DRGs. Both specialty heart and peer heart hospitals have a favorable selection of patients compared with community hospitals in the specialty heart hospitals' markets, as well as with all IPPS hospitals.

TABLE 1

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

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

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

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

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

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

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

Payment recommendations

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

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

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

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

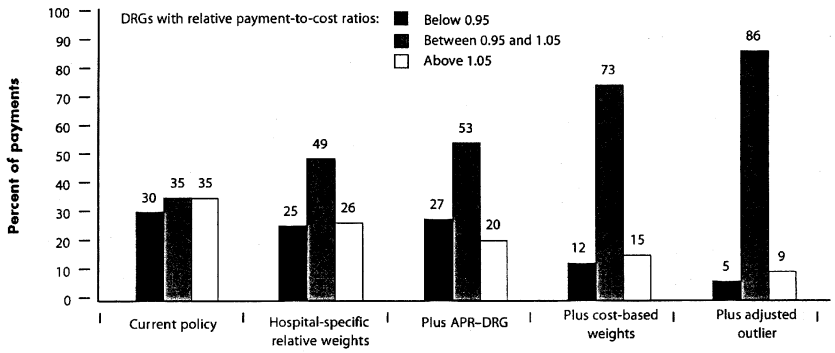
All of these actions are within the Secretary's current authority.

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

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

FIGURE 2

Improvement in payment accuracy from policy changes



Note: DRG (diagnosis-related group), APR–DRG (all-patient refined diagnosis-related group).
Source: MedPAC analysis of Medicare hospital inpatient claims and cost reports from CMS, fiscal year 2000-2002.

These payment system refinements would affect all hospitals—both specialty hospitals and community hospitals—and many would see significant changes in payments. A transitional period would mitigate those effects and allow hospitals to adjust to the refined payment system. Thus, the Commission recommends the Congress and the Secretary should implement the payment refinements over a transitional period.

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

Recommendations on the moratorium and gainsharing

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

Aligning financial incentives for physicians and hospitals could lead to efficiencies. Physician ownership fully aligns incentives; it makes the hospital owner and the physician one in the same, but raises concerns about self-referral. Similar efficiencies might be achieved by allowing the physician to share in savings that would accrue to the hospital from reengineering clinical care. Such arrangements have been stymied by provisions of law that prevent hospitals from giving physicians financial incentive to reduce or limit care to patients because of concerns about possible stinting on care and

quality. Recently, the Office of Inspector General has approved some narrow gainsharing arrangements, although they have been advisory opinions that apply only to the parties who request them.

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

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

RESPONSE TO A QUESTION FROM SENATOR GRASSLEY

Question: Mr. Hackbarth, in your testimony and in MedPAC's report you indicated that: "The Commission is concerned with the issue of self-referral and its potential for patient selection and higher use of services. However, removing the exception that allows physician ownership of whole hospitals would be too severe a remedy given the limitations of the available evidence, although we may wish to reconsider it in the future."

Closing the loophole would still allow physician owners to self-refer to full service hospitals treating a wide range of patients but it would not allow physician owners to self-refer to specialty hospitals that treat only a certain type of patient. Is this assumption correct?

Answer: Whether physicians would still be allowed to refer patients to full-service hospitals in which they invest depends on how the whole-hospital exception would be modified. If the exception were completely eliminated, this would subject physician ownership of any hospital, whether full-service or single specialty, to the self-referral prohibition of the Stark law. However, the exception could instead be modified to permit physician investment only in full-service hospitals but not specialty hospitals. Given the limitations of evidence on the quality and efficiency of specialty hospitals, we do not at this point recommend modifying or eliminating the exception. We may wish to reconsider our position in the future as more evidence becomes available.

RESPONSES TO QUESTIONS FROM SENATOR CRAPO

Question: In your testimony you write: "Because hospitals provide many kinds of services, an exception was created [in the Ethics in Patient Referrals Act] that allowed physicians to refer patients to hospitals in which they invest. This is the "whole-hospital" exception. Physician investors have a greater opportunity to influence profits at single-specialty hospitals—which generally provide a more limited range of services—than at full-service hospitals."

Do physician-investors also have a greater opportunity to influence profits at ASCs in which they own stakes?

Answer: The OIG has concluded that physicians' investment in an ASC where they perform services involves minimal risk of overuse. This judgment is based on the premise that an ASC is, for practical purposes, an extension of a physician's office practice (OIG 1998). Because physicians who invest in ASCs perform procedures there themselves, there is less risk of overuse than when they refer patients for services performed by others, such as laboratory tests. Moreover, physicians already have an incentive to perform surgery to generate a professional fee, so the revenue they earn from ASC facility fees might not substantially increase their incentive to perform surgery.

In 1999, OIG established "safe harbors" that protect physician investments in ASCs from prosecution under the anti-kickback statute (OIG 1999). The ASC safe harbors are limited to physicians who routinely use the facilities and to facilities that do not provide ancillary services (such as lab tests) other than those included in Medicare's bundled ASC facility fee. These two conditions limit the incentive to

overuse services and to profit from services physicians do not personally perform. By contrast, the whole-hospital exception in the Stark law makes no such distinction between services personally performed by the referring physician and those that are not. The exception applies to all services billed by the hospital. For example, it permits physicians who invest in a hospital to share in the profits from ancillary services they do not perform (such as radiology and laboratory) as well as profits related to procedures they perform.

Question: Is MedPAC aware of any studies that demonstrate any evidence of kickbacks or referral abuse by physicians who own interests in ASCs? If so, please provide such.

Answer: We are not aware of any studies that examine whether physicians who invest in ASCs engage in kickbacks or referral abuse.

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RESPONSES TO QUESTIONS FROM SENATOR KYL

Question: From page 2 of your testimony, you are quoted as stating the following: "Improving the accuracy of the payment system would help make competition more equitable between community hospitals and physician-owned specialty hospitals, whose physician owners can influence which patients go to which hospital. It would also make payment more equitable among community hospitals that currently are advantaged or disadvantaged by their mix of DRGs or patients."

Does this mean that after revising the DRG payment as you have recommended, that you believe specialty hospitals should be able to then compete with general hospitals and, in fact, should be left alone?

Answer: If our recommended changes to the inpatient prospective payment system are implemented, specialty hospitals' advantage based on the selection of certain types of Medicare cases and patients should be substantially reduced. In this case, specialty hospitals would have to compete with community hospitals on a more level playing field. Nevertheless, the Commission has some remaining concerns about whether there is an inherent conflict of interest in physician ownership. In addition, our limited, early evidence does not show that specialty hospitals have lower costs than community hospitals. Although we considered recommending that the Congress repeal the whole-hospital exception in the Stark law, we decided against doing so because specialty hospitals may be an important competitive force that promotes innovation. We do not want to preclude their development before gaining a fuller understanding of their quality and efficiency. As more information on service use and community impact becomes available, we may reconsider the advisability of repealing or modifying the whole-hospital exception.

Question: If so, why does continuing the moratorium on their development make sense? While you are reforming that payment system for all hospitals, why should a general hospital be allowed to expand or to open, especially in States without a certificate of need process in place? Why should other hospitals—community hospitals, satellite facilities associated with academic medical centers, for-profit whole hospitals—be allowed to develop while the DRGs are revised and specialty hospitals should not?

Answer: Physician-owned specialty hospitals are advantaged under the current inpatient payment system because they tend to treat patients in profitable DRGs and low-cost patients within DRGs. Some community hospitals also are advantaged under the current payment system while others are disadvantaged. This factor—coupled with our finding that physician-owned specialty hospitals do not have lower costs than other hospitals and our concern that there may be an inherent conflict of interest in physician ownership of hospitals—led the Commission to recommend extending the moratorium on physician-owned hospitals rather than inhibiting the development of all hospitals. This extension would provide more time to gather information on specialty hospitals' efficiency and quality and their effects on community hospitals and overall use of services. Extending the moratorium would also give

the Secretary and the Congress time to consider our recommended changes to the inpatient prospective payment system.

Question: In the January 12, 2005 public MedPAC meeting, you made the following statement: "I think all of us would agree that right now the burden of providing care to Medicaid recipients or uncompensated care is not evenly distributed. That's an issue that long predates specialty hospitals, and it's an issue that has very important implications for the system. And to say that stopping specialty hospitals is going to materially alter that problem, fix that problem, I don't think that's the case."

We can agree that the majority of people who require cardiac surgical procedures by their sheer demographics are not usually Medicaid patients. Medicaid patients tend to be women and children. I hear from hospitals, aside from this issue, about problems they are having financially, whether there is a specialty hospital in the vicinity or not. How do you believe specialty hospitals can exist in the market, whether it is the market we currently have or one we create? Do you believe specialty hospitals should be able to exist at all?

Answer: Although GAO found that few cardiac patients in general hospitals were Medicaid beneficiaries (6 percent of the total), this was twice the proportion in specialty hospitals (3 percent of the total) (GAO 2003). Should specialty hospitals be able to exist? Our report found that physician-owned specialty hospitals have an advantage because they tend to treat patients in profitable DRGs and low-cost patients within DRGs. Therefore, the accuracy of the inpatient prospective payment system should be improved to help make competition more equitable between physician-owned specialty hospitals and community hospitals. Beyond that, the Commission is concerned that there may be an inherent conflict of interest in physician ownership. On the other hand, physician-owned specialty hospitals may be an important competitive force that promotes innovation and may be an appropriate response to physician frustration with community hospitals' lack of responsiveness and physicians' desire for control. We therefore do not want to preclude their development before gaining a fuller understanding of their quality and efficiency. As more information becomes available, we may reconsider the advisability of repealing or modifying the whole-hospital exception.

Question: Is it just a matter of physician ownership, or would corporate ownership be permissible?

Answer: We are primarily concerned about physician ownership of specialty hospitals because of the potential for financial incentives to influence clinical decisions. However, the problems with the current inpatient payment system affect both physician-owned and non-physician-owned hospitals. Thus, we recommend that the accuracy of the payment system be improved to reduce financial incentives to select certain cases.

PREPARED STATEMENT OF DR. ALAN H. PIERROTT

Mr. Chairman and members of the committee, my name is Alan Pierrot. I am an orthopedic surgeon from Fresno, CA and a founding member of the Fresno Surgery Center, a multispecialty physician-owned surgical hospital. I am here today on behalf of the American Surgical Hospital Association (ASHA), the national trade organization representing 75 physician-owned hospitals that specialize in surgical care, the vast majority of such hospitals in the United States. I served as the first president of ASHA and continue to be active on the board of directors. I appreciate the chance to represent our patients, our staff, our doctors and our facilities. ASHA is very pleased to have the opportunity to testify at today's hearing, the first Congressional hearing on the subject of physician-owned specialized hospitals.

THE VALUE OF SPECIALTY HOSPITALS

The Fresno Surgery Center opened as an ambulatory surgery center in 1984, largely in response to the problem surgeons were having with operating room schedules and the efficiency at the local hospitals. Four years later we added a 20-bed inpatient care unit under a pilot project authorized by the California legislature. In 1993 we converted that unit to a licensed hospital. We promised the legislature that we could improve surgical care and patient satisfaction, and we did. Physicians in other communities have now adopted this structure as a response to their frustration with general hospital operations. Our hospital is licensed by the State of California as an acute care facility, just like all the general hospitals in the State. This is the case in other States as well.

The Fresno Surgery Center and the other members of ASHA provide cost effective, high quality surgical care in a very efficient manner. Specialty hospitals offer

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

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

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

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

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

I know that CMS will soon issue its report, which will include an analysis on quality. I am confident that our hospitals will do well. I would also encourage the committee to look at *HealthGrades.com,* an independent service that evaluates hospital quality for specific procedures. Using Medicare data and other resources, this service calculates an expected complication rate for each hospital. Actual performance is then measured and compared to the projected rates. I am pleased to note that on a risk-adjusted basis, Fresno Surgery Center had the highest scores in three of the four categories rated and an average that was superior to any of the general hospitals in its market. This has also been the case for other surgical hospitals.

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

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

For the past 4 years there has been a great deal of rhetoric about specialty hospitals, but little solid information. We now have reports from the Government Accountability Office (GAO) and the Medicare Payment Advisory Commission (MedPAC) that shed more light on the issues in the debate. The forthcoming report of the Centers for Medicare and Medicaid Services (CMS) will provide important information on quality of care, patient satisfaction and physician referral patterns. In addition, reports are now available from non-governmental sources. There have been numerous articles in the press on this issue, as well as in scholarly journals, like the *New England Journal of Medicine.*

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

MedPAC's bottom line is that general hospitals have not been harmed. They have effectively responded to the competition posed by specialty hospitals and remained as profitable as their peers in communities where no specialty hospitals exist. This is certainly true in Fresno, where the general hospitals have thrived since Fresno Surgery Center opened. I know this to be the case in other cities where specialty hospitals operate. No proof of harm to general hospitals, risk to patients or abuse of the Medicare program because of excessive or unnecessary surgery has been found. Therefore, there is no justification to continue the moratorium beyond the legislated expiration date.

I want to make an important observation about the current moratorium. I think there is a widespread view that the 18-month moratorium is benign, allowing existing specialty hospitals to proceed unhindered, while only limiting new development. This leads to the false conclusion that an extension of the moratorium as recommended by MedPAC would also not harm existing facilities. In fact the moratorium is not benign, but has hurt many well-established specialty hospitals. That is because it limits the expansion of facilities, the introduction of new services and the addition of new investors in response to changing needs and circumstances in our communities. Most of our members are located in areas experiencing rapid population growth, yet they have not been able to expand the number of beds or add new specialties to meet that increased patient demand.

Our ability to serve our patients and our physicians has been eroded. Another moratorium would only exacerbate this situation. There is no justification for extending the moratorium on a model of care that does not harm general hospitals and that provides superior care and patient satisfaction.

ASHA also believes that none of MedPAC's findings would justify any change to the current law governing physician ownership of hospitals. We are pleased that MedPAC decided against including any recommendations on the whole-hospital exemption to the Stark law.

MedPAC's analysis of specialty hospitals did show that Medicare's inpatient hospital payment system needs substantial revision. ASHA agrees with their recommendations and urges Congress and CMS to act on them this year. We also urge adoption of MedPAC's recommendations on gain-sharing to encourage hospitals and physicians to work in concert to improve the quality and efficiency of health care. Finally, ASHA encourages the committee to act on MedPAC's recent proposals on pay for performance measures in the hospital setting.

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

THE WHOLE-HOSPITAL OWNERSHIP EXEMPTION IN STARK II

I noted with interest the recent petition of the Federation of American Hospitals calling on the Department of Health and Human Services to restrict the whole-hospital exemption in the Stark law to hospitals that "provide a full range of services customarily offered by general community-based hospitals." ASHA believes that no evidence exists that should cause Congress or the department to modify the current hospital ownership exemption. Physician ownership of hospitals and other facilities is not new. Physicians who owned the facilities started many of today's finest medical clinics, like the Mayo Clinic.

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

The American Hospital Association also encouraged Congress to incorporate flexibility in the law governing referral arrangements. In testimony before the Ways and Means Committee in 1989, AHA noted, "Oftentimes, joint ventures which are the subject of H.R. 939 are well intended to provide the highest quality, most accessible and most reasonably priced medical care to the community." AHA urged Congress

to take a "more flexible or less proscriptive approach, allowing ventures consisting of referring physicians, if such ventures are for a legitimate business reason. . . ."

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

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

As previously noted, MedPAC debated whether or not to include a recommendation on the whole-hospital exemption but decided not to incorporate one in their report on specialty hospitals. Among the concerns expressed during discussion of this idea was the fact that no one could predict where elimination or modification of the exception might lead. For example, physicians have purchased rural hospitals in an effort to keep them open. Those acts of community concern could be outlawed if the exemption were to be amended or eliminated. The recent purchase of a Tenet hospital in California by the physicians who had a long-standing relationship with the hospital might not be allowed. It is obvious that there is no clear line that easily distinguishes physician ownership of one hospital versus another. If HHS accepts the recommendations of the FAH, it will only further muddy already complex laws and regulations, making obedience to the law more difficult and enforcement nearly impossible. Congressional action to limit or eliminate the current provisions governing physician ownership of hospitals would have a similar effect.

SPECIALIZED HOSPITALS IN THE UNITED STATES

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

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

A careful examination of general hospitals in this country would show that they vary widely in the types of services they offer, consistent with their facilities, staffing and the kinds of physicians present in the community. For example, few hos-

pitals have burn units and most do not have heart programs. Level 1 trauma centers are not common. The emergency services offered by most general hospitals are not of that caliber. Rural hospitals routinely send complex medical and surgical cases to their larger colleagues. The less difficult cases stay behind. Yet no one is accusing rural hospitals or critical access facilities of "unfair competition" or "skimming the cream" or "cherry picking."

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

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

Our members are located in 18 different States. GAO found that 28 States had at least one specialty hospital, but approximately two-thirds were located in seven States. In MedPAC's sample, almost 60 percent were concentrated in four States. This concentration is primarily due to the presence of certificate of need (CON) laws governing hospital construction. Most specialty hospitals are in States that do not have hospital CON requirements. Since CON laws tend to protect existing facilities from new entrants into the market, it should come as no surprise that our members are usually found in States that do not have such barriers to market entry. It is worth noting that both the Department of Justice and the Federal Trade Commission have called for an end to CON because of its anticompetitive effects.

WHY PHYSICIANS ESTABLISH SPECIALTY HOSPITALS

It is important that the committee understand why physicians establish specialty hospitals. Those reasons will vary in each community, but the interest in a specialty hospital usually begins after physicians have failed to persuade the general hospitals at which they practice to make changes that will improve physician efficiency and patient care. For example, the Stanislaus Surgical Hospital in Modesto was established first as an ambulatory surgery center and later as a hospital by surgeons who could not get reasonable access to the operating rooms at the two other hospitals in town. These hospitals were profiting from their cardiovascular and neurosurgery services. Those cases had first call on the OR. Orthopedics, urology, ENT and other surgical disciplines took what was left, and even then were often bumped by trauma and other emergency cases. The result was that elective cases were delayed until 10 p.m. or later, to the great unhappiness of patients and surgeons alike. While no one disputes the need for hospitals to deal quickly and effectively with emergencies, many hospitals have figured out ways to keep the rest of the surgical schedule moving along. Stanislaus arose out of this unresolved conflict.

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

To the best of my knowledge, only five members of this committee represent States with functioning physician-owned specialty hospitals—Utah, Arizona, Idaho, Montana and Arkansas. Mr. Chairman, your home State of Iowa is not on that list, although Mercy Medical Center in Sioux City does have a joint venture with Iowa and South Dakota physicians that is located in Dakota Dunes, SD. A number of Iowa residents receive their surgical care at that facility. The specialty hospital would probably have been built in Iowa were it not for the State's regulations governing hospital construction. The remaining States represented by the members of this committee have laws and regulatory systems that effectively prevent the construction of physician-owned specialty hospitals.

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

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

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

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

RESPONSES TO CRITICS OF PHYSICIAN-OWNED SPECIALTY HOSPITALS

I would like to turn to the main criticisms of physician-owned specialty hospitals and address them. Fundamentally these are allegations that specialty hospitals hurt general hospitals financially and engage in unfair competition because they have physician owners. There are a number of arguments used to justify these criticisms. These are (1) ASHA members have a favorable payor mix and refuse to admit or otherwise limit the number of Medicare, Medicaid and charity cases; (2) they focus on the highest paying inpatient DRGs; (3) they only take the easier cases in those DRGs; (4) physician ownership is a conflict of interest and gives specialty hospitals an unfair competitive advantage in the market; and (5) physician ownership leads to increased, and unnecessary utilization of surgical services.

