Approved: April 1, 2005
Date

MINUTES OF THE SENATE HEALTH CARE STRATEGIES COMMITTEE

The meeting was called to order by Chairman Susan Wagle at 1:15P.M. on March 3, 2005 in Room 231-N of the Capitol.

Committee members absent:

Committee staff present: Ms. Emalene Correll, Kansas Legislative Research Department
Ms. Terri Weber, Kansas Legislative Research Department
Mr. Jim Wilson, Revisor of Statutes Office
Ms. Margaret Cianciarulo, Committee Secretary

Conferees appearing before the committee: Mr. Jim Sergeant, Administrator, Salina Surgical Hospital, & President of Kansas Surgical Hospital Association
Dr. William O. Reed Jr., Chairman of the Board, Heartland Spine & Specialty Hospital, and Orthopedic Surgeon, Overland Park, KS
Mr. Ricardo Fontg, Lawyer, Kansas City, Missouri
Dr. Badr Odbeis, Wichita physician
Dr. Lyle Zepick, Wichita physician
Dr. Edward Wade, Anesthesiologist, Wichita
Dr. Gary Benton, Cardiothoracic Surgeon, Wichita
Dr. Alberto Carro, Wichita physician
Dr. Claudia Perez-Tomayo, Radiation Oncologist, Netwon
Mr. Ben Lawrence, Mayor, City of Andover
Mr. Jeff Bridges, City Administrator, Andover
Dr. Aaron Waters, Family Physician, Arkansas City
Mr. Wayne Short, Mayor, Arkansas City
Mr. Uzo Ohaebosina, Wichita physician
Mr. Doug Palzer, CEO Physicians General Hospital
Mr. Daryl Thorton, COO, Kansas Spine Hospital, Wichita
Mr. Alan Burke, Director, LTACH Ventures of Kansas
Secretary Roderick Bremby, KS Department of Health and Environment

Hearing on SB235 - an act concerning hospitals; instituting a moratorium on establishment of certain hospitals prior to July 1, 2006

Upon calling the meeting to order, the Chair stated the Committee would be hearing opponent testimony on **SB235** today and to those who wanted to testify, that the Committee is most concerned about how this effects the quality of care and making sure everyone has health care in the state of Kansas. She then called upon the first of seventeen conferees to testify, Mr. Jim Sergeant, Administrator, Salina Surgical Hospital and President of the Kansas Surgical Hospital Association KSHA), who offered a brief overview of the membership of KSHA, statistics illustrating the quality of their facility, and the impact it has on the Kansas economy. He also offered KSHA's reasoning of why this bill would stifle competition and is unnecessary. (i.e., It would deprive patients of the opportunity to choose from the future development of new healthcare models, which may benefit both themselves and their families.) A copy of his testimony plus two handouts (information sheet on KSHA and the Academy Health: 2004 Annual Research Meeting) are (Attachment 1) attached hereto and incorporated into the Minutes as referenced.

The next to testify was Dr. William O. Reed Jr., Chairman of the Board for the Heartland Spine & Specialty Hospital, and Orthopedic Surgeon, Overland Park, KS, who spoke of the "Center of Excellence" concept, provided background of the specialty hospital, its technology, their profits, service, quality, and insurers, and stated as long as hospitals are allowed to employ doctors and direct referrals, using facility income to pay salaries never achieved in private practice, caring physicians should be allowed to own and control their own facilities. He ended his testimony by stating that the MEDPAC Committee of the US Congress had released on Monday, February 28, 2005, a study supporting the concept for relating reimbursement to quality care indicators. Dr. Reed also offered two handouts, the September 10, 2004

Medicare Payment Advisory Commission public meeting in Washington, D.C. and a report by the Federal Trade Commission and the Department of Justice entitled "Improving Health care: A Dose of Competition". A copy of his testimony and handouts are (Attachment 2) attached hereto and incorporated into the Minutes as referenced.

The third proponent was Mr. Ricardo Fontg, a Kansas City, Missouri, lawyer, who offered comparison regarding perception vs. reality, reasons for developing speciality hospitals, and fundamental questions (i.e. how do general hospitals plan to use their tax-exempt margins?) He also offered a memorandum from the Citizens Health Care Association (CHCA) to the Committee that included: a brief history of the bill, the federal specialty hospital moratorium, framing the issue, Medicaid/Medicare preemption, and additional issues and conclusion. A copy of his testimony and CHCA's memorandum are (Attachment 3) attached hereto and incorporated into the Minutes as referenced.

Dr. Badr Odbeis, a Wichita physician, was the fourth opponent who offered answers to what he felt, were 3 major concerns: competition, basics of access for Kansas (caring for the uninsured), on not harming the community hospitals. He also offered a brief which offered explanations of other concerns the proponents had (i.e. federal scrutiny and regulation, quality and access issues, capacity shortages, medical school residency training program, etc.) Dr. Odbeis also offered two CD's of financial, MEDPAC, FCC, and OF studies. A copy of his brief and the CD's have been filed in Senator Wagle's office. Please contact Dr. Odbeis for copies.

Fifth to testify was Dr. Lyle Zepick, also a Wichita physician, who offered testimony on specifics of the Andover "project" stating "with large insurance companies, layers of administrators in large city hospitals and vertical integration, reborn was the idea of physician run hospitals where they made both clinical and the business decisions." A copy of his testimony is (Attachment 4) attached hereto and incorporated into the Minutes as referenced.

Dr. Edward Wade, an anesthesiologist and sixth opponent, stated he has performed anesthetics at all major hospitals, most of the specialty hospitals, many of the surgery centers in Wichita, in addition to various other medical centers and hospitals throughout Kansas and experience has taught him that each hospital has its own special bond with the patient population that it services. He offered comments regarding the hospital planned for Andover (i.e. serving Butler County as an educational center for nurses and others in training at the community college.) Dr. Wade stated he is a practicing anesthesiologist at Via Christi/.St. Francis in Wichita, "and it seems the administration learned about my position with Andover hospital in planning" and with his letter to the Committee. Subsequent to that he was told by the member of the Board of the company that employed me (Anesthesiologist Consulting Services) that I was to resign because of my position with opposition to **SB235** and for no other reason." A copy of his testimony is (Attachment 5) attached hereto and incorporated into the Minutes as referenced.

The seventh to testify was Dr. Gary Benton, who is a Cardiothoracic Surgeon who works in Wichita and resides in Andover. He testified that in the past five years, regional medical centers have developed in Hutchinson, Hays, and Salina delivering tertiary care to rural folks that might not otherwise seek it in urban centers and that these programs have been very successful in attracting new specialists, improving the overall quality of medical care in the community, and dramatically improved medical access in rural Kansas. A copy of his testimony is (Attachment 6) attached hereto and incorporated into the Minutes as referenced.

Dr. Alberto Carro, a Wichita physician and the eighth proponent, stated he was asked to testify because he was the first residency trained board certified Emergency Medical Physician in this state in 1985, came to help St. Joseph and St. Francis, and assisted the community to improve better relations and care. He stated that this planned community hospital would not only help the people of Andover, but smaller surrounding towns like Benton and Augusta who recently lost their hospital. Dr. Carro had no written testimony to offer.

Next was Dr. Claudia Perez-Tomayo, a Radiation Oncologist, who stated she has worked in all hospitals in Kansas, specifically: Salina, Newton, Emporia, and Great Bend. She stated, to be able to do what she does, requires à full service of everything (i.e. surgery, internal medicine, diagnostics, lab, etc.) and is referred by a doctor that is seeing the patients, so therefore, if she didn't have a full specialty representation it would be a very expensive endeavor. Also, in dealing with corporate organizations, she stated she has found that many times the decisions made by these organizations are made not on what is right for the area but what is right for someone else and has been the victim of this with the closure of Halstead and Riverside hospitals. Dr. Perez-Tomayo also had no written testimony to offer.

The Chair then recognized the tenth conferee, Mr. Ben Lawrence, Mayor, City of Andover, who stated that since the closing of the Augusta Hospital several years ago, Butler County has only one hospital serving a land area larger than the State of Rhode Island, and although well respected, cannot and does not provide a full range of services. He also stated that Butler County has only four ambulances on duty at one time and if one has to transport a patient into Wichita or El Dorado, they loose the services of that unit for over an hour, but having a full service community hospital in Andover would decrease the time that these ambulance units are out of service and keep them available for emergency operations in butler county a higher percentage of the time. A copy of his testimony is (Attachment 7) attached hereto and incorporated into the Minutes as referenced.

Next recognized was Mr. Jeff Bridges, City Administrator of Andover, who offered comments regarding the bill regarding the economics of free trade, health care matters, and the economic impact (i.e. lessen the tax burden across the area and given the severity of non-funded mandates by the state and federal government, coupled with the 100% elimination of LAVTR and the city-county revenue sharing, it will be a welcome relief.) A copy of his testimony is (Attachment 8) attached hereto and incorporated into the Minutes as referenced. He said in the interest of time, and his testimony is in writing, the Committee could review at their leisure

Dr. Aaron Waters, the twelfth opponent and a rural Family Physician residing in Arkansas City, stated that their medical staff, the hospital, and community are in the process of obtaining a FHA HUD 242 insured mortgage loan, to build a replacement hospital. He also stated this loan came as the last and only available option to them because this model worked even though technically no this is not a replacement hospital since they will be receiving a new medicare number and is partially physician owned.. A copy of his testimony is (Attachment 9) attached hereto and incorporated into the Minutes as referenced.

The next conferee to be recognized was Mr. Wayne Short, Mayor, Augusta who stated that the City of Arkansas City is currently the owner of the South Central Kansas Regional Medical Center Hospital in Arkansas City, serving its residents, southern Cowley county and northern Oklahoma, built over 50 years ago, but still the key to the economic future of their community. He stated that for nearly ten years, they have been looking for solutions to provide for either significant renovation of the facility or a replacement facility and that after all the years of effort and over a million dollars of expense that has gone into getting this project to its current point, it would be a devastating blow to their community if the new private replacement hospital could not proceed. A copy of his testimony is (Attachment 10) attached hereto and incorporated into the Minutes as referenced.

Conferee fourteen, was Dr. Uzo Ohaebosina, a Wichita lawyer, who stated he was not attending the Committee meeting as legal counsel for the Andover project but the son of a doctor who was affected by consolidation. He stated his father, an Osteopath, helped set up the Riverside Hospital. It was consolidated, bought out, and after they ceased to be profitable they were closed down. The hospital does exist with only 10 beds, but doctors cannot admit patients there at this time, which puts a burden on the community. His father, as well as the other doctors affected would welcome this new Andover project to help out the low and middle income patients that have been affected with the Riverside Hospital closing. Dr. Ohaebosina did not have written testimony available.

Conferee fifteen, Mr. Doug Palzer, CEO of Physicians General Hospital in Lenexa, Kansas stated he had provided a statement to the committee on March 3, 2005 that he had intended to read today, outlining the

critically needed services that his hospital will provide and the impact that this full service hospital will have on the community it will serve and asked the Committee to review at their leisure. Today, he stated, he would rather address some of the issues discussed in yesterday's committee meeting with proponent testimony. A copy of his testimony and the letter he had prepared for March 2, 2005 are (Attachment 11) attached hereto and incorporated into the Minutes as referenced.

The sixteenth conferee was Mr. Daryl Thornton, COO, Kansas Spine Hospital, Wichita, and a resident of Augusta, stated that efforts were made by the Augusta City and Hospital leaders to partner with either Wesley Medical Center or Via Christi Regional Medical Center to provide much needed primary and emergency care services to Augusta and surrounding residents, but both said no to any type of partnership. He then went on to provide information regarding Butler County (i.e. largest county in terms of land size, projected to have the second highest increase in population growth in the State , second to that of Johnson County. A copy of his testimony is (Attachment 12) attached hereto and incorporated into the Minutes as referenced.

The final conferee was Mr. Alan Burke, Director, LTACH Ventures of Kansas, who explained that LTACH's are a creation of the federal government specifically designed to form a symbiotic relationship with community and regional hospitals to provide service to medically complex patients, typical after a surgical stay in an acute care hospital where the hospital has exhausted its reimbursements. He also stated that in this creation, the federal government restricted to a degree, the ability of the acute care hospital to build and own these forms of health care systems. Mr. Burke also provided a handout entitled "Refining Competition in Health Care". A copy of his testimony and his handout are (Attachment 13) attached hereto and incorporated into the Minutes as referenced.

Written opponent testimonies from the following are (Attachment 14) attached hereto and incorporated into the Minutes as referenced:

1. Mrs. Mary Benton, resident of Arkansas City, Kansas

2. Mr. Corey Peterson, Executive Vice President of the Associated General Contractors of Kansas, Inc.

3. Mr. Mark Hutton, President, Hutton Construction, Wichita, Kansas

Neutral written testimonies were also offered from the following and are (Attachment 15) attached hereto and incorporated into the Minutes as referenced:

1. Kansas Medical Society

2. Secretary Roderick Bremby, Kansas Department of Health and Environment

The Chair did ask Secretary Bremby if he wanted to speak, he did request to address three quick points:

1.) KDHE has not been involved in health facilities planning or control of health assets since the "Certificate-of-Needs' law expired in 1985, and as a result cannot provide professional recommendations as such;, and cannot provide professional recommendations as such;

2. Currently KHDE and KHI are currently studying Kansas impact of specialty hospitals and their impact on general, or full-spectrum hospitals and accordingly, do not sufficient information to either oppose or support **SB235**; and

3. And lastly, more importantly yesterday Senator Journey mentioned technical clarification that was needed. On page 1 , line 23 of this bill , the term "commence" needs to be clarified as it can mean anything from the point of intent to groundbreaking.

The Chair thanked all of the conferees and asked for questions or comments from the Committee. Senators Brungardt, Wagle, Barnett, Haley, and Palmer asked questions of Secretary Bremby and others including: when do you plan to have an analysis of KHI, cannot resolve the stark difference in the map of the numbers of facilities in Kansas, Oklahoma, Texas, and Louisiana vs. the rest of the country, are you getting data you need from specialty hospitals and specifically the Wichita hospitals, would it be incomplete data if you do not have the Golish facility, charitable care (i.e. document here from Via Chrisi with Dr. Odbeis's testimony) what percentage of care in a community hospital is for the uninsured or what kind of write-off do they have compared to a specialty hospital and unreimbursed expenses, likened this measure to the protected interest for consumerism, the WalMart factor but we as government are trying to provide for the greater good , clarification of no threat to community hospital and no shift from Susan B. Allen Hospital, located in El Dorado and that services will be complimentary, and recognizing the senior class of the School of Nursing.

Adjournment

As it was going on 2:30 p.m. Senate session time, the Chair adjourned the meeting.

The next meeting is on call of the Chair.

Senate

HEALTH CARE STRATEGIES COMMITTEE GUEST LIST

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DATE: 3-3-05

NAME	REPRESENTING
Joseph P Conroy	Emporia Surgical Hospital.
Ron Hein	HCA
DOUGLAS PALZER	PHYSICANS GENERAL HOSPITAL
Julie Hein	HCA
Jim McLean	KHI
Cynthia Smith	Sisters of Charity of Leavenworth H.S.
Cindy Allison	KHI
Aaron Walters MD	SKRMC, Ark City Physicians.
David K Ross M.D.	Self
Joe Ahrens	Self
ARLETA RICE	City of Arkansas City KS
Lloyd Lisk	City of Arkansas City, KS
WAYNE SHORT	CITY OF ARKANSAS CITY
Charlie & Mary Benton	Arkansas City, KS
GARY BENTON M.D	ANDOVER / ARKANSAS CITY, KS
Dick Hay	Self
Ira Stamm	self
Daryl Thornton	Kansas Spine Hospital
Gordon Funk	Wichita - Business Management & Dev.
Jim Sergeant	Salina Surgical / Kansas Surgical Hosp Assoc
Nathan Adams	CHCA
Aaron Otto	Lt. Gov. Ofc.
Melissa Hungerford	KHA
Edward & Lawanda Wade	Kansas Medical Center - Andover
Claudia Zapata	KS Medical Center Andover
Brad Smoot	KC Cancer Center
Ricardo Fuentes	United Fuels

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Name	Representing
William Snead	UKHA
Alberto Carro MD	KMC
Uzo Ohaebosim	Doctors for a Healthier KS
BADR IDRIS, MD	KMC
~~Rebecca Lopek~~	Doctors for a Healthier KS
Kyle Zepeda MD	KMC
ALAN L. BURKE	VISIONS 2000
Jeff Bridges	Andover
Ben Lawrence	ANDOVER
John D. Finegan	Kansas Medical Center LLC
Kathy Dunn	Saint Lukes Health Syst
JOHN C. BOTTENBERG	CHCA
Patricia Hubbell	CHCA

The Committee on Healthcare Strategies
Testimony Re: Senate Bill 235
Presented by Jim Sergeant, Administrator for Salina Surgical Hospital
On behalf of
Kansas Surgical Hospital Association
March 3, 2005

Madam Chairman and Members of the Committee:

My name is Jim Sergeant, and I am the Administrator of the Salina Surgical Hospital and President of the Kansas Surgical Hospital Association. I appreciate the opportunity to speak to you today concerning Senate Bill 235.

First, I would like to describe to you the membership of the Kansas Surgical Hospital Association so that my following comments might be better understood. Kansas Surgical Hospital Association is comprised of 10 member hospitals. We have a variety of ownership structures, 20% are joint ventures between physicians, community leaders and community hospitals, 40% are joint ventures between physicians and management companies, with the final 40% being 100% physician owned facilities. We have facilities ranging from 4 inpatient beds to 55 inpatient beds.

Some of the following statistics will illustrate the quality of our facilities. For example, our infection rate average is .3%, while the national average is 2% to 5%. Our transfer rate to a higher acuity facility is less than 1%. Our general administrative costs are under 16% while the national average is 24.3%. Our turnover rate for nursing staff is less than 7%, while the national average is over 14%. Our nurse to patient ratio is 1:3; right now the only state that is requiring ratios is California, and they are recommending 1:6 in most community hospitals.

I should also point out our satisfaction rate with our patients. Every one of our facilities has a satisfaction survey. The overall patient satisfaction is 97% and when we asked patients "would they recommend the surgical hospital to another?", we get a resounding 98% that say "yes". Our surgical hospitals treat a variety of patients. 42% of our patients are Medicare patients, 4% are Medicaid, and 40% come from commercial industry. The other percentages fall into workman's compensation and other commercial carriers.

We also have an impact on the Kansas economy. Our annual payroll for the 10 hospitals is $35.8 million. The Kansas Surgical Hospital Association employs over 826 Kansans. The Kansas Surgical Hospital Association members are also members of the American Surgical Hospital Association, which is comprised of approximately 92 surgical hospitals across the United States.

Senate Health Care Strategies Committee
Date: March 3, 2005
Attachment 1

The Kansas Surgical Hospital Association is a proponent of patient choice and works to excel in providing excellent medical care in our communities. We also strive to improve the quality of life for the surgeons and the staff.

We of the Kansas Surgical Hospital Association believe that Senate Bill 235 would stifle competition and is unnecessary. The creation of a new hospital today, already has natural barriers to entry with its high capital costs and regulatory requirements. In a free market economy it is neither wise, nor desirable, to create artificial barriers as would be created by Senate Bill 235.

For example, had Senate Bill 235 existed 5 to 6 years ago, the Salina Surgical Hospital, a joint venture with Salina Regional Health Center, a community hospital, and the leading physicians in Salina, would not exist today. This facility, which I am very proud of, has performed over 38,000 surgeries for the community in the past 5 years while maintaining an exemplary low infection rate, and high patient satisfaction rate. In fact, we have not received a patient survey that has rated us any lower than a 98% in patient satisfaction. And, as another point, when asking patients if they would refer a family member to our facility, an outstanding 100% of those patients said yes.

Salina Surgical Hospital would not have been the only facility affected had this law been in effect 5 years ago. Other similar facilities exist in our community such as Via Christi, Kansas Surgery and Recovery, St Luke's and Kansas City Orthopedic Institution. All of these institutions found that the surgical model, which 5 years ago was a new concept, was a good model to deliver high levels of care in a specialized manner while improving patient care and reducing costs.

The anticompetitive nature of Senate Bill 235 is exactly what the State of Kansas does not need. In fact, the study entitled "Improving Healthcare: A dose of Competition", in which over 2 years worth of hearings were conducted, by the Federal Trade Commission and the U.S. Department of Justice's Antitrust Division found that competition was exactly what healthcare needs. This extensive 6,000 page document, supported by hundreds of professionals in the healthcare and related fields, found that competition in healthcare is beneficial and improves the quality of services provided as well as reduces costs. This study recommended that states discard the certificates of need programs. Certificate of need, or CON, did not control health care costs. In some cases CON protected large hospital systems, which then created barriers to entry into the market for other competitors, and effectively drove up the cost of healthcare for those employers and employees.

Senate Bill 235 would not foster the development of new patient care models and/or new services at lower costs to the healthcare market. Most of all, this bill would deprive patients of the opportunity to choose from the future development of new healthcare models, which may benefit both themselves and their families. In the

recent MEDPAC (Medical Payment Advisory Commission) study requested by Congress, it was found that surgical hospitals provide an excellent alternative site for elective surgeries with a higher level of patient satisfaction and lower level of infections and in many cases lowered the cost of the hospital stay. It would not be beneficial for the State of Kansas to legislate the patient's choice away from them and to stifle new competitive models from entering the market. Anti-competitive bills like Senate Bill 235 ignore the benefits of improved quality and efficiency that new hospital models bring to the medical community.

To reiterate, Kansas Surgical Hospital Association believes that Senate Bill 235 would stifle future competition for medical services and will certainly increase the cost of healthcare in the State of Kansas by protecting the status quo.