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

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

I know for a fact that, in Fresno, the specialty hospital model has had no negative financial impact on local hospitals. The same is true in nearby Modesto, which also has a specialty hospital. The other hospitals are either expanding or have plans to

expand. Kaiser is building a new hospital in Modesto. In fact, hospital construction nationwide totals in the billions of dollars, hardly a sign of an industry in financial distress. General hospitals obviously have access to capital and are sufficiently sound financially that lenders continue to finance their projects.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Specialty hospitals have been challenged on the basis that they select only the highest paying DRGs. While MedPAC has demonstrated that some of the DRGs are

more profitable than others, many of the cases treated in specialty hospitals are not drawn from the "rich" DRG pool. In fact, many surgical DRGs are no more or less profitable than other services. To the extent that this is an issue, however, the payment recommendations of MedPAC would correct any disparities between rich and poor DRGs.

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

When GAO looked at this issue, its analysis revealed little real difference in acuity of admissions. For example, among admissions to surgical hospitals, 2 percent of the cases were in the highest acuity groups, while general hospitals had 4 percent of their admissions for the same surgery fall into the most severe classification. In other words, 98 percent of admissions to surgical hospitals were healthy and 96 percent of admissions for the same services to general hospitals were in equally good health.

In hospitals that specialized in orthopedic care, 95 percent of admissions were in the lesser acuity categories, while 92 percent of comparable admissions to general hospitals had the same severity classification. In heart hospitals GAO found only a 5-percent difference in acuity between specialized facilities and general hospitals.

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

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

MedPAC has determined that specialty hospitals do not add to the volume of surgery. The commission could not find evidence that the increase in service volume experienced in communities with specialty hospitals was higher than that found in areas that had no specialty hospitals.

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

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

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

A great challenge to the committee and to Congress generally will be digging through the layers of rhetoric, spin and cant to get to the real facts. It amazes me that so much has been said or written, much of it wrong or false, about fewer than 100 hospitals that make up about 1 percent of Medicare inpatient payments. However, it will be worth the effort to get past the rhetoric and examine the facts, be-

cause there is solid information available to you on many points in the debate. I hope you will rely on that data to make any decisions about legislation that might impact the future of specialty hospitals.

In summary, after thorough study, the allegations against specialty hospitals have not been proven. Therefore, ASHA urges the committee to allow the moratorium to expire as scheduled in June. The reforms to Medicare's inpatient payment system and the hospital pay for performance recommendations suggested by MedPAC would greatly benefit the Medicare program and should be adopted. However, there is no evidence to justify putting specialty hospitals under another moratorium during the period these needed changes are implemented, or imposing any other limit on physician ownership of hospitals.

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

AMERICAN SURGICAL
HOSPITAL ASSOCIATION

2004 MEMBERSHIP SURVEY RESULTS

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

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

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

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

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

The type of joint venture varied widely, with 46 percent of hospitals reporting that they had a corporate partner. One third of joint ventures were with local community not for profit hospitals, and 20 percent were a hybrid with both hospital and corporate partners. However, investors are not the only physicians to use ASHA member hospitals. The typical member has 92 physicians with admitting privileges, far in excess of the number of investors. This is consistent with the findings of the Government Accountability Office in its 2003 reports on surgical hospitals.

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

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

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

Economic and Policy Analysis of Specialty Hospitals*

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Economic and Policy Analysis of Specialty Hospitals

EXECUTIVE SUMMARY

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

Demand

Demand for services provided at specialized inpatient and outpatient facilities has been growing rapidly in the past decade due to a combination of factors, including increased incidence of specific diseases, new treatment processes and technologies, and changes in consumer preferences. An important factor contributing to the growth of specialty hospitals is that some procedures or specialized services are more profitable than others, given existing Medicare and private payment rates. Not surprisingly, there has been little or no entry by specialty hospitals targeted at unprofitable services.

Efficiency

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

Quality

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

Effects on General Hospitals' Financial Stability

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

Based on a longitudinal study of general hospital profit margins in markets with and without specialty hospitals, we find that profit margins of general hospitals have not been affected by the entry of specialty hospitals. Consistent with economic theory, the models consistently showed that the most important predictor of general hospital profitability was the extent of competition from other *general* hospitals in the same market area. General hospitals in less competitive markets (i.e., those with fewer competitors) had higher profit rates than general hospitals in more competitive markets. Contrary to the conjecture that entry by specialty hospitals erodes the overall operating profits of general hospitals, general hospitals residing in markets with at least one specialty hospital have higher profit margins than those that do not compete with specialty hospitals. These findings are also consistent with economic theory, which suggests that firms will enter markets in which extant profit margins are comparatively higher.

Effects on Access to Care

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

Physician Self Referral

There is no evidence to support the contention that physician self-referral to specialty hospitals has any adverse effect on patient or societal welfare. The literature on self-referral generally shows higher rates of service utilization associated with physician ownership of ancillary services. However, any inference of causality in this association is problematic at best, because those physicians most likely to use such ancillary services most intensively also have the most to gain from increased control over the availability of such services, independent of any incentive associated with a return on investment in the

facility itself. Thus, it is extremely difficult to quantify the impact of the financial incentive associated with physician ownership *per se* on the volume of self-referrals.

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

1. INTRODUCTION

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

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

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

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

[2] These states were chosen due to the relatively high proportion and maturity of specialty hospitals. Site visits generally involved question and answer sessions with all levels of

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

1.1 Methodology

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

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

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

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the management team (including physician owners) at each facility, followed by tours. Also provided were documents on management strategy, quality assurance, consumer satisfaction, physician ownership, and cost management.

Table 2
Survey of ASHA Member Hospitals:[1] Means for Selected Survey Items

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

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

2. OVERVIEW OF HOSPITAL MARKET

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

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

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

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

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[3] For example, the General Accounting Office defines specialty hospitals as those that "tend to focus on patients with specific medical conditions or who need surgical procedures" (General Accounting Office 2003b).

Table 1
Trends in Numbers of Specialty Hospitals, 1990-2003

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

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

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

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

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

3. EFFICIENCY

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

3.1 Economies of Scale

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

3.2 Economies of Scope

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

Evidence on economies of scope in the U.S. hospital industry is inconclusive. Menke (1997) found limited evidence of inpatient-outpatient scope economies in chain and non-chain hospitals. Similarly, Fournier and Mitchell (1992) found significant scope economies among select outpatient services and surgery services, but their study is based on 20-year old data from one state. Sinay and Campbell (1995) examined 262 merging acute care hospitals in the U.S. during the period 1987 to 1990. Of the service pairings

studied, evidence of economies of scope was found between acute care and sub-acute care (in merging hospitals) and between intensive care and outpatient visits (in control hospitals); all other pairings showed either diseconomies of scope (e.g., acute care and outpatient care; intensive care and sub-acute care) or were statistically insignificant. Rozek (1988) failed to observe scope economies in general hospital diversification into psychiatric services, and Li and Rosenman's (2001) study of hospitals in the state of Washington reached inconclusive findings on scope economies. The lack of consistent findings on economies of scope suggests that it is probably not a significant source of production economies for general hospitals. Thus, it would be difficult to argue that specialty hospitals are less efficient than general hospitals due to the absence of scope economies.

3.3 Learning and Competencies

Skinner (1974) stressed that "simplicity, repetition, experience, and homogeneity of tasks breed competence." Learning occurs as the experience of production in one time period influences the production in a later time period; that is, the production process is assumed to have some degree of flexibility and can change over the relevant range of output (March 1996; Nooteboom 2000; Greve 2003). The implication is that the costs of producing the first batch of output are greater than the costs of the producing a subsequent batch due to the learning that occurred during the production of the first batch. Assuming that experiences of producing the first batch can be applied to the second batch (and other subsequent batches), the average costs of production are expected to decline as output cumulates over time. The learning effect will depend on the ability of the firm to process information during the production process and then apply that information appropriately.

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

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

conduct meaningful quasi experiments is attenuated." Given the complexities of the learning process, the costs of learning in some cases may be lower for smaller specialized firms. Smaller firms may have the advantage of being able to allocate the majority of the resources available for learning and adaptation to a relatively small set of related production process (Almeida, Dokko, and Rosenkopf 2003).

Learning and core competencies have been shown to be important determinants of the performance of health care organizations. In health care setting the learning process is to some extent evident in the positive association between procedure volume and outcomes (discussed in greater detail in the next section). During our site visits, we consistently observed a culture supportive of coordination and cooperation aimed at achieving ongoing improvements in efficiency and quality. Specialty hospital managers generally attributed their success in process adaptation to three factors: (1) relatively small size, which enables more rapid and efficient decision making; (2) flat hierarchical structures, which allow decision making and process improvement to migrate to the most appropriate level; and (3) focused and consistent management goals, which make it easier for team members to learn and their roles. Managers also emphasized the importance of performance feedback, mainly through surveys of customer satisfaction. Again, managers indicated that their relatively small size allowed them to spend more time collecting, analyzing and acting on customer feedback. While it is possible that diversified general hospitals are able to achieve similar learning effects, the smaller scale of specialty hospitals may lower the costs associated with learning.

In health care settings, there also appear to be distinct advantages to focusing production within core competencies.[5] Shortell, Morrison, and Hughes (1989), in their three-year case study of eight large hospital systems, found that the best performing systems and hospitals were the ones that avoided diversification into unrelated activities, thereby minimizing diseconomies of scope and maximizing efficiencies associated with learning. Eastaugh (2001) examined a panel of 219 U.S. acute care hospitals from 1991 to 2000, finding that a 31 percent increase in specialization over the time period was associated with an eight percent decline in costs per admission. Douglas and Nyman (2003) review the theory of core competencies in hospitals and test the theory using data from the 32 largest hospital markets in the U.S. They found that the degree to which hospitals focused on core competencies was positively related to hospital financial performance.

In terms of core competencies, our site visits reached similar conclusions. When asked why their facility performed one set of procedures or services and not another, managers consistently indicated that they had a strong desire to not venture too far from the core of their collective knowledge. Managers and owners emphasized that the key decision makers are typically physician owners, most of whom are likely to feel most comfortable

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[5] The relationship between core competencies and hospital efficiency is relatively understudied. General discussions are provided by Eastaugh (2001; 1992); Snail and Robinson (1998); Douglas and Ryman (2003); Coddington, Palmquist, and Trollinger (1985), Porter and Teisberg (2004), Herzlinger (2004c), Moore (1990), and Walker and Rosko (1988).

focusing on the delivery of services in their specialty field. One chief executive officer and physician owner stressed that specialty hospitals often attract the most highly trained and skilled physicians in the community by allowing them to essentially redesign the care process based on the state of the art in their field. We found corroborating anecdotal evidence in the trade press (Walker 1998; Baum 1999; Daus 2000; Casey 2004; Wolski 2004; Zuckerman 2004).[6]

3.4 Volume-Outcome Effects

Several studies have found a positive association between the volume of services a hospital performs and the quality of the outcomes (Hillner, Smith, and Desch 2000; Halm, Lee, and Chassin 2002; Shahian and Normand 2003). One potential criticism of specialty hospitals is that the volume of cases may be too low to capture the positive effects of volume on patient outcomes. There are, however, five important limitations to these findings. First, the magnitude of the relationship is highly sensitive to case mix adjustment (Halm, Lee, and Chassin 2002). Second, there is considerable debate over how much volume is necessary to improve outcomes. For example, a common belief is that outcomes for percutaneous coronary interventions are better in hospitals that perform more than 400 such procedures per year. However, Epstein et al. (2004) found that there were no significant mortality differences between hospitals with medium volume (200-399 cases per year) and high volume (400-999 cases per year). Third, many studies do not differentiate between individual physician effects and hospital effects. It is possible that the volume-outcome relationship reflects differences in experience levels of individual physicians, most of whom maintain admitting privileges at multiple institutions (Robinson et al. 2001). Fourth, volume-outcome relationships are likely to be procedure specific. Again, on average specialty hospitals have higher procedure-specific volumes than their general hospital counterparts (Cram, Rosenthal, and Sarrazin 2004).

The fifth limitation is that the causal relationship between volume and outcome is unclear: do patients treated at high-volume hospitals achieve better outcomes because of learning and practice (the "practice makes perfect" hypothesis), or do hospitals with better quality reputations attract higher volumes of patients (the "selective referral" hypothesis) (Hughes et al. 1988)? Some recent studies have used instrumental variable techniques to disentangle these effects; one such paper found strong evidence of the

[6] MedCath's description of their facilities is apposite: "Externally, MedCath's heart hospitals appear typical; however, a step inside reveals important differences: Physicians empowered to make decisions about hospital operations; state-of-the-art operating rooms; cutting-edge equipment and technology; centrally located services such as radiology, pharmacy and laboratories; nursing stations strategically positioned to allow better patient monitoring; and large, single-patient, fully equipped rooms that avoid unnecessary patient moves and permit family members to remain overnight. Above all, physicians and nurses freed from bureaucratic and administrative chores so they can devote a majority of their time and energy directly to caring for their patients." (MedCath Corporation 2001)

"practice makes perfect" hypothesis for coronary artery bypass graft surgery.[7] There is some evidence that both hypotheses explain differences in outcomes but, nonetheless, taken together these two hypotheses explain a relatively small proportion of the overall variation in patient outcomes (Luft 1980; Luft, Hunt, and Maerki 1987).

3.5 Summary

The preceding discussion suggests that there are several areas in which specialty hospitals achieve production economies. First, specialty hospitals are able to take advantage of economies of scale and scope by producing relatively high volumes of a limited scope of services, and by lowering fixed costs by reengineering the care delivery process. Second, the site visits consistently found evidence of learning and core competencies. Managerial and clinical staff indicated a strong desire to focus on a relatively narrow array of tasks, and indicated a commitment to perfecting those tasks. The evidence on scale and scope economies and core competencies suggests that there are efficiency reasons for some degree of diversification, but that expansion into unrelated activities can result in diminished financial performance. Specialty hospitals also may in some cases possess a technological advantage or resource that is unique in the market. This is likely to be the case for many entering specialty hospitals, as most have had the opportunity to redesign care delivery processes from the ground up.

Perhaps as a result of these efficiencies, specialty hospitals appear to be capable of offering more intensive services for the same price. Specialty hospitals tend to have substantially higher nurse-patient ratios[8] and tend to place greater emphasis on ancillary services identified by patients as important, such as comfortable family-friendly rooms, more attention from administrative and clinical staff, and the mitigation of common inconveniences (e.g., appropriately located elevators and convenient parking). Specialty hospitals also appeal to physicians by offering newer equipment, more staff assistance, and more flexible operating room scheduling. These are costly services, yet specialty hospitals must compete for contracts with the same managed care organizations that general hospitals do; similar to general hospitals, they must also accept the Medicare fee schedule as payment in full.

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[7] Unpublished working paper: Seider H, M Gaynor, and WB Vogt (2004) "Volume-Outcome and Antitrust in U.S. Health Care Markets" Carnegie-Mellon University.

[8] Kovner et al. (2002) found that the median number of RN hours per adjusted patient day was 6.43 for the study's 534 general hospitals. For the five specialty hospitals we visited, RN hours per adjusted patient day ranged from 10 to 15 hours per patient day. Ideally, however, the appropriate comparison would be between cardiac and orthopedic units of specialty hospitals and cardiac and orthopedic units of general hospitals. We know of no such studies, and we were not able to identify a source of data on nurse staffing ratios within specific units of general hospitals.

4. CASE MIX AND QUALITY

4.1 Case Mix

There is some evidence that, on average, specialty hospitals treat patients with lower acuity compared to general hospitals (General Accounting Office 2003a, 2003b; Cram, Rosenthal, and Sarrazin 2004).[9] These findings are consistent with the observed case mix differences between ambulatory surgery centers and general hospitals (Winter 2003). The focused nature of specialty facilities may be better suited to patients whose care involves relatively little uncertainty, or whose condition is reasonably well defined. General hospitals may be more efficient in treating complex cases, particularly cases that allow them to exploit scope economies across service lines. In sum, it is possible that the apparent cost advantage of specialty hospitals is in part attributable to a healthier average case mix.

It should also be noted that prospective administered pricing mechanisms create incentives for general and specialty hospitals alike to focus on diagnosis categories and procedures where the administered price exceeds facilities' average costs. Medicare's administered pricing system (PPS) has been shown to affect the scope of services offered by acute care hospitals. The PPS system employs a fee schedule based on approximately 500 diagnosis related groups (DRGs); each DRG is mapped to a price, with some hospital-specific adjustments. Payment by DRG provides strong incentives to hospitals to specialize in those DRGs for which they have relatively low production costs (Dranove 1987). In the context of specialty hospitals, Robinson (2005) posits that "The success enjoyed by the specialized firms reflect astute selection of services and markets as much as efficiency in delivering care."

4.2 Quality

Empirical evidence on the quality of care provided by specialty hospitals is limited to two studies, one by the Lewin Group (2004) and another by Cram et al. (2004) from the University of Iowa. The Lewin study used Medicare Part A (MedPAR) data to compare eight MedCath heart hospitals to 1,056 peer general hospitals that perform open-heart surgery in the U.S. After adjusting for risk of mortality, MedCath heart hospitals on

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[9] Dobson (2004), in a study conducted by Lewin Group for the MedCath Corporation, found case-mix results counter to the GAO study and Cram et al. (2004). The Lewin Group found that MedCath cardiac hospitals have a 21 percent higher case mix severity for cardiac patients compared to their community general hospital peers. The differences in findings are likely attributable to differences in the sample and the measurement of severity or complexity. For example, the Lewin Group study used DRG weights to measure severity, whereas Cram et al. used a predicted mortality model based on age and presence of seven comorbid conditions. However, the Lewin Group findings are consistent with anecdotal and empirical evidence that admitting physicians may perceive specialized facilities as being more appropriate for complicated cases, due in part to the positive volume-outcome relationship (Baum 1999; Magid et al. 2000).

average exhibited a 16 percent lower in-hospital mortality rate for Medicare cardiac cases compared to peer general hospitals.

Cram, Rosenthal, and Vaughan-Sarrazin (2004) found no significant differences in mortality for cardiac patients treated at specialty hospitals and general hospitals, after adjusting for lower severity and higher procedure volume at specialty hospitals.[10] Similar results have been found when comparing ambulatory surgery centers and general hospitals (e.g., Warner, Shields, and Chute 1993; Mezei and Chung 1999). Data gathered from our site visits mirror these findings. Managers of specialty hospitals consistently reported two factors they believed to have been critical to achieving high quality patient outcomes: high volume and high nursing intensity. Consistent with the Cram et al. findings of higher procedure volume, managers of specialty strongly believed that they were improving care through ongoing learning and improvement. Specialty hospitals also reported nurse-patient ratios higher than the national average,[11] which suggests that they may be able to capture some of the positive quality and outcome effects associated with richer nurse staffing (Kovner et al. 2002; Lang et al. 2004; Stanton and Rutherford 2004; Mark et al. 2004).

Limited scope is also likely to increase accountability associated with the smaller set of procedures. For example, a specialty hospital leader at one of the visited hospitals remarked that "four procedures account for seventy percent of our business; if we develop any kind of quality problem in one or more of those procedures it's a huge problem for our organization." In addition, specialty hospitals typically engage in extensive collection of data on quality and patient satisfaction, and use these data to modify care processes (Walker 1998; Fine 2004; Iqbal and Taylor 2001). Among the ASHA member hospitals surveyed, 92 percent reported that they engage in regular assessments of customer satisfaction. Finally, there is consistent anecdotal evidence that the kind of care delivered by the typical specialty hospital is consistent with the general trend toward "consumer-driven" health care (e.g., O'Donnell 1993; Baum 1999; Leung 2000; Urquhart and O'Dell 2004; Hoffer Gittell 2004; Herzlinger 2004b).