KSH

Kansas Surgical Hospital Association

The Kansas Surgical Hospital Association is a not-for–profit trade organization created for the purpose of exchanging knowledge, promoting health education, and representing the interests of the healthcare consumer who may prefer to choose a surgical hospital for delivery of care in the state of Kansas.

Surgical Hospital Facts [1]

Kansas Member Hospitals	10
Physician Ownership Structures Joint Venture with Community Hospital Joint Venture with Management Company 100% Physician Ownership	 20% 40% 40%
Total Number of Inpatient Beds Range 4 to 55	221
Average Infection Rate National average is 2-5% [2]	0.30%
Patient Transfer Rate	Less than 1%
Average Payor Mix Medicare Medicaid Commercial Worker's Comp	 42% 4.0% 40% 14.0%
Average General Administrative Costs	Less than 16%
Annual Nursing Staff Turnover Rate National Average 14.75% [3]	Less than 7%
Average Nurse to Patient Ratio California is the only state to legislate patient to nurse ratios at 1:6 most community hospitals exceed this ratio.	1 to 3

1 2003 Membership Survey Data
2 KFMC News Release October 7, 2003
3 Hospital Salary and Benefits Report 2004-2005

For Further Information Contact:
Kansas Surgical Hospital Association
Paul Kerens - Secretary
3651 College Boulevard
Leawood, Kansas 66211
(913) 319 - 7575

Patient Opinion [4]

Overall Patient Satisfaction Rate	97%
% of Patients Who Would Recommend A Surgical Hospital To Others	98%

4 2003 Patient Satisfaction Surveys

Kansas Economic Impact [3]

Annual Kansas Payroll	> $ 35.8 mil
Kansans Employed by Surgical Hospitals	> 826

3 Represents Data from nine of eleven Kansas hospitals

Why a Surgical Hospital ?

By narrowing the clinical focus and minimizing administrative overhead, surgical hospitals can target and maximize resources. This results in an improved and more efficient healthcare delivery environment that supports clinical excellence and achieves sustainable and measurable cost savings.

The surgical hospital provides another option for healthcare. The patient who decides to undergo elective surgery should have the choice to select care in a surgical hospital that provides a more accessible, relaxed, healthful, surrounding where individual attention is the rule.

Surgical hospitals provide high satisfaction levels for both the surgeon and the patient. Other benefits of a surgical hospital include: lower costs lower infection and mortality rates, and higher patient satisfaction.

Patients Should Have a Choice in Their Healthcare

The growth of specialty hospitals has risen from the demand of patients, physicians, nurses and payers for a more efficient, cost effective and patient friendly healthcare system. Dissatisfied with the deterioration of the quality of care that has occurred. Patients are demanding more input into their own care. They want more choices. Studies have shown that patient and physician satisfaction rates are highest when care is provided in a specialty hospital environment. Patient care is more intimate and personal because of a lower nurse to patient ratio at specialty hospitals. Where physicians have more control over their work environment, the result is an improvement in quality of care. Because physicians have more control in a specialty hospital they have a vital interest in fostering an environment where patients are happier, nurses are more content, and scheduling runs more smoothly. The movement to a non-institutional environment that is friendlier to patients, efficient for physicians, and preferred by nurses has been dramatic. The growth of the specialty hospital industry is living proof that a better solutions exists. In order to ensure that this continues, we need a healthcare system that promotes innovation and encourages competition This is an environment where everyone wins!

Competition in Our Healthcare Industry is Vital

Traditional hospital special interest groups, such as the American Hospital Association, have strongly supported efforts to stop the development of specialty hospitals. Although they claim that the growth of specialized hospitals threatens community access to basic healthcare services they have failed to substantiate their rhetoric with facts. Traditional hospitals not only do not want to compete with the specialty hospital model, they do not know how to compete. For the first time, they are facing a competitor that is able to provide services more efficiently and at a lower cost.

Physician Investment is Not a Conflict of Interest

Critics of specialty hospitals have time and time again failed to substantiate their claims that physician investment in specialty hospitals is a conflicts of interest. For years traditional hospitals have been buying large physician groups and clinics in an effort to shore up their market share. The hospital employed physicians become beholden to the respective owner hospital, their board or directors, or the foundation that issues their paychecks. By acquiring the assets of these medical groups the traditional hospitals make it nearly impossible for the physicians to return to private practice. The conflict of interest is a tactic used by well funded special interest groups to restrict healthcare competition. Our country's skyrocketing healthcare costs need to be reigned in and controlled. One of the ways to do this is through healthy competition and innovative solutions. This is something we should demand of out healthcare system, not discourage.

Patients Receive Superior Care from Specialty Hospitals

The case for specialization is compelling and has demonstrated that there are too many benefits to this model of care to have it stifled to appease the protectionist policies of the traditional hospital lobby and related special interest groups. The surgical hospital model focuses and specializes on surgery and surgery related services. The employees are more experienced due to the volume of procedures performed. Supplies and equipment can be consolidated and purchased in volume to save costs. Standardization results in fewer errors, shorter turnover times, lower infection rates, fewer complications, The ultimate outcome is that patients receive better care, at a lower cost than at a traditional hospital. The concept of specialization promotes innovation and improvement in our healthcare system.

Specialty Hospitals Don't Harm Traditional Hospitals

Specialty hospital development has been under attack from well funded special interest groups such as the American Hospital Association, The Federation of American Hospitals, and the Coalition of Full Service Hospitals. These groups continually make claims that specialty hospitals threaten the communities access to basic health services by "cherry picking" or skimming only the most profitable and healthiest patients by not providing care to the indigent, or elderly. To date none of these groups has been able to substantiate their rhetoric with any credible studies or statistics. A recent GAO study illustrates that Medicare inpatient margin averages 9.4% at specialty hospitals and 8.9% at general hospitals. Every specialty hospital participates in Medicare/Medicaid and they also all provide services for which no compensation is received. Specialty hospitals play by the rules, no specially hospital has ever had to pay millions of dollars in fines and penalties for Medicare fraud or abuse.

AcademyHealth

Advancing Research, Policy and Practice

Academy Health: 2004 Annual Research Meeting

The Surgical Hospital -

Threat or Non-Threat to the Local Hospital

Presented by:

ROBERT JAMES CIMASI, ASA, CBA, AVA, FCBI, CM&A, CMP
President

TIM ALEXANDER, MLS
Vice President of Library and Research Services

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San Diego, CA - June 6, 2004

9-1

Introduction

- In recent years, cost pressures on government and private payors have forced providers to find more efficient means of delivering services. As surgical and specialty hospitals are able to focus on specific diagnosis and procedures, these facilities achieve higher volume, decreased cost, and lower mortality.
- Government payment and legislation have encouraged the movement of health care services from inpatient to outpatient care.
- In addition, the reduction of physician professional fees has led physicians to look outside of traditional medical practice towards new means of revenue, such as investment in surgical or specialty hospitals.
- In June 2003, Senator Breaux (D-LA) launched a frontal attack on specialty hospitals by proposing an amendment to the 2003 Medicare Drug Act prohibiting physicians from having an ownership interest in a "specialty hospital".

1-7

Objectives of Preliminary Analysis

- Compare general acute care hospitals operating in markets with a surgical hospital with hospitals operating in markets without a surgical hospital.
- Compare variables related to utilization, profitability, and case mix for each market.

1-8

The Breaux Amendment – Surgical Hospital Definition

- *"Hospital[s] that [are] primarily or exclusively engaged in the care and treatment"* of cardiac, orthopedic, or surgical patients.
- The Secretary of HHS could also designate other *"specialized categor[ies] of patients or cases..."* as *"inconsistent with the purpose of permitting physician ownership"* of hospitals.[1]
- The amendment does not define what volume would deem a hospital as "primarily" engaged in the treatment of a specialty.

[1] "Clarifications to Certain Exceptions to Medicare Limits on Physician Referrals" U.S. Senate, S.1 §453(a)(7).

Alternate Definition: Surgical Hospital

GAO Definition of "Surgical" Hospitals:

U.S. Government Accounting Office (GAO), in their 2003 report on specialty hospitals, **defined a surgical hospital as a private, short-term acute care hospital where *"two-thirds or more of its inpatient claims were for surgical diagnosis-related group (DRGs)"* excluding:**

1. ***"government-owned hospitals;***
2. ***hospitals where the majority of inpatient claims were for MDCs that related to rehabilitation, psychiatry, alcohol and drug treatment, children, or newborns; and,***
3. ***hospitals with fewer than 10 claims per bed per year."*** [1] [emphasis added]

[1] "Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served" U.S. General Accounting Office, April 18, 2003.

Methodology

Case Definitions

•**Surgical Hospital** – *"two-thirds" or more of total DRGs being surgical DRGs" as utilized in the 2003 GAO report.*

•**Excluded Facilities** – governmental, behavioral, long-term care, and rehabilitation hospitals

Selection of Markets

•As a general rule, any effect that might be determined to exist from the inclusion of surgical hospitals in geographic markets would be magnified in smaller markets. Therefore, the sixteen markets selected for comparison in eight areas of geographic proximity each have a population of less than 600,000.

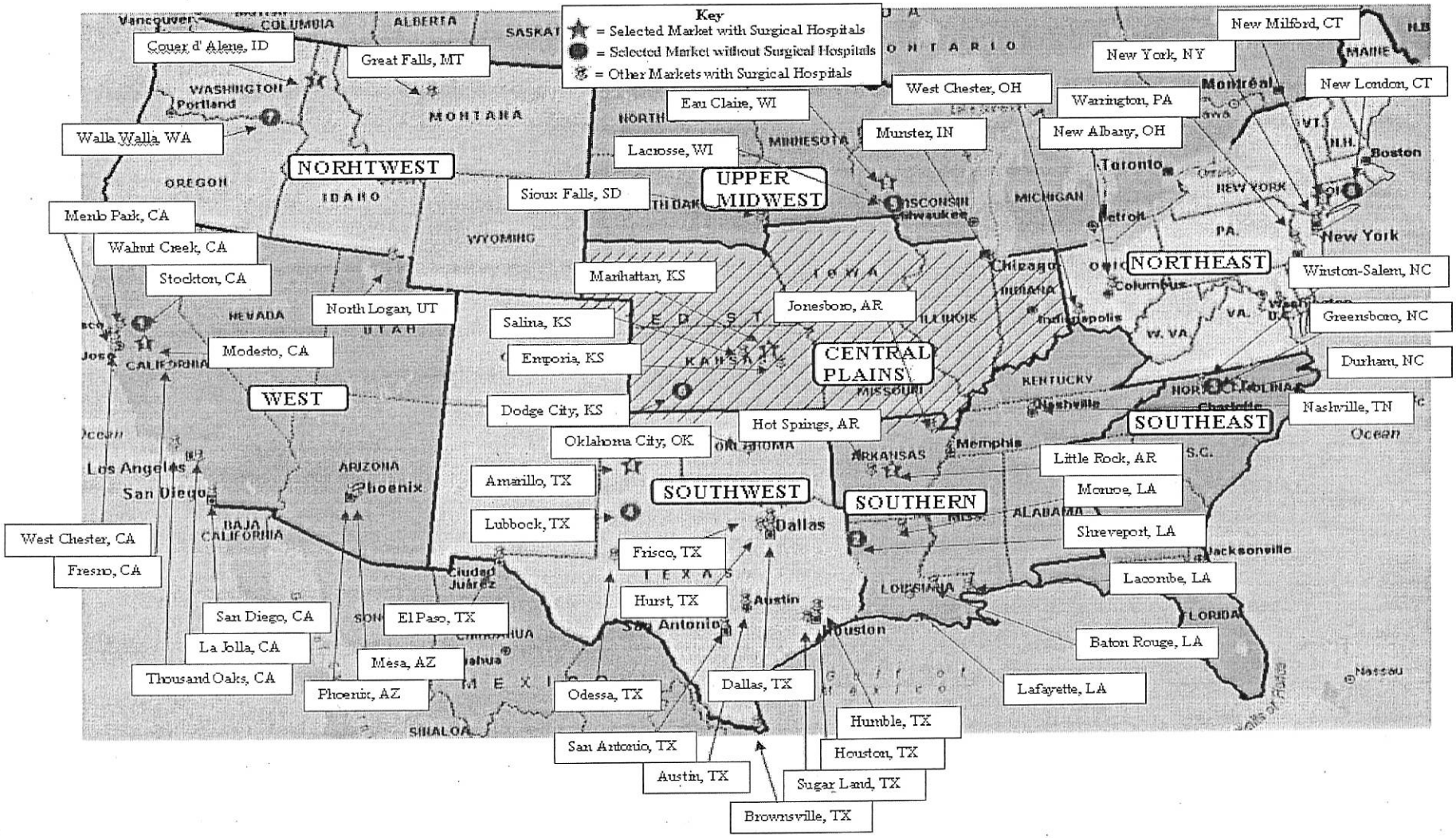
• Market pairs were identified in each of the eight general regions of the U.S.: the Northeast, Southeast, Upper Midwest, Central Plains, Southern, Southwest, West, and Northwest.

•Each pair selected is relatively close in terms of proximity, with approximately the same number of general acute care hospitals, and a similar population size. Each pair selected included one market without any surgical hospitals and one market including at least one surgical hospital.

Selection of Markets

	Population Regions	Markets With No Surgical Hospital	Markets With One Surgical Hospital
		Name	Name
1	WEST	Stockton, CA	Modesto, CA
2	SOUTHERN	Shreveport, LA	Little Rock, AR
3	SOUTHEAST	Greensboro, NC	Durham, NC
4	SOUTH WEST	Lubbock, TX	Amarillo, TX
5	NORTH EAST	New London, CT	New Milford, CT
6	UPPER MIDWEST	La Crosse, WI	Eau Claire, WI
7	NORTH WEST	Walla Walla, WA	Coeur D'Alene, ID
8	CENTRAL PLAINS	Dodge City, KS	Manhattan, KS

Map: Regional Markets Selection



1-13

Admissions Per Bed

Exhibit 1

EXHIBIT 1:

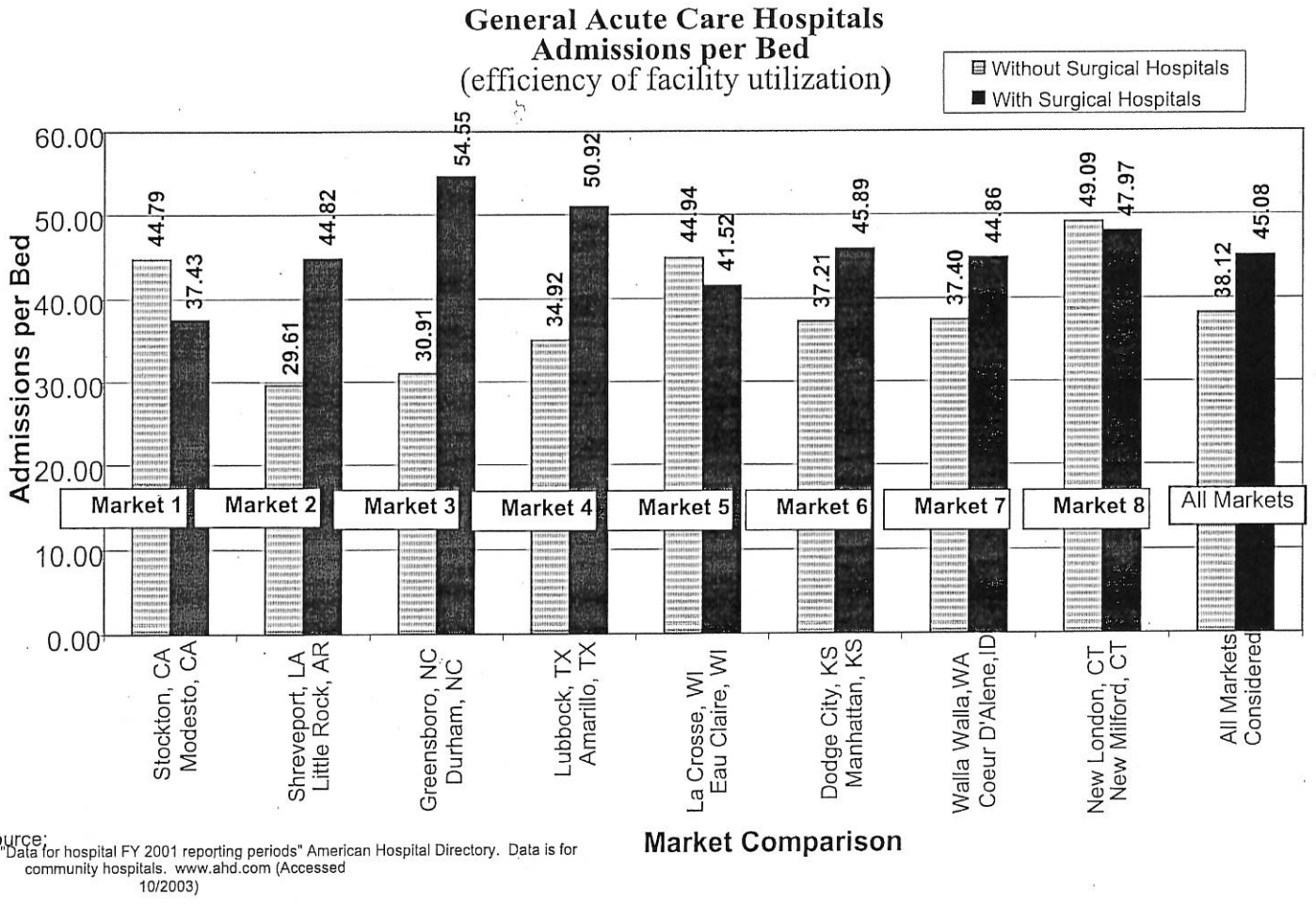
Admissions per Bed

DESCRIPTION:

Efficiency of facility utilization

FINDINGS:

Admissions per Bed were higher than in markets without surgical hospital refuting the "threat".



Source: "Data for hospital FY 2001 reporting periods" American Hospital Directory. Data is for community hospitals. www.ahd.com (Accessed 10/2003)

I-14

Average Length of Stay

Exhibit 2

EXHIBIT 2:

Average Length of Stay

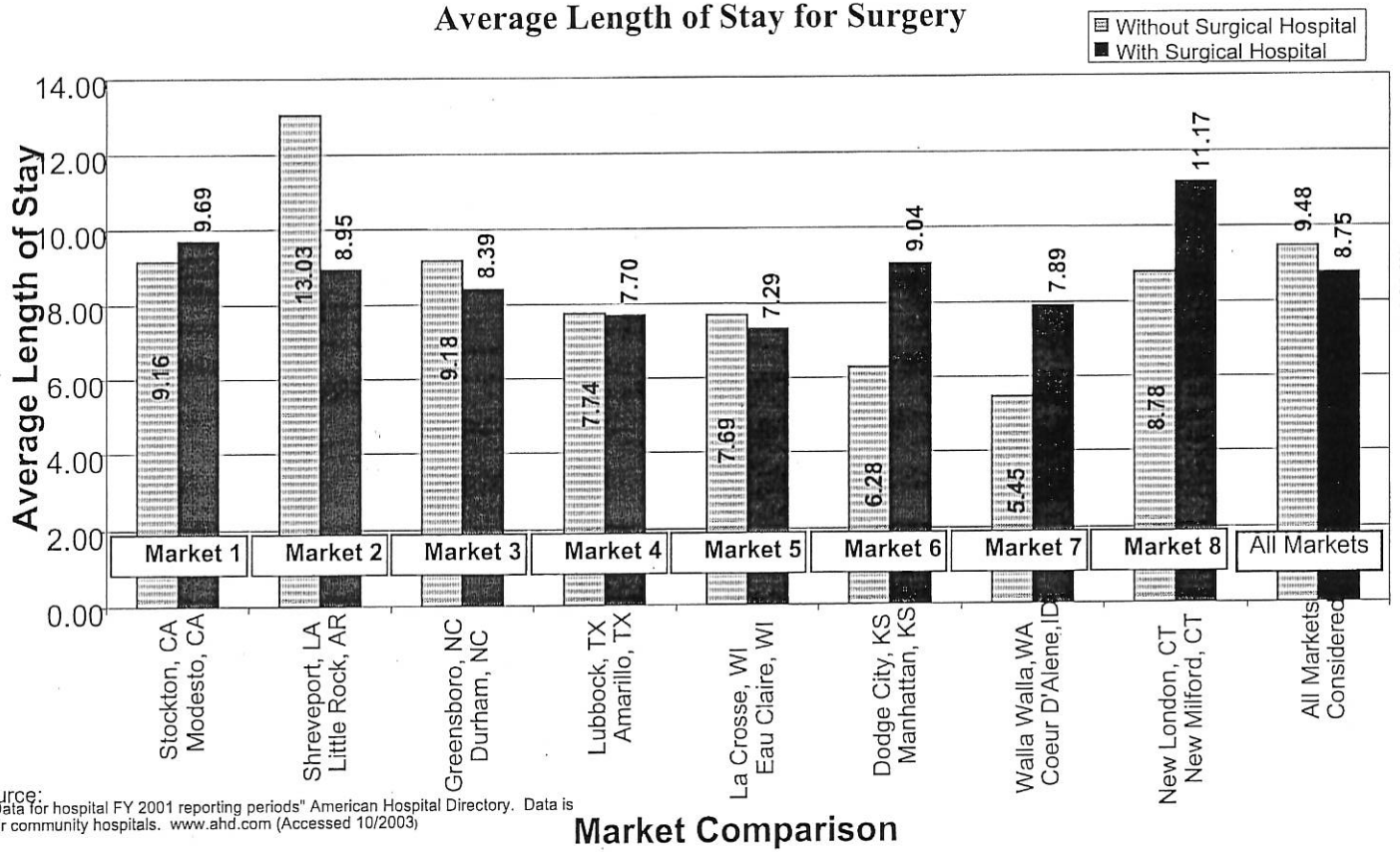
DESCRIPTION:

Cost Efficiency

FINDINGS:

ALOS was indicated as lower in markets with a surgical hospital refuting the "threat".

General Acute Care Hospitals
Average Length of Stay for Surgery



Source:
Data for hospital FY 2001 reporting periods" American Hospital Directory. Data is
Fr community hospitals. www.ahd.com (Accessed 10/2003)

Surgical DRGs as a % of Total DRGs

1-16

EXHIBIT 3:

Surgical DRGs as a Percentage of Total DRGs

DESCRIPTION:

Surgical Volume Proportion

FINDINGS:

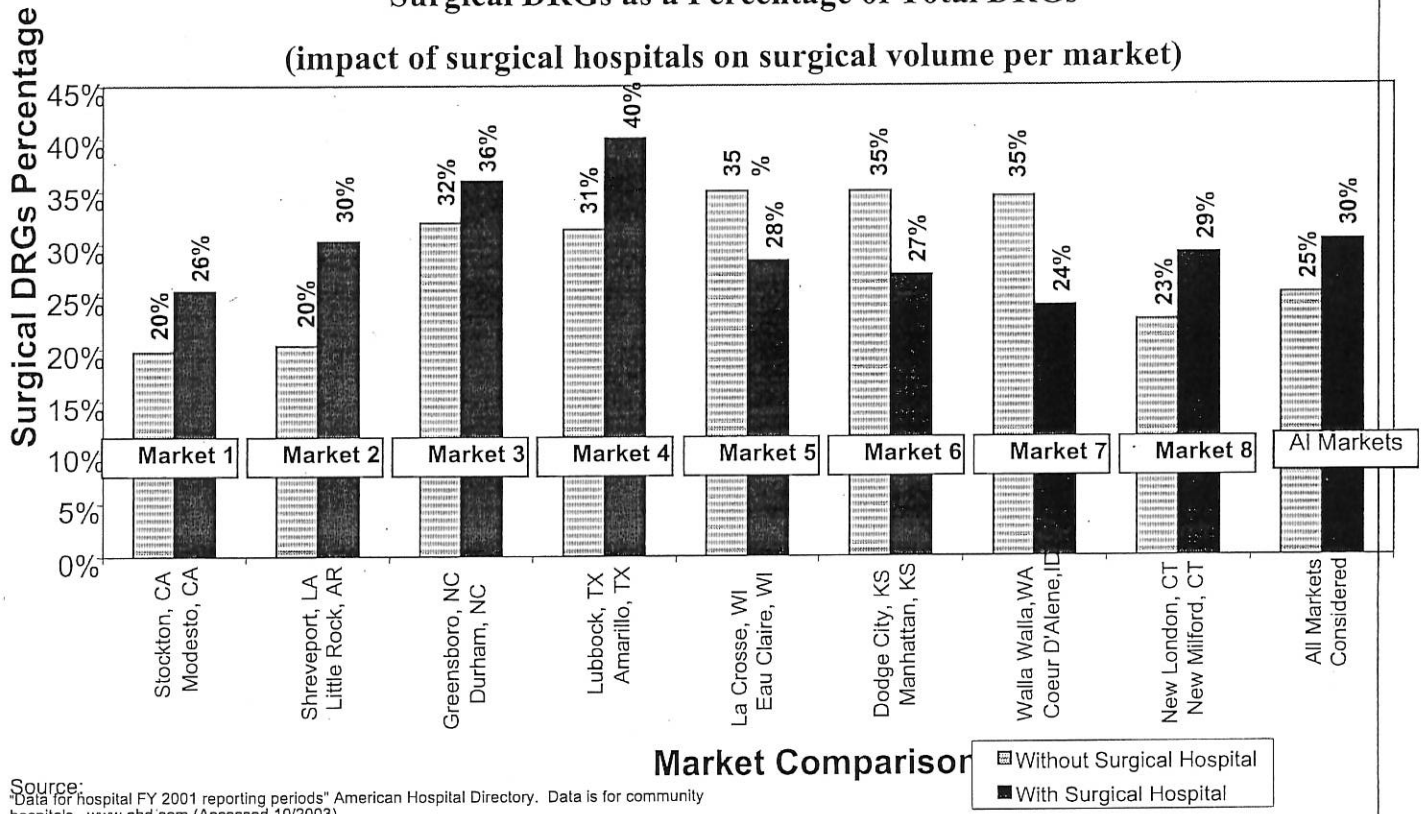
Surgical DRGs as a percentage of total DRGs was indicated as higher for the hospitals in markets with a surgical hospital refuting the "threat".

Exhibit 3

General Acute Care Hospitals

Surgical DRGs as a Percentage of Total DRGs

(impact of surgical hospitals on surgical volume per market)



Source:
"Data for hospital FY 2001 reporting periods" American Hospital Directory. Data is for community hospitals. www.ahd.com (Accessed 10/2003)

Net Income Per Admission

Exhibit 4

EXHIBIT 4:

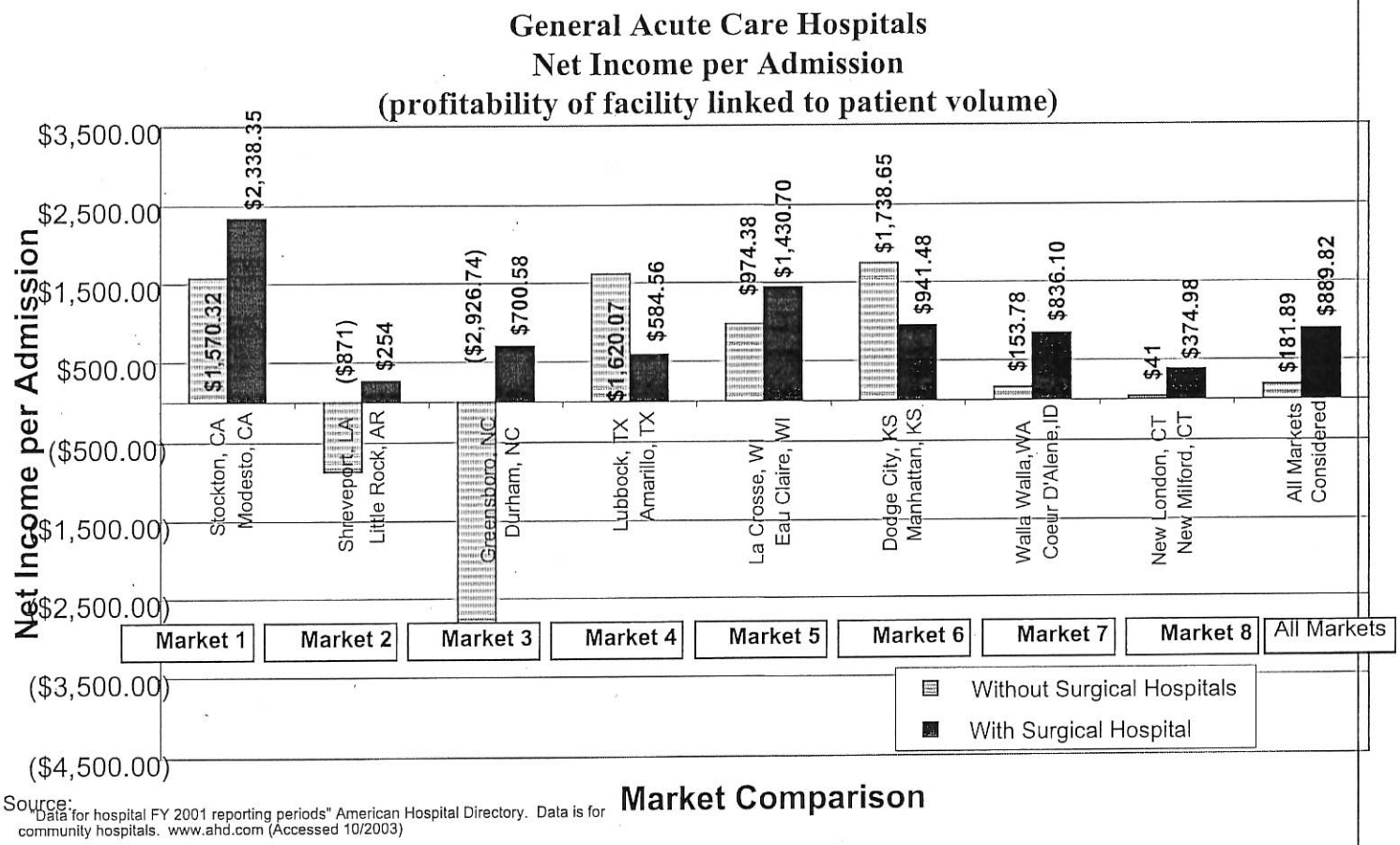
Net Income Per Admission

DESCRIPTION:

Profitability of facilities linked to patient volume

FINDINGS:

Net income per admission was indicated as being higher in markets with a surgical hospital refuting the "threat".



Source: "Data for hospital FY 2001 reporting periods" American Hospital Directory. Data is for community hospitals. www.ahd.com (Accessed 10/2003)

1-17

Net Income per Bed

Exhibit 5

EXHIBIT 5:

Net Income per Bed

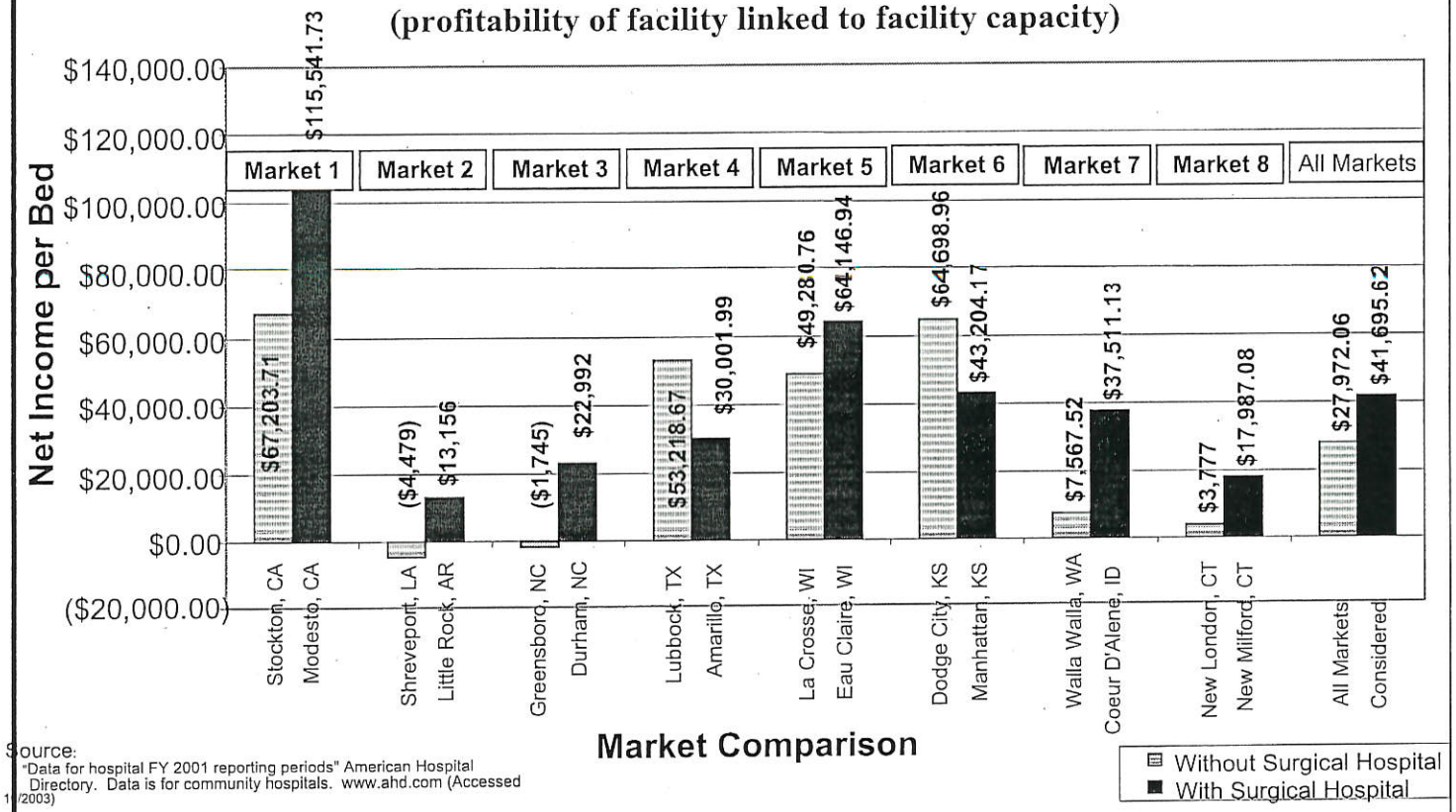
DESCRIPTION:

Profitability of facilities linked to patient (volume)

FINDINGS:

Net income, on a per bed basis, was indicated as being higher in markets with a surgical hospital refuting the "threat".

General Acute Care Hospitals
Net Income per Bed
(profitability of facility linked to facility capacity)



Source:
"Data for hospital FY 2001 reporting periods" American Hospital Directory. Data is for community hospitals. www.ahd.com (Accessed 1/2003)

I-18

Case Mix Adjusted Cost of Surgery

Exhibit 6

EXHIBIT 6:

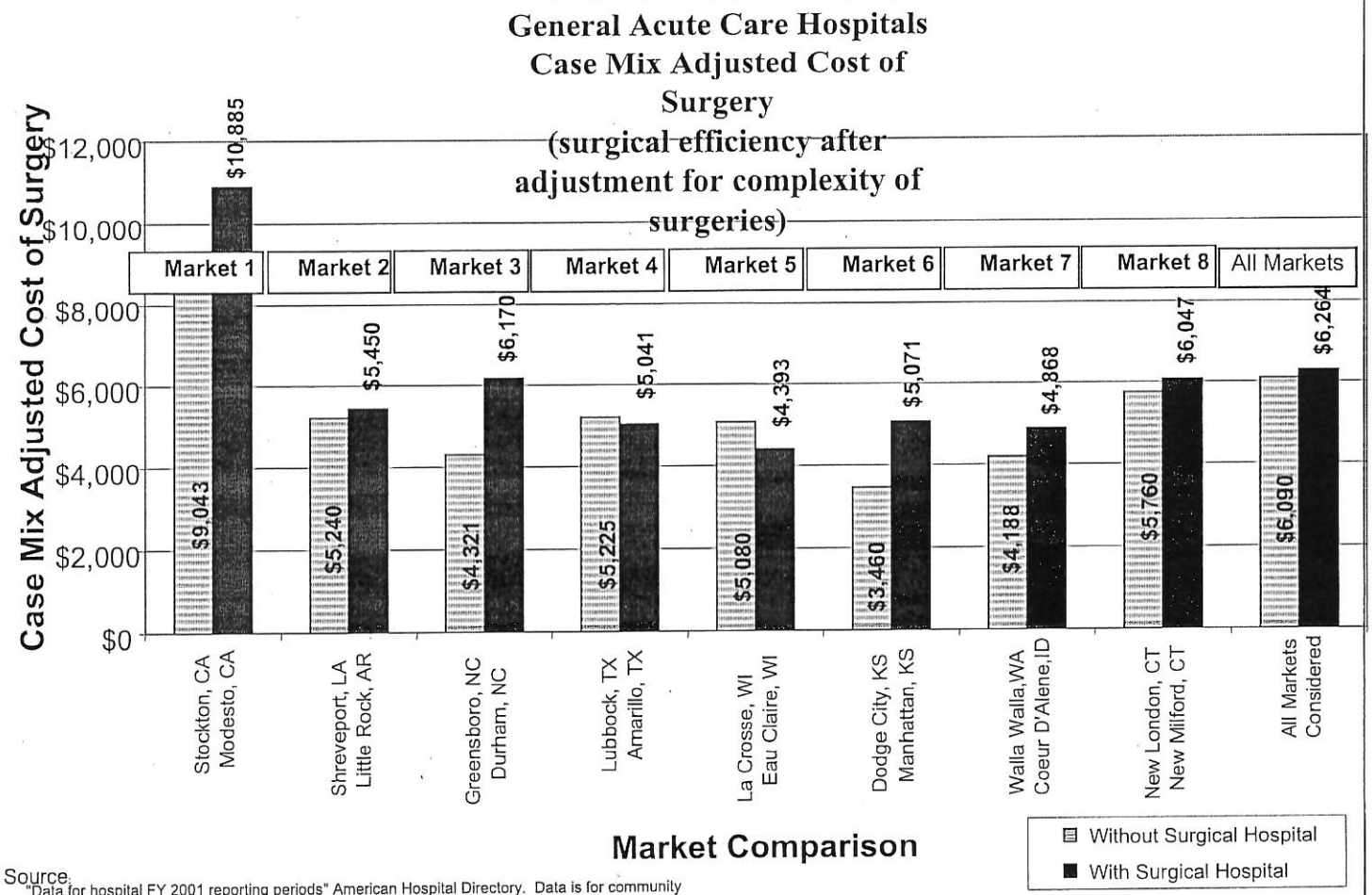
Case Mix Adjusted Cost of Surgery

DESCRIPTION:

Surgical efficiency after adjustment for acuity

FINDINGS:

Case Mix adjusted cost of surgery was indicated as being approximately equal in markets with surgical hospital refuting the "threat".



Source:
"Data for hospital FY 2001 reporting periods" American Hospital Directory. Data is for community hospitals. www.ahd.com (Accessed 10/2003)

1-19

Case Mix Index

1·20

EXHIBIT 7:

Case Mix Index

DESCRIPTION:

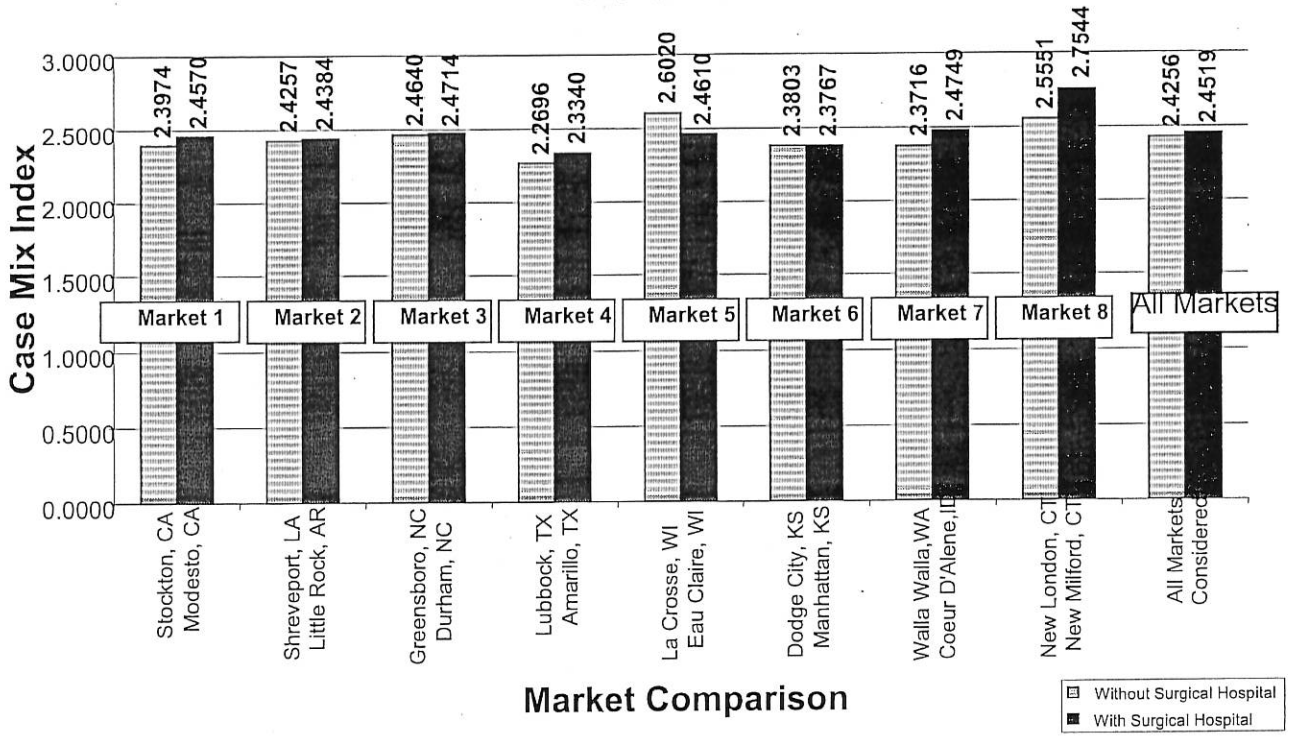
Relative complexity of a facility's cases

FINDINGS:

Case Mix Index was indicated as being approximately equal in markets with surgical hospital refuting the "threat".

Exhibit 7

General Acute Care Hospitals
Case Mix Index



Source: "Data for hospital FY 2001 reporting periods" American Hospital Directory. Data is for community hospitals. www.ahd.com (Accessed 10/2003)

Findings

VARIABLE (DESCRIPTION)	FINDINGS
1. Admissions per Bed (Efficiency of facility utilization)	Admissions per Bed were higher than in markets without a surgical hospital refuting the "threat".
2. Average Length of Stay (Cost efficiency)	ALOS was indicated as lower in markets with a surgical hospital refuting the "threat".
3. Surgical DRGs as a Percentage of Total DRGs (Surgical volume proportion)	Surgical DRGs as a percentage of total DRGs was indicated as higher for the hospitals in markets with a surgical hospital refuting the "threat".
4. Net Income per Admission (Profitability of facilities linked to patient volume)	Net income per admission was indicated as being higher in markets with a surgical hospital refuting the "threat".
5. Net Income per Bed (Profitability of facilities linked to patient (volume)	Net income, on a per bed basis, was indicated as being higher in markets with a surgical hospital refuting the "threat".
6. Case Mix Adjusted Cost of Surgery (Surgical efficiency after adjustment for acuity)	Case Mix Adjusted Cost of Surgery was indicated as being approximately equal in markets with surgical hospitals refuting the "threat".
7. Case Mix Index (Relative complexity of a facility's cases)	Case Mix Index was indicated as being approximately equal in markets with surgical hospitals refuting the "threat".