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[10] In this respect the Cram et al. study and the Lewin Group study found similar results, although the Lewin study found that risk-adjusted in-hospital mortality rates in cardiac hospitals were 16 percent *lower* on average than the mortality rates of community hospital peers.

[11] Kovner et al. (2002) found that the median number of RN hours per adjusted patient day was 6.43 for the 534 hospitals studied. For the five specialty hospitals we visited, RN hours per adjusted patient day ranged from 10 to 15 hours per patient day. However, these data comparisons are limited; ideally, nurse staffing ratios should be compared only within particular product and service lines (e.g., orthopedic).

4.2.1 HealthGrades Analysis

HealthGrades is a national organization that produces hospital quality reports for over 5,000 U.S. acute care hospitals.[12] We merged membership data from ASHA and MedCath to publicly available quality data published on the HealthGrades website. There were 22 matched hospitals, representing approximately 31 percent of the ASHA hospital sample. For those hospitals, we examined the mean quality score (based on a 1-5 Likert scale) for the most common sets of procedures performed by the 22 hospitals. Consistent with the Lewin Group study and Cram et al., the results show that specialty hospitals typically performed at least as well as general hospitals in the same geographic region. Based on measures of in-hospital mortality (including 1 and 6 month post-discharge mortality rates), the mean score for the 22 specialty hospitals was a 3.86 out of 5, which was not statistically different from the mean scores for general hospitals in the same market areas.

5. POLICY ISSUES

The debate over specialty hospitals has raised several policy questions, two of which have received a high level of attention. First, do specialty hospitals harm the ability of general hospitals to provide indigent care? Some argue that specialty hospitals take profitable business away from general hospitals, and as general hospitals lose market share, particularly in high-margin product lines, they are hampered in their ability to provide low-margin services and meet their implied obligations to serve the community. Second, does having an ownership stake in the facility create financial incentives for physicians to provide inappropriate and unnecessary treatment? What are the optimal policy options to address these questions? Rather than make explicit policy recommendations, we discuss some of the salient economic issues concerning these two policy problems.

In this section policies are discussed in terms of their effectiveness in accomplishing intended objectives. In order to assess the net effect of a policy, ideally it is necessary to take into account all direct and indirect effects attributable to the policy. The sum of these effects is analogous to what economists refer to as change in net social welfare; that is, the extent to which the policy effects aggregate well-being. For example, the Federal Trade Commission recently emphasized that health care policies intended to mitigate some of the less desirable side effects of competition must be weighed against the losses normally resulting from restrictions on market entry and competition (Federal Trade Commission and U.S. Department of Justice 2003, 2004).

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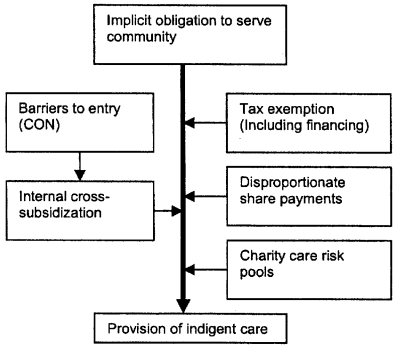
[12] HealthGrades quality measures are based on data from Medicare Part A (hospital) discharge abstracts for the time period 2001-2003. For more information on methodology and analysis, refer to www.HealthGrades.com and the HealthGrades report entitled "The Seventh Annual HealthGrades Hospital Quality in America Study" (HealthGrades Inc. 2004)

5.1 Indigent Care and Cross-Subsidization

The indigent care issue has several components. The first issue has to do with the practice on the part of general hospitals to meet their implicit obligation to serve the community[13] by cross-subsidizing low-margin services with high-margin services combined with other government subsidies. Many of the former state rate regulation programs were explicitly designed to help acute care hospitals meet these obligations (Fournier and Campbell 1997; Schneider 2003); however, all but one of the state rate regulation programs were dismantled during the 1990s. In the absence of state rate regulation, hospitals have relied on six other mechanisms to pay for unprofitable services: (1) tax-deductible donations, (2) tax-exempt bond financing, (3) exemption from income and property taxes, (4) internal cross-subsidization, (5) Medicaid disproportionate share payments (additional payment for treating a disproportionate share of Medicaid patients), and (6) state-administered charity care risk pools[14] (Figure 1).

Figure 1
Non-Profit General Hospital Methods for Funding Indigent Care



Tax exemption is perhaps the most widespread subsidy provided to non-profit general hospitals. Non-profit tax status allows hospitals to avoid property and income tax in exchange for an obligation to serve the community. However, Kane and Wubbenhorst (2000) found that the amount of charity care provided by hospitals is significantly less

[13] Acute care hospitals' implicit obligation to serve the community is based on two policies: the Hospital Survey and Construction Act of 1946 and non-profit tax exemption. The nominal intent of the Hospital Survey and Construction Act of 1946 (commonly known as the Hill-Burton Act) was to bolster the relatively under-developed postwar hospital industry by requiring states "to develop programs for the construction of such public and other non-profit hospitals as will, in conjunction with existing facilities, afford the necessary physical facilities for furnishing adequate hospital, clinic, and similar services to all their people" (*Hospital Survey and Construction Act* 1946).

[14] See generally Lewin and Altman (2000).

than the amount of tax benefit accrued through non-profit status.[15] Thus, even if tax exemption were the only means for hospitals to fund indigent care, the amount of the benefit on average appears to be more than sufficient to fund prevailing levels of indigent care. Although specialty hospitals generally provide less charity care (approximately 2.1 percent of gross patient care revenues; Table 2), per facility they contribute on average approximately $2 million annually in state and federal taxes. This represents an additional 5.1 percent of gross patient care revenues. The combined 7.2 percent of gross patient care revenues exceeds the average charity care provision of tax-exempt general hospitals, which is approximately 5 to 6 percent of revenues (American Hospital Association 2005).

Hospital internal cross-subsidization is to be distinguished from the popular notion that hospitals shift costs between third-party payers; that is, "one group pays more because another pays less" (Morrisey 1994). In this case, hospitals cross-subsidize low-margin indigent services with the proceeds from high-margin services. Under normal circumstances, hospital internal cross-subsidization would not be sustainable, mainly because sustained high margins on some services would encourage market entry, and as firms entered the excess profits would be competed away.[16] In order for cross-subsidization to work, government must restrict market entry, either through certificate of need (CON) or some other means. Indeed, that is how many states currently approach the problem, and an important reason why Congress has resorted to the specialty hospital moratorium.

There at least two problems with policies encouraging cross-subsidization of this kind. First, the policy relies on CON to limit market entry, and there is a large volume of research critical of CON.[17] Studies of the impact of CON programs have consistently found the programs to be ineffective at controlling costs and enhancing access. Sloan and Steinwald (1980) found that mature CON programs had an insignificant effect on hospital costs, and immature CON programs actually increased hospital costs. Lanning, Morrisey and Ohsfeldt (1991) and Antel, Ohsfeldt, and Becker (1995) also conclude that CON is associated with higher inpatient costs and expenditures per capita. A possible explanation is that the CON constraint prevents hospitals from employing the least-cost

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[15] A summary of these issues can also be found in Nancy Kane's recent testimony to the Subcommittee on Oversight of the U.S. House Committee on Ways and Means (Kane 2004).

[16] This is a common occurrence in most industries. In the language of the current debate, this would be considered cream skimming. An important question is whether it is optimal policy to discourage triaging of care across settings according to intensity, given the extensive literature on the cost and quality benefits associated with moving patients from inpatient to outpatient settings following the implementation of Medicare's PPS.

[17] Currently, 14 states have no CON program and another six states maintain CON programs only for long-term care (Conover and Sloan 2003).

combination of inputs to produce inpatient services, resulting in allocative inefficiency.[18] Further, there is no evidence that the repeal of CON was associated with an increase in hospital expenditures (Conover and Sloan 1998).[19] As a result of the apparent failure of CON to achieve its stated goals, many state CON programs have been either terminated or significantly reformed since the repeal of the Health Planning Act in 1986 (Conover and Sloan 1998). It would be more difficult in theory for hospitals located in competitive markets in non-CON states to engage in internal cross-subsidization; instead, such hospitals would have to rely on tax exemption, disproportionate share payments, and charity care risk pools to fund indigent care.

Second, it is not clear whether the losses in net social welfare associated with restricting market entry exceed the costs of alternative means of assuring the provision of indigent care, such as direct subsidies. The Federal Trade Commission's recent report on health care competition integrated this point into one of their policy recommendations, emphasizing that "[competition] does not work well when certain facilities are expected to cross-subsidize uncompensated care. In general, it is more efficient to provide subsidies directly to those who should receive them, rather than to obscure cross subsidies and indirect subsidies in transactions that are not transparent" (Federal Trade Commission and U.S. Department of Justice 2004 p.23).

The U.S. experience with airline regulation provides an excellent example. In order to develop air travel infrastructure, airline regulation required carriers to cross-subsidize unprofitable routes with profitable ones. Cross-subsidization appeared to contribute to infrastructure development in the early years of regulation, but eventually led to extraordinarily high costs (Morrison and Winston 1986). Consumer welfare and producer surplus improved markedly following deregulation (Winston 1998; Peltzman and Winston 2000). If subsidizing indigent care is a policy objective, the economically optimal public policy would be to directly subsidize any hospital for providing indigent care.[20] Protecting incumbent hospitals from competitive entry may be just as likely to

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[18] The poor performance of CON is attributed to four factors: the administrative burden associated with determining appropriateness of new investments, the potential for CON laws to create and maintain hospital cartels by erecting barriers to new hospital entrants, the susceptibility of the CON process to industry influence (e.g., Payton and Powsner 1980), and the potentially sub-optimal input allocation induced by the CON constraint on the use of capital inputs.

[19] Some studies have found that CON programs can be used to enhance patient outcomes by concentrating services in high-volume facilities (e.g., Vaughan-Sarrazin et al. 2002). However, these studies are limited by the causality problem described in Section 3.4, and the lack of analysis of whether improvement in outcomes compensates for the net social welfare losses associated with barriers to market entry (Federal Trade Commission and U.S. Department of Justice 2004).

[20] One of the criticisms of specialty hospitals is that many do not provide 24-hour emergency services. But it is not clear whether any current means of funding emergency room services are optimal. From a societal perspective, it may be more economically

allow incumbent firms to maintain higher prices and facilitate slack in organizational processes, rather than permit them to fund additional indigent care.

A related concern is that specialty hospitals engage in unfair competition with general hospitals by treating only less severe and more profitable patients (i.e., cream skimming). As noted, there is some evidence that specialty hospitals, like their ambulatory surgery center predecessors, treat healthier patients with fewer comorbid conditions. However, from a policy perspective, treating healthier patients in less intensive settings is likely to improve patient welfare, given the extensive literature on the cost and quality benefits associated with triaging patients from inpatient to outpatient settings following the implementation of Medicare's PPS. Thus, the cream skimming issue, as others have observed, is predominantly a function of (1) variation in operating margins within DRG and (2) crude case-mix adjustments in current reimbursement rates. Case-mix adjustment methodology has improved dramatically in recent years, and CMS maintains the administrative data necessary for such adjustments (FitzHenry and Shultz 2000; Iezzoni 2003). Again, according to economic theory, establishing administered prices that are more closely aligned with average costs together with improvements in case-mix adjustment would be superior policy mechanisms compared to restrictions on market entry.

In sum, there are significant drawbacks to the current four-part strategy to encourage the provision of indigent care. Tax exemption should in theory be sufficient compensation for indigent care, particularly when combined with disproportionate share payments and charity care risk pools. However, there are no explicit mechanisms in place to control how hospitals allocate the proceeds from tax exemption.[21] Internal cross-subsidization would not be sustainable in competitive markets; therefore, costly entry-barrier regulations must accompany cross-subsidization. Both of these policies are sub-optimal insofar as they result in net losses in social welfare. Losses in net social welfare are likely to exceed the value of indigent care delivered. Policies such as direct subsidies for indigent care and more accurate case mix adjustment of payments would likely result in overall gains in net social welfare.

5.1.1 Effects on General Hospital Profit Margins

Were it the case that specialty hospitals erode profits of general hospitals in the same market, we should observe lower or at least declining profit margins among general hospitals in markets where there is at least one specialty hospital. In order to further

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efficient to fund and operate emergency rooms no differently than police and fire departments.

[21] Two recent law suits filed against large hospital chains have challenged the extent to which hospitals have been operating in accordance with the implicit contracts (Taylor 2004; Davies 2004). The suits allege that acute care hospitals, particularly those granted non-profit status, have been failing in their implicit obligation to serve mostly through aggressive bad-debt collection processes and turning away consumers with outstanding balances due.

examine this issue, we statistically analyzed the extent to which profit margins of general hospitals are affected by the presence of one or more specialty hospitals in the market. We obtained Medicare Hospital Cost Report Data for 1997 through 2003 for all U.S. acute care hospitals. For each hospital in the dataset, county and metropolitan statistical area (MSA) market areas were identified and additional market-level data from the Bureau of Health Profession's Area Resource File were merged. Mean general hospital profit rates[22] were calculated for all county and MSA market areas in the U.S.

The analytic approach was to estimate what economists refer to as a profit function—a mathematical expression of the likely relationship between profit margin, the dependent variable, and the factors expected to affect profit margin, referred to as covariates. We estimate a standard "ad hoc" profit function of the following basic linear form: $MARGIN_{it} = \alpha_0 + \alpha_1 D_{it} + \alpha_2 S_{it} + \alpha_3 P_{it} + \alpha_4 Z_{it} + \varepsilon_{it}$. In this expression, $MARGIN_{it}$ refers to the mean of the operating margins (profit rates) of general hospitals within the i^{th} county (or MSA) in year t. It is hypothesized that the mean area-level general hospital profit rate is a function of demand factors (D_{it}), supply factors (S_{it}), input prices (P_{it}), a vector of market area characteristics (Z_{it}), and an error term (ε_{it}) representing unexplained or unmeasured factors. The demand factors included in this model are per capita income, population density, the percent of the population at or below the poverty level, and the area unemployment rate. The latter two measures are included to capture the likely indigent care burden faced by general hospitals. Supply factors include output measures (inpatient days per population and outpatient visits per population) and the number of physicians per capita. Price measures include the mean area wage for hospital workers (from the U.S. Bureau of Labor Statistics) and the Medicare Part A (hospital) average adjusted price per capita (AAPCC).

The main variables of interest are the specialty hospital indicator variables and the measure of market competition. We constructed two variables to measure the presence of specialty hospitals, each of which was based on our survey of ASHA membership. The first is a simple indicator variable (SCP) that equals 1 if the market area has one or more specialty hospital (most markets have only one). For example, if specialty hospital X opened in 1999, than SCP equals zero in 1997 and 1998 and equals one thereafter. The second specialty hospital indicator is the total number of physicians admitting patients to the specialty care provider in the market area.

The other main variable of interest is a measure of market concentration. Although not an ideal measure of market concentration, a standard method of measuring market concentration is the Herfindahl-Hirschman Index (HHI). The HHI is calculated by summing the squares of each firm's market share in the county; that is, $HHI = \sum^{i} 100 * s_i^2$,

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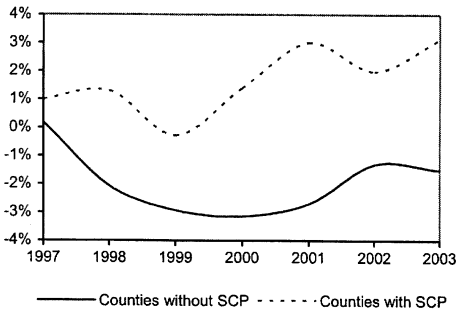
[22] Profit rates were calculated as the difference between gross patient care revenue and total patient care costs (i.e., net income from patient care activities), divided by gross patient care revenue. Mean profit margins reported here are somewhat lower than those reported elsewhere, for two reasons: (1) for the purposes of this study profit margins are based on patient care revenue rather than total revenue; and (2) profit margins are aggregated to the county or MSA level.

where *s* denotes the market share of firm *i*. This method allows for firms with relatively large market share (e.g., 60 percent) to be more heavily weighted in the index. The HHI index equals 10,000 when an industry or market consists of a single seller. For the multivariate models of mean area profit rates, we assume the county or the MSA to be the relevant geographic market. In addition, since we are primarily interested in the effects of competition, we excluded from the analysis any county or MSA with only one acute care hospital (i.e., counties or MSAs with HHI = 10,000).

The model is specified as a fixed effects panel data regression, which is designed to estimate the impact of the covariates on profit rates both cross-sectionally (county or MSA) and over time (year). This allows for the effects of specialty hospital entry to accrue over time, effects that may not be observable looking only at a cross-sectional snapshot. The regression models are based on 933 counties and 299 MSAs.

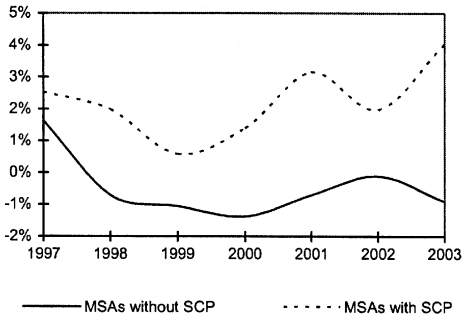
Descriptive trend comparisons of mean general hospital profit rates for counties and MSAs are shown in Figure 2 (counties) and Figure 3 (MSAs). The results for counties and MSAs are similar. Mean general hospital profit margins in counties with at least one specialty hospital were greater in all years of analysis. In the county-level analysis, the year 2001 and 2003 differences were statistically significant ($p \leq 0.05$). In the MSA-level analysis, the year 2001, 2002, and 2003 differences were statistically significant ($p \leq 0.05$).[23]

Figure 2. Trends in General Hospital Profit Margins: U.S. Counties with Specialty Hospitals Compared to U.S. Counties Without Specialty Hospitals, 1997-2003



[23] In addition, MSA-level year 2000 differences were significant at $p \leq 0.10$.

Figure 3. Trends in General Hospital Profit Margins: U.S. MSAs with Specialty Hospitals Compared to U.S. MSAs Without Specialty Hospitals, 1997-2003



The regression results are consistent with the descriptive findings. The results of the regression model are shown on Table 3 (counties) and Table 4 (MSAs). For each geographic level of analysis, three models are reported: (1) specialty hospital variables are limited to the indicator variable SCP; (2) specialty hospital variables are limited to the total number of physicians admitting patients to the specialty care provider in the market area; and (3) including both specialty hospital indicator variables.

The estimated coefficients of the key variables have the anticipated sign.[24] The key variables of interest are (1) the HHI market concentration measure, (2) an indicator variable for the presence of a SCP, and (3) the number of MDs admitting patients to the specialty care provider. Consistent with economic theory, the models consistently showed that market concentration had a positive effect on profits; that is, as markets become more concentrated, profits increase. Interestingly, we also found that both of the specialty hospital variables were positive and significant in four of the six models, without regard to the geographic unit of analysis. This relationship was remarkably stable, evident in all model specifications tested.[25]

The interpretation of this finding is that, contrary to the conjecture that entry by specialty hospitals erodes the overall operating profits of general hospitals, general hospitals residing in markets with at least one specialty hospital have higher profit margins than those that do not compete with specialty hospitals. These findings are also consistent

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[24] Note that it is not uncommon in profit models for only a relatively small proportion of the variation in profit rates to be explained by the covariates; the best models often explain between 5 and 20 percent of the variance in profit rates. Our models explain less of the variation because the unit of analysis is the market area rather than the hospital.

[25] The analysis included several variants of the linear equation. For each model tested, the coefficients did not differ significantly from what is reported here.

with economic theory, which suggests that firms will enter markets in which extant profit margins are comparatively higher.