1-21

Findings (continued)

Five Variables appear to be more favorable for those general acute care hospitals in markets which contain a surgical hospital:

1. Admissions per Bed
2. Average Length of Stay
3. Surgical DRGs as a Percentage of Total DRGs
4. Net Income per Admission
5. Net Income per Bed

Two variables appear to be approximately identical for the general acute care hospitals in markets which contain a surgical hospital:

6. Case Mix Adjusted Cost of Surgery
7. Case Mix Index

Preliminary Analysis: Limitations

(1) The narrow scope of this preliminary analysis limits the application of its findings on a nationwide basis.

(2) Inclusion of additional data on the hospitals prior to the development of the surgical hospitals would be useful in providing a baseline from which to measure changes, if any, attributable to the development of surgical hospitals.

(3) An examination of markets without surgical hospitals in which new general acute care hospitals have opened would serve as a control to analyze the specific impact of surgical hospitals on the local market.

Literature Review

In recent years, the volume and tone of articles in the general media and healthcare professional literature regarding the expanding markets of specialty and surgical hospitals has changed dramatically. HCC's Library and Research Department has conducted a systematic literature review analyzing both sides of the debate over surgical hospitals' impact on healthcare markets. The following bibliographies have been posted to our website as a public service:

- Specialty Hospital Articles Bibliography:
  http://www.healthcapital.com/refpdfs/SpecialityHospitalsBiblio.pdf
- Surgical Hospital Articles Bibliography:
  http://www.healthcapital.com/refpdfs/SurgicalHospitalsBiblio.pdf
- Specialty and Surgical Hospital Studies Bibliography:
  http://www.healthcapital.com/refpdfs/SpecialtyHospitalsStudies.pdf

1-25

Previous Studies*:

Center for Studying Health System Change

Center for Health Systems Change (CHSC) Report
(published Nov. 12, 2003 in *Health Affairs* Nov./Dec. issue)

The Center for Studying Health System Change conducted site visits to twelve nationally representative communities, describing the recent rapid increase in physician-owned specialty hospitals and ambulatory surgery centers, reasons for the increase, possible impacts and potential policy options. Report findings indicate the following:

- Specialty hospitals may actually have superior quality and efficiency.
- Specialty hospitals could lead to provision of unnecessary services and reduction in community hospitals' ability to subsidize community services.
- Specialty hospitals could function as "focused factories" and improve quality and cut costs.
- Data on the impact of these hospitals are inconclusive, so **"regulatory intervention should be cautious."**

* This is a listing of several prominent studies. Note that Lewin also conducted a study on MedCath.

Previous Studies: GAO Studies

General Accounting Office (GAO) Report, April 2003

Examined share of the national market comprising of specialty hospitals

- In February 2003, the 92 cardiac, orthopedic, surgical, and women's hospitals identified accounted for less than 2 percent of short-term acute care hospitals nationwide.
- The number of specialty facilities has tripled since 1990 and an additional twenty facilities are under development.

Extent to which physicians have ownership interests in specialty hospitals

- About 70 percent of specialty hospitals in existence or under development had some physician ownership. Among these hospitals, total physician ownership averaged slightly more than 50 percent.
- Patients served by specialty hospitals compared with those served by general hospitals, in terms of illness severity
- Patients at specialty hospitals tend to be less sick than patients with the same diagnosis at general hospitals.

General Accounting Office (GAO) Report, October 2003

Specialty hospitals are clustered in areas where state policy and local demographic conditions favor growth

The 4 specialty hospital types differed from general hospitals in size and scope, but also differed from one another

Specialty hospitals rivaled general hospitals in certain market share measures and financial performance

Conclusions

- The number of specialty hospitals is growing rapidly, with an expected 25% increase within the next few months.
- Specialty hospitals are among the larger competitors facing general hospitals
- The economic impact of specialty hospitals on general hospitals remains unknown and the term "specialty hospital" remains undefined

Forthcoming Studies: MedPAC

The Medicare Act of 2003 requires the following study be performed related to specialty and surgical hospitals. The study will be published in February 2004.

"The Medicare Payment Advisory Commission shall conduct a study to determine

*A) **any difference in the costs of health care services furnished to patients by physician-owned specialty hospitals** and the costs of such services furnished by local full-service community hospitals within specific diagnostics related groups;*

B) the extent to which specialty hospitals, relative to local full-service community hospitals, treat patients in certain diagnosis-related groups within a category, such as cardiology, and an analysis of the selection;

*C) **the financial impact of physician-owned specialty hospitals on local full-service community hospitals;***

D) how the current diagnosis-related group system should be updated to better reflect the cost of delivering care in a hospital setting; and

E) the proportions of payments received, the type of payor, between the specialty hospitals and local full-service community hospitals."[1] [emphasis added]

[1] "Medicare Prescription Drug, Improvement, and Modernization Act of 2003" (Public Law 108-173, Section 507) U.S. Congress, Dec. 8, 2003, p. 117 Stat. 2296-2297.

Forthcoming Study: U.S. Dept. of Health & Human Services

The Medicare Act of 2003 requires the following study be performed related to specialty and surgical hospitals:

"The Secretary shall conduct a study of a representative sample of specialty hospitals –

A) to determine the percentage of patients admitted to physician-owned specialty hospitals who are referred by physicians with an ownership interest;

B) to determine the referral patterns of physician owners, including the percentage of patients they referred to physician-owned specialty hospitals and the percentage of patients they referred to local full-service community hospitals for the same conditions;

C) to compare the quality of care furnished in physician-owned specialty hospitals and in local full-service community hospitals for similar conditions and patient satisfaction with such care; and

D) to assess the difference in uncompensated care, as defined by the Secretary, between the specialty hospital and local full-service community hospitals, and the relative value of any tax exemption available to such hospitals." *[1]* [emphasis added]

[1] "Medicare Prescription Drug, Improvement, and Modernization Act of 2003" (Public Law 108-173, Section 507) U.S. Congress, Dec. 8, 2003, p. 117 Stat. 2296-2297.

1-28

1-29

Description of the Expanded Study

HYPOTHESIS

The development and operation of surgical hospitals has not had a significant negative effect on general acute care hospital viability as indicated by representative measures of operating performance and financial status variables and ratios related to utilization and profitability.

STUDY DETAILS

HCC is currently expanding its preliminary analysis to include additional markets containing surgical hospitals as well as data from the set of all markets without a surgical hospital. In order to avoid the potential for bias in the selection of market pairs, HCC's expanded study will compare groups of hospitals rather than markets.

1-36

Data Sources & Time Period

HCC's initial, preliminary analysis and expanded study will utilize financial data obtained from the American Hospital Directory (which contains data for over 6,000 hospitals based on Medicare claims data, Medicare Hospital Cost Report Systems Master File, Medicare Hospital OPPS Limited Data Set, Medicare Provider Analysis and Review (MedPAR) file, and other public use files, as well as the American Hospital Association's Annual Survey Data) pertaining to the general acute care hospitals in the selected markets.

The issue of timing of the market entry of surgical hospitals is also of interest. Any effect on general acute care hospitals in a market caused by the operation of a surgical hospital may not be immediately measurable or may grow over time. Ideally, a before and after analysis (columns C and D in the table above) could be performed once a long enough period of time has passed after the market entry of the surgical hospital. This would require obtaining operational data on the subject surgical hospitals as well as some adjustments for inflationary, economic, demographic, and other types of variables in the defined healthcare markets.

Markets for Potential Analysis

Populations and Markets For Potential Analysis

		A	B	C	D	E
		All Surgical Hospitals	**All General Hospitals**	**General Hospitals in Markets Before Entry of Surgical Hospitals**	**General Hospitals in Markets After Entry of Surgical Hospitals**	**General Hospitals in Markets Without Surgical Hospitals**
1	**All Surgical Hospitals**	N/A	Quality, profitability, occupancy	Quality, profitability, occupancy	Quality, profitability, occupancy	Quality, profitability, occupancy
2	**All General Hospitals**	Quality, profitability, occupancy	N/A	Utilization, profitability, case mix	Utilization, profitability, case mix	N/A
3	**General Hospitals in Markets Before Entry of Surgical Hospitals**	Quality, profitability, occupancy	Utilization, profitability, case mix	N/A	All variables	Utilization, profitability, case mix
4	**General Hospitals in Markets After Entry of Surgical Hospitals**	Quality, profitability, occupancy	Utilization, profitability, case mix	All variables	N/A	Utilization, profitability, case mix
5	**General Hospitals in Markets Without Surgical Hospitals**	Quality, profitability, occupancy	N/A	Utilization, profitability, case mix	Utilization, profitability, case mix	N/A

1-32

Scope and Limitations

The current expanded study:

- Builds upon the scope of HCC's initial, limited, and preliminary analysis to allow for findings which may be statistically valid relating to the effects of surgical hospitals on general acute hospitals on a nationwide basis.
- Incorporates additional variables in order to provide a more statistically robust picture of the operating performance and financial status variables and ratios related to the utilization and profitability of the subject hospitals.
- Includes further statistical adjustments to account for differences in facilities, market size, demographics, health status, and other variables.
- Takes into account timing measurements of the surgical hospitals' entry into the different markets will provide a baseline from which to measure changes.

1.33

Government and Private Payor Support of More Efficient Surgical Facilities

- The government has sought to transition services from an impatient to an outpatient basis by encouraging the development of Ambulatory Surgery Centers (ASCs) through reimbursement, as well as through the specific protection of physician ownership.
- The Investments in ASCs Safe Harbor final rule, published November 1999, protects investment interests in four categories of freestanding Medicare-certified ASCs: surgeon-owned ASCs; single-specialty ASCs; multi-specialty ASCs; and hospital/physician-owned ASCs.
- A February 2003 report issued by the U.S. Department of Health and Human Services (HHS) Inspector General urged CMS to set consistent reimbursement levels for hospital outpatient departments (HOPD) and freestanding ASCs.[1] In two-thirds of the procedures examined in the report, all of which can be performed in either setting, HOPDs were reimbursed more than ASCs for the same procedures. The median overpayment was $282. This discrepancy results in overpayments to hospitals of $1 billion dollars annually.

[1] "Hospitals cry foul: HHS report urges reimbursement adjustments" Modern Healthcare, Feb. 17, 2003, p. 10.

1-34

The Case of Inadequate Emergency Room Reimbursement

- The current ASC Medicare fee schedule is based on 1986 cost surveys adjusted yearly for inflation, making it possible that payments are not consistent with costs.[1]
- The American Hospital Association (AHA) argues that hospitals need to be overpaid in order to support their emergency rooms, intensive care units, 24 hour service, charity care, and generally sicker patients.[2]
- If costs are to be controlled and quality maintained through competitive forces then there must be a level playing field for competitors. If there was a rational, empirically based indication that hospital outpatient procedures are reimbursed at too high a level, then the government should restructure payments levels to increase reimbursement for emergency care and intensive care services. And similarly, if reimbursement for certain surgical and specialty procedures are too high, then payment should be appropriately readjusted.

[1] "Ambulatory Surgery Centers' Medicare Pay Rate Questioned" AMedNew.com, 11/25/02.

[2] "Hospitals cry foul: HHS report urges reimbursement adjustments" Modern Healthcare, 2/17/03.

Observations of Market Competition

New provider entrants, no matter how efficiently and creatively they might innovate to contribute to higher quality, more beneficial outcomes, and lower *overall* healthcare costs, face substantial opposition by established oligopoly interests, who, historically, have actively strived to limit competition with the resulting impact of denying patient choice.

Barriers to market entry, such as the moratorium on specialty hospital development, serve only to promote the oligopoly interests of existing, large established provider organizations who may find market competition inconvenient.

Note that the American Surgical Hospital Association (ASHA), the association representing the surgical hospital industry is working with researchers at the University of Iowa on an independent study of the impact of surgical hospitals on healthcare markets.

1.35

Observations of Market Competition

Proponents of the moratorium on specialty hospital development are willing to sacrifice cost-effective improvements through innovation; investment in new technologies; quality services; and, patient choice and convenience which, as the technology of healthcare advances, offer a true and valid opportunity to provide cost-effective quality healthcare.

The ideal healthcare delivery system seeks value by considering all-important components: access, quality, beneficial outcomes, the appropriate cost benefit relationship, as well as *patient choice*.

Oligopoly and *monopoly* impede the pursuit of the value ideal in the U.S. healthcare delivery system.

BACKGROUND ON THE PRESENTERS AND HCC

HCC
HEALTH CAPITAL CONSULTANTS
(800) FYI-VALU
www.healthcapital.com
9666 Olive Blvd., Suite 375
St. Louis, MO 63132-3013

Company Background

Founded in 1993, Health Capital Consultants, has developed significant research resources and a staff of experienced professionals with strong credentials; a dedication to the discipline of process and planning; and, an organizational commitment to quality client service as the core ingredients for the cost effective delivery of professional consulting services. HCC has served a diverse range of healthcare industry and medical professional clients in over 35 states including surgical and specialty hospitals, Emerging Healthcare Organizations (EHOs); hospitals and systems (both tax exempt and for profit); ambulatory, outpatient and diagnostic imaging centers; Physician Practice Management Companies (PPMCs); Management Services Organizations (MSOs); clinics, solo and group private practices in a full range of medical specialties, subspecialties and allied health professions; community/employer coalitions, managed care organizations; other healthcare enterprises and agencies; and, legal and accounting firms.

Brief Description of Services

Health Capital Consultants (HCC) is a nationally recognized healthcare consulting firm specializing in physician/practice integration, valuation consulting, mergers and acquisitions, intermediary services, financial analysis and modeling, litigation support and industry research and library services for healthcare providers and their advisors.

Specialty Hospital Consulting

Over the years, the scope of HCC's professional activities have required and permitted our firm to conduct extensive research and analysis in the areas of healthcare delivery; public health planning; healthcare economics and market competition; as well as, other specialty hospital related topics. HCC maintains an extensive library collections of surgical and specialty research related literature and data.

1.31

1-38

About the Presenters

Robert James Cimasi, ASA, CBA, AVA, FCBI, CM&A, CMP

Robert James Cimasi, ASA, CBA, AVA, FCBI, CM&A, CMP is President of Health Capital Consultants (HCC) with over nineteen years of experience in serving clients, in over forty (40) states, with a professional focus on the financial and economic aspects of healthcare service sector entities including: valuation consulting; litigation support; business intermediary and financing services; certificate-of-need consulting; and, healthcare transactions including sales, mergers, and acquisitions. Mr. Cimasi holds the Accredited Senior Appraiser (ASA) designation inBusiness Valuation, as well as, the Certified Business Appraiser (CBA), Accredited Valuation Analyst (AVA), Certified Business Intermediary (Fellow) (FCBI), the Alliance of Merger & Acquisition Advisors CM&A, and the Certified Medical Planner (CMP) designations (see Professional Designations section below). Mr. Cimasi is a nationally known speaker on healthcare industry topics, who has served as conference faculty or presenter such organizations as the American Society of Appraisers (ASA), Institute of Business Appraisers (IBA), International Business Brokers Association(IBBA), American Institute of Certified Public Accountants (AICPA), American College of Healthcare Executives (ACHE), National Association of Healthcare Consultants (NAHC), National CPA Health Care Advisors Association, National Litigation Support Services Association (NLSSA), and many other national and state healthcare companies and organizations, as well as industry associations and professional societies (see Presentations section below). He has been certified and has served as an expert witness on cases in several states, and has provided testimony before federal and state legislative committees.He is the author of A Guide To Consulting Services for Emerging Healthcare Organizations (John Wiley & Sons, 1999), The Valuation of Healthcare Entities in a Changing Regulatory and Reimbursement Environment (IBA Course 1011 text - 1999), and the author of An Exciting Insight Into the Health Care Industry and Medical Practice Valuation (AICPA Business Valuation course text 1997, rev. 2002.) He has written chapters on medical practice valuation in The Handbook of Business Valuation (John Wiley & Sons), Valuing Professional Practices and Licenses: A Guide for the Matrimonial Practitioner, 3rd ed., 1999 (Aspen Law & Business), and Valuing Specific Assets in Divorce (Aspen Law & Business) and has been a contributor to The Guide to Business Valuations (Practitioners Publishing Company) and Physician's Managed Care Success Manual: Strategic Options, Alliances, and Contracting Issues (Mosby). He has written numerous published articles, has presented several papers and case studies before national conferences, and is often quoted by healthcare industry trade publications and the general media. Mr. Cimasi's latest book, The Healthcare Certificate of Need Sourcebook, is due to be published later this year by Beard Books.

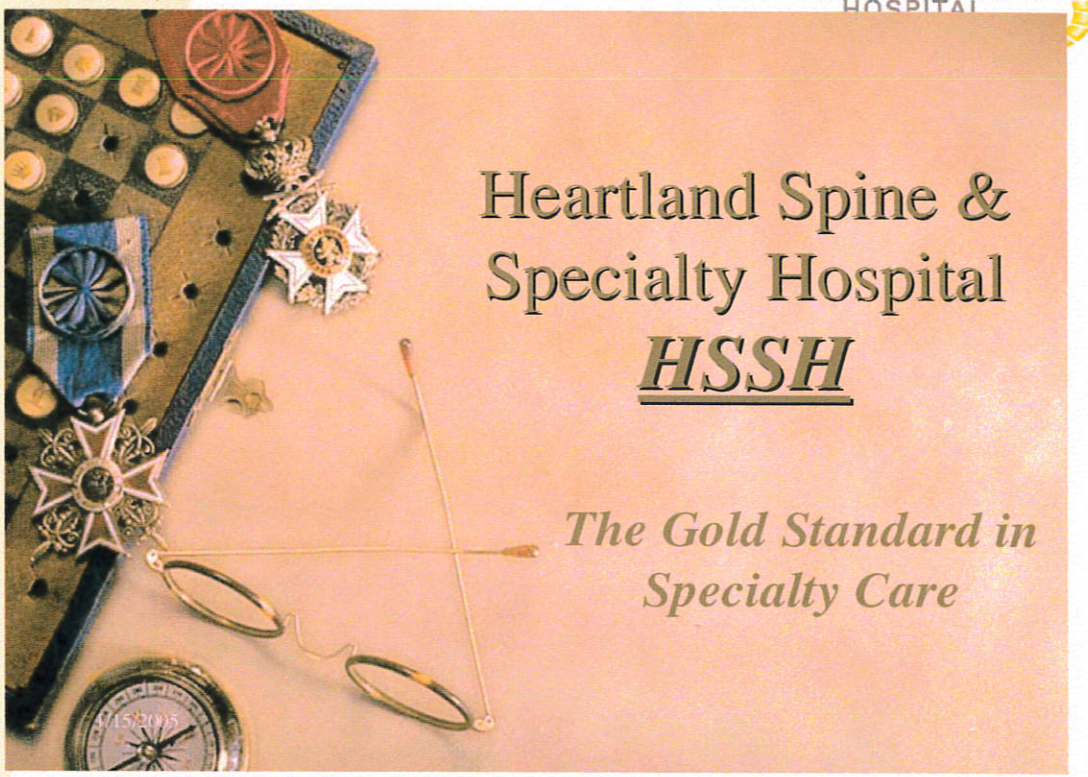
Timothy E. Alexander, MLS

Tim Alexander is Vice President of Library and Research Services with Health Capital Consultants. He oversees all research for client and internal projects on a wide range of healthcare industry subjects including the valuation of healthcare entities, mergers & acquisitions, competition in healthcare, medical specialty trends, healthcare regulatory issues, governmental and insurance reimbursement, managed care, physician supply and demand, financial benchmarking for healthcare businesses, physician integration, and related topics. Mr. Alexander has broad experience in traditional and online research methods as well as the organization of university and corporate libraries. He has both written and spokenon these topics publicly.

Mr. Alexander holds a Master of Library Science degree from the University of Missouri and a Bachelor of Arts in Mathematics from the University of Iowa. Mr. Alexander is a member of the American Library Association and other professional associations related to medical and special libraries.

Thursday, March 03, 2005

HEARTLAND SPINE & SPECIALTY HOSPITAL



Dedicated To Our Patients

Senate Health Care Strategies Committee
Date: March 3, 2005
Attachment 2

10720 NALL, OVERLAND PARK, KANSAS 66211 • PHONE: 913-649-7300 • FAX: 913-385-5559 • WWW.HSSH.ORG

Thursday, March 03, 2005

HEARTLAND SPINE & SPECIALTY HOSPITAL

Thank You Madame Chairman and Members of the Committee for this opportunity to appear before you today. I am Dr. William O. Reed, Jr., a resident of Kansas since 1983, a Board Certified Orthopaedic Surgeon, a Board Certified Upper Extremity surgeon, and Member of the North American Spine Society. I am also the Founder and Board Chairman of Heartland Spine & Specialty Hospital in Overland Park, Ks, and Vice-Chairman of the Board of Citizens Health Care Association. I am here to speak against SB 235, because it is not in the best interest of Kansans.

Our 100% Physician owned facility, Heartland Spine & Specialty Hospital, has a compelling story to tell. I am a retired Major from the Air Force where my experience as a Flight Surgeon and Orthopaedic Surgeon taught me the intrinsic value of collegiality among different specialists, and how positively it impacted quality of care. Concurrent training at Duke University Medical Center revealed the "Center of Excellence" concept based upon collegiality combined with Physician operational control. This model was a powerful tool to combine superlative talents and technology to combat illness and injury, conferring world class recognition to Duke Medical Center. When I moved to Kansas, I was determined to bring this "Center of Excellence" concept to reality here as well.