Table 3
Multivariable Profit Function Regression Models, Dependent Variable is Market Area (County) General Hospital Profit Margin, 1997-2003

Independent variable[1]	County		
	(1)	(2)	(3)
Per capita income	-0.00000143**	-0.00000137**	-0.00000143**
Population density	0.00000218	0.00000203	0.00000219
Inpatient beds per capita	3.47753300**	3.55058200**	3.46631100**
MDs per 1000 pop.	-0.00400460	-0.00421430	-0.00401000
Inpatient days per 1000 pop.	-0.00000524	-0.00000545	-0.00000522
Outpatient visit per capita	-0.00126660	-0.00136540	-0.00126630
Medicare Part A AAPCC	0.00024970**	0.00024770**	0.00024970**
Unemployment rate	-0.00065720	-0.00067840	-0.00065280
Poverty rate	0.00194070**	0.00193060**	0.00194040**
Annual wage (hospital staff)	0.00000017	0.00000023	0.00000017
HHI	0.00000336**	0.00000329**	0.00000338**
1= SCP present	0.03676190**	---	0.03464330**
MDs admitting to SCP	---	0.00032730**	0.00006750
Constant	-0.09486860	-0.09659210	-0.09488130
Number of observations	6424	6424	6424
F	5.34	4.64	4.94
Prob.>F	0.0000	0.0000	0.0000
Overall R-squared	0.0111	0.0125	0.0110

Sources: Survey of ASHA membership, Medicare HCRIS Cost reports, Area Resource File, and Bureau of Labor Statistics; see section 5.1.1 for description.
Notes: *Significant at p ≤ 0.10 (t-test); **Significant at p ≤ 0.05 (t-test)

Table 4
Multivariable Profit Function Regression Models, Dependent Variable is Market Area (MSA) General Hospital Profit Margin, 1997-2003

Independent variable[1]	MSA		
	(4)	(5)	(6)
Per capita income	-0.00000073	-0.00000057	-0.00000072
Population density	-0.00002250	-0.00002380	-0.00002260
Inpatient beds per capita	7.56830900*	7.51012900*	7.52111000*
MDs per 1000 pop.	-0.01176980	-0.01183570	-0.01174600
Inpatient days per 1000 pop.	0.00000699	0.00000783	0.00000686
Outpatient visit per capita	-0.00283480	-0.00287550	-0.00286490
Medicare Part A AAPCC	0.0003083**	0.00031420**	0.00030700**
Unemployment rate	-0.00269240	-0.00274240	-0.00261580
Poverty rate	-0.00127800	-0.00156110	-0.00131490
Annual wage (hospital staff)	-0.00000064	-0.00000061	-0.00000064
HHI	0.00000395*	0.00000360	0.00000399*
1= SCP present	0.0323107**	---	0.02809040**
MDs admitting to SCP	---	0.00032330**	0.00013120
Constant	-0.01532120	-0.01553810	-0.01475440
Number of observations	1465	1465	1465
F	4.00	3.39	3.75
Prob.>F	0.0000	0.0001	0.0000
Overall R-squared	0.0454	0.0415	0.0462

Sources: Survey of ASHA membership, Medicare HCRIS Cost reports, Area Resource File, and Bureau of Labor Statistics; see section 5.1.1 for description.
Notes: *Significant at p ≤ 0.10 (t-test); **Significant at p ≤ 0.05 (t-test)

5.2 Physician Self-Referral

The remaining policy issue is the potential effects of physician self-referral. The costs and benefits of physician self-referral has been debated for many years, mainly because the dominant physician payment mechanism in the U.S. has been and continues to be fee-for-service, which creates financial incentives for self-referral. In the case of specialty hospitals, the general argument against physician self-referral is that physician ownership may result in financial incentives to admit patients to the facilities in which they have an ownership stake. These arguments are to some extent based on research that has found that utilization of ancillary services is higher when an ownership relationship exists between referring physicians and ancillary services (Mitchell and Sass 1995; Lynk and Longley 2002; Kouri, Parsons, and Alpert 2002; Zientek 2003; O'Sullivan 2004). However, there are at least four important limitations to applying these arguments to acute care hospitals.

First, the vast majority of studies of higher utilization resulting from self-referral are based on physician ownership of *ancillary* services, rather than acute care hospitals. Mitchell and Sass (1995), in their frequently cited study of physician referral, failed to find higher utilization rates associated with self-referral to acute care hospitals. This lack of association has been one of the main reasons that the two phases of Stark anti-kickback legislation have exempted physician ownership of acute care hospitals (Stout and Warner 2003; Rohack 2004; O'Sullivan 2004). In addition, there is no direct evidence that the observed higher utilization rates resulting from self-referral to ancillary services represent inappropriate or unnecessary care (Kouri, Parsons, and Alpert 2002; Zientek 2003).

Second, there is no direct evidence that physician self-referral is motivated disproportionately by financial incentives. Physician self-referral is motivated by four factors: appropriateness, quality, efficiency, and financial returns. The relative magnitude of each of these incentives has been the subject of debate, but there is no direct evidence to suggest how, on average, physicians assign weights to each factor. Consistent with the empirical findings, anecdotal evidence suggests that physicians may disproportionately weight financial incentives when the referral is for standardized products or services (e.g., lab or pharmacy), and disproportionately weight appropriateness and quality when the referral is for more intensive procedures, such as surgery (Moore 2003).

Third, there is no evidence that self-referrals result in worse outcomes than other types of referral (Kouri, Parsons, and Alpert 2002; Zientek 2003). A likely reason for these findings is the endogeneity of three factors: physician quality, the likelihood of self-referral, and the quality of patient outcomes. In the case of specialty hospitals, site visits and trade press literature indicate that physician investors in specialty hospitals tend to be those who highly value efficiency in quality and cost dimensions. Thus, for many physician investors, self-referral is likely to represent the most optimal referral in terms of quality and cost.

Fourth, in the case of physician ownership of acute care facilities, it is likely that the magnitude of financial incentives is limited. The General Accounting Office (2003a) found that 30 percent of specialty hospitals surveyed had no physician investors. For half of the facilities with physician investors, the average individual physician ownership share was less than two percent. In the ASHA survey, virtually all physician investors owned only five percent or less (Table 2). Moreover, the entrepreneurial returns (i.e., the fraction of the facility fee considered operating margin) for any single case are likely to be substantially less than the professional fee charged by physicians. Given the order of magnitude difference between these two revenue streams, physician incentives are likely to be driven more by professional fees, which do not vary significantly by practice setting.[26] Indeed, in this context the potential for a surgeon to enhance his or her own productivity is a more likely source of financial incentive for self-referral to a specialty hospital. In other words, the primary financial motivation may be to enhance the return on investment for the surgeon's investment in "human capital" (associated with the number of procedures performed)[27] rather than any effort to assure a return on investment in the form of financial assets (associated with the overall financial performance of the hospital).

In terms of policy options, even if we were to assume that these limitations were not important, a more central question is whether creating barriers to market entry are the most appropriate means of addressing the issue. The net social welfare losses associated with barriers to market entry are likely to be greater than those attributable to physician referral incentives, particularly in light of the weakness of these incentives.

6. CONCLUDING REMARKS

In this study we have reviewed the theory and evidence on some of the key characteristics of specialty hospitals, including efficiency, demand, case mix, and quality. These findings were supported by observations from five specialty hospital site visits. We also conducted statistical analyses of the effects of specialty hospitals on the profit margins of general hospitals. The main findings of the study can be briefly summarized in the following three points.

First, there are economic advantages associated with specialization, due mainly to process redesign, learning, avoidance of diseconomies of scope, and focus on core competencies. Specialty hospitals appear to have equal or better patient outcomes compared to their general hospital counterparts. Hence, there is no evidence to suggest

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[26] It should also be noted that high variation in utilization and referral patterns exist without respect to physician ownership. For example, Weinstein et al. (2004) recently observed significant variation in utilization patterns for major surgery for degenerative diseases of the hip, knee, and spine in several South Florida hospital referral regions where there are no physician-owned specialty hospitals.

[27] Refer to section 3.4

that specialty hospitals should be barred from entering acute inpatient care markets on the basis of efficiency or quality of care.

Second, there is no evidence, other than anecdotal, to suggest that general hospitals have been financially harmed by competition from specialty hospitals, or that such competition is undesirable from a societal perspective. Specialty hospitals compete with general hospitals in the same manner in which general hospitals compete with each other. Based on a longitudinal study of general hospital profit margins in markets with and without specialty hospitals, we find that profit margins of general hospitals have not been affected by the entry of specialty hospitals. Consistent with economic theory, the models consistently showed that the most important predictor of general hospital profitability was the extent of competition from other *general* hospitals in the same market area. General hospitals in less competitive markets (i.e., those with fewer competitors) had higher profits than general hospitals in less competitive markets. Contrary to the conjecture that entry by specialty hospitals erodes the overall operating profits of general hospitals, general hospitals residing in markets with at least one specialty hospital have higher profit margins than those that do not compete with specialty hospitals. These findings are also consistent with economic theory, which suggests that firms will enter markets in which extant profit margins are comparatively higher.

Third, though often cited as a significant policy concern, there is no evidence that physician self-referral is a problem in specialty hospitals. Physician self-referral is likely to play a relatively minor role in specialty hospitals, for four reasons: (1) the vast majority of studies of higher utilization resulting from self-referral are based on physician ownership of *ancillary* services, rather than acute care hospitals; (2) there is no direct evidence that physician self-referral is motivated disproportionately by financial incentives; (3) there is no evidence that self-referrals result in worse outcomes than other types of referral; and (4) in the case of physician ownership of acute care facilities, it is likely that the magnitude of financial incentives is limited.

APPENDIX A

2004 Survey of Specialty Hospitals

Instructions:

1. These results will be kept strictly confidential. Under no circumstances will the data leave the control of ASHA and its principal contracted researcher, John Schneider. Only aggregate data will be presented publicly (e.g., means and standard errors).
2. All responses, unless otherwise noted, should refer to your previous full fiscal year. If your facility has not been open for an entire fiscal year, indicate so at the beginning of the questionnaire. Also, unless otherwise specified, responses should refer to the main patient care facility.
3. Please answer each question as accurately as possible. In the event that it is not possible to answer a question, use the following codes: Unknown = **DK**, Refused = **RF**, Not applicable = **NA**. Before resorting to these codes try to at least provide a reasonable estimate.
4. For technical questions contact John Schneider at john-schneider@uiowa.edu or 319-331-2122.

Question	**Response**
1. Name of facility:	
2. Zip code (main patient care facility)	
3. Has your facility been open for at least one whole fiscal year? (1=Yes; 0=No)	
4. Beginning date of most recent full fiscal year (MM/DD/YYYY)	
Licensing & Accreditation	
5. Is your facility licensed in your state as an inpatient hospital? (1=Yes; 0=No)	
6. Accredited by Accreditation Association for Ambulatory Health Care? (1=Yes; 0=No)	
7. Accredited by Joint Commission on Accreditation of Health Care Organizations (JCAHO)? (1=Yes; 0=No)	
8. Other accrediting organizations (1=Yes; 0=No) Specify:	
History	
9. First calendar year in which facility was licensed as inpatient hospital	
10. First calendar year in which beds were added, if different from Q9	
Beds and Capacity	
11. Total bed capacity	
12. Number of staffed inpatient beds	
13. Number of operating rooms	
14. Number of intensive care beds	
15. Number of recovery beds (all stages)	
16. Do you maintain & staff an urgent/emergent care center? (1=Yes; 0=No)	
17. If Q16 = yes, how many hours per day is the care center staffed?	
Ownership Structure (Q21-Q24 sum to Q20)	
18. Total number of owners	
19. Total number of physician owners	

20. Total number of physician owners who admit[28] at least 5 patients per year	
21. Number of physicians in Q20 with 0-1% ownership stake	
22. Number of physicians in Q20 with 2-5% ownership stake	
23. Number of physicians in Q20 with 6-9% ownership stake	
24. Number of physicians in Q20 with 10% or more ownership stake	
Volume and Case Load	
25. Number of inpatient discharges	
26. Number of inpatient days (overnight stay)	
27. Number of inpatient days (observation days)	
28. Number of surgeries (overnight stay)	
29. Number of outpatient surgeries (no overnight stay)	
Patient Care Revenue	
30. Total gross patient care revenue (inpatient + outpatient)	$
31. Outpatient revenue as percent of total gross patient revenue (Q30)	%
Sources of Patient Revenue (Q32-Q35 sum to 100%)	
32. Medicare revenue as percent of gross patient revenue	%
33. Medicaid revenue as percent of gross patient revenue	%
34. Commercial (private health plan) insurance revenue as percent of gross patient revenue	%
35. Other revenue as percent of gross patient revenue	%
Charity Care	
36. If your state has a charity care risk pool, do you pay into it? (1=Yes; 0=No)	
37. If the answer to Q29 was yes, indicate annual amount paid into risk pool	$
38. Charity care as a percentage of gross patient care revenue	%
Taxes Paid[29]	
39. State income tax paid previous tax year	$
40. Federal income tax paid previous tax year	$
41. Property tax paid previous tax year	$
Expenses and Income	
42. Total operating expenses	$
43. Net income after all expenses but before taxes	$
Nurse Staffing	

[28] Admitted for inpatient care

[29] All tax information should refer to the most recent full tax year. Facilities organized as partnerships typically allocate taxes to owners. In these cases please provide and estimate of the total tax liability for the entity for all owners combined.

44. Total number of full-time equivalent (FTE) RNs	
45. Average patient to RN ratio (e.g., for 3:1 write "3;" for 5:1 write "5")[30]	
Quality	
46. Do you employ a computerized physician order entry (CPOE) system? (1=Yes; 0=No)	
47. Do you employ an electronic medical record (EMR) system? (1=Yes; 0=No)	
48. Do you attempt to collect patient satisfaction data on all patients post-discharge? (1=Yes; 0=No)	
49. Percent of admitting physicians with admitting privileges at community / general hospitals in market area	%
50. Number of admitted inpatients transferred to community / general hospitals in market area	
51. Do you have a transfer arrangement with one or more community / general hospitals in market area? (1=Yes; 0=No)	
Competitors	
52. Number of inpatient hospitals in market area which you consider to be competitors	
53. Number of outpatient surgery centers and clinics in market area which you consider to be competitors	

[30] Patient to nurse ratios are expected to vary by stage of care (i.e., first and second stage recovery) and by shift. For this question, estimate an overall facility average; i.e., report the average number of patients per RN across all stages of care.

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RESPONSES TO QUESTIONS FROM SENATOR GRASSLEY

Question: As you know, the MedPAC report shows that physician-owned specialty hospitals treat fewer Medicaid patients than general hospitals, instead tending to treat healthier patients. The GAO report released in 2003 states that "specialty hospitals tended to treat a lower percentage of Medicaid inpatients among all patients with the same types of conditions." Does your organization, the Fresno Surgery Center, currently treat Medicaid patients? What has been your Medicaid volume and Medicaid revenue over the past couple of years? What percentage is this of overall discharges and overall revenue?

Answer: Yes, Fresno Surgery Center will accept and treat Medicaid patients. However, less than 1 percent of our revenue and case load comes from Medicaid because Medicaid patients in California are covered by HMOs, and we cannot get access to the HMO contracts. In Fresno, almost all of the Medicaid patients go to University Medical Center/Community Hospitals of Central California, which has the contract.

Question: What percentage of the cases at Fresno Surgery Center would be affected by MedPAC's payment recommendations to change the inpatient prospective payment system?

Answer: Approximately 25 percent of FSC revenue is from Medicare. We assume that the changes would have an impact, since MedPAC estimated a 14–16 percent decrease in Medicare revenue for all specialty hospitals if the changes were enacted. However, MedPAC has not been specific enough in its recommendations for us to determine on a DRG-specific basis what the impact would be for FSC.

Question: The GAO found that about 70 percent of specialty hospitals in existence or under development had some physician owners. Among these hospitals, total physician ownership averaged slightly more than 50 percent. The average share owned by an individual physician was more than 2 percent at half the hospitals and less than 2 percent at the other half. What share of your facility is physician-owned? And what is your individual share?

Answer: 86 percent of FSC is owned by a C corporation, FSC Health, Inc. The remaining 14 percent is owned by 25 physicians. FSC Health, Inc. has 109 physician shareholders and approximately 20 non-physician shareholders. The 109 physician shareholders own 95 percent of FSC Health, Inc. Approximately 60 of the FSC Health owner-physicians are retired or not in active practice. Physicians in active practice own less than half of the FSC Health, Inc. stock. I own approximately 29 percent of the FSC Health, Inc. stock. I have retired from active practice and, therefore, do not refer patients to FSC. To the best of my knowledge, there are no physicians in active practice who own more than a 3-percent interest, and the overwhelming majority own less than 1 percent each.

PREPARED STATEMENT OF DR. J. ANDY SULLIVAN

INTRODUCTION

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

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

As a practicing physician for the past 36 years, I know all too well the frustrations and constraints that affect our medical practices nationwide. We continually face increasing medical malpractice premiums, unpredictable Medicare and Medicaid reimbursement, the pressures of managed care, and demanding on-call requirements. For those working in a community hospital, often there is a need to engage management for purchasing and scheduling decisions. Within this environment, it is understandable that some physician specialists would be attracted to a specialty hospital's promise of personal financial gain. However, each of these challenges requires a comprehensive solution that aims to reform a fractured health care system, not an anti-competitive solution in the form of self-referral to specialty hospitals, which ultimately impacts patient access to health care. Unfortunately, this is exactly what is occurring today with the expansion of physician-owned specialty hospitals.

SELF-REFERRAL IS THE ISSUE

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

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

SELF-REFERRAL IMPACT ON EMERGENCY SERVICES

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

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

Maintaining an operational, fully functioning emergency department is OU Medical Center's commitment to our community. We are open 24 hours per day, 7 days per week. Unfortunately, America's hospital emergency rooms have become our *de facto* public health care system, the primary point of access to quality health care services for the Nation's uninsured. The committee undoubtedly is aware that hospitals equipped with emergency rooms must provide medical evaluation and required treatment to everyone, regardless of their ability to pay. Since the advent in recent years of these physician-owned specialty hospitals, which skim profitable service areas for low-risk patients, this burden has grown even heavier. While specialty hospitals treat the most profitable patients, full-service hospitals are left with the task of handling uninsured and high-risk patients within their community. As such, maintaining an emergency department for those who truly need it also means contending with a regular population of people with little or no health care options. Moreover, this population often seeks emergency room care only once an illness has reached a level of acuity that makes their case more complex and costly.

For the most part, from what I have witnessed in Oklahoma City, specialty hospitals simply do not share in this commitment to our communities. For instance, a 2003 study by the GAO found that while 92 percent of full-service hospitals main-

tained emergency departments, merely 45 percent of specialty hospitals had emergency rooms. Even among those few specialty hospitals with emergency departments, most provided care limited to that particular hospital's specialty, and only 63 percent were staffed 24 hours per day. Overall, specialty facilities nationwide treated less than one-tenth the number of patients admitted at the emergency departments in full-service hospitals. And in Oklahoma, despite a licensure provision requiring that all hospitals be capable to provide emergency services, a significant number of the State's specialty facilities provide little or no emergency care. For example, one physician-owned specialty hospital in Oklahoma generated only $4,300 in charges for emergency services against its total charge base of $89 million.

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

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

OU Medical Center presently operates the only Level 1 trauma center in the State of Oklahoma. Trauma centers in the U.S., which are credentialed by the American College of Surgeons ("ACS"), require that Level 1 centers must be capable of treating the most severely injured patients. Typically, those requiring treatment at a Level 1 trauma center arrive with multiple broken bones, along with injuries to other vital body systems, such as head and chest wounds. Prior to the designation of OU Medical Center as a Level 1 facility in 2001, Oklahoma's health care system served a population of 3.5 million residents without a single Level 1 trauma center in the entire State.