Seven years of work with five different hospital systems followed, with the same result every time. Although interested, ultimately the systems would not grant operational control nor fiscal responsibility to physicians. It thus became clear that the essential elements of a true "Center of Excellence" in spine and upper extremity would depend upon individual efforts. Thus with like minded colleagues, who also grew weary of the inefficiencies, stagnancies, and bureaucracy of established hospitals, Heartland Spine & Specialty Hospital came into being. The physician founders of HSSH invested personally and heavily in the most advanced technology available anywhere for diagnosis, treatment, and teaching that the Midwest has seen.

Now, let me tell you about our first patient after opening. Mr. D. H., a farmer from Southern Kansas, had been already turned away from 11 hospitals in three states, including academic centers, with four nearly

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HEARTLAND SPINE & SPECIALTY HOSPITAL

amputated fingers at the base from a saw accident. He was accepted by HSSH immediately without questions as to his ability to pay, seen in our small ER, received ten hours of advanced microsurgical care, with salvage of all fingers. Thus with our index patient we had demonstrated a commitment to be not accused cherry-pickers, but rather part of the safety net for sick and injured Kansans. This continues today as we are accepting Medicare, Medicaid, and uninsured patients referred without question or challenge from our medical staff members. Physicians in control of a hospital will do what Physicians have always done in their practices, take care of patients, many of whom have little or no ability to pay. Are these patients healthier than others? Quite the reverse, where our severity of illness scores at HSSH substantially exceed those of our neighboring hospitals in the Metro.

Technology:
Our 3.0 Tesla whole-body MRI is one of only 135 in the world. We have more square footage per operating room than any other facility to implement our advanced imaging technology. We have all private rooms for patient comfort and family privacy. We are unique in offering High Definition Endoscopic video equipment for our surgeons. We have attracted four FDA investigational studies for advancing medical care, and now teach high school students through practicing physicians locally and internationally through our advanced videoconferencing OR technology, available nowhere else in the Metro.

Profits:
While being open eighteen months, we have no profits to report, but we are a high paying employer who contributes substantially to the tax base of the community, instead of existing as a tax-free, not for profit entity. This venture on the behalf of my patients has substantially reduced my personal income as direct patient care activities have moved to my colleagues. Meanwhile, allegations of detrimental affect on the surrounding community hospitals, is countered by the Kansas City Business Journal which just reported income increases for 24 of 25 acute care hospitals in the Metro compared to 2003.

Thursday, March 03, 2005

HEARTLAND SPINE & SPECIALTY HOSPITAL

Service:
I chose to practice first in Bethany Medical Center, in Kansas City Kansas, now closed as the not-for-profit system chose to move services to a more suburban location. While accused of "cherry-picking" patients, we observe multiple closures of hospitals within our city while the parent hospital system builds new replacement facilities in the suburbs. I would submit that this is cherry picking on a zip code basis, leaving critical access problems for thousands of individuals. Yet we physicians are prevented legislatively by the moratorium from expanding into these abandoned areas with ER or hospital services ourselves.

Quality:
We passed our Kansas State Licensure Inspection with zero deficiencies, and the Joint Commission on Accreditation of Healthcare Organizations awarded to HSSH full certification as an acute care hospital in only nine months, with a three year review interval, both unprecedented achievements. Our quality health report card lists an infection rate one-tenth the national average, patient satisfaction rate of 98%, length of stay time 50% of the national average, and nurse to patient ratios of two to four times higher. Despite demonstrably higher technology, higher quality, and lower cost we are currently and would be further limited from adding to our hospital services or emergency capabilities by current and proposed moratorium language.

Insurers:
While higher technology and higher quality and lower cost are offered by HSSH to all insurers, we continue to remain out of network with most due to threats of canceling contracts and raising prices by local hospital systems if the insurers were to choose our facility for in-network contracting. Health insurers like BCBS and United are implementing payment policies designed to discriminate against physician owned facilities. Thus Kansans are frequently denied choice based upon quality, technology and cost alone. This intimidation of insurers must stop so they are free to make rational, economic, quality driven decisions.

10720 NALL, OVERLAND PARK, KANSAS 66211 • PHONE: 913-649-7300 • FAX: 913-385-5559 • WWW.HSSH.ORG

Thursday, March 03, 2005

HEARTLAND SPINE & SPECIALTY HOSPITAL

Final:

As long as hospitals are allowed to employ doctors and direct referrals, using facility income to pay salaries never achieved in private practice, caring physicians should be allowed to own and control their own facilities. Only by effective competition will health care facilities be driven by the standards of higher quality and lower cost. Competition is the backbone of American economic greatness, and physician owned facilities clearly demonstrate that these market forces work in the best interest of patients when left to their own.

On Monday the MEDPAC committee of the US congress released a study supporting the concept for relating reimbursement to quality care indicators. We support this endeavor as it is quality based. Let us work together on improving access, improving quality, and lowering cost, not listening to those who support the status quo and limiting competition. I would ask each member, since when has the status quo been good for Kansas, or America. We cannot remain stagnant in facilities and remain premier health care providers at the same time. Thank you for your attention and I trust your judgment will be rendered only after thorough investigation, just as you expect from a physician's medical care.

Respectively Submitted,

William O. Reed, Jr., M.D.
Board Chairman, Heartland Spine & Specialty Hospital
Vice-Chairman, Citizens Health Care Association

Thursday, March 03, 2005

HEARTLAND SPINE & SPECIALTY HOSPITAL

1. MedPAC report moves closer to pay-for-performance.
In its March Report to the Congress, the Medicare Payment Advisory Commission (MedPAC) made several recommendations that shift policy toward pay-for-performance measures. The report recommends higher payments for higher quality performance, quality measures that reflect the use and function of information technology systems, establishment of "quality standards" for providers who perform imaging studies and physicians who interpret them, and measurement of resource use of physicians serving Medicare beneficiaries. In addition, MedPAC recommended an update to the physician fee schedule equal to the projected change in input prices less an allowance of 0.8 percent for productivity. The report can be accessed at: http://www.medpac.gov/publications/congressional_reports/Mar05_TOC.pdf (Acrobat Reader required)

Why a specialty hospital?

"Advances in medical care have demanded greater specialization in physicians. Quality and efficiency in delivery of this care has favored specialization in facilities as well. This is a nationwide trend. Some general hospitals have tried to answer this by advertising many special areas within. In other instances, physicians themselves have organized to develop and control an independent "Center of Excellence" for the benefit of patient care.

There can be opinions in support of each approach. Understandably, existing hospitals may protest before eventually accepting this desirable specialization of facilities. In the end however, objective standards such as efficiency, quality of care, and patient satisfaction will dictate the viability of each model. We must keep in mind that healthy competition in the field of medicine will most certainly benefit the patient in every respect.

Be assured that the physicians of Heartland Spine & Specialty Hospital, are free to focus, develop, cooperate and innovate within the scope of their specialty, for their patient's best interest, without the burden of distractions and conflicts previously endured."

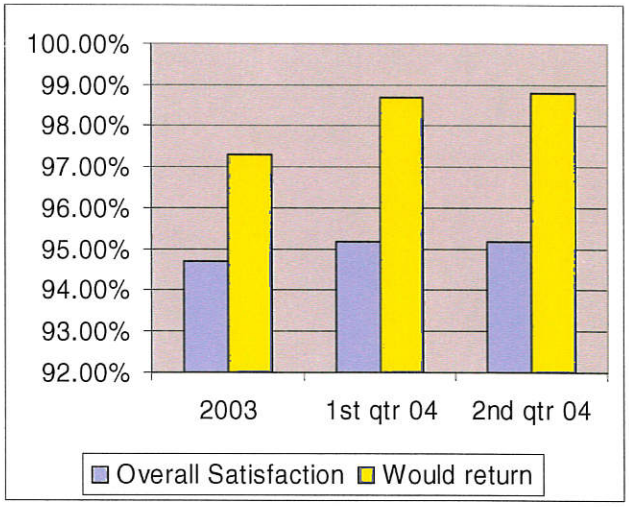
William O. Reed Jr., M.D.
Board Chairman, Heartland Spine & Specialty Hospital

Thursday, March 03, 2005

HEARTLAND SPINE & SPECIALTY HOSPITAL

Patient Satisfaction Scores

Patient Satisfaction has been measured since opening in September, 2003. We have a 37% return rate on patient satisfaction surveys. Patient satisfaction surveys are one tool that we use to evaluate our effectiveness of patient care delivery.

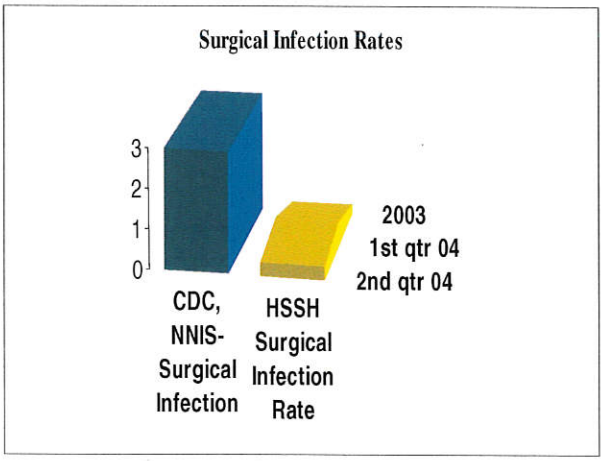


Surgical Site Infection Rates

Surgical site infection rates* for spinal fusions and ORIF's average a rate of 3.0-3.3 (per 100 cases). HSSH surgical site infections are reported as follows:

- 2003 0.23
- 1st Quarter 2004 0.62
- 2nd Quarter 2004 0.32

*CDC, National Nosocomial Infections Surveillance (NNIS) System Report, Data Summary from January 1992-June 2001, Issued August 2001



THE LIST

TOP AREA ACUTE-CARE HOSPITALS

(ranked by 2004 gross operating revenue)

2005 Rank	Hospital name / Address / Phone/Fax/Internet	Gross operating revenue 2004 2003	Net Revenue 2004 2003	Physicians Nurses Employees	Number of beds Licensed Staffed	Admissions 2004 2003	Top officer	Specialty services
1.	**Saint Luke's Hospital of Kansas City** 4401 Wornall Road 816-932-2000 Kansas City, MO 64111 FAX 816-932-5990 www.saintlukeshealthsystem.org	$1,105,400,000 $1,022,600,000	N/A N/A	486 759 2,616	623 519	18,731 19,773	G. Richard Hastings President and CEO	cardiovascular, brain and stroke center, high-risk maternity, neonatology, oncology, level I trauma, emergency
2.	**University of Kansas Hospital** 3901 Rainbow Blvd. 913-588-5000 Kansas City, KS 66160 FAX 913-588-1280 www.kumed.com	1,048,659,498 904,361,261	N/A N/A	388 522 2,584	620 475	17,803 17,432	Irene Cumming President and CEO	cardiology and cardiovascular surgery, cancer, neurosciences, regional transplant center, level I trauma
3.	**Shawnee Mission Medical Center** 9100 W. 74th St. 913-676-2000 Merriam, KS 66204 FAX 913-676-7792 www.shawneemission.org	820,665,806 748,960,749	N/A N/A	702 408 1,950	383 326	19,196 19,924	Samuel Turner Sr. President and CEO	cardiac and vascular, emergency, women's, surgery, oncology, behavioral health
4.	**Research Medical Center** 2316 E. Meyer Blvd. 816-276-4000 Kansas City, MO 64132 FAX 816-276-4387 www.researchmedicalcenter.com	813,917,000 708,794,000	$233,329,000 $214,483,000	319 485 1,605	511 446	14,245 14,022	Niels Vernegaard CEO	transplant institute, stroke center, oncology, nephrology, cardiovascular services, pulmonary services, high-risk ob
5.	**North Kansas City Hospital** 2800 Clay Edwards Drive 816-691-2000 North Kansas City, MO 64116 FAX 816-346-7020 www.nkch.org	775,374,947 652,555,316	273,036,329 248,753,696	383 836 2,307	351 351	22,430 20,802	David Carpenter President and CEO	open-heart surgery, level II trauma center, open MRI, wound care, hospice, palliative care, radiation/ oncology
6.	**Children's Mercy Hospital and Clinics** 2401 Gillham Road 816-234-3000 Kansas City, MO 64108 FAX 816-346-1370 www.childrens-mercy.org	587,365,878 496,277,552	324,113,314 282,581,609	339 1,059 3,417	295 269	12,833 11,861	Randall O'Donnell President and CEO	pediatric specialty care, neonatology, pediatric cardiology and cardiovascular surgery, pediatric hematology/oncology
7.	**Providence Medical Center** 8929 Parallel Parkway 913-596-4000 Kansas City, KS 66112 FAX 913-596-4098 www.providence-health.org	385,050,167 359,042,644	140,118,416 134,145,733	215 305 1,147	400 257	11,141 10,931	James Paquette CEO	cardiac center and rehabilitation, cancer care and radiation oncology center, diabetes center, family-care center, joint center, spine center
8.	**Saint Joseph Health Center** 1000 Carondelet Drive 816-942-4400 Kansas City, MO 64114 FAX 816-943-2845 www.carondelethealth.org	344,000,000 358,000,000	153,348,000 155,319,111	646 259 971	300 269	12,284 12,926	Michele Schaefer CEO	maternity, medical mall, Carondelet Heart Institute, rehabilitation, wellness, emergency
9.	**Truman Medical Center-Hospital Hill** 2301 Holmes St. 816-404-1000 Kansas City, MO 64108 FAX 816-404-3508 www.trumed.org	341,655,000 293,580,194	203,366,000 203,006,941	426 536 2,039	247 205	11,823 11,598	John Bluford President and CEO	level I trauma/emergency medicine, women's health, asthma, high-risk maternity, neonatal intensive care, diabetes
10.	**Olathe Medical Center Inc.** 20333 W. 151st St. 913-791-4200 Olathe, KS 66061 FAX 913-791-4313 www.ohsi.com	323,772,278 291,338,275	144,265,693 135,513,444	313 386 1,069	300 228	11,343 11,337	Frank Devocelle President and CEO	Kansas Cadiovascular Center, Women's Health Center & The Birth Place, Kansas Joint Specialty Center, Kansas Regional Oncology
11.	**Liberty Hospital** 2525 Glenn Hendren Drive 816-781-7200 Liberty, MO 64068 FAX 816-792-7117 www.libertyhospital.org	281,797,685 267,565,496	118,532,668 113,780,011	311 233 991	235 215	12,043 11,172	Joseph Crossett Administrator	orthopedics, trauma II, home health, hospice, birthing center
12.	**Saint Luke's South** 12300 Metcalf Ave. 913-317-7878 Overland Park, KS 66213 FAX 913-317-7909 www.saintlukeshealthsystem.org	211,600,000 157,000,000	N/A N/A	529 168 454	105 93	5,255 4,304	Julie Quirin CEO	maternity, cardiovascular, women's health, primary care, rehabilitation, outpatient surgery services
13.	**Saint Luke's Northland Hospital** 5830 N.W. Barry Road 816-891-6000 Kansas City, MO 64154 FAX 816-891-6008 www.saintlukeshealthsystem.org	210,400,000 190,300,000	N/A N/A	246 146 569	174 115	5,515 5,421	N. Gary Wages CEO	maternity, level II nursery, primary care, rehabilitation, behavioral health, outpatient services
14.	**St. Mary's Hospital of Blue Springs** 201 N.W. R.D. Mize Road 816-228-5900 Blue Springs, MO 64014 FAX 816-655-5408 www.carondelethealth.org	147,000,000 146,000,000	67,791,000 65,918,750	332 151 450	139 134	6,810 7,191	Gordon Docking CEO	birthing center, medical mall, cardiology, emergency, radiation therapy, wound care, sleep lab, pain clinic
15.	**Truman Medical Center-Lakewood** 2301 Holmes St. 816-404-7000 Kansas City, MO 64108 FAX 816-404-8467 www.tmcmed.org	116,044,000 99,848,561	84,787,000 80,074,401	426 200 855	314 295	5,156 5,003	John Bluford President and CEO	women's health, orthopedic surgery, general surgery, family medicine, medical rehabilitation, geriatrics
16.	**Kindred Hospital Kansas City** 8701 Troost Ave. 816-995-2000 Kansas City, MO 64131 FAX 816-995-2171 www.kindredhospitalkc.com	73,670,135 75,973,263	31,032,333 27,752,998	41 64 214	167 94	608 492	Mark Stepanik CEO	surgical wound and hyperbaric medicine, respiratory illness and ventilator weaning, chronic diseases, dialysis, medical behavior
17.	**Cass Medical Center** 1800 E. Mechanic St. 816-380-5888 Harrisonville, MO 64701 FAX 816-380-4639 www.cassmedicalcenter.com	63,333,956 53,515,910	24,340,243 22,897,974	21 46 242	49 38	2,032 1,817	J. Christopher Lang CEO	cardiac and pulmonary rehab, diabetic education, emergency, home health, ICU, behavioral health unit, lab
18.	**Saint John Hospital** 3500 S. Fourth St. 913-680-6000 Leavenworth, KS 66048 FAX 913-680-6013 www.providence-health.org	62,171,310 59,496,120	26,557,826 27,668,542	98 75 201	76 39	2,402 2,424	James Paquette CEO Greg Madsen Administrator	women's center, emergency services, ambulatory surgery center, rehabilitation services, home health, sr. behavorial health
19.	**Excelsior Springs Medical Center** 1700 Rainbow Blvd. 816-630-6081 Excelsior Springs, MO 64024 FAX 816-629-2701 www.esmc.org	33,417,834 31,184,849	14,298,780 14,564,951	125 75 181	129 105	670 729	Sally Nance CEO	orthopedic, cardiology, ENT, surgery, convalescent center, home health/hospice

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PATIENTS OR PAPERWORK?

THE REGULATORY BURDEN FACING AMERICA'S HOSPITALS

CARE SETTINGS	EVERY HOUR OF PATIENT CARE REQUIRES
Emergency Care	1 hour of paperwork
Surgery and Inpatient Acute Care	36 minutes of paperwork
Skilled Nursing Care	30 minutes of paperwork
Home Health Care	48 minutes of paperwork

SOURCE: American Hospital Association

NOTES

Information was compiled from questionnaires and telephone interviews with hospital representatives.

Employment figures indicate the number of active physicians, full-time registered nurses and licensed practical nurses, and total staff (full-time equivalent).

UnitedHealthcare®

A UnitedHealth Group Company

February 25, 2005

Heartland Spine & Specialty Hospital
10720 Nall Avenue
Overland Park KS 66211

Dear Sir or Madam:

UnitedHealthcare is committed to keeping health care affordable for you and your employees and providing access to a broad network of health care professionals. UnitedHealthcare has a broad national network of more than 420,000 physicians and 3,700 facilities and has negotiated specific payment rates on your behalf, based on scientific cost-based methodology that is nationally accepted. We are now implementing a new strategy for specific specialties of physicians with whom we have had challenges in contracting.

What is the change?
With the recent renewal of your UnitedHealthcare health benefits, your Certificate of Coverage was amended to include a change in assignment of benefits for non-network physicians and health care facilities. This means that if your employee receives care from a non-network physician, the claim reimbursement check may be sent to your employee directly, rather than to the non-network provider of care as in the past. Your employee must then pass this reimbursement on to the non-network physician or facility. There is no change in the claim reimbursement level. The process change will be implemented no earlier than March 1, 2005.

Why is this change being implemented?
In an effort to keep health care affordable, we are initially addressing non-network hospital-based physicians that cost more because they generally are paid at the network benefit level if they provide services at a network facility. Hospital-based physicians such as radiologists, anesthesiologists, pathologists, hospitalists are not usually specifically chosen by your employees to provide care, but are assigned based on hospital schedules.

The benefits to you and your employees of using participating physicians:

- Negotiated fee arrangements with network physicians keep health care affordable for employers and employees
- Physician tools to support the practice of evidence-based medicine – report cards on practice patterns
- An improved health care experience
- Financial responsibility is limited to copays and minimal out of pocket expenses
- Direct reimbursement of claims to the physician

We believe this change will reinforce the value of our contracted network, promote quality care and will impact only those employees using non-network physicians. Reimbursement to the employee for non-network hospital-based physicians will be tested in targeted markets before implementing nationwide. We recognize that this change may cause some concerns for you and your employees. We are committed to working with you to resolve any issues that you may encounter.

If you have any questions, please feel free to contact me at 314-592-7393.

Sincerely,

David Milich
Vice President
Key Account Sales and Account Management

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, N.W.
Washington, D.C.

Friday, September 10, 2004

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
JOHN M. BERTKO
FRANCIS J. CROSSON, M.D.
AUTRY O.V. DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
CAROL RAPHAEL
WILLIAM J. SCANLON, Ph.D.
DAVID A. SMITH
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Mandated report on specialty hospital (Legal overview, description of specialty hospitals, site visits, markets, payer mix)
-- Ariel Winter, Carol Carter, Jeff Stensland

MR. HACKBARTH: Good morning. First on our agenda this morning is the mandated report on the specialty hospitals.

MR. WINTER: Good morning.

The Medicare Modernization Act requires us to study the issue of physician-owned specialty hospitals. The report is due in March of next year.