Ideally, the resources of Level 1 trauma centers should be conserved for treatment of the most seriously injured patients. Studies by ACS suggest that under optimal circumstances within any particular service region, a Level 1 trauma center should treat 80 percent of the most serious trauma victims, but only 20 percent of those less seriously injured patients; the remaining less seriously injured patients instead should be treated at Level 2 trauma centers or full-service community hospitals. With the migration of specialists to specialty hospitals, however, this scenario was not the case in Oklahoma. Despite its mission, OU Medical Center was treating a full 80 percent of all trauma patients across the Oklahoma City metropolitan area, along with transports from other areas of the State. This overloading of our Level 1 trauma center with less seriously injured patients taxes our capacity, and jeopardizes its continued survival.

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

Trauma centers rely upon six surgical sub-specialties, including anesthesiology, which are essential to providing adequate trauma care. Nonetheless, the unavailability of sufficient specialty physicians for on-call duty is not rooted in a lack of specialists. For example, the United States averages one neurosurgeon for every 59,000 citizens, yet the Oklahoma City metropolitan area is home to one neurosurgeon for every 39,000 residents. Despite this seemingly adequate supply of qualified specialty doctors, Oklahoma is witnessing a crisis in on-call coverage for neurosurgery, and nearing a crisis for meeting on-call coverage demands within the subspecialties of orthopedics, facial trauma, anesthesiology, and general surgery. Clearly, the issue does not derive from a lack of capacity.

Rather, the problem is attributable directly to the many specialists who have relocated their practices away from the community hospitals, to specialty hospitals in which they have an equity interest. Before the advent of physician ownership of specialty facilities, physicians typically would maintain an affiliation with multiple hos-

pitals within their geographic service region. As a result, the various hospitals would have access to a substantial universe of available doctors when assigning their on-call schedule. With the introduction of physician ownership and self-referral, however, this scenario has changed dramatically. Rather than retaining privileges at hospitals in which they do not own a financial stake, many specialty physicians have reduced or eliminated their affiliations with other facilities, instead committing their practice to where they have an equity stake.

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

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

At the inception of our Level 1 trauma center, OU Medical Center boasted a staff of six neurosurgeons. We now struggle to maintain just two neurosurgeons on staff in order to sustain our emergency coverage for head trauma patients. In fact, the hospital recently committed nearly $1 million annually in temporary staffing (*in locum tenum*) for the required neurosurgery coverage, just to keep the doors open to our trauma center. We also were forced to resort to a stop-gap on-call system for trauma. Under this plan, OU Medical Center, the other full-service hospitals, the county medical society, and the State hospital association developed a voluntary Level 2 trauma rotation. As a result, a group of neurosurgeons and other critical sub-specialists who had dropped out of call rotation agreed on a voluntary basis to provide coverage at one Oklahoma City hospital each night, ensuring that our metropolitan region continually maintains the Level 1 center, as well as one additional full-service hospital able to accept Level 2 trauma patients around-the-clock. The State also agreed to provide a $5.7 million subsidy to support the operations of OU Medical Center's Level 1 trauma center. These various short-term measures, though costly, have ensured at least the temporary survival of a single Level 1 trauma center and other viable trauma facilities to serve the needs of our State.

Let me stress, however, that these solutions only are temporary. Without stable, permanent neurosurgery staffing, OU Medical Center risks losing the accreditation of our neurosurgery residency training program, which would create yet another vicious cycle: the loss of accreditation in one residency training program invariably would affect and risk the loss of accreditation for our other residency programs. Together, these programs train many of the physicians who choose to remain in practice in the State of Oklahoma. Their loss would be devastating, resulting in fewer specialty physicians practicing in Oklahoma, and a further exacerbation of our State's crisis in emergency service coverage. In addition, the loss of our neurosurgery residency program would put even our Level 1 trauma center designation at risk. In my view, this crisis in emergency services simply would not have occurred in Oklahoma but for the rapid growth of physician-owned specialty hospitals.

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

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

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

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

Besides diverting revenue from full-service community hospitals, physician-owned specialty hospitals also divert limited human resources. Within the 1-year period following the departure of our cardiovascular group, OU Medical Center lost 56 staff members who joined that facility, 40 of whom were registered nurses. The estimated cost of turnover—including increased salaries, retention bonuses, and recruitment training costs—totaled approximately $2.6 million. We narrowly avoided the closure of our intensive care unit by paying nearly $500,000 in retention bonuses.

CONCLUSION

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

It is my hope that Congress will protect community hospitals like OU Medical Center by removing the opportunity for self-referral. I understand the Congress is weighing recommendations by MedPAC that would seek to level the playing field through Medicare payment adjustments. With over 30 years of Medicare reimbursement experience, I can assure the committee that Medicare payment adjustments alone will not solve the self-referral problem. The fact of the matter is that any of my medical specialty staff could leave tomorrow and double their income at a specialty hospital, where the value of their investment increases as a direct result of the self-referral. As long as any financial gain can be generated through a referral, competition will be neither free nor fair between community hospitals like OU Medical Center and our neighboring specialty facilities.

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

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

PREPARED STATEMENT OF LARRY VEITZ

Good morning, Mr. Chairman. I'm Larry Veitz, chief executive officer of Lookout Memorial Hospital in Spearfish, SD. I appreciate the opportunity to testify today on the issue of physician-owned, limited-service hospitals.

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

To protect patients and the health care safety net, Congress should close the loophole in Federal law by permanently banning physician self-referral to limited-service hospitals.

Here's what has happened in our community. Lookout Memorial Hospital is a 40-bed community hospital located in rural Spearfish, SD, a town of 9,300 people. Although Spearfish itself is a relatively small town, our hospital serves 35,000 people across three States: Wyoming, Montana, and South Dakota. Because of our very rural location, patients, who live 120 miles away or more, rely on our hospital for the care they need.

During the 1990s, Lookout Memorial was a thriving rural hospital and, in 1996, was recognized by *U.S. News and World Report* as one of the top 100 hospitals in the United States. Today, however, we are struggling to exist and to continue to provide care to those 35,000 people who rely on our health care services across a 3-State region. The primary reason why we have fallen from being a thriving rural hospital to one struggling just to keep its doors open to the community can be directly attributed to a physician-owned, four-bed surgical hospital that opened in 2000 just blocks away from our hospital.

Unlike our hospital and other community hospitals across the country that provide a wide range of medical services, the four-bed surgical hospital in Spearfish primarily focuses on general and orthopedic surgery. It does not take on the responsibility of daily, round-the-clock emergency services like we do. The Spearfish Surgery Center merely duplicated programs and equipment already available in our area and took nurses, technologists and technicians away. It did not add a single new program of benefit to the community. This physician-owned surgery center has created a profitable business in two ways—by targeting healthier patients and those with good health insurance coverage and by targeting well-reimbursed services. Meanwhile, Lookout Memorial continues to care for everyone in need of care—the poor, the elderly, the uninsured and sicker patients. We turn no one away.

THE IMPACT OF PHYSICIAN SELF-REFERRAL IN SPEARFISH, SD

Yet, by steering well-insured patients away from Lookout Memorial and focusing on surgical procedures that are well-reimbursed by Medicare and private insurers, the surgical hospital has successfully siphoned off resources critical to our hospital's continued ability to provide important medical services to our service area. The negative effects resulting from the surgical hospital's practices have already been experienced in several ways.

First, by selectively referring and treating only healthier, well-insured patients and providing only elective and highly reimbursed procedures, the surgical hospital also has left our communities with significant challenges that jeopardize the health care safety net in our area. Lookout Memorial now treats a greater share of poor and uninsured patients with less financial support for essential services that are seldom self-supporting, such as emergency care, cardiac rehab, home health, diabetic education, and obstetrical services.

For our Wyoming patients, the financial impact of the physician-owned surgical hospital has been particularly harsh, forcing us to make very difficult decisions. For example, we had to eliminate our hospice program for our Wyoming patients because we no longer had the financial means to support it. This means that some of those Wyoming residents with terminal illnesses, who are not expected to live beyond 6 months, will likely spend their final days as a hospital inpatient rather than being able to die with dignity at home surrounded by family and friends. It means that we no longer have the ability to provide support services to those Wyoming residents who have struggled with the stress and grief of caring for and losing a loved one with a terminal illness.

Fewer resources also forced us to curtail our home health program for our Wyoming patients. This program allows frail, elderly patients to stay at home with their loved ones and receive needed nursing care or physical therapy. Now, the alternative for some of these patients is a nursing home—a setting that many elderly patients fear because of its high-costs and because it takes them away from their spouses and social support systems.

Physician-owned, limited-service hospitals, such as the surgical hospital in Spearfish, duplicate services already available at full-service community hospitals and jeopardize our ability to provide care to all patients, whether it is care for uninsured or Medicaid patients, or emergency care for everyone in the area.

EXPLOITING A LOOPHOLE

Congress has historically been concerned with the potential conflict of interest that can arise when physicians refer patients to labs, hospital departments and other health facilities they own. Research at that time showed that physicians order more services when they have an ownership interest in the entity that is going to provide those services. That is why laws were passed in 1989 and 1993 prohibiting

physician self-referral to a wide range of health services where a doctor is also an owner. However, Congress made an exception to allow physicians to be owners in "whole hospitals" with the reasoning that no specific patient referral would economically benefit an individual physician.

At the time these laws were passed, however, lawmakers could not have envisioned that specific departments or specialties within a hospital, such as surgery, cardiac care or orthopedics, would be turned into four-bed, limited-service facilities disguised as "whole" hospitals. Yet, that is exactly what has happened. Certain enterprising physicians have exploited the exception in current law, are investing in these limited-service facilities and are referring only carefully selected, financially rewarding patients to them, clearly to the financial benefit of these physician owners.

Both the Government Accountability Office (GAO) and the Medicare Payment Advisory Commission (MedPAC) in separate studies have uncovered troubling evidence with respect to the business practices of physician-owned, limited-service hospitals. Specifically, they found that physician owners refer only patients with the best health coverage and those who are less sick to their limited-service hospitals. As a result, full-service hospitals are left to treat a higher percentage of poor and uninsured patients requiring more intensive care. Further, the GAO and MedPAC also found that limited-service facilities were much less likely to offer emergency services and tend to offer only highly profitable services, while community hospitals provide emergency treatment, burn care and other vital services for which payment seldom covers cost. Interestingly, MedPAC also discovered that the limited-service hospitals do not have lower costs per case in treating Medicare patients than do full-service community hospitals.

Based on these findings, it is not surprising that MedPAC questioned whether financial gain—not clinical considerations—may be driving some physicians to refer patients to those limited-service hospitals where they have an ownership interest. The issue of whether doctors' personal financial gain is driving patient care decisions deserves serious examination and congressional action.

Congress was so concerned about the rapid proliferation of physician-owned limited-service hospitals and the potential conflicts of interest posed by physician ownership that in 2003 it implemented a moratorium prohibiting physicians from referring Medicare patients to new, physician-owned limited-service hospitals as part of the Medicare Modernization Act. That moratorium, however, is set to expire in June.

THIS IS NOT ABOUT COMPETITION

Advocates for physician-owned limited service hospitals argue that full-service community hospitals simply do not want to compete based on services and quality. This could not be further from the truth. Full-service community hospitals around the country compete every day in our market-driven health care system. They compete by introducing innovations in medicine, technology and care delivery to offer the best services to their patients. But the power of physician owners to direct where patients get their care and refer only well-insured patients to their own facilities is not competition—it is conflict of interest. It is illegal for full-service community hospitals to offer any financial inducements to physicians in exchange for patient referrals. Yet, these physician-owned limited-service hospitals are masking inducements to refer patients under the guise of ownership.

Full-service community hospitals are more than willing to compete based on cost, quality and efficiency. But, currently, there is an unlevel playing field that is unfairly rewarding certain physicians for selectively referring healthier, well-reimbursed patients to limited-service hospitals they own. Full-service community hospitals are, therefore, placed at an unfair competitive disadvantage.

THIS IS NOT ABOUT QUALITY

Although physician-owned limited service hospitals claim that patients receive higher quality care in their facilities, there is no credible, independent evidence to date to suggest any quality differences between physician-owned limited service hospitals and full-service community hospitals.

Limited-service hospitals use the same medical technology as the full-service community hospitals. Often, these facilities have the same doctors and nurses that practiced at the full-service community hospital—they just opened their own facility a few miles away. Given all this, it is hard to see why there would be differences in quality. What is clear is the duplication of services already available at the full-service community hospitals.

SELF-REFERRAL CREATES CONFLICT OF INTEREST

When physicians own facilities to which they refer patients, their decisions about when to provide care and which facility to send any particular patient to are subject to competing interests. Studies have shown that physician self-referral can lead to increased use of services and add cost to the system. Also, the ability to direct patients to one facility or another causes a competitive distortion that generally cannot be overcome as long as referring physicians own competing entities.

CONCLUSION

The growing body of evidence suggests that physician-owned limited-service hospitals represent a serious conflict of interest that could threaten patient access to emergency and other medical services. That is why MedPAC has recommended that Congress extend the current moratorium on physician self-referral of Medicare patients to new, limited-service hospitals until January, 2007.

I respectfully urge Congress to close the loophole in Federal law by permanently banning physician self-referral to limited-service hospitals. Community hospitals are created and sustained by the community to serve all patients regardless of their health status or ability to pay. The conflict of interest created when physicians refer patients to limited-service hospitals they own is robbing our community hospitals of their ability to serve everyone and is risking patient access to essential medical services.

COMMUNICATIONS

STATEMENT FOR THE RECORD
BY
AMERICAN COLLEGE OF SURGEONS
TO
COMMITTEE ON FINANCE
UNITED STATES SENATE
ON
PHYSICIAN-OWNED SPECIALTY HOSPITALS
MARCH 8, 2005

The American College of Surgeons is pleased to submit a statement for the record of the Committee's hearing on physician ownership of specialty hospitals. This is a very important issue for the College and its members. As you know, surgeons provide patient care in all of America's hospitals. The College strongly believes that maintaining care in all types of hospitals, including specialty hospitals, is necessary to sustain full patient access to the highest quality of surgical care.

Surgeons advocate the following policies for addressing the issue of specialty hospitals:

- We oppose elimination of the whole hospital exception, either by legislation or regulation;
- We oppose extension of the MMA moratorium temporarily or permanently; and
- We support refining the hospital DRGs to ensure that Medicare payments properly reflect the cost of providing care.

Specialty hospitals are an important marketplace innovation. Indeed, when the hospital prospective payment system was implemented in 1982, it was widely expected to lead to hospital specialization in order to increase efficiency and improve the quality of care. This is exactly what is happening today with the establishment of specialty hospitals. These hospitals provide more choices for patients and they provide high-quality care. Patients frequently choose these hospitals and they report high satisfaction with their care and experience.

Physician-ownership of specialty hospitals is a positive trend. It is the joint ventures among physicians, hospitals, and other investors that are making possible the growth of specialty hospitals and the improvements they bring. Frequently, the initiative to create a specialty hospital comes from a physician group, often a group recognized in the community for its clinical excellence, as Regina Herzlinger notes in her case study of MedCath.[1] Physicians and hospitals working together, and with shared incentives, are able to make important changes in the delivery of health care.

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

The College is concerned about the misplaced emphasis that some attach to financial gain as the prime motivator for physicians becoming involved in these ventures. Physicians are motivated to form specialty hospitals because they recognize the potential to increase productivity and efficiency while also improving quality of care and patient satisfaction. Sometimes physicians have been frustrated while trying to achieve these goals in existing community hospitals. At a MedPAC meeting last September, a MedPAC analyst reported on site visits, saying, *"We repeatedly heard about the frustrations physicians had with community hospitals. Many community hospital administrators acknowledged they had been slow to react to the issues raised by their physicians."*[2]

We want to emphasize that physicians have experienced very significant gains in productivity and efficiency through their involvement in specialty hospitals. According to a MedPAC staff report, *"Physicians … told us that they can perform about twice as many cases in a given time period at specialty hospitals as at community hospitals. Physicians mentioned operating room turnaround times at specialty hospitals of 10–20 minutes, compared with over an hour at the community hospitals where they also practice. …At one specialty hospital, we were told that physician incomes had increased by 30 percent as a result of increased productivity*.[3]"

Finally, the entry of a specialty hospital into a community can be a powerful force for change and improvement. Efficiency and quality are the result of competition, which is healthy for the marketplace. In fact, the Federal Trade Commission recently reported that state certificate-of-need laws have an adverse impact on health care because they stifle competition. Further evidence comes from MedPAC, which reported that community hospitals in areas it visited responded to marketplace pressure created by specialty hospitals and improved their own performance. Specialty hospitals provide efficient, high-quality care, and patient satisfaction is high. They bring value to local health care systems.

Indeed, quality and efficiency are the prime motivators for surgeons who choose to practice in these hospitals—including those who have no ownership interest. They can be more productive and have greater access to specialized equipment and staff than is possible in a general hospital. The end result is higher quality at lower cost.

The criticisms of physician-owned specialty hospitals are not well founded. Critics say that they lead to increased utilization and unnecessary services, but there is no evidence to support this claim. Critics also say specialty hospitals do not serve low-income patients or those who lack health insurance coverage. While it is true that

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[2] Transcript of public meeting: Medicare Payment Advisory Commission, September 10, 2004, Washington, D.C; available at www.MedPAC.gov

[3] Specialty hospital study meeting brief: prepared for meeting of Medicare Payment Advisory Commission, September 9-10, 2004, Washington, D.C.

specialty hospitals tend to treat relatively few Medicaid and uninsured patients, this is because of the markets where they are located. Investors tend to build specialty hospitals in financially stable suburban areas, where community hospitals also tend to treat fewer Medicaid and uninsured patients. Further, unlike most hospitals in these markets, specialty hospitals support their communities through the taxes they pay.

Finally, critics say that specialty hospitals tend to treat less severely ill—and more profitable--patients, thus leaving the less profitable patients to community hospitals that provide a full range of services to all types of patients. Many of these services tend to be unprofitable. Unprofitable services, for example, include medical admissions rather than surgical ones, emergency and trauma care, and burn care. Thus, critics are concerned that specialty hospitals will drain resources from full-service community hospitals and perhaps hurt them financially.

The College would share this concern, but we do not believe that this will occur or that prohibiting specialty hospitals is the most appropriate way to address the issue. As you know, the College has long championed improvements to our nation's emergency medical systems and trauma care systems, and we continue do so. We also support the DRG changes that will address this issue of unprofitable services, as recommended by MedPAC in its March 1 report to Congress and repeated today in its report on specialty hospitals.

It is also important to recognize that, by their nature, specialty hospitals can only treat patients whose medical needs can be met by their resources. Patients with underlying conditions beyond a hospital's capabilities must be referred to more comprehensive facilities. The same is true for ambulatory surgical centers (ASCs)–some patients cannot be cared for appropriately in these facilities and must be referred to general or tertiary care hospitals. We also note that some comprehensive hospitals have denied privileges to physicians who practice in competing hospitals or ASCs, a development that clearly should cause concern among patients.

Like nearly all hospitals, specialty hospitals are paid based on DRG payments that vary according patient diagnosis, complications, procedures, and the average resources required to treat comparable cases. The recent MedPAC reports describe flaws in the Medicare DRG system that cause payments for some cases to be higher than would be dictated by the average cost of providing services and, conversely, to pay less than would be indicated for other cases. These discrepancies can provide an opportunity for any hospital, whether specialty or comprehensive, to select patients that are more profitable and to provide fewer services--or even none at all--for less profitable patients. The College believes that these perverse incentives ought to be addressed and so we strongly support the recommendations advanced by MedPAC in its recent reports to Congress.

We also are pleased that, as reported in the President's budget for FY 2005, CMS plans to adopt MedPAC's recommendation by initiating a DRG refinement process. Done properly, this process will ensure that Medicare payments accurately reflect the cost of

providing care and that *all* hospitals are paid fairly and appropriately for their services to Medicare patients. We believe that these changes should resolve concerns that have been raised about the impact that specialty hospitals can have on community hospitals. In effect, the changes will create a level playing field in which healthy competition can operate, leading to enhanced quality and efficiency in the delivery of all healthcare services. The College believes that improvements like those recommended by MedPAC must be implemented in order to ensure the financial viability of providing emergency and trauma care as well as the broad range of care provided by tertiary care centers and other comprehensive hospitals.

In closing, we want to emphasize that specialty hospitals are not new—physicians and others have been establishing them for 75 years. In fact, some of the nation's finest hospitals are specialty specific. Also, it is worth noting that the average physician investor has a very small financial stake in specialty hospitals, and the majority of surgeons who work in physician-owned hospitals have no ownership interest. Further, a ban on physician ownership of specialty hospitals will not stop the trend. Corporations, including hospitals, are building them and they will continue to do so. Clearly, any action to prohibit specialty hospitals would be an action to limit the competition that is so vital to keep the healthcare system improving its efficiency, quality of care, and patient satisfaction. This is healthy competition and it is an example of the values that have been promoted by the Administration and by Congress. We must work together to preserve specialty hospitals, support healthy competition, and end distortions in our payment systems that can interfere with patient access and harm providers.

Surgeons remain committed to community health care. Teaching hospitals, tertiary care centers, trauma and burn centers, and the network of community hospitals are all vital to the well-being of surgical patients. Considering this, the American College of Surgeons encourages all physician hospital owners to practice according to the following principles:

- Specialty hospitals should accept all patients for which they can provide appropriate care, without regard to source of payment.

- Patient selection should be based on medical criteria and facility capabilities. Those patients with needs that extend beyond a facility's resources should be referred to a tertiary care center or other hospital that is appropriately equipped and staffed.

- Surgeons practicing in specialty hospitals should maintain their commitment to providing the emergency services needed in their communities and should take call in community hospital emergency departments, as necessary.

- The issue of whether specialty hospitals should have their own emergency rooms is, and should remain, a matter of state law and community need.

- Physician investors should disclose their financial interest to patients they propose to treat in a specialty hospital.

Thank you for the opportunity to share the views of the College of Surgeons. Questions and comments may be directed to the College's Washington Office, at 202-337-2701.

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Statement
of the
American Hospital Association
before the
United States Senate
Committee on Finance
on
"Physician-Owned Specialty Hospitals: In the Interest of Patients or a Conflict of Interest"

March 8, 2005

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

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

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

The History of Self-Referral

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

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

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

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

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

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

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

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

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

But at the time the self-referral laws were passed, policy makers did not foresee that specific departments or specialties within a hospital (e.g., cardiac care, orthopedics, surgery) would become stand alone hospitals. Because of concerns with this practice, the Medicare

Modernization Act of 2003 (MMA) imposed a temporary moratorium on physician self-referrals under Medicare to new limited-service providers. The moratorium is set to expire June 8, 2005.

This is Not About Competition

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

Full service hospitals are more than willing to compete based on cost, quality and efficiency. They compete with other providers in their market areas every day. But when physician owners of limited-service hospitals can pick and choose the services they provide, and when they can pick and choose the patients – often the healthier, well-insured patients – they refer to the facilities they own, they have unfair advantages. And that's anti-competitive.

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

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

The Facts

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

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

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

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

- tend to treat lower shares of Medicaid patients;
- concentrate on certain diagnoses (diagnostic related groups (DRGs))
- treat relatively low-severity patients within those DRGs; and

- do not have lower Medicare costs per case.

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

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

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

Why Physician Conflict of Interest is a Serious Problem

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

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

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

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

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

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

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

The Impact on Care

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

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

- Continue providing essential services that are seldom self-supporting, such as emergency departments, burn units, trauma care, and care for the uninsured.

- Maintain specialty "on-call" coverage in their emergency departments, as physician-owners of limited-service hospitals no longer want to participate in this broader community commitment. Lack of specialty coverage in our nation's emergency departments can jeopardize a hospital's trauma level status and cause emergency patients to be transported much farther to access needed specialty care.

- Overcome growing inefficiencies, such as more downtime and less predictable staffing needs, that result from a higher proportion of emergency admissions at full service hospitals. These result as physician-owners move more and more elective admissions to their own limited-service hospitals.

- Coordinate care for patients in their community when more and more are being treated for a single condition by a limited-service hospital. Also, complications unrelated to the condition being treated (for example, a heart attack or a blood clot during or following surgery) result in last-minute emergency transfers to full-service hospitals, increasing the risk to patients.

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

The study shows that when physician-owned limited-service hospitals open in an area, the financial health of the full service hospitals decline. Because the patient selection tactics of the

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

At the same time, self-referral creates an un-level playing field for the services offered and access to care provided by full service hospitals. The McManis study documents that in two communities, patient access to emergency and trauma care was put at risk. In the Black Hills, South Dakota region and in Oklahoma City, a critical mass of physician-owners in key specialties opted out of community emergency call obligations. The lead organizers of the Black Hills Surgery Center, who were the most active neurosurgeons in the region, no longer provide emergency coverage at the full service hospital. And no emergency service is offered at the surgical hospital.

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

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

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

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

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

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

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

Many Others are Concerned

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

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

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

Statement

For the Record

of the

American Medical Association

to the

Committee on Finance
United States Senate

Re: Physician Owned Specialty Hospitals

March 8, 2005

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.

The AMA would like to take this opportunity to commend the Committee for holding this hearing on physician owned specialty hospitals. As you may know, hospitals that provide care for a specific type of a patient or a defined set of services are not new. Specialty hospitals have been in existence for most of the latter half of the twentieth century. Yet more recently, numerous market and environmental factors have led to the increase in physicians' desire to own and operate these hospitals. Since 1995, the number of specialty hospitals has grown significantly. This growth has led to concern among general hospitals who must compete with these facilities.

The AMA strongly supports and encourages competition between and among health facilities as a means of promoting the delivery of high-quality, cost-effective health care. Consistent with AMA Council on Ethical and Judicial Affairs Opinion E-8.032, we support health facility ownership and referral by physicians if they directly provide care or services at the facility. The growth in specialty hospitals is an appropriate market-based response to a mature health care delivery system and a logical response to incentives in the payment structure for certain services.

The AMA also supports changes in the inpatient and outpatient Medicare prospective payment systems to more accurately reflect the relative costs of hospital care, thus eliminating the need for cross-subsidization. In addition, we support policy changes that would help ensure the financial viability of safety-net hospitals so they can continue to provide adequate access to health care for indigent patients. Together, these changes would ensure the continued financial stability of general and safety net hospitals. Therefore, the AMA believes there is no need to extend the moratorium on physician referrals to specialty hospitals.

BACKGROUND

As this 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 physicians investors in certain specialty hospitals not already in operation or under development as of November 18, 2003.[1] The MMA required the Medicare Payment Advisory Commission (MedPAC), in consultation with the Government Accountability Office (GAO), and the Secretary of the Department of Health and Human Services (HHS) to conduct studies of specialty hospitals and report their findings and recommendations to Congress.

According to the GAO,[2] there are 100 existing specialty hospitals – hospitals that focus on cardiac, orthopedic, women's medicine, or on surgical procedures. This number excludes numerous other specialty hospitals that have been in existence for some time, such as eye and ear hospitals, children's hospitals, and those that specialize in psychiatric care, cancer, rehabilitation, and respiratory diseases. Of the 100 specialty hospitals identified by the GAO and 26 others under development in 2003, there were various owners/investors, including both hospitals and physicians. Seventy percent had some degree of physician ownership. One-third of these specialty hospitals were joint ventures with corporate partners, one-third were joint ventures with hospitals, and one-third were wholly owned by physicians.

FACTORS CONTRIBUTING TO THE GROWTH OF SPECIALTY HOSPITALS

There are numerous market and environmental factors that have contributed to the growth of specialty hospitals, including:

- Many physicians are frustrated over hospital control of management decisions and investment decisions that affect their productivity and the quality of patient care. Physicians often have little or no involvement in governance and management, control over reinvestment of profits in new equipment, or influence over scheduling and staffing needs for cases performed in the operating room. They believe that hospitals are not collaborating with them to align hospital processes or engage in joint ventures. Physicians who invest in specialty hospitals are able to increase their productivity, improve scheduling of procedures for patients, maintain appropriate staffing levels, and purchase desired equipment, all of which improve the quality of patient care.

- Medicare and private insurer payment rates are perceived to be relatively high for certain services, often exceeding hospital costs associated with these services, and relatively low for other hospital services.

- Payments for physician professional services have declined while the costs of medical practice, such as professional liability premiums, have continued to escalate substantially. As a result, some physicians have sought to increase their practice revenues with the facility fees or technical component payments derived from investment in a specialty hospital.

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[1] The MMA defined specialty hospitals as those primarily or exclusively engaged in cardiac, orthopedic, surgical procedures and any other specialized category of services designated by the Secretary.

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

- Advances in technology (e.g., minimally invasive surgery) have allowed care to be provided in a variety of settings.

- Data shows that facilities that focus on certain procedures and perform a significant number of them have better quality outcomes.

- Availability of business partners to provide capital and management expertise.

EFFICIENCY, QUALITY AND PATIENT SATISFACTION

For various reasons, specialty hospitals have achieved better quality, greater efficiency, and higher patient satisfaction than general hospitals. Specialty hospitals are able to achieve production economies by taking advantage of high volumes of a narrow scope of services, and by lowering fixed costs by reengineering the care delivery process. Managerial and clinical staff at specialty hospitals focus on a relatively narrow set of tasks, thus providing the capability to perfect those tasks and benefit from increased accountability for the quality of care provided to patients. According to the Center for Studying Health System Change, the health services literature supports the premise that "focused factories" can lead to higher quality and lower costs as a result of more expert and efficient care.[3]

Managers of specialty hospitals consistently report the factors they perceive as critical to achieving high quality patient outcomes: high volume and high nursing intensity.[4]
Specialty hospitals tend to have higher nurse-patient ratios despite the fact that physicians at specialty hospitals contend that they spend about 30% of their operating expenses on labor, compared to 40 to 60% for general acute-care hospitals.

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

Specialty hospitals are well positioned to address projected increases in demand for cardiac, orthopedic, and surgical services because they are a more efficient and effective way to deliver the services. In 2002, for example, 500,000 patients were diagnosed with congestive heart failure. With the estimated number of Americans at risk of cardiovascular disease projected to mushroom over the next decade, cardiovascular surgeons and cardiologists will need to see twice as many patients in ten years as they see today. Aging of the population, population growth, higher functioning and higher quality of life expectations associated with the baby boom generation are driving increased demand for cardiac, orthopedic, and surgical services. The greater efficiency of specialty hospitals will better enable physicians to care for these patients. Furthermore, the GAO found that 85 percent of specialty hospitals are located in urban areas and tend to locate in counties where the population growth rate far exceeds the national average.[5]

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[3] Kelly J. Devers, Linda R. Brewster and Paul B. Ginsburg, *Specialty Hospitals: Focused Factories or Cream Skimmers?* HSC Issue Brief Number 62, April 2003.
[4] John E. Schneider, PhD, et al., *Economic Policy Analysis of Specialty Hospitals*, February 20, 2005.
[5] GAO, *supra* note 2.

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

HOSPITAL INDUSTRY RESPONSE TO INCREASED COMPETITION

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

According to the GAO, the financial performance of specialty hospitals tended to equal or exceed that of general hospitals in fiscal year 2001.[6] The 55 specialty hospitals with available financial data tended to perform better than general hospitals when revenues and costs from all lines of business and all payers were included. When the focus was limited to Medicare inpatient business only, specialty hospitals appeared to perform about as well as general hospitals.[7]

General hospitals and their respective national and state hospital associations feel threatened by the growth of specialty hospitals and physician-owned ambulatory facilities, (e.g., ambulatory surgery centers, GI labs, imaging facilities, radiation oncology centers). Although they claim to support healthy competition, general hospitals have recently engaged in an aggressive assault on facilities owned and operated by physicians which they have characterized as "niche-providers."

The three core strategies the hospital industry is employing to address physician ownership of specialty hospitals are:

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

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

- Fight physicians that try to open a competing facility by building barriers – The hospital aggressively limits the potential for developing competing services by implementing actions to restrict physicians' capabilities to do so (e.g., adopting "economic credentialing" or "exclusive credentialing" policies that revoke or refuse to grant medical staff membership or clinical privileges to any physicians that has an indirect or direct financial investment in a competing entity).

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[6] *Id.*
[7] *Id.*

The hospital industry has engaged in numerous focused strategies to prohibit physicians from opening a competing facility. At the state level, hospitals have initiated several different types of legislative strategies to limit physician-owned specialty hospitals. These initiatives include, but are not limited to, the following:

- Adopting legislation banning the creation of any facility that focuses on cardiac care, orthopedic services or cancer treatment. (Florida)
- Proposing legislation prohibiting physicians from having a financial ownership in specialty hospitals. (Ohio and Washington)
- Proposing legislation to expand Certificate of Need (CON) requirements to include other physician-owned facilities such as ambulatory surgery centers and diagnostic imaging facilities. (Minnesota)
- Resisting efforts to repeal CON legislation. (Iowa)
- Proposing legislation and or regulations requiring specialty hospitals (but not other hospitals) to provide emergency departments and/or accept Medicare, Medicaid, and uninsured patients. (Washington)

Individual general hospitals have implemented a variety of strategies and tactics to discourage members of their medical staff from investing in competing physician-owned specialty hospitals. These initiatives include, but are not limited, to the following:

- Adopting economic/exclusive credentialing/conflict of interest policies and medical staff development plans that revoke or refuse to grant medical staff membership or clinical privileges to any physicians or other licensed independent practitioner that has an indirect or direct financial investment in a competing entity.
- Hospital-owned managed care plans denying patient admissions to competing specialty hospitals.
- Requiring health plans to sign an exclusive managed care contract or otherwise discouraging them from contracting with competing facilities.
- Removing physicians that have a financial interest in a competing facility from their referral and on-call panels.
- Refusing to cooperate with specialty hospitals, (i.e., refusing to sign transfer agreements).
- Requiring primary care physicians employed by the hospital or vertically integrated delivery system to refer patients to their facilities or those specialists that are closely affiliated with the hospital/health care delivery system.
- Requiring subspecialists to utilize the hospital/vertically integrated delivery systems facilities for all of their medical group's referrals, for specified services such as outpatient surgery and procedures, all imaging and laboratory work, therapy, and inpatient admissions.
- Hiring in-house specialists to build "centers of excellence" or service lines, sometimes intentionally competing with its own medical staff members.

- Limiting access to operating rooms and cardiac catheterization labs of those physicians that have a financial interest in a competing entity.

- Removing competing physicians from extra assignments at the hospital, such as directors of departments or reading EKGs, ultrasounds, echocardiography, and x-rays.

The hospital industry's overarching message is that physicians who invest in a specialty hospital have a conflict of interest. They use this to justify their strategies to eliminate legitimate competition. However, physicians are ethically and legally permitted to invest in and refer patients to health facilities.

Current public policy generally prohibits physicians from profiting from their referral decisions absent a legitimate justification for the referral. AMA ethical opinion E-8.032, "Conflicts of Interest: Health Facility Ownership by a Physician," delineates two scenarios where physicians may appropriately make patient referrals to health facilities in which they have an ownership interest. First, it sets forth a general rule that physicians may appropriately make such referrals if they directly provide care or services at the facility in which they have an ownership interest. Second, it describes a separate situation where physicians may appropriately make such referrals, which arises when a needed facility would not be built if referring physicians were prohibited from investing in the facility. In the latter case, the appropriateness of the referrals would not depend upon whether the physicians have personal involvement with the provision of care at the facility, but whether there is a demonstrated need for the facility. Physician ownership of specialty hospitals and referral of patients for treatment at such facilities fits squarely within this ethical opinion.[8]

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

In fact, it is disingenuous for the hospital industry to claim that physicians have a conflict of interest when many general hospitals engage in self-referral practices. One hospital association claims that a "community hospital that tried to buy admissions in this way would be outlawed."[10] Ironically, however, general hospitals often channel patients to their facilities and services. They do this mainly by acquiring primary care physician practices or by employing primary care physicians, and requiring those physicians to refer all of their patients to their facilities for certain services such as x-ray, laboratory,

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[8] The hospital associations, however, claim otherwise by distorting AMA ethical opinion E-8.032. They claim that it prohibits physician referrals to facilities in which they have an ownership interest unless there is a demonstrated need in the community. (July 6, 2004 letter to members of Congress from the Federation of American Hospitals (FAH) and the American Hospital Association (AHA)) The AMA quickly set the record straight, but the hospital associations continue to distort AMA policy. (August 4, 2004 letters from Michael D. Maves, MD, MBA to House Energy and Commerce Committee, House Ways and Means Committee and Senate Finance Committee.) Although a demonstrated need in the community is one ethical justification for a referral to a facility that one owns, it is a mischaracterization of AMA ethical opinion to state that it is the only justification.

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

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

therapy services, outpatient surgery, and inpatient admissions. They also require such referrals by physicians under certain contractual arrangements or by adopting policies that require members of the medical staff to utilize their facilities.

Hospitals value these controlled referral arrangements to such a degree that they maintain them despite the fact that many of these primary care practices and other physician arrangements operate at a loss for the hospital. The hospitals are frequently willing to subsidize these practices with profits derived from other departments and services provided by the hospital or health system.

Hospital efforts to control referrals would pose as much a concern as would physician self-referral if it were proven that such referrals led to an inappropriate increase in utilization. Worse yet, by dictating to whom physicians may refer, the hospital governing body or administration takes medical decision-making away from physicians. This runs counter to patient expectations, introduces financial concerns into the patient-physician relationship, imposes upon the professionalism of physicians, and can run counter to what the physician believes is in the best interest of the patient. These hospital self-referral practices also limit patient choice.

The AMA is very concerned about efforts by hospitals and health systems to control physician referrals and believes they pose a number of significant concerns. To reduce the interference in the patient-physician relationship, the AMA believes that disclosure requirements for physician self-referral, where applicable, should also apply to hospitals and integrated delivery systems that own medical practices, contract with group practices or faculty practice plans, or adopt policies requiring members of the medical staff to utilize their facilities and services.

Despite claims by the hospital associations that physician ownership of specialty hospitals is a conflict of interest, the data does not support their assertions. MedPAC found no evidence that overall utilization rates in communities with specialty hospitals rose more rapidly than in other communities. In addition, of the specialty hospitals identified by the GAO with some degree of physician ownership, the average share owned by an individual physician was less than two percent. Of particular significance, the GAO found that the majority of physicians who provided services at specialty hospitals had no ownership interest in the facilities. Overall, approximately 73 percent of physicians with admitting privileges at specialty hospitals were not investors in those hospitals.[11] Therefore, the vast majority of physicians who admit patients to specialty hospitals receive no additional financial incentives to do so. Further, of those physicians who do have an ownership interest in the hospital, there is no evidence that their referrals are inappropriate or have increased utilization.

Specialty hospitals with physician investors believe that the playing field is actually tilted in support of nonprofit hospitals. Nonprofit hospitals are exempt from federal and state income taxes and local property taxes and have access to tax-exempt financing. Most nonprofit hospitals also receive Medicare and Medicaid DSH payments.