Specifically, we're required to compare costs of care of physician-owned specialty hospitals to community full service hospitals, compare the extent to which type of hospital treats patients in specific DRGs, compare the mix of payers for each type of hospital, analyze the financial impact of specialty hospitals on community hospitals, and finally examine whether the inpatient prospective payment system should be revised to better reflect the cost of care. Today's presentation will include four topics. I will provide an overview of the federal laws governing physician investment in the hospitals and other facilities and also discuss strategies used to align physician and hospital financial incentives. Carol will then describe the characteristics of physician-owned specialty hospitals and the markets in which they are located. Jeff will present preliminary data from our analysis of payer mix. And finally, Carol will discuss the findings from our site visits to three markets with specialty hospitals.

Our discussion of the legal restrictions on physician investment in health care facilities is based on research conducted by Kevin McAnaney for MedPAC and I want to thank him for his excellent work.

This topic is important because the context for our report is the Medicare Modernization Act's moratorium on physician investment in new specialty hospitals.

In addition, these laws relate to other services the Commission has examined, such as outpatient imaging.

First, we'll look at the arguments put forth by critics and supporters of physician ownership of health care providers. We will then discuss the major federal laws in this area, the anti-kickback statute and the Stark law. Finally, we'll review strategies used by hospitals to align their financial incentives with those of physicians and how these approaches are constrained by federal laws. Some of these approaches are relevant to the specialty hospital issue.

Supporters of physician ownership contend that physicians are a valuable source of capital for health care facilities. They also argue that physician investments can improve quality, efficiency and access to care. For example, physicians with a financial stake in an ambulatory surgical center or hospital may have a greater incentive to streamline operations.

On the other side, there are generally three rationales for restricting physician investment in facilities to which they refer patients. First, several studies by GAO, the OIG and other researchers have found that physicians with a financial interest in ancillary equipment and facilities have higher referral rates for those services than other physicians.

Second, there is a concern that physician ownership could improperly influence professional judgment. Ownership creates a financial incentive to refer patients to the facility owned by the physician which may or may not be best for the patient. There could also be incentives to refer patients for too many services and to economize on care in ways that reduce quality.

The third concern is that physician investment could create an unlevel playing field between facilities. Physician-owned providers could have a competitive advantage over other facilities because physicians influence where patients receive care.

The anti-kickback statute was enacted in 1972 and has been amended several times since. It prohibits offering or receiving anything of value to induce the referral of patients for services covered by federal health programs. Violators can be subject to criminal penalties, civil monetary penalties, and exclusion from the Medicare and Medicaid programs.

The statute applies to all types of services and entities but it requires proof that there was knowing and willful intent to violate the law. It is enforced on a case-by-case basis, which limits its deterrent effect.

In the late 1980s, the OIG attempted to apply the statute to physician investments and ancillary facilities to which they refer patients. The OIG's position is that some of the companies organizing these joint ventures are, in effect, buying physician referrals by offering the physicians high returns on modest investments with little financial risk.

However, the OIG has been largely unsuccessful at using the statute to restrict physician joint ventures. Such cases are resource intensive, time consuming and face a high burden of proof.

These limitations led to the Stark law, which is focused exclusively on financial arrangements between physicians and facilities to which they refer patients. The Stark law prohibits physicians from referring Medicare and Medicaid patients for certain services to a provider with which the physician has a financial relationship. Violators can be subject to denial of claims, civil monetary penalties and exclusion from the Medicare and Medicaid programs, but not criminal penalties.

The Stark law goes beyond the anti-kickback statute by prohibiting many types of financial arrangements between physicians and entities to which they refer patients regardless of any intent to influence referrals. Unlike anti-kickback, the Stark law applies to a clearly defined set of services.

The original Stark law applied only to clinical labs but amendments to the Stark law known as Stark II extended this prohibition to several other services, which are all listed on the slide. The Stark laws generally prohibit physician ownership of facilities that provide these services. Compensation

arrangements between physicians and facilities are usually allowed if the physicians are paid fair market value for their services.

The Stark law permits certain financial arrangements based on the belief that they are unlikely to lead to overuse of services. Here are some relevant examples. First, the law allows physicians to own ASCs as long as the ASC does not provide ancillary services. There's a perception that physician investment in ASCs where they perform services involves less risk of overuse because the physician receives a professional fee regardless of where he or she performs the service.

Physician who do procedures in ASCs that they own may also receive profits from the facility fees. However, these profits are probably only a small additional financial incentive.

In addition, the ASC could be viewed as an extension of the physician's office practice and there's a principle that physicians should have autonomy over their work place.

Second, the in-office ancillary exception permits physicians to provide most ancillary services in their own offices. The logic is that there is often a need for quick turnaround time on diagnostic tests, although the exception also applies to other services such as physical therapy.

Third, the law protects physician investment in hospitals as long as the interest is in the whole hospital rather than a hospital subdivision. Because hospitals generally provide a wide range of services, the theory is that referrals by an individual physician would be unlikely to have a significant effect on overall profits.

The growth of physician-owned single specialty hospitals raises important questions. Because specialty hospitals derive their revenue from a limited range of services, is there a greater opportunity for individual physician investors to influence hospital profits which could affect their referrals? Or is physician ownership of a specialty hospital justified because the hospital may function as an extension of the physician's practice?

The MMA prohibited the development of new physician-owned specialty hospitals for a period of 18 months, ending in June 2005.

Finally, the Stark II final rule permits physician ownership of entities that provide equipment and services to facilities covered under Stark as long as the physicians don't own a facility that actually bills Medicare. For example, a physician could own an MRI machine and lease it to an imaging center for a fixed amount per use. Every time the physician refers a patient to the imaging center for an MRI, he or she receives a fee from the imaging center for the use of the equipment. This creates the same financial incentives as direct physician ownership of the imaging center.

So far we have focused on the physician perspective. Now we're going to look at strategies used by hospitals to align their financial incentives with those of physicians and the legal constraints on those activities.

One approach we've already talked about is offering physicians an ownership stake in the hospital. Aside from

specialty hospitals, there's broad protection under the Stark law for this type of arrangement. Other strategies include medical practice support, acquisition of physician practices, partnering with physicians and economic credentialing.

Medical practice support can include help with recruiting physicians, subsidized office space and low interest loans. These activities carry legal risk under Stark and anti-kickback if the support is provided for less than fair market value.

Another approach is to buy physician practices which provides the hospital with a source of patients. In theory, this vertical integration would also increase the hospital's bargaining power with health plans. The Stark law allows hospitals to control referrals made by employee physicians subject to the patient's own choice and insurance coverage and the physician's professional judgment.

This strategy carries legal risk if the hospital overcompensates employee physicians and there have been several expensive legal settlements in such cases. Many hospitals have found this model unprofitable and have divested their physician practices.

Another strategy is for hospitals to partner with physicians by co-investing in joint ventures such as ASCs and imaging centers or by creating gainsharing arrangements. In gainsharing, the hospital shares cost savings with physicians who cooperate in efforts to reduce costs. For example, the physicians may agree to use less expensive equipment and supplies.

However, the OIG has ruled that gainsharing violates a legal provision prohibiting hospitals from paying physicians to reduce services to Medicare patients. This provision was meant to prevent hospitals from providing financial incentives to physicians to discharge patients quicker and sicker under the inpatient prospective payment system. The OIG said that gainsharing has the potential to improve care and reduce costs but that they need statutory authority to regulate these arrangements.

Because of the potential to better align hospital and physician financial incentives, gainsharing may be a productive area for us to do further research.

Finally, economic credentialing is an approach in which hospitals restrict staff privileges for physicians who invest in or are employees of competitor facilities. This can take two forms. In some cases, the hospital prohibits its medical staff from having financial relationships with competitors. In others, the hospital requires its staff to admit a certain percent of their patients to the hospital. This strategy has recently attracted fierce opposition from physicians and has been challenged in several state courts.

Now we'll move on to Carol's presentation.

MS. CARTER: To conduct our study of specialty hospitals, we first had to define them. To meet our mandate, our first criteria is that the hospital has to be physician-owned. The law also specifically discussed hospitals primarily engaged in heart, orthopedic and surgical cases.

We developed a criterion of concentration based on Medicare data, since it is the only nationally available dataset. We

defined a specialty hospital has having 45 percent of its Medicare discharges in the heart or orthopedic MDC or were surgical cases. Or a hospital could have 66 percent of its cases in two of these categories. This is very consistent with the definition that GAO used on two of its studies last year. They used 66 percent of its cases in two MDCs.

To include the hospitals in our study and to make sure that each hospital had enough cases to analyze, we included every hospital that had at least 25 Medicare discharges in 2002. This is also consistent with what GAO did. where they included 20 cases for every hospital. The GAO study also included hospitals that were not physician-owned and also included women's hospitals.

Using these criteria, we found 48 hospitals that met our criteria: 12 of them were heart, 25 were orthopedic and 11 were surgical. We know that there's been rapid growth in specialty hospitals and there are an equal number of hospitals that have formed a since 2002. But because we didn't have data on them, we could not study them.

Our mandate also required that we compare specialty hospitals to community hospitals. Our first comparison group was any community hospital in the same market. Here we used the Dartmouth Hospital referral regions as our definition of hospitals.

We also developed two other comparison groups. First, we looked at hospitals that were identical to specialty hospitals in terms of concentration but were not physician-owned. We called them peer hospitals. Peer hospitals do not have to be in the same market as specialty hospitals.

A second category included hospitals that were located in the same market as specialty hospitals and provided similar services as specialty hospitals, and we called these competitors.

We first looked at ownership characteristics. All specialty hospitals were for-profit compared with 17 percent of PPS hospitals. Twenty-three percent are partly owned by another hospital. A larger proportion of surgical hospitals were owned by another hospital, compared with heart and orthopedic hospitals.

Forty-three percent of specialty house are part of a chain and this is comparable to the share in all PPS hospitals. A larger proportion of heart hospitals are part of a chain than orthopedic and surgical hospitals.

On average, 60 percent of the hospital is owned by its physicians but this ranged from 18 percent to the entire hospital. Surgical hospitals had the highest share owned by their physicians, averaging 73 percent, compared with heart hospitals where only 35 percent of them were owned by their physicians.

The median share owned by a single physician is 4 percent. There was a large range in the individual shares owned. At a third of the hospitals, the largest share was 2 percent or less. And yet at 20 percent of the hospitals the largest share was 15 percent or more.

More heart hospitals had smaller shares owned by a single

physician.

Looking at location, we found that the specialty hospitals are not evenly distributed across the country. Ninety-four percent are located in states without certificate of need. Specialty hospitals are concentrated in certain states. We found 59 percent were located in just four states: Kansas, Oklahoma, South Dakota and Texas. Some of these state have much larger shares of specialty hospitals than they do of PPS hospitals. For example, South Dakota has less than 1 percent of PPS hospitals but has 16 percent of specialty hospitals. Kansas has 2 percent of PPS hospitals but 12 percent of specialty hospitals.

We've noted that newly formed specialty hospitals that are not part of this analysis also tend to be located in the same states and often in the same markets.

Licensure laws may facilitate where hospitals locate. Some states, such as Kansas and South Dakota, have two categories of hospital licenses. There specialty hospitals do not have to offer a full array of services to be licensed as a hospital. Other states preclude their development, such as Florida. And not all states require emergency rooms or emergency departments.

When we looked at the characteristics of the hospital locations, we found that specialty hospitals tended to be located in mid-sized MSAs that have larger population growth, a lower proportion of elderly, lower managed care penetration, and similar poverty and per capital incomes.

Their MSAs also tend to have fewer beds and fewer surgical specialists per capita. And there was a little bit of variation by the type of specialty hospital market. Heart hospital MSAs tend to locate in high managed care penetration areas and do not have low surgical specialists per capita.

The beneficiaries in MSAs with and without specialty hospitals had comparable health status and service use.

Turning to hospital characteristics, the first thing to note is that specialty hospitals are small. The average heart hospital has 52 beds. The average orthopedic and surgical hospital has about 15.

Two-thirds of Medicare cases are treated in specialty hospitals that are heart hospitals. Once specialty hospital is a teaching hospital and about six receive disproportionate share payments.

About half the specialty hospitals have an emergency department but there is considerable variation across the different types of specialty hospitals. Two-thirds of heart hospitals have an emergency department but only one of the surgical hospitals did.

Regarding their staffing, all of the heart hospitals staff their emergency departments with physicians night and day, compared with only one orthopedic hospital and no surgical hospital. At these other specialty hospitals, they use a mix of physicians in the hospital and on call.

When we looked at the mix of patients treated at specialty hospitals, we see quite a bit of concentration. Heart hospitals are more focused on heart care and within heart care the specialty hospitals were more focused on surgeries and procedures.

At heart hospitals, 66 percent of their heart cases are surgical compared with 40 percent at their competitors and 29 percent at community hospitals. Thirty-three percent of specialty hospitals are medical cases compared with 71 percent at community hospitals. Over one-third of the cases at heart hospitals are coronary artery bypass grafts and angioplasties compared with 19 percent at competitors and 14 percent at community hospitals.

Looking at specialty hospital market shares, we found that specialty hospitals account for a much larger share of the surgeries and procedures done in their markets than their overall market share. For example, heart hospitals treated 4.5 percent of the cases in their markets but performed over a quarter of the local angioplasties and CABGs.

Given their smaller size, orthopedic and surgical hospitals play a smaller role in their markets. But even here, they treat a much larger share of the orthopedic cases in their markets compared to their overall market share. For example, they treated 1 percent of their market cases but almost 5 percent of the orthopedic surgery cases.

DR. REISCHAUER: Excuse me, Carol. Are these Medicare-only numbers?

MS. CARTER: Yes, they are.

Now, Jeff's going to talk about payer mix.

DR. STENSLAND: The Medicare Modernization Act requires that MedPAC compare the payer mix of physician-owned specialty hospitals to full-service community hospitals. We also compare physician-owned specialty hospitals to the set of peer hospitals that Carol described earlier.

First, we'll look at why would payer mix differ and then we'll take a look at the data.

The payer mix of physician-owned specialty hospitals may differ from the community hospitals for several reasons. First, starting at the upper left-hand corner of this slide, we have patient selection. Community hospitals frequently assert that physicians have a financial incentive to send profitable patients to their hospital and unprofitable patients to the community hospital.

Second, we have types of services offered. For example, if the specialty hospital does not offer obstetric services, it may have a lower than average share of Medicaid patients.

Third, emergency room services. If a hospital does not have a staffed ER, it may receive fewer indigent patients.

Fourth, there's simply the geographic location of the hospital.

And fifth, community hospitals may try to freeze out physician-owned hospitals from private payer contracts. If a community hospital is successful in obtaining an exclusive preferred provider contract with a large insurer, the specialty hospital may have difficulty attracting patients with that type of private insurance.

Now let's take a look at the data. First, we examine cost report data on hospital discharges. The table shows that physician-owned heart and orthopedic hospitals tend to have lower Medicaid shares than community hospitals in the same markets.

Heart hospitals tend to have a high share of Medicare patients while orthopedic hospitals tend to have an average share of Medicare patients.

There are couple of limitations in the cost report data. First, Medicare cost reports don't have data on self-pay patients. They are lumped together with privately insured patients in that all other category of patients you see on the right-hand side of the slide.

Second, the differences we see in Medicaid shares may be just due the types of services provided by the hospital. To address these limitations, we conducted a survey of 134 hospitals that met our criteria for being either a physician-owned specialty hospital or a peer hospital. Using survey data, we compare physician-owned specialty hospitals to peer hospitals that focus on a similar set of services.

This slide differs from the prior table in several ways. First, we're using survey data. The hospitals are self-reporting their fields of clinical specialization and self-reporting their payer mix. Second, we are measuring payer mix by examining net patient revenue rather than discharges. Third, we're focusing just on heart hospitals on this slide.

We find that physician-owned heart hospitals tend to have lower Medicaid shares than peer heart hospitals. This holds true for physician-owned hospitals with an ER and those without an ER. We do not see big differences in the revenue from self-pay patients.

Of course, hospitals may have a small share of net patient revenue from self-pay patients either due to treating few self-pay patients or due to collecting little from the self-pay patients they treat.

Now, we'll turn to the orthopedic and surgical hospitals.

From this table, we see that physician-owned orthopedic and surgical hospitals tend to have lower levels of Medicaid revenue than their peers who describe themselves as orthopedic or surgical hospitals. However, we should caution that there's a high level of variance in the Medicaid shares for peer, orthopedic and surgical hospitals. A few nonprofit orthopedic and surgical hospitals have very high Medicaid shares but many peer hospitals have Medicaid shares of 3 percent or less. The 9 percent Medicaid share shown on the slide for peer hospitals is the mean value for this highly variable group.

Orthopedic and surgical hospitals tend to receive a majority of their revenue from patients with private insurance. Physician-owned peer hospitals often have similar levels of net revenue from self-pay patients.

To summarize our payer mix findings, first physician-owned specialty hospitals tend to have lower Medicaid shares than both community hospitals in their market and peer hospitals that provide similar services. However, it should be noted that there's a wide variance in the Medicaid shares among peer, orthopedic and surgical hospitals. Heart hospitals tend to have high Medicare shares. Orthopedic and surgical hospitals tend to have high shares of patients with private insurance.

These findings are consistent with earlier work by the GAO and consistent with what we found on site visits to communities

with physician-owned hospitals.

Carol will now talk about those site visits.

MS. CARTER: As part of our study, we conducted site visits to three markets with specialty hospitals to hear from stakeholders about the issues surrounding specialty hospitals and about the impact specialty hospitals have had on community hospitals. We visited Austin, Wichita and Manhattan, Kansas, and Sioux Falls, South Dakota.

We picked our sites to be geographically diverse, represent a mix of types of specialty hospitals within a single site, and include hospitals that had been around long enough to hear about the impacts on community hospitals.

Each of our sites included a heart hospital because even though they represent only one-quarter of specialty hospitals, they treat two-thirds of the Medicare cases seen at specialty hospitals.

At each site we spoke with a mix of physicians, some practiced at both types of facilities, some only at community hospitals. We talked with hospital CEOs, CFOs, and in markets where the specialty hospitals had emergency rooms, the city's director of emergency medical services.

The hospitals were generous with their time in preparing materials for us and in making people available to us during our visits.

I'd like to emphasize here that what we're reporting here is what physicians and the hospital personnel told us, much of which we could not verify. There were large discrepancies in what we heard. Some of the issues, such as case selection, will be examined in detail later in other analysis and we'll present it later this fall.

The physicians we spoke with told us they set up specialty hospitals for two reasons: governance and opportunities to increase their income. The most frequently mentioned reason was governance. Physicians wanted to control decisions made about the patient care areas of the hospitals so they could improve their productivity, improve the quality of care provided and make the hospital more convenient to them and their patients.

At hospitals that had started at ASCs, the facilities worked so well they wanted to expand their practices into patient care areas that required overnight stays.

We repeatedly heard about the frustrations physicians had with community hospitals. Many physicians said they tried to work with the community hospitals but that decision making took too long and did not support their practices. Some physicians acknowledged that community hospitals had multiple priorities, which the appreciated but did not want to compete with.

Many community hospital administrators acknowledged they had been slow to react to the issues raised by their physicians. Less frequently we heard about physicians wanting to generate more revenue to counter perceived declines in their incomes.

Specialty hospitals created three kinds of opportunities for physicians. The first is increased throughput. They can treat more cases in a given amount of time. For investors, most older facilities pay out annual dividends, frequently in excess of 20 percent. The third is they can capture the facility portion of

payments.

There was considerable variation in how important governance versus ownership was to physician involvement. Several physician investors we spoke with said that ownership had not been key to their decision and they would have been content to have the community hospitals address their concerns.

The first order of business in developing a specialty hospital is to secure a core set of admitters. Usually, at the hospitals we visited, the key admitters were owners. Physicians typically sought financing for 70 to 80 percent of the cost of the hospitals. Banks often wanted to see evidence of physician commitment in the form of physician investment before loans were made. Rather than find all of the equity themselves, physicians often turned to outside investors. Particularly at the start of facilities, physicians wanted to minimize their risk and outside investors -- often non-physicians, sometimes a national chain and sometimes a local hospital were sought. More often the investors were local business people.

In these cases, physicians made small investments, typically on the order of $25,000 to $50,000. When owners sell their shares, for example when they retire from practice, the shares are generally sold to other physicians. A couple facilities noted they expected their physician investors to bring at least some of their volume to the specialty hospital.

The specialty hospitals we visited usually required their physicians to have privileges at a community hospital. As a result, physicians could admit certain types of cases to one hospital and other cases to another. Physicians practicing at most specialty hospitals accept restrictions on the range of supplies, stents, implant devices, restrictions physicians told us they had resisted when they practiced at the community hospital.

Many of the specialty hospitals we visited did not have emergency rooms, which increases their control over admissions. But even having an emergency room didn't mean the hospital was ready to treat emergencies. At one hospital we visited, it had to turn on the lights of its emergency room to show us the space.

However, at two of the four heart hospitals we visited had emergency rooms and were fully staffed day and night. They accepted cardiac and non-cardiac cases. Another heart hospital we visited is planning to open an emergency room.

Many physicians practicing at orthopedic and surgical specialty hospitals acknowledge that they selected patients who were appropriate for their facility. Some couch selection in terms of specialization and service offerings. The specialty hospital didn't have certain services so the physician couldn't responsibly admit patients who might need them.

Physicians practicing at heart hospitals more frequently disagreed about patient selection. Some said they admitted medically complex cases to community hospitals. Others said they didn't selectively admit cases to one type of hospital or another.

Data from one heart hospital chain indicated that fewer of its patients were classified into the highest severity patient

groups compared with community hospitals.

There was a lot of disagreement about transfers. Community hospitals complained about two types of transfers: cases that were stabilized and then transferred to the specialty hospital where physicians had an ownership share for the procedure or surgery. And the second type were cases where the course of care didn't go well and the case was transferred to a community hospital. Data from one community hospital showed that one-third of its transfers from specialty hospitals died.

Specialty hospitals uniformly denied selecting cases based on payer mix but the specialty hospitals we visited had much lower Medicaid shares and provided less uncompensated care. One physician told us the specialty hospital had used the lack of uninsured patients as a marketing pitch to him.

Some selection may be a function of the referral base of the physicians. The specialty hospital may take all comers, but their referring physicians don't.

Service mix may be another explanation. For example, hospitals that don't have obstetric services or an ER will have a different mix of payers.

Turning to the impact of specialty hospitals on community hospitals, many site visit community hospitals reported large initial declines in volume associated with specific physicians who had moved their practices to specialty hospitals but that overall volume declined only slightly and mostly had recovered.

Surgical and orthopedic specialty hospitals had much more varying impacts, depending on the size of the community and the number of other hospitals in it. The replacement volume was reported to be less profitable. Most of the hospitals remained profitable.

In rural markets, volume declines were much more difficult for the community hospitals to rebuild. It was harder for them to recruit physicians and it was unclear if the community hospitals would fully recovered.

But community hospitals told us that rebuilding their volume was costly. The costs associated with physicians included signing bonuses, income guarantees and on-call pay, particularly we heard about for neurosurgeons and less frequently orthopedists. The costs associated with staff included retention bonuses for key staff members and offering raises to staff working the less desirable shifts.

All hospitals we spoke with talked about the hiring away of experienced staff, most often nurses but also pharmacists, radiation technologists and nurse anesthetists who were attracted by the better hours. Replacement nurses at community hospitals were typically recent graduates with much less experience.

Some community hospitals also added new operating rooms or new cath labs as inducements for their physicians.

Some community hospital administrators told us that the development of a community hospital in their market was like getting a wake-up call to make improvements. The community hospitals we visited responded to the pressure of specialty hospitals by improving their own performance. We heard numerous examples that included extending service hours of the operating room, improving the operating room scheduling and turnaround

times, and upgrading their equipment. But community hospitals told us there were limits to the improvements they could make in their efficiency given the wider range and more complex mix of patients that they treat.

Some community hospitals talked about the impact of specialty hospitals on the market's health care resources. For example, in Wichita, specialty hospitals had added 13 operating rooms and 130 beds. In Austin specialty hospitals had added 13 operating rooms and 89 inpatient beds. It was unclear if the added capacity is meeting unmet need or resulting in induced demand.

Some community hospital physicians raised concerns that physician investors were making medical decisions based on economic considerations, treating marginal cases where indications were less clear and perhaps performing surgery instead of pursuing a medical alternative.

Hospital relations with private payers varied widely across the markets we visited. Some specialty hospitals had been excluded from some private payer plans but this was unusual. Lower cost at some specialty hospitals had resulted in lower private plan payment rates. One payer noted that even though some of its per-service payments were lower, its total hospital spending could be increasing due to higher utilization.

We did not hear consistent differences between the quality of care provided at community and specialty hospitals. Some thought that because the same physicians practiced at both types of hospitals, often using the same protocols, that the technical quality would be similar. Some physicians practicing at specialty hospital thought the quality was higher at specialty hospitals where the nursing ratios were higher. Lower complication, infection and mortality rates at some specialty hospitals could reflect measured and unmeasured differences in the mix of patients they treat.

Physicians at community hospitals told us that the lack of diversity in a medical specialties practicing at specialty hospitals would weaken their peer review.

We heard about three types of retaliatory activities community hospitals had engaged in. One community hospital had adopted economic credentialing barring its physicians from investing in specialty hospitals and others were considering it. One hospital had included non-compete clauses in its contracts with its physician employees. One community hospital had removed all investor physicians from its ER rotation for unassigned cases, thereby taking away volume from them.

In conclusion, though there were distinct differences across specialty hospitals, there were common themes. Specialty hospitals appear to increase physician productivity and present revenue opportunities for physicians. They represent an attractive alternative for patients and their families. And they often stimulated community hospitals to make changes that would make their operations more efficient.

But there were concerns raised. First, there was evidence of patient selection, both in terms of the complexity and the payer mix of the patients treated at specialty hospitals. Some of the transfers raised concerns about the quality of care

provided by some specialty hospitals.

And finally, it was unclear if the expansion of capacity would increase service provision and, if it did, whether this would represent meeting unmet need or inducing demand.

MR. HACKBARTH: Thank you. Very well done.

This is the first of a series of presentations that we will receive on this issue over the next couple of months. I thought it would be helpful for the Commissioners just for Mark to outline what's to come so you understand where we're going from here.

DR. MILLER: I may miss a couple, but we've been asked to think about the payment system issues. And so we are doing work and will be bringing work to you on trying to look at the profitability of DRGs.

A way to think about this is many of the same issues that were just implicated in the site visit we're going to be trying to look empirically. So the profitability of DRGs, the selection issues between specialty hospitals and community hospitals, and whether more lesser severe patients. Trying to quantify more precisely the impacts on community hospitals.

Also, ideally we would look at differences in the quality of care but I want to be very tentative on that because our ability to do that with these small ends is going to be relatively limited.

Did I miss any of the big ones?

DR. STENSLAND: Cost differences.

DR. MILLER: Right. I lumped that into the community hospital impacts and looking across the two different facilities, relative cost, that type of thing.

DR. STENSLAND: And utilization.

MS. DePARLE: Did you guys look at anything about readmission from specialty hospitals to community hospitals? Are there impacts that you would expect to see there?

MS. CARTER: We did not look at that but if it's an area, if we were to do quality analysis, that would be one of the things we would look at.

DR. NELSON: A question, I presume that they are all Joint Commission accredited. Either that or else state certified, HCFA or CMS. That might be one area where some quality data might be obtained, from the Joint Commission.

I presume that you are, in terms of volume and utilization, are you looking at the small area variations and correlating the presence or absence of specialty hospitals with the volume of services within those areas?

DR. STENSLAND: We're planning to look at larger areas actually. One of the things we might look at is referral regions for cardiac care and look at utilization before the introduction of the heart hospitals and then after the introduction of the heart hospitals, to look at that rate of change in utilization. And if that rate of change differs from other referral regions that didn't have the introduction of heart hospitals.

DR. WAKEFIELD: Your definition of rural hospitals, are you using MSA/non-MSA? And I assume these are all PPS? Even though the bed sizes are small, they're all PPS? We don't have any CAH hospitals in this mix, do we? They're all PPS hospitals?

MS. CARTER: That's right.

DR. WAKEFIELD: Your comment about rural community hospital volumes, the sense that they're more difficult and having greater difficulty than their urban counterparts to rebuild volume, just a question thinking about a little bit of the threat potentially to the financial bottom line of some of the small smaller rural community hospitals and how that might over time affect access to services.

I know we're talking about a really small end when we're looking at the subcategory rural specialty hospitals, but can you tell me whether or not those rural specialty hospitals that you're looking at generally tend to have emergency rooms or don't? Do you know? The ones you looked at, the rural category?

MS. CARTER: They tend not to, the specialty hospitals.

DR. WAKEFIELD: Specialty hospitals in rural community tend not to?

MS. CARTER: Right.

DR. STENSLAND: In terms of ERs, almost all the staff ERs were at heart hospitals and I think there was only one in our sample of a non-heart hospital that had a fully staffed ER, where they would staff it with a physician 24 hours a day. And heart hospitals are usually in bigger markets because that's specialized. I mean, you can't have a heart hospital in a real small town.

DR. CROSSON: As I've thought about this, it seems to me that we have at least two compelling issues to look at. One of them is the impact of specialty hospitals, whether they're physician-owned or not, on the community hospitals. I think the issue there is that more or less community hospitals are viewed as a public resource, at least in some communities. And with respect to the needs of beneficiaries, damaging those would create a problem of access and potentially a problem of quality. I guess we're going to get into that issue later.

I think the second issue has to do with the potential for conflict of interest for owning and referring physicians, so I'd like to spend a second on that. It struck me that in reading the material that the advent of physician-owned specialty hospitals, particularly ones that are good deal smaller than community hospitals, seems to violate the idea of the whole hospital exception in the sense that -- you know, I wasn't there at the time. But my sense of that is that the whole hospital exception was placed there because it has something that might be called a principal of dilution.

That is that because the whole hospital takes care of lots of different kinds of patients and there's all different kinds of physicians admitting patients there that the likelihood that any one individual physician in a large general hospital is going to significantly gain by referral patterns and the impact of those on the profitability or lack thereof of the hospital is fairly small.

But that seems to have changed, at least based on the analysis that we had, where we have hospitals that have a census of 10, 20 or 30 patients and physicians who own up to 15 percent of the hospital. It seems like a different set of questions.

So when you think it through and say well, what might be a solution to this if that's the direction we're going in, one might be to try to return to some sort of balance that corresponds to the thinking of the whole hospital exception. At least as I think that through, it suggests something like limiting degree of ownership or potential profit that any individual physician could receive from ownership of one of these hospitals.

I would be interested in, as we get into this further, is to see if we could rough that out. And that would be what percentage of ownership of the average physician specialty hospital, based on what we know about the profitability of those hospitals, would have what impact on the annual income of the average physician? I realize that there's a lot of modifiers there.

And yet, this is not an unknown dilemma in medicine, which is how to balance the impact of finances on the professional judgment of physicians and other professionals. I think it's a human fact that judgment is more likely to be influenced by the potential to gain $1 million than it is by the potential to gain $5,000, at least for someone who's already making a substantial amount of money.

And I just would offer that we might take a look at that.

MR. HACKBARTH: Let me just pick up on your initial framing of the issue. I think of it coming in three basic parts. One is their effectiveness on professional judgment of physicians.

A second, as you said, is the impact on community hospitals and their ability to provide services to the public that may not be completely funded, adequately funded through other means, means other than cross-subsidies.

And then the third that I would include is the accuracy of payment. Is the way that we're paying for patients creating opportunities for selection of certain types of patients and then exceptionally large profits on those patients?

Those are the three big issue categories that I see here.

DR. MILSTEIN: I think that our being able to make a strong recommendation in this area is going to very much hinge on the quality of the underlying analysis. And I'm also respectful of the fact that we have limited time to complete that analysis. So my comments are really directed at some of my thoughts on what the analysis might, at a minimum, want to include if we're going to have maximum confidence in our recommendation.

I think of there being three major categories of potential impact of this new life form, one being impact on appropriateness. We have bases in this country for judging appropriateness. It's not particularly sensitive but the American Heart Association and American College of Cardiology have given us a three-part classification system. I don't know how feasible it's going to be to see if we can piggyback on research already underway or otherwise be able to get a sense of what the distribution is in specialty hospitals serving heart patients versus community hospitals on the distribution of cases across the three AHA ACC categories.

The second area of potential performance impact would be cost efficiency. That is, assuming that the treatment made sense

to begin with, are these specialty hospitals more cost efficient, either using charges per stay or charges per stay -- as Nancy was inferring -- to some kind of downstream longitudinal notion analogous to what Jack Wennberg has shown light on.

To the degree possible, it would be great if our cost efficiency analysis, irrespective of what longitudinal time frame we use to denominate it, could do everything we can to ensure that it includes a trued up analysis for cost of teaching, research -- obviously both efficiently provided as we previously discussed -- indigent and underinsured care, truing up for that difference. And also for what we believe to be the cost of the standby capacity associated with having to accept transfers in when patients don't do well and need to be handled by community hospitals.

And then last is this question of patient outcome. Are we pursuing opportunities to partner with the American College of Cardiology or the Society for Thoracic Surgeons, both of which maintain the only really good quality risk adjusted outcomes database, at least for heart care.

I know that at least some of the specialty hospitals that I've interacted with do participate in those programs and they do the best that science can now do for us in terms of a good risk adjusted comparison of outcomes for two of the primary procedures being done at least in heart hospitals, being bypass graft and various PCI procedures.

So we have limited time, limited budget, but I think our confidence we would have in our recommendation will very much hinge on the quality of our analysis.

MR. MULLER: Let me also commend the three of you and the rest behind you who did all this work. I think it's very well done and I look forward to the work that Mark indicated is to come.

Some of my comments really have been anticipated by what Jay and Glenn and Arnie had said.

But I think the thesis as to why is it in heart? Why is it orthopedics needs to be tested a little bit more. Why don't we have a lot of birthing hospitals? Why don't we have neurosurgical hospitals? One can surmise that perhaps in neurosurgical cases there just aren't enough to create a hospital.

Why don't we have breast cancer or prostate cancer hospitals? My sense is some of it has to do with volume and some of it has to do with the thesis of where the payment system may be skewed and therefore we should look at that.

But if you look at societal need, if you did it on the basis of need, one might think that there are other kinds of specialty hospitals that come forth if we look at societal need and they may be more linked to payment system than it is to need.

So I think we need to look at some other specialty areas and see whether there's something in the payment system and so forth that doesn't cause them to come forth.

I'm not going to repeat the necessity of getting the outcome and margin data, which I think is very important in this, so I look forward to that coming forth.

I do think we have to, and we've discussed at other times in

other settings how well the DRG recalibration goes on some kind of basis. But since at least the number of these hospitals, more from what your analysis indicates on the orthopedic side than on the heart side, have a lot of private payers where the charge system -- which we'll be talking about later -- may have some effect on the margins.

My sense is that if the charges are higher in certain areas within a year or two, the DRGs should be recalibrated to take that into account. But there seems to be something going on that over the years -- I mean heart hospitals and heart services with general hospitals have been more profitable than other services for probably 10 years or 20 years, since 1983 and so forth.

So there's something going on here where recalibration doesn't work quite as well. I'm not quite sure what it is and whether, Glenn and Mark, you want to do that inside this study or elsewhere. I think it's something we have to keep looking at because there does seem to be consistency over a period of years in certain services being more profitable and other services being less so, even inside the Medicare system let alone inside the private payment system.

So to sum it up, I think Jay's points about looking at the effects on the community is something we should look at. Certainly if there's any way of trying to capture those standby costs that general hospitals or community hospitals have to sustain that are not captured in hospitals that don't have ERs - I mean, you don't want to judge off anecdotes but certainly if you have to turn the lights on in an ER, then the marginal costs of running that ER have to be pretty low.

Therefore, the staffing may not -- my guess is there weren't staff standing there in the dark. So they probably didn't have a lot of staffing costs in that ER.

So I think looking at those kind, whether there's some kind of way of capturing what the general standby costs are of these community hospitals vis-à-vis the specialty hospitals. The drive toward specialization, not just in specialty hospitals but one can see it in imaging centers and labs, et cetera, and so forth, is not going away. And given that is by and large where our economy develops, there's no reason to think that even if there's some changes along the lines that may or may not come out of Jay's comments in terms of what kind of limitations we put on these, the drive towards specialization is going to continue.

So thinking about what the advantages are of specialization vis-à-vis the general role of community or facilities and what they can do in general for the needs of the public that Medicare serves, I think is an important thing for us to keep looking at because, in fact -- once you undermine that general capacity it takes an awful long time to bring it back.

So the whole sense of what we get out of specialization versus the costs of it, whether this is the right time to take that on. But I think that's a theme we have to keep going on, not just in specialty hospitals. Because at this moment we don't have whole imaging hospitals. They still tend to be imaging centers. But based on the work we did a year two ago, we know that's one of the biggest proliferating areas within Medicare. I think we had growth rates about 14 or 15 percent in imaging. So

one could conceive that three or four or five years down the road that we have whole imaging hospitals. There's reasons to think they're not 12 months away but one could see this happening, as well.

So again, looking at the community hospital costs, vis-à-vis the specialty hospital costs, looking at the margin outcome data, looking at, looking at the DRG recalibration system I think is very important to see why after 20 years we still have some services continuing to be making more margin.

And then any thinking we have about why there's some services that are very much needed by communities. Around the country right now, due to malpractice crises and other issues, the availability of OB services is being restricted. If there's a community for OB services, why don't we have birthing hospitals being created to meet that need?

MR. SMITH: Much of what I wanted to say has been said by Ralph and Arnie and Jay. So let me just try to dig in on a couple of those points.

Glenn, I thought your three-part distinction was right, the professional judgment/community impact/payment accuracy. I want to pick up on something Jay said, sort of linking the question of how this economic arrangement works out to the question of community impact. It's important to understand that the impact on community hospitals is going to be the same whether or not the competing local heart hospital is investor-owned or physician-owned or some mix. And I suspect that the normal financial transaction here is investor initiated and who recruit physicians rather than, as was adjusted in the slides, the other way around.

So as we look at community impacts, I want to make sure that we look at the impact of specialty hospitals, the kinds of broad specialization questions that Ralph was raising, not simply the impact on community hospitals, the ones where physicians are part of the ownership mix. And concentrate on the physician side on the impacts on professional judgment.

The standby capacity. we should remember, there are two pieces of this. In the report from the site visits, Carol told us both that community hospitals had become more efficient, had invested more and had improved their general performance, and that they had also shut down some services. We need to think about how those things interact.

And it's partly a function of just reduced income because payment is flowing to new competitors. But it's also the question of whether or not you can then any longer afford to maintain a services or to keep it open. The community impact question is a complicated one.

And lastly Jay, I'd be a little concerned about thinking we can capture how much is corrupting and decide that the dividing line is 15 percent or 13 percent and that at 16 percent you're hopelessly underwater, for a couple of reasons. One, because I think it's very hard to do that. But second, because these financial arrangements are very complicated.

I could have as big a financial stake in my referral pattern because I owned a real estate investment trust that invested in a lot of hospital real estate without ever having an equity stake

in the actual operating hospital.

So I think it's awfully hard to say this much, both as a matter of sort of ethical analysis, but also the financial transactions I think bedevil this in ways that we ought to be careful not to think that we know more than we do.

MR. DeBUSK: As you know, the hospitals right now are going through a real increase in the number of uninsured patients that's showing up at the doors. And going forward, I think if we can get at some more recent data about the uninsured, that would be very important to look at in this report.

MR. BERTKO: I'd just liked to add a thought about one of Arnie's comments. Sometimes getting to quality and outcomes data can be very difficult. I'll point to, I think, the transfer comment on slide 30 to say maybe some of your analysis on the costs might be patient-based as opposed to admission or episode based. If you could link them together, that is if a patient starts in one facility and transfers to another, what's the overall average cost in say some of the site visits? I would hope that that might be a more practical approach in some cases.

MS. RAPHAEL: I was very interested in the concentration of specialty hospitals in four states, I think it is. I was wondering if we could learn more about what's happening in the states?

For example, can you tell us what led to Florida prohibiting specialty hospitals? And are there any studies that have been done at the state levels that have kind of informed some of the decisions whether to allow for licensing or to prohibit it?

MS. CARTER: I would have to get back to you on those. I know that a number of hospital associations are conducting their own studies of specialty hospitals, so I can look into that for you.

MR. DURENBERGER: First, I'd like to start, too, by complimenting the staff and not just for the presentation that's in front of us now, but the work at the retreat where everything was a little bit more relaxed and getting your consultant in. That was really, really helpful, Mark, in the way in which we were able to prepare for the subject, for me and I think for everybody else, laying the groundwork for this was really great.

Secondly, I want to acknowledge that every once in a while somebody leaves the policymaking arena who makes a significant contribution by doing something with looks negative, and that's John Breaux. I think about all the people that are going to be missed around that place, as the number of good folks dwindles. John is probably -- for those of us who had experience with him -- going to be missed the most.

He's the guy that contributed the moratorium, which I don't think he necessarily believes is the ultimate solution to the problem. But he made everybody stop in their tracks and say this is really an important issue.

And I want to endorse the comments of all of my colleagues about not just looking at this as fulfilling a mandate or something like that. But I think as you pointed out, Mr. Chairman, this covers a lot of the other work we're doing. And so I want to endorse your three categories. I think that's the best way to say it.

In the issue of conflicts of interest and physician judgment one of the most important judgments -- that's why I like Arnie's suggestion to work with ATS, working with AAOS, those kinds of people -- the connection between physician judgment, ownership and productivity is really very important. And how we define it, whether you define it as a Permanente, you define it as a Mayo, a Cleveland, whatever it is, there's something very, very important to all of us in terms of enhancing the quality of the work, the quality outcome, in having some kind of an interest, if you while, measured financially, measured profession and so forth, in that outcome.

So however we look at this so-called -- conflict of interest sounds like a negative connotation. It would be nice to flip it over and say there's a positive side to this, as well. And then, as we deal with the positive side of it, how do we guard against conflict of interest or something like that?

But there's a whole lot of issues that my colleagues have commented on that belong in there. But the importance of the connection between ownership and productivity, I think, is really critically important.

And then the other two that we've already commented on, that I simply want to endorse because of their importance, the whole issue of the pricing distortions. We already know, from our work, that we're overpaying hospital outpatient compared with ambulatory surgery centers. We'd love to know why. A lot of other people would love to know why.

But we're already doing that kind of work. So it seems like some of that work is incorporated in here. I haven't read Joe's book yet, but I'm looking forward to reading Joe Newhouse's book on this whole issue of price distortion because I think we're not going to solve it in this study but I think it's really critically important to look at that in the light of the other things we're doing. And that includes the efficiency analysis and stuff like that.

And the third one that's really hard to deal with but it needs to be referred to is the issue of cross-subsidies because that's the one that distinguishes one community from the other and it gets really very difficult, from a public policy standpoint, to deal with it.

And yet, if we're thinking about beneficiaries and we're thinking about high-quality care and we're thinking about how to get the best that medicine has to offer to everybody in every community, we do need to deal with that issue of cross-subsidies, as you pointed out. And in some way at least point policymakers to the failures in the current system that deal more appropriately with issues like uncompensated care and Medicaid payments and a variety of things like that.

So I basically just want to endorse the comments of my colleagues and the work of the staff so far.

MR. HACKBARTH: Just to pick up on your first point, it's difficult not to feel ambivalent about some of these issues. On the one hand, people are understandably concerned about compromising professional judgment through inappropriate financial incentives. But in many instances over the years, we've talked about the need or the potential for aligning the

incentives of physicians and hospitals to do good things for patients and improve the efficiency of the system.