On the whole, the impact of specialty hospitals has not proven to be harmful to patients or to general hospitals. Specialty hospitals represent about two percent of all short-term, acute care hospitals.[12] The most recent Medicare discharge data indicate that the 80 specialty hospitals in existence in 2001 accounted for slightly less than one percent of Medicare spending for inpatient services. MedPAC also found that the financial impact on community hospitals in the markets where physician owned specialty hospitals are located has been limited. These hospitals have managed to compensate for any losses of patients and revenues and demonstrate financial performance comparable to other community hospitals.

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[11] GAO, *supra* note 2.
[12] *Id.*

Another study found that general hospitals residing in markets with at least one specialty hospital actually have higher profit margins than those that do not compete with specialty hospitals.[13] MedPAC also found that specialty hospitals have forced community hospitals to become more competitive, and that specialty hospitals are an attractive alternative for patients and their families.

COMPETITION SHOULD BE PROMOTED AND CROSS-SUBSIDIES SHOULD BE ELIMINATED

The AMA continues to have serious concerns about the tactics being employed by hospitals in their attempts to eliminate competition by prohibiting physician referrals to specialty hospitals in which they have an ownership interest. The AMA believes that the growth in specialty hospitals is an appropriate market-based response to a mature health care delivery system and a logical response to incentives in the payment structure for certain services. If general inefficiencies exist in the hospital industry, this type of market response will create an incentive for general hospitals to increase efficiencies to compete. If the cross-subsidies that hospitals use from profitable services are truly enabling them to provide unprofitable services, these cross-subsidies should be eliminated by making payments adequate for all services.

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

> Governments should reexamine the role of subsidies in health-care markets in light of their inefficiencies and the potential to distort competition. Health-care markets have numerous cross subsidies and indirect subsidies. Competitive markets compete away the higher prices and profits needed to sustain such subsidies. Competition cannot provide resources to those who lack them, and it does not work well when providers are expected to use higher profits in certain areas to cross-subsidize uncompensated care. In general, it is more efficient to provide subsidies directly to those who should receive them to ensure transparency.[14]

Support for specialty hospitals in no way diminishes the important role of the general hospital in the community. Emergency and safety net care are important and necessary aspects of hospital care – and general and non-profit hospitals should be adequately reimbursed for these and other essential services. The AMA does not believe that cross-subsidization by high-profit service lines is the appropriate method to fund community health and medical services. To ensure that hospital payments better compensate for these services so that safety-net hospitals receive proper funding, Congress should change the Medicare Hospital Prospective Payment System to minimize the need for cross-subsidization and accurately reflect relative costs of hospital care.

MedPAC is expected to recommend that CMS improve payment accuracy in the hospital inpatient prospective payment system (PPS) by refining the hospital Diagnosis Related Group (DRG) payments to more fully capture differences in severity of illness among patients, basing the DRG relative weights on the estimated cost of providing care rather than on charges, and basing the weights on the national

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

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

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

The AMA supports such recommendations and believes that such payment changes will go a long way towards leveling the playing field and promoting full and fair competition in the market for hospital services. Consistent with Council on Ethical and Judicial Affairs Opinion E-8.032, the AMA supports health facility ownership by physicians if they directly provide care or services at the facility. The AMA also supports competition between and among health care facilities because it promotes the delivery of high-quality, cost-effective health care.

In addition, the AMA believes that further policy changes are necessary to protect America's public safety net hospitals. Safety-net hospitals provide a significant level of care to low-income, uninsured, and/or vulnerable populations. Public hospitals in the largest metropolitan areas are considered key safety-net hospitals. These hospitals make up only about 2% of all the nation's hospitals, yet they provide more than 20% of all uncompensated care. Compared with other urban general hospitals, safety-net hospitals are nearly five times as likely to provide burn care, four times as likely to provide pediatric intensive care, and more than twice as likely to provide neonatal intensive care. Safety-net hospitals are also more likely than other urban general hospitals to offer HIV/AIDS services, crisis prevention, psychiatric emergency care, and other specialty care.

Safety-net hospitals rely on a variety of funding sources. However, to finance the significant portion of uncompensated care, safety-net hospitals rely on local or state government subsidies, Medicaid and Medicare Disproportionate Share Hospital (DSH) payments, cost shifting, and other programs. As a group, safety-net hospitals are in a precarious financial position because they are uniquely reliant on governmental sources of financing.

The AMA believes that CMS should correct the flawed methodology for allocating DSH payments to help ensure the financial viability of safety-net hospitals so they can continue to provide adequate access to health care for indigent patients. In addition, the current reporting mechanism should be modified to accurately monitor the provision of care by hospitals to economically disadvantaged patients so that policies and programs targeted to support the safety net and the populations these hospitals serve can be reviewed for effectiveness. Medicare and Medicaid subsidies and contracts related to the care of economically disadvantaged patients should be sufficiently allocated to hospitals on the basis of their service to this population in order to prevent the loss of services provided by these facilities. The AMA recognizes the special mission of public hospitals and supports federal financial assistance for such hospitals, and believes that where special consideration for public hospitals is justified in the form of national or state financial assistance, it should be implemented.

CONCLUSION

There is no evidence that general hospitals are suffering as a result of the growth of physician owned specialty hospitals. Specialty hospitals increase competition in the hospital industry and provide patients with more choice – forcing existing hospitals to innovate to keep consumers coming to them. This is a win-win situation for patients. Supporting health delivery innovations that enhance the value of health care for patients is the only way to truly improve quality of care while reigning in health care costs.

Based on the MedPAC and FTC/DOJ recommendations and the limited data currently available on physician ownership of specialty hospitals, **the AMA believes that patients will be better served if Congress does not act to extend the moratorium on physician referrals to specialty hospitals in which they have an ownership interest. After the payment changes take effect, MedPAC, HHS and others should continue to monitor specialty hospitals and the impact on general hospitals and patient care.**

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

CEDARS-SINAI HEALTH SYSTEM®

Statement for the Record

William W. Brien, M.D.
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To the
U.S. Senate
Committee on Finance

"Physician-Owned Specialty Hospitals: In the Interest of Patients or a Conflict of Interest?"

March 8, 2005

I am Dr. William Warren Brien, director of orthopedic surgery and the clinical chief of the department of surgery at Cedars-Sinai Medical Center in Los Angeles. I also serve as a state commissioner on the California Health Policy and Data Advisory Commission.

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

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

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

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

The Situation in Los Angeles

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

The medical center annually provides about $100 million of charity care. We deliver primary health care services directly to inner-city children and adults through mobile units. We offer community clinics to uninsured patients and those covered by Medi-Cal — the state's Medicaid program — with more than 29,000 clinic visits annually. In fact, Cedars-Sinai is one of the top five Medi-Cal providers among private hospitals in L.A. County and is one of the largest Medi-Cal providers in the state of California.

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

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

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

The Effects of Limited-access Facilities

During the last two years, nine community hospitals in the Los Angeles area closed their doors forever. In 2004, the County of Los Angeles closed the Level I Trauma Center at Martin Luther King Jr. Medical Center. The loss of those nine hospitals and their emergency departments combined with the closure of the Martin Luther King Trauma Center has created a significant

strain on the Cedars-Sinai trauma system and raises a serious access-to-care issue for the people of Los Angeles.

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

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

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

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

Because limited-access facilities often treat only a single condition, I worry as a physician about the safety of some patients treated there. Patients are placed at an increased risk when they suffer complications following surgeries at limited-access facilities, such as blood clots and heart attacks, and must be transferred to the full-service hospitals for treatment. Care for those patients cannot be well-managed and coordinated.

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

Government Concerns

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

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

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

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

Conclusion

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

Specialty Hospitals, Induced Demand and Certificate of Need

Written Testimony to the Senate Finance Committee, by Sean Parnell, Vice President - External Affairs, The Heartland Institute

Submitted Monday, March 7, 2005

Introduction

The issues surrounding specialty hospitals and the soon-to-expire moratorium on development of new physician-owned medical facilities[1] are many and complex. Over the past several months, I have researched and written on this subject for *Health Care News*, a monthly newspaper covering public policy. I have attached to my written testimony excerpts from the three articles published in the October and December 2004 and the January 2005 issues of *Health Care News*.

These three articles focus on issues relating to quality of care, the historical development of specialty hospitals, the charges leveled against specialty hospitals by industry rivals, and the potential benefits of allowing specialty hospitals to resume their expansion.

In my written testimony, I would like to focus on two particular areas relevant to the moratorium: the argument that specialty hospitals create what is known as "induced demand," and arguments that Certificate-of-Need legislation is an appropriate policy to keep specialty hospitals from competing with general hospitals. Nearly all of my research is based on publicly available documents, including several produced or commissioned by the federal government and state governments.

Induced Demand

One major concern of the American Hospital Association (AHA) is that because specialty hospitals are typically owned by doctors, there is an incentive for doctors to recommend treatment and refer patients to a specialty hospital in order to generate profits, regardless of what is in the best interest of patients.[2]

This problem is connected to the economic ideas of agency, asymmetric knowledge, and supplier-induced demand. Dr. Douglas Popp, Chair of the Department of Emergency Medicine at Advocate-General Lutheran Hospital in Chicago, described the problem as follows:

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[1]Technically, the moratorium is only on referral of Medicare patients to facilities in which a physician has an ownership interest. However, since the effective result is that no new facilities are likely to be developed due to Medicare representing a substantial share of potential patients, it is generally referred to as a moratorium or even a "ban" on all new development of such facilities.

[2]"Impact of Limited-service Providers on Community and Full-service Hospitals," September 2004 issue of *TrendWatch*, published by the American Hospital Association, p. 2

> ...agency refers to... where one person with unique knowledge (e.g. the physician agent) is given the authority to make decision by, and for the less informed principal (patient)... [The] physician can order expensive tests and/or medications for the patient, based on asymmetric knowledge, while transferring the financial risk to the patient or third party payer (insurance company) for that decision... This creates the opportunity for supplier induced demand where the physicians is increasing the cost of care (e.g. ordering more tests) with the ulterior motive presumably being to positively impact their own wellbeing (e.g. personal income).[3]

In layman's terms, the concern is that most patients don't have the medical knowledge necessary to know if medical treatment is needed or not, so doctors may order excessive and unneeded health care in order to generate more income for themselves. The American Hospital Association notes physician ownership of specialty hospitals "can create an inherent conflict between the clinical needs of the patient and the financial interests of the physician."[4]

The risk of such a conflict, however, seems remote. Doctors earn their incomes almost entirely through fees charged for medical services, not profits at medical facilities they may have an ownership stake in. Whatever incentive exists for an unethical doctor to induce demand, the incentive is irrelevant to whether the surgery is performed in a general hospital or a specialty hospital.

As recent GAO reports demonstrate, the potential profits from referring any one case to a specialty hospital are relatively small. Margins at for-profit specialty hospitals average about 12.4% for Medicare patients and about 9.7% for all payers. These margins are not significantly out of line with those of for-profit general hospitals, which average 14.6% for Medicare patients and 9.2% for all payers.[5]

Also according to the GAO, 72.5% of physicians with admitting privileges at specialty hospitals had no financial interest in the hospital[6] and at 70.4% of hospitals the largest share owned by a physician was 6% or less.[7] The median ownership share for an admitting physician with an ownership interest was 2%.[8]

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[3] *Macroeconomics of Healthcare*, Dr. Douglas Propp, online at the IL College of Emergency, http://www.icep.org/edsurvival/documents/HealthcareEconomics_000.doc.

[4] "Impact of Limited-service Providers on Community and Full-service Hospitals," September 2004 issue of TrendWatch, published by the American Hospital Association, p. 2.

[5] "Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance," October 2003, United States General Accounting Office, pp. 25 – 26.

[6] "Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served," April 2003, United States General Accounting Office, p. 10.

[7] Ibid.

[8] Ibid.

Putting together the modest operating margins and the low physician ownership stakes typical of specialty hospitals, and factoring in the relative income potential from surgeon's fees vs. hospital profits, the incentive created by physician ownership of specialty hospitals to induce is extremely small.

Consider the case of a relatively expensive surgical procedure, coronary bypass surgery. There are two primary DRG's for Medicare reimbursement of coronary bypass, 107 and 109. According to MedCath, a national chain of 13 specialty hospitals focusing on cardiac care, the average reimbursement for DRG 107 is $26,434 and represents approximately 64% of bypass surgeries performed in their hospitals, and the average Medicare reimbursement for DRG 109 is $23,499, representing the remaining 34% of procedures performed.[9]

MedCath also reports that the reimbursement for participating surgeons under DRG 107 is $3,622 for DRG 109 it is $2,910.[10]

By applying the information on operating margins and physician ownership of specialty hospitals to the data on reimbursement, we can get an idea of what the potential increase in income would be for a surgeon who is recommending unneeded treatment. Performing an unnecessary DRG 107 coronary bypass, a for-profit specialty hospital could expect an operating margin of $3,277.82 (12.4% avg. operating margin x $26,434). If the surgeon performing the procedure owns 2% (the median ownership share), their share of that would be $65.66. These raw figures are before taxes and other expenses - the actual amount of profit is even less than these numbers might indicate.

Comparing the surgeon's expected fee of $3,622 to the potential profits from an ownership share of a specialty hospital, it is hard to imagine that these few extra dollars would be sufficient incentive to induce demand.

The case of Richard Mathews[11], an executive at a benefits consulting company in Michigan, is a real life example of how the induced demand argument made against specialty hospitals does not stand up in the real world.

Mathews had reconstructive knee surgery in February of 2004 at the Beaufort Surgical Center, a specialty orthopedic hospital in Beaufort, South Carolina. His insurance company paid the entire bill, approximately $1,227 for hospital charges and $2,059 for the surgeon's and anesthesiologist's fees plus other expenses. Reviewing the hospital bill, Mathews noted that "There is simply no way that there is any huge profit in using his hospital. There may be a little – but the real advantage is for better patient service and excellence."

Even if the surgeon operating on Mathews was one of the very few in the country who has an

[9]Information from Alanna Porter, MedCath Inc., received March 3, 2005 via e-mail.

[10]Ibid.

[11]Based on interview with Richard Mathews on 2/15/05.

ownership interest of 15% or more in a specialty hospital[12], the potential income gains are too small to realistically think a doctor would recommend unnecessary treatment. Assuming a 9.7% margin on this procedure, a doctor with a 15% stake in the hospital would gain less than $18 in income through that ownership, minuscule compared to their share of the nearly $2000 in doctors fees. A doctor with the average 2% ownership stake would stand to gain less than $2.38. Again, these potential gains are before taxes and other expenses.

Mathews also described the strict disclosure standards that his surgeon followed. As a patient, he had to sign a disclosure acknowledging he was aware of the surgeon's financial interest in the hospital.

Adding to his description of his surgery, Mathews said "My doc told me straight out that he and [his] peers started their specialty hospital solely for access to excellence — they control the entire surgical team and every part of the process. They simply cannot get the excellence they need to have and offer to patients from local area hospitals."

Plainly, the charge that physician ownership of specialty hospitals create incentives for doctors to abuse their position and recommend unneeded treatment is not supported by the facts.

Certificate of Need

The issue of Certificate-of-Need (CON) laws is relevant to the issue of specialty hospitals for two reasons:

- The American Hospital Association, one of the main advocates for extending the moratorium on specialty hospitals, noted that what they call "limited service providers"[13] are mostly located in states without CON laws.[14] A reasonable assumption is that should the moratorium end as it is scheduled to, the AHA and other opponents of specialty hospitals will turn their lobbying efforts to enacting CON laws at either the federal or state level in order to impede competition.

- The history of CON laws demonstrates succinctly how attempts to limit or prevent competition between health care facilities does not benefit patients or control costs, and more often only protects the market share and profits of existing providers.

CON laws were first enacted in 1964 in New York as a response to rising health care costs

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[12] "Specialty Hospitals: Information on National Market Share, Physicians Ownership, and Patients Served," April 2003, United States General Accounting Office, p. 10.

[13] "Limited-service provider" is the AHA's term which they (and others) apply to both specialty hospitals, which generally require overnight stays, and ambulatory surgical centers, which do not.

[14] "Impact of Limited-service Providers on Community and Full-service Hospitals," September 2004 issue of *TrendWatch*, page 2, published by the American Hospital Association.

driven in part by what was then a common health insurance reimbursement system known as retrospective reimbursement, also called "cost-plus." Under retrospective reimbursement, insurers would pay hospitals an amount equal to their costs, plus a certain percentage above cost for profit and overhead.

With the cost-plus system, there was little if any incentive for medical providers to become more efficient or for patients to be price sensitive. CON was a clumsy way to try to stop the inevitable spending binge the system created.

In 1972, Congress voted to require states review and approve all capital expenditures of $100,000 or more, as well as changes in bed capacity or what they termed a "substantial change" in services. By 1980, all 50 states had imposed CON laws

By 1986, it was evident that CON laws were not succeeding in keeping health care costs down, and by limiting competition were even contributing to rising costs. Congress repealed the federal CON requirement. Since then, fourteen states have followed by repealing CON entirely, and six more have repealed it for everything except nursing homes and long term care services.

Some of the most extensive research on CON laws has been done by Christopher Conover, Ph.D., and Frank Sloan, Ph.D., with Duke University's Center for Health Policy, Law, and Management. Their research, originally done for the Delaware Health Care Commission in 1996, was published in a June 1998 article in the *Journal of Health Politics, Policy and Law*.[15]

Conover and Sloan found that CON laws had no effect on overall health care spending. While they found a modest reduction in hospital costs, this decline was offset by an increase in physician costs.[16] They also note that CON laws "result in a slight (2 percent) reduction in bed supply but higher costs per-day and per admission, along with higher hospital profits."[17]

In a later study prepared for the Michigan Department of Community Health, Conover and Sloan confirmed their earlier findings. Among their major conclusions was that repeal of CON laws does not "lead to a 'surge' in either acquisition of new facilities or medical expenditures."[18] They also found evidence to suggest that CON results in an increase in costs, contrary to the goal of these laws. [19]

Another study, prepared by the University of Washington's school of public health for the state legislature, had similar findings. The authors found "strong evidence that CON has not

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[15]"Does Removing Certificates-of-Need Regulations Lead to a Surge in Health Care Spending?" Christopher Conover, Ph.D., and Frank Sloan, Ph.D., June 1998 *Journal of Health Politics, Policy and Law*, pp. 455

[16]Ibid, p. 463

[17]Ibid, p. 466.

[18]"Evaluation of Certificate of Need in Michigan," by Christopher Conover, Ph.D. and Frank Sloan, Ph.D, May 2003 report to the Michigan Department of Community Health, p. 74.

[19] Ibid, pp. 30.

controlled overall health care spending or hospital costs."[20]

The Federal Trade Commission (FTC) and U.S. Department of Justice (DOJ) have also weighed in on the impact of CON laws. In a July 2004 report jointly prepared by the two agencies, they concluded that there is "considerable evidence that [CON laws] can actually drive up prices by fostering anticompetitive barriers to entry."[21]

This is only a sampling of the literature available on the failure of CON laws to restrain health care costs. CON today is little more than a shield that protects incumbent providers from competition, allowing entrenched interests to maintain market share and profits. Congress rightly repealed this law in 1986, although it remains on the books in many states.

General Hospitals Face Real Challenges

The final issue I would like to address, if only briefly, is the condition many general hospitals find themselves in.

Although I do not find most of the American Hospital Association's charges against specialty hospitals to be either credible or relevant, I recognize that they face real and pressing challenges. Competition from smaller specialty hospitals, which often provide superior care at a lower overall cost, is just one of the challenges that general hospitals must deal with. Some of these challenges are self-inflicted, while others are largely imposed by a dysfunctional health care market burdened by excessive regulation, third-party payment, bureaucratic central planning, price controls, and monopsony power.[22]

Many procedures hospitals perform are reimbursed at less than cost by both private insurers and government payers like Medicare and particularly Medicaid. To a limited extent this can be offset by generous margins for other procedures, reimbursed well above cost. However, many of the financial difficulties experienced by hospitals today are the result of a mix of patients where profitable procedures do not make up for losses caused by unprofitable procedures.

Another challenge facing many hospitals is a series of lawsuits stemming from a pricing system that bears little resemblance to reality.[23] These lawsuits have been filed against both non-profit and for-profit hospitals over pricing practices that frequently charge the highest prices to uninsured patients while large insurers and government programs get substantial "discounts"

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[20]"Effects of Certificate of Need and Its Possible Repeal," Health Policy Analysis Program of the University of Washington's School of Public Health and Community Medicine, January 8 1999 report to the State of Washington Joint Legislative Audit and Review Committee, p. 9.

[21]"Improving Health Care: A Dose of Competition," July 2004 report prepared jointly by the Federal Trade Commission and the U.S. Department of Justice, p. 302.

[22]Monopsony power exists where there is a single or dominant *purchaser* of a good or service. Just as monopoly power allows a single *seller* of a good or service to demand higher prices than would exist in a competitive market with multiple sellers, monopsony power allows the buyer to dictate lower prices than would exist in a competitive market with multiple buyers.

[23]"6 More Class Action Lawsuits Filed Against Nonprofit Hospital Systems and Hospitals By Uninsured Patients," August 27, 2004, *MedicalNewsService.com*

from "list prices" for the same procedures. These pricing practices are difficult to defend, since they often impose large bills on low-income individuals.

Congress would be wise to review and examine policies imposed on hospitals that contribute to these challenges. The reality of these challenges and others, however, should not justify preferential treatment from Congress or state legislatures that would shield them from competition and protect their market share and profits.

Conclusions and Recommendations

On the two points I specifically address two conclusions are warranted:

- Physician ownership of specialty hospitals does not create a significant incentive for physicians to perform unnecessary procedures.
- The history of Certificate-of-Need laws demonstrates that polices that restrict or prevent competition among health care providers do not benefit patients or lower costs, and unnecessarily protect the profits and market share of incumbent firms.

On the broad question of whether to continue the moratorium on physician ownership of new specialty hospitals, I would urge the Congress to take the following steps:

1. Allow the moratorium to expire in June 2005, as it is presently scheduled to do.

2. Monitor and take action where needed to ensure the U.S. Department of Justice is examining potential anti-competitive actions by existing providers attempting to use Certificate-of-Need laws to restrain trade in violation of anti-trust laws.

3. Continue to collect, examine, and make available information regarding the quality of care provided by specialty hospitals, ambulatory surgical centers, and general hospitals.

4. Review and consider revising laws and regulations imposed on health care providers, particularly general hospitals that create unneeded burdens and financial difficulties.

I believe that if Congress takes these actions, the result will be increased excellence and lower costs for health care.

Sean Parnell is Vice President - External Affairs for The Heartland Institute*, a non-partisan research institute in Chicago. He is a regular contributor to* Health Care News*, a monthly public policy newspaper sent to state and national elected officials across the country. He has a degree in economics from Drake University in Des Moines, Iowa. Prior to joining* Heartland *he worked for then Congressman Greg Ganske, M.D.*

Selected Excerpts from *Health Care News*

October 2004 Issue: *Specialty Surgical Hospitals Deliver Quality Care and Comfort* by Sean Parnell

> ...By freeing themselves of the bureaucracy of a traditional general hospital, [Ambulatory Surgical Centers] have been able to provide high-quality care at a lower cost. The key is specialization: A surgeon or facility devotes all of its energies to a few specific areas of care, resulting in increased efficiency and effectiveness...
>
> ...Many specialty surgical hospitals appear to provide better care than their traditional counterparts, as measured by patient outcomes...The mortality rate from open heart surgery for Medicare cases at MedCath hospitals was 16 percent lower than at community hospitals and 12.5 percent lower than at teaching hospitals...The average length of stay for MedCath patients was 21.9 percent shorter than at community hospitals, and 25.6 percent shorter than at teaching hospitals.
>
> ...A major reason for the lower rate of infection is that specialty surgical hospitals focus on elective and pre-planned surgeries. A patient who is scheduled for heart surgery and shows up at a specialty surgical hospital with a cold or the flu can be rescheduled for surgery after the illness goes away. In the Surgicenter Online interview, Lipomi noted infection rates in specialty surgical hospitals are lower because they don't perform surgery on "someone who is throwing up or bleeding or presenting with possible infectious conditions ... We think the otherwise healthy patient needs a place to go where ...infection rates are less than 1 percent instead of 5 percent or more."

December 2004 Issue: *Specialty Hospitals Criticized by Competitors* by Sean Parnell

> ...Greg Scandlen, a health policy expert at the Galen Institute in Washington, DC, expresses doubt about the charge that doctors improperly direct patients to clinics in which they have an ownership stake... Scandlen writes, "Given the scandalous track record of hospitals in patient safety and quality, it is entirely possible that physicians invest in facilities in order to assure better quality, and naturally refer their patients to facilities in which they have some influence over the quality of the care provided."
>
> ..."These hospitals are more efficient exactly because of specialization. They deliver the highest standard of quality care since they are not expected to be all things to all people by offering everything from an ER to a maternity ward," says Conrad Meier, senior fellow in health care for The Heartland Institute. "This is like a supermarket trying to shut down a drugstore because it doesn't sell fresh

> meat and produce, but it's ok for the supermarket to sell prescription drugs."
>
> ...In a study of MedCath's 13 hospitals, Lewin researchers found Medicare cardiac patients treated by MedCath had a Case Mix Index (a measure of patient severity and case complexity) 20 percent higher than their counterparts at general hospitals, indicating MedCath facilities were generally treating patients less healthy than those of competing hospitals.
>
> It is not difficult to understand why doctors might refer their most difficult cases to specialty hospitals, where they feel the most confident about being able to offer the best care to these patients. Linda Gorman, who follows health care policy for the Colorado-based Independence Institute, noted, "specialty hospitals may provide an alternative for doctors who are dissatisfied with the quality of care, efficiency, and bureaucracy of general hospitals."

January 2005 Issue: *Specialty Hospitals Offer Savings, Improved Care in Future*, by Sean Parnell

> ... by adding new capacity to the health care system, particularly in areas like cardiac surgery and orthopedics, specialty hospitals could play a major role in ensuring there is enough capacity to treat the growing number of elderly who require more health services, particularly as the Baby Boomer generation begins to retire...

Specialty Hospitals, Induced Demand and Certificate of Need

Written Testimony to the Senate Finance Committee by Sean Parnell, Vice President - External Affairs, The Heartland Institute

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SUBMITTED FOR THE RECORD

HEARING OF MARCH 8, 2005

SENATE COMMITTEE ON FINANCE

STATEMENT OF JAMIE HARRIS

EXECUTIVE VICE PRESIDENT AND CHIEF FINANCIAL OFFICER
MEDCATH CORPORATION

(AS GIVEN BEFORE THE HOUSE COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH, MARCH 8, 2005)

INTRODUCTION

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

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

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

THE NEED FOR HIGH-QUALITY CARDIOVASCULAR SERVICES

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

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

WE ARE FULL SERVICE HOSPITALS THAT PROVIDE EMERGENCY CARE

Each of our hospitals operates a staffed emergency department that is open 24 hours a day, 7 days a week, equipped with an average of eight Intensive Care Unit beds, in addition to the inpatient beds to which patients can be transferred. As a result, MedCath heart hospitals are

capable of treating nearly every patient regardless of their condition or ability to pay.[1] We are capable of doing this because each of our hospitals includes a medical staff of 175-300 specialists, sub-specialists, and primary care physicians (most of whom are not owners of the hospital) who are available to care for patients that walk through our doors, whether they are a patient with a heart problem or not.

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

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

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

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

- **Only approximately 30 percent of our referrals are from physician-owners**.
- **Approximately 24 percent of MedCath's in-patient admissions came as referrals from other hospitals**, *particularly those located in rural areas*. These referrals were from hospitals that either did not have the capacity or the expertise to treat the patients.[3]

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

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

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

- **Approximately 31 percent of MedCath's hospital admissions arrived through our emergency departments**.

- **Approximately 14 percent of MedCath's referrals were from physicians who did not have an ownership interest in our hospitals**, but who prefer to practice there.

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

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

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

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

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

The involvement of our physician partners in the governance and operations of our hospitals is a critical factor that contributes to quality patient care and is a logical by-product of their status as owners and board members. MedCath partners with local physicians who have established reputations for clinical excellence. We believe this alignment of interest between the physicians and the hospital operator is a primary reason MedCath hospitals have been able to improve the quality of care, reduce the average length of stay, save money for government payors, and

achieve high levels of patient satisfaction.[4] MedCath has found that the economic commitment of physicians, under a physician ownership model, is in the best interest of the communities served and has resulted in the provision of a higher level of care and cost efficiencies.

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

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

A "WAKE-UP" CALL TO COMMUNITY HOSPITALS

While competition, regardless of the industry, is not always welcomed, the communities where MedCath hospitals are located have benefited significantly from our competitive presence. As indicated by MedPAC's findings, physician-owned specialty hospitals often serve as a "wake-up call" for the traditional acute care hospitals in a community to improve services and efficiencies. Specifically, MedPAC found that specialty hospitals focus community hospitals on the issues of hospital operations and physician relations. Community hospitals in these markets have made constructive improvements, including extended service hours, improved operating room scheduling, standardization of supplies in the operating room, and upgraded equipment. This is evidence that community hospitals are responding to the new competitive pressures from specialty hospitals in a way that benefits patients, doctors and the entire community.

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

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

[into the marketplace] has had a number of beneficial consequences for consumers who receive care from these providers."

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

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

MEDCATH'S HOSPITALS DO NOT ADVERSELY IMPACT PROFITABILITY AND UTILIZATION

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

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

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

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

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

ANTI-COMPETITIVE TACTICS IN RESPONSE TO COMPETITION FROM OUR HOSPITALS

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

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

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

MEDCATH HOSPITALS HAVE BETTER OUTCOMES AND FEWER COMPLICATIONS

The Lewin Group has confirmed that:

- MedCath hospitals provided **better care on average** (as measured by lower in-hospital mortality rates and lower rates of complications) **in a shorter period of time** than the peer community hospitals.

- After adjusting for risk of mortality, MedCath heart hospitals on average exhibited a **16 percent lower in-hospital mortality rate** for Medicare cardiac cases compared to the peer community hospitals, including major teaching facilities.

- MedCath heart hospitals also had **shorter average lengths of stay** for cardiac cases (3.81 days) than the peer community hospitals (4.88 days) after adjusting for severity.

- **Approximately 90% of our patients are discharged to their home** instead of being discharged to a subacute care facility, home health agency, or skilled nursing facility. Not only is this better for the patient, the Lewin Group also estimates it saves Medicare approximately $1.5 million per facility per year.

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

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

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

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

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

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

These percentages, especially the levels of Medicaid and self-insured/uninsured, are very similar to the typical general acute care hospital's cardiovascular services. In terms of Medicaid in particular, MedPAC's findings are misleading for several reasons. First, the volume of Medicaid patients is not uniformly distributed across hospitals (including both general and specialty hospitals). In most communities, only one or two hospitals serve the vast majority of Medicaid patients with the other hospitals in the community serving the remainder. Based upon 2002 Medicare hospital cost report data, only 10 percent of hospitals provided nearly 60 percent of inpatient care for Medicaid patients.

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

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[8] See note 1 supra.

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

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

As MedPAC Chairman Hackbarth noted at the January 12, 2005 public meeting of the commission, "…I think all of us would agree that right now the burden of providing care to Medicaid recipients or uncompensated care is not evenly distributed. That's an issue that long predates specialty hospitals and it's an issue that has very important implications for the system. And to say that stopping specialty hospitals is going to materially alter that problem, fix that problem, I don't think that's the case. Among community hospitals, some do a lot of uncompensated care, have a lot of Medicaid patients. Others do a few. So that's an important issue. But to address it you need measures that are appropriate to its scope. And it's huge."

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

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

- Because most of our hospitals are relatively new facilities with most beds being intensive care beds and equipped with state-of-the-art medical equipment, our depreciation costs are substantially higher than that of the average community hospital. As our hospitals age, however, we believe depreciation expenses will become more aligned to those of community hospitals.

- Our newly-built hospitals require financing of working capital until they can become fully operational, which we refer to as "startup" or "ramp up" costs. The interest cost on this debt and construction debt is very significant and substantially higher than the average community hospital. As our hospitals ramp up operations, repay this debt and become fully operational, however, these interest costs will become more aligned to those of community hospitals.

- MedCath hospitals are required to pay property and income taxes, which is not required of not-for-profit hospitals due to their tax exempt status, thus our cost per discharge is inherently higher.

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

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

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

A growing number of not-for-profit healthcare systems around the country have embraced the concept of physician ownership – seeing the opportunity for improving the quality of care and cost effectiveness within their own healthcare systems. For example, Baylor Health Care System (Baylor), located in Texas, is one of our nation's largest and most respected not-for-profit, faith-based systems. While not a MedCath partner, Baylor (along with other not-for-profit systems around the country) understands the importance of aligning physicians and their hospitals. As such, systems such as Baylor's are partnering with physicians who have ownership in order to provide higher quality healthcare services to their communities. Clearly, physicians must be an integral part of solving the nation's health care crisis.

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

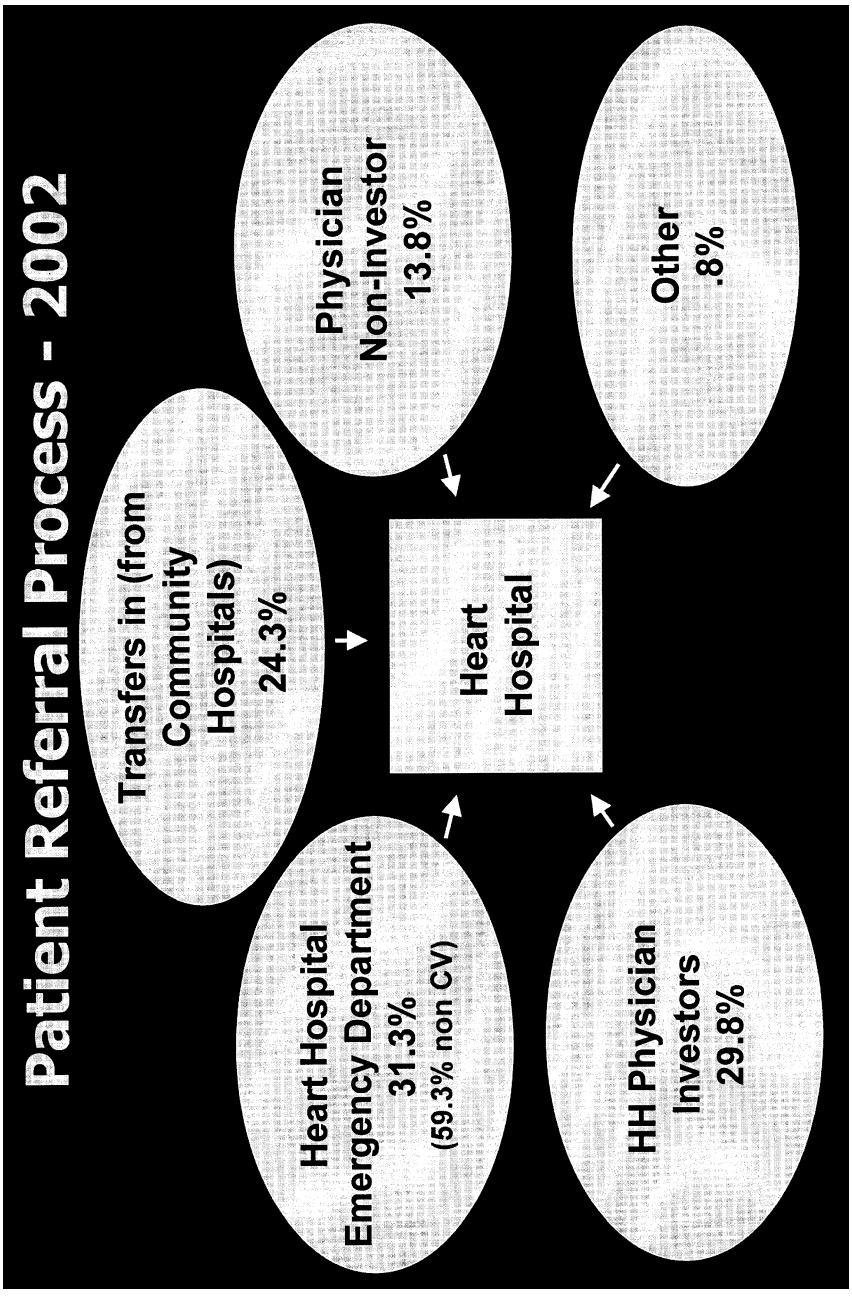
Both of these partnerships embrace the collective expertise of each group and align all interests to deliver high-quality care to the community and to patients. We believe partnerships like these are critical to the future of delivering high-quality health care to a rapidly aging population.

CONCLUSION

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

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

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


Patient Referral Process - 2002
Transfers in (from Community Hospitals) 24.3%
Physician Non-Investor 13.8%
Other .8%
Heart Hospital
Heart Hospital Emergency Department 31.3% (59.3% non CV)
HH Physician Investors 29.8%

Nebraska Hospital Association

Senate Committee on Finance
Attn. Editorial and Document Section
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Testimony submission of:

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Dear Committee Members:

On behalf of Nebraska's 85 member hospitals, I urge you to oppose the growth of physician-owned, limited service hospitals. As evidenced in the recent AHA survey reviewing the affects of limited service hospitals on communities, these facilities devastate community hospitals and threaten the public's access to care.

The opening of physician-owned limited-service hospitals has led to increased costs and use of health care services, forced cutbacks in other services at full-service hospitals, and placed access to emergency and trauma services at risk. In Lincoln, Nebraska, annual revenues at BryanLGH Medical Center have fallen by $10 million since the Nebraska Heart Hospital arrived in 2003. While BryanLGH Medical Center continues to provide other, less profitable services, such as behavioral health programs, the loss of revenue threatens the long-term viability of these types of health care programs.

Community hospitals have a mission and legal obligation to provide full-service health care, including emergency services, to their communities. Physician-owned, niche hospitals are focused solely on a single type of highly profitable service, such as cardiac or orthopedic care. These types of facilities rarely have emergency rooms or 24-hour availability. Physicians frequently refer patients to specialty hospitals in which the physician has ownership, creating a direct conflict of interest.

Congress has historically been concerned with the conflict of interest present when physicians refer patients to facilities where the physician is also an owner. That is why federal law bans self-referral to a long list of health services. But physicians who own specialty hospitals have found a loophole in the law that has allowed these facilities to gain a foothold in most cities across the U.S. Because of the concern over self-referral, Congress placed a moratorium on the practice of self-referral of Medicare patients to new

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physician-owned limited-service hospitals. The moratorium expires in June and the Nebraska Hospital Association urgently supports its indefinite continuation.

The American Hospital Association's study on specialty hospitals reinforces findings of previous government reports, which have shown that physician-owned, limited-service hospitals remove financially rewarding patients and services from full-service hospitals.

This is not a case of fair competition. Community hospitals provide a wide variety of services and staffing 24-hours a day. The specialty hospitals focus on only the most profitable services and insured patients. Community hospitals cannot support the continued erosion of Medicare and Medicaid reimbursements, the increasing number of uninsured and charity care patients, and expect to compete with specialty hospitals.

On behalf of Nebraska's 85 member hospitals that provide quality health care 24-hours a day to their communities, I urge you to continue the moratorium on specialty hospitals, ensuring that ALL of our citizens get the health care they need and deserve.

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