So there is little that's black or white. The trick here is to find an appropriate blend and it's a very interesting problem, as well as a difficult one.

DR. WOLTER: Just an observation and pick up a little bit on something that Jay said earlier. I think one of the things that is happening is there is this blurring on between ASC, specialty hospital, and whole hospital. And as ASCs add overnight capacity, as ancillaries of one kind or another are added, specialty hospitals are of one size or another. Some do several service lines. Some are primarily one service line. And that really complicates, I think, this issue.

Which is why I think the core issue around self-referral and what Stark covers and what it doesn't cover really is one of the key things that we need to address.

I like Dave's suggestion that maybe there's a way to flip this and look at it positively. For example, in the Stark regulations there are the group practice exceptions where physician ownership is certainly allowed of some of these services but there are distinctions about how salaries are created directly related to the referral to certain service lines versus sort of how the organization as a whole performs.

So I think there are some distinctions that we may be able to get into that would help us as we move forward.

DR. SCANLON: I'd just like to make a short comment. I think that the prior comments have really revealed some of the complexity of what we're dealing with here. And I think, given our time frame, the ability to deal with many of them is going to be constrained.

Unfortunately, I want to add another issue to the table which is that the idea that we are talking about hospitals may be a misnomer in terms of how we characterize this issue because our hospital, in some respects, is a building concept. It's what goes on in a particular building. The entities that we're talking about may be something that's owned by a system, owned by a chain. And I think that totally changes the economics that is underlying the issue here.

If a community hospital chooses to do its cardiac surgery in another building that is independently certified, that's completely different than if an independent entity opens up and takes patients from that community hospital.

If we think about we're going to change rules with respect to referrals under Stark, how are we going to think about all of the permutations that may exist in terms of the kinds of arrangements that might exist?

Jay's idea of a threshold in terms of ownership, that may be an interesting avenue to pursue. But then again, when we're talking about a chain, how the threshold rules would be adapted to deal with that issue.

Given all of this, I think I comeback, Glenn, to your characterization and think that you really have hit on the three big areas. And at a minimum we maybe should be very intent in focusing on the question of the payment system and what is the payment system doing here? Is it, as Ralph indicated, failing in

terms of the recalibration effort? And that we need to be worried about what the consequences of that failure are in terms of creating incentives for the system to operate in one way or another.

I think that may be, at a first step, the most important piece of what we do.

MR. SMITH: Glenn, I was struck several times during this discussion but particularly at Dave's last comment about how seamlessly we have made a transition from a conversation we've often had about impact on Medicare beneficiaries to impact on the entire health care system at a community level. We've asked ourselves, and we are entering in this one in a significant way, to what extent should we think about Medicare's role in the health care system or simply Medicare's ability to provide high-quality services to its beneficiaries?

We haven't in this discussion, not a single one of us has confined ourselves to beneficiary or access issues. we've talked about much broader impacts. I think that's a step forward but it struck me as an important transition.

DR. CROSSON: Just a couple of last comments on the physician incentive issue, and I do agree with Dave that probably characterizing it as incentives or the appropriate balance of incentives is a better way to put it. Because that's really what it's about. It's really about trying to get incentives or trying to influence incentives in such a way that they're balanced, balanced between quality, professional judgment and the finances, the complex finances.

It is messy. There's no question about it. You're mixing up law, finance and human motivation. If we can only get rid of that last part it would be a lot easier, because once you get that in it is messy.

And I would say again that while that's true, yet other laws that we have heard summarized earlier have attempted to do that. So that as the Stark laws were put into place, people tried to wrestle with these issues and accepted some things and allowed other things. For example, the whole hospital exception. I believe that was done because folks looked at the likelihood of extraordinary incentives and decided that they were not present and therefore that should be allowed.

So even though that is messy I think nevertheless, to be responsible, those kinds of judgments need to be made when they can and when they're appropriate.

The last note is, having said all that, I think we did get a case presented by the staff that there were other reasons why physicians involve themselves in creating these hospitals, some of which were subsequently addressed by the community hospitals, others of which were not.

I would just say that while the incentive issue is a real one, there's a separate issue of physician governance. And as we work our way through this I think we should, if we can, consider those things differently because there may be a compelling reason in these hospitals to have physicians involved in governance in a major way. And yet, there may be reasons to separate that from ownership, if that's possible.

DR. REISCHAUER: Just a footnote on that point, and that is

to go back to Ralph's question which has why haven't these specialty hospitals sprung up in other specialties? Because certainly it isn't only the cardiologists that are upset with the management of the community hospital. And so I think we get, as you said, right back to the getting the payments right issue first. And then see what the ramifications of that are.

Just one comment on the community repercussions and how complex this is really going to be for us. Everybody is concerned that proliferation of specialty hospitals could reduce the social benefits that come from having a community facility. But the question we et into immediately is how much do you need of that?

We're often talking about communities with three full-service hospitals and the fact that one of them is having a huge problem because the heart and orthopedic business went somewhere else can be true for that hospital, but in a sense may not be true for the community as a whole because we don't know what that threshold level is of this social benefit that we want to preserve. And we want to preserve it for the community but also for the Medicare beneficiaries in everything else that they might do.

MR. HACKBARTH: I was struck also, Dave, by that seamless transition. And I think a complete analysis of this issue requires careful consideration of the community impact of this development.

On the other hand, there are huge issues in terms of how you finance those desirable public goods. At one extreme you finance them through cross-subsidization. You basically protect from competition. You allow the payment system to be inaccurate and people to reap large profits here to cross-subsidize social goods there.

The other end of the continuum is that you promote competition, especially competition that is quality enhancing and efficiency improving and then say if we want those public goods we pay for them directly.

I think one of the intriguing aspects of this issue is that it forces that discussion out into the center stage.

DR. NELSON: I think we have to recognize also, though, that the development of heart and orthopedic surgical techniques has come a long way in the past 10 years. There are people walking around with their knees done that we wouldn't have thought of that 10 years ago.

By the same token, the advancement in cardiovascular surgery, because of new technology and transfer of that technology, there is obviously an increased need for facilities to handle that.

You can't say the same thing about gastrectomy because that's gone the other way. And endoscopic surgery has changed the face of a lot of abdominal surgery.

So I have no doubt that payment policy is a factor but it's certainly not the only factor.

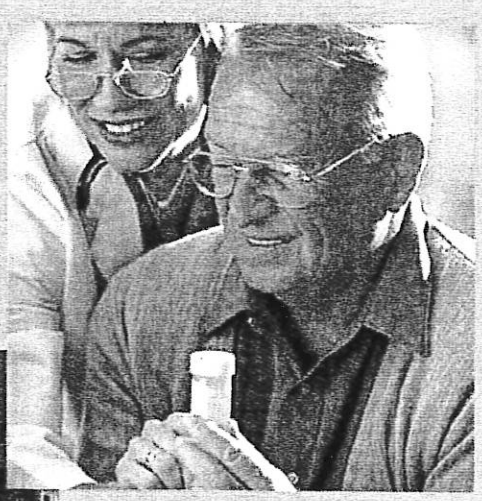
MR. HACKBARTH: Any other comments or questions?

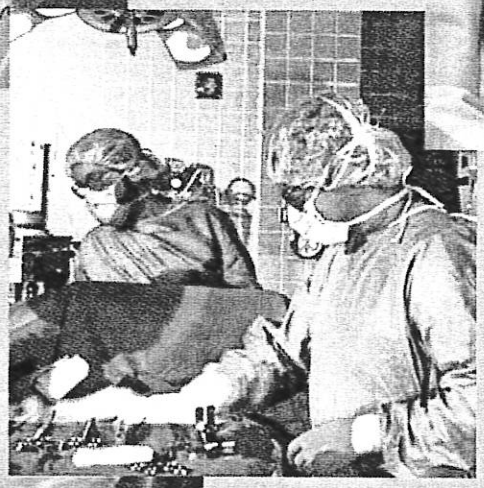
Okay, thank you very much. Good piece of work.

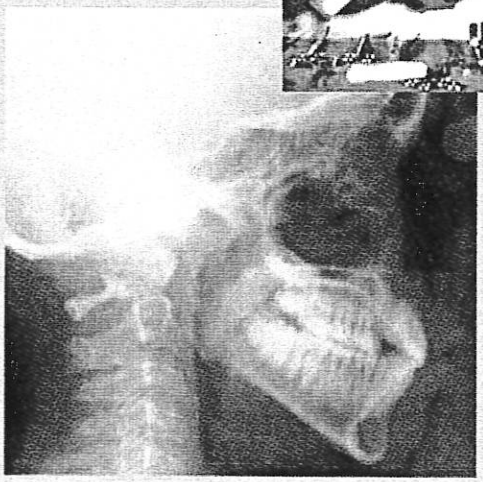
DEPARTMENT OF JUSTICE

FEDERAL TRADE COMM

Improving Health Care: A Dose of Competition







A Report by the Federal Trade Commission and the Department of Justice

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EXECUTIVE SUMMARY

Health care is a vital service that daily touches the lives of millions of Americans at significant and vulnerable times: birth, illness, and death. In recent decades, technology, pharmaceuticals, and know-how have substantially improved how care is delivered and the prospects for recovery. American markets for innovation in pharmaceuticals and medical devices are second to none. The miracles of modern medicine have become almost commonplace. At its best, American health care is *the* best in the world.

Notwithstanding these extraordinary achievements, the cost, quality, and accessibility of American health care have become major legislative and policy issues. Substantial increases in the cost of health care have placed considerable stress on federal, state, and household budgets, as well as the employment-based health insurance system. Health care quality varies widely, even after controlling for cost, source of payment, and patient preferences. Many Americans lack health insurance coverage at some point during any given year. The costs of providing uncompensated care are a substantial burden for many health care providers, other consumers, and tax payers.

This Report examines the role of competition in addressing these challenges. The proper role of competition in health care markets has long been debated. For much of our history, federal and state regulators, judges, and academic commentators saw health care as a "special" good to which normal economic forces did not apply. Skepticism about the role of competition in health care continues.

This Report by the Federal Trade Commission (Commission) and the Antitrust Division of the Department of Justice (Division) (together, the Agencies) represents our response to such skepticism. In the past few decades, competition has profoundly altered the institutional and structural arrangements through which health care is financed and delivered. Competition law and policy have played an important and beneficial role in this transformation. Imperfections in the health care system have impeded competition from reaching its full potential. These imperfections are discussed in this Report.

The Agencies based this Report on 27 days of Joint Hearings from February through October, 2003; a Commission-sponsored workshop in September, 2002; and independent research. The Hearings broadly examined the state of the health care marketplace and the role of competition, antitrust, and consumer protection in satisfying the preferences of Americans for high-quality, cost-effective health care. The Hearings gathered testimony from approximately 250 panelists, including representatives of various provider groups, insurers, employers, lawyers, patient advocates, and leading scholars on subjects ranging from antitrust and economics to health care quality and informed consent. The Hearings and Workshop elicited 62 written submissions from interested parties. Almost 6,000 pages of transcripts of the Hearings and Workshop and all written submissions are available on the Commission website.

The Report addresses two basic questions. First, what is the current role of competition in health care, and how can it be

enhanced to increase consumer welfare? Second, how has, and how should, antitrust enforcement work to protect existing and potential competition in health care?

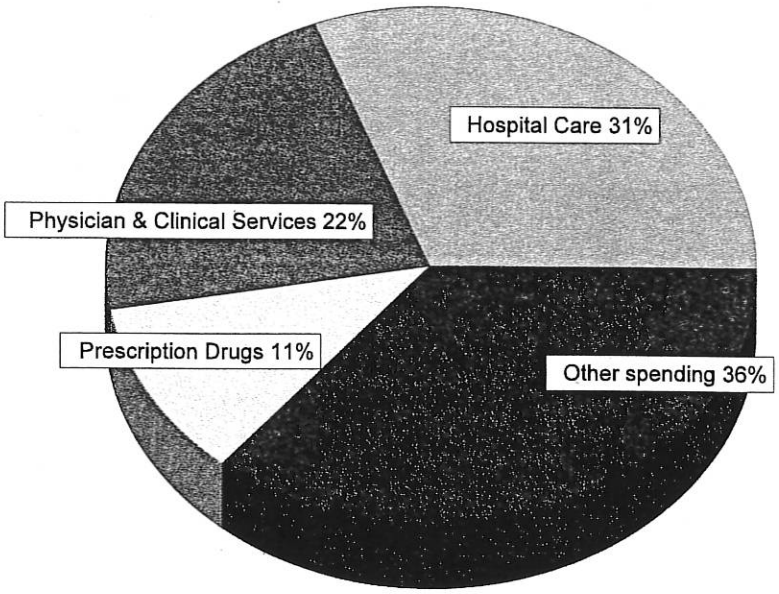
This Executive Summary outlines the Agencies' research, findings, conclusions, recommendations, and observations. Subsequent chapters provide in-depth discussion and analyses. Chapter 1 provides an overview and introduction. Chapter 2 focuses on physicians. Chapters 3 and 4 address hospitals. Chapters 5 and 6 consider insurance. Chapter 7 focuses on pharmaceuticals. Chapter 8 addresses a range of issues, including certificate of need, state action, long-term care, international perspectives, and remedies. We begin with a review of why health care issues are so important.

I. CURRENT HEALTH CARE CHALLENGES

A. Health Care Expenditures Are Once Again Rising Dramatically

Health care spending in the United States far exceeds that of other countries. Approximately 14% of gross domestic product, or $1.6 trillion in 2002, is spent on health care services in the United States. Federal, state, and local governments pay for approximately 45 percent of total U.S. expenditures on health care; private insurance and other private spending account for 40 percent; and consumer out-of-pocket spending accounts for the remaining 15 percent.

Figure 1: Total Health Care Spending



As Figure 1 reflects, in 2002, 31 percent of the $1.6 trillion spent by Americans on health care went to inpatient hospital care; that percentage has declined substantially over the past twenty years, as hospitalization rates and lengths of stay have declined. Physician and clinical services account for 22 percent, but physicians' decisions and recommendations affect a far larger percentage of total expenditures on health care. Prescription drugs account for about 11 percent; that percentage has increased substantially over the past decade. The remaining 36 percent is split among long-term care, administrative, and other expenditures.

The percentage of gross domestic product spent on health care rose substantially during the 1970s and 1980s,

but stabilized during most of the 1990s at around 13.5 percent. In the last few years, however, dramatic cost increases have returned, attributable to both increased use of and increased prices for health care services. Inpatient hospital care and pharmaceuticals are the key drivers of recent increases in expenditures. These trends are likely to continue – and even accelerate – as new technologies are developed and the percentage of the population that is elderly increases.

B. Health Care Quality Varies

Quality has multiple attributes. Many health services researchers and providers focus on whether the care that is provided is based on empirical evidence of efficacy. The Institute of Medicine defines quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." The Agency for Healthcare Research and Quality defines quality health care as "doing the right thing at the right time in the right way for the right person and having the best results possible." Some consumers may focus on how long they must wait for an appointment, and how they are treated at the provider's office. Many health care providers and health services researchers treat the cost of care (and the resources of consumers) as immaterial; for them, you either provide high quality care to a particular patient or disease set, or you do not.

From a consumer perspective, health care quality encompasses several distinct factors, and the delivery system must perform well on each if it is to provide high quality care. These factors include whether the diagnosis is correct, whether the "right" treatment is selected (with the "right" treatment varying, depending on the underlying diagnosis and patient preferences), whether the treatment is performed in a technically competent manner, whether service quality is adequate, and whether consumers can access the care they desire. Information is necessary for consumers to make decisions regarding their care, and determine how well the health care system is meeting their needs.

If we focus strictly on technical measures, what is known about the quality of health care in the United States? Commentators and panelists agree that the vast majority of patients receive the care they need, but there is still significant room for improvement. Commentators and panelists note that treatment patterns vary significantly; procedures of known value are omitted, and treatments that are unnecessary and inefficacious are performed and tens of billions of dollars are spent annually on services whose value is questionable or non-existent. As one commentator stated, "quality problems . . . abound in American medicine. The majority of these problems are not rare, unpredictable, or inevitable concomitants of the delivery of complex, modern health care. Rather, they are frighteningly common, often predictable, and frequently preventable."[1]

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[1] Mark R. Chassin, *Is Health Care Ready for Six Sigma Quality?*, 76 MILBANK Q. 565, 566 (1998).

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C. *The U.S. Economy Typically Relies on Market Competition*

In the overwhelming majority of markets, the government does not decide the prices and quality at which sellers offer goods and services. Rather, rivals compete to satisfy consumer demand, and consumers make decisions about the price and quality of goods or services they will purchase. A well-functioning market maximizes consumer welfare when consumers make their own consumption decisions based on good information, clear preferences, and appropriate incentives.

Vigorous competition, both price and non-price, can have important benefits in health care as well. Price competition generally results in lower prices and, thus, broader access to health care products and services. Non-price competition can promote higher quality and encourage innovation. More concretely, competition can result in new and improved drugs, cheaper generic alternatives to branded drugs, treatments with less pain and fewer side effects, and treatments offered in a manner and location consumers desire. Vigorous competition can be quite unpleasant for competitors, however. Indeed, competition can be ruthless – a circumstance that can create cognitive dissonance for providers who prefer to focus on the necessity for trust and the importance of compassion in the delivery of health care services. Yet, the fact that competition creates winners and losers can inspire health care providers to do a better job for consumers. Vigorous competition promotes the delivery of high quality, cost-effective health care, and vigorous antitrust enforcement helps protect competition.

At the same time, competition is not a panacea for all of the problems with American health care. Competition cannot provide its full benefits to consumers without good information and properly aligned incentives. Moreover, competition cannot eliminate the inherent uncertainties in health care, or the informational asymmetries among consumers, providers, and payors. Competition also will not shift resources to those who do not have them. The next section identifies some of the features of health care markets that can limit the effectiveness of competition.

II. FEATURES OF HEALTH CARE MARKETS THAT CAN LIMIT COMPETITION

A. *The Health Care Marketplace is Extensively Regulated*

An extensive regulatory framework, developed over decades, at both the federal and state levels of government affects where and how competition takes place in health care markets. Much of the regulatory framework arose haphazardly, with little consideration of how the pieces fit together, or how the pieces could exacerbate anticompetitive tendencies of the overall structure. Proposals for new regulatory interventions have often focused solely on their claimed benefits, instead of considering their likely costs, where proposals fit into the larger regulatory framework, and whether proposals frustrate competition unnecessarily. Failure to consider such matters can reinforce existing regulatory imperfections and reward incumbent interests. Indeed, in health care, some commentators see competition as a problem to be tamed with top-down prescriptive

regulations, instead of an opportunity to improve quality, efficiency, and enhance consumer welfare.

As a significant purchaser in most health care markets, the government uses regulations to influence the price and quality of the services for which it pays. The government's actions as both purchaser and regulator have profound effects on the rest of the health care financing and delivery markets as well. Price regulation, even if indirect, can distort provider responses to consumer demand and restrict consumer access to health care services. Regulatory rules also can reduce the rewards from innovation and sometimes create perverse incentives, rewarding inefficient conduct and poor results. Restrictions on entry and extensive regulation of other aspects of provider behavior and organizational form can bar new entrants and hinder the development of new forms of competition. The scope and depth of regulation is also not universal; providers offering competing services are routinely subject to widely varying regulatory regimes and payment schedules.

B. *Third-Party Payment Can Distort Incentives*

Health insurance shifts and pools the risks associated with ill health. By providing greater predictability, health insurance protects the ill and their families from financial catastrophe. Nonetheless, third-party payment of health-related expenses can distort incentives and have unintended consequences.

Consumer Incentives. Insured consumers are insulated from most of the costs of their decisions on health care treatments. The result is that insured consumers have limited incentive to balance costs and benefits and search for lower cost health care with the level of quality that they prefer. A lack of good information also hampers consumers' ability to evaluate the quality of the health care they receive.

Provider Incentives. Panelists and commentators agreed that providers have a strong ethical obligation to deliver high quality care. The health care financing system, however, generally does not directly reward or punish health care providers based on their performance. When this fact is coupled with the consumer incentives outlined above, the result is that providers who deliver higher quality care are generally not directly rewarded for their superior performance; providers who deliver lower quality care are generally not directly punished for their poorer performance and, worse still, may even be rewarded with higher payments than providers who deliver higher quality care.

Payor Incentives. Insurers generally offer coverage terms tied to professionally dictated standards of care, restricting the range of choices and trade-offs that consumers may desire. Insurers aggregate consumer preferences, but there can be incentive mismatches because insurers generally bear the costs but do not capture the full benefits of coverage decisions and because insurance contracts have a defined term (usually annually) that is generally shorter than the period of interest to the consumer.

C. *Information Problems Can Limit the Effectiveness of Competition*

The Lack of Reliable and Accurate Information about Price and Quality. The public has access to better information about the price and quality of automobiles than it does about most health care services. It is difficult to get good information about the price and quality of health care goods and services, although numerous states and private entities are experimenting with a range of "report cards" and other strategies for disseminating information to consumers. Without good information, consumers have more difficulty identifying and obtaining the goods and services they desire.

The Asymmetry of Information between Providers and Consumers. Most consumers have limited information about their illness and their treatment options. Consumers with chronic illnesses have more opportunity and incentive to gather such information, but there is still a fundamental informational asymmetry between providers and patients. There is also considerable uncertainty about the optimal course of treatment for many illnesses, given diverse patient preferences and the state of scientific knowledge.

Consumer Uncertainty about Reliability of Health Care Information. Uncertainty increases transaction costs, fraud, and deception dramatically. Although the Internet can provide access to information about health care, it also enhances the risks of fraud and deception regarding "snake oil" and miracle cures.

Information Technology. Health care does not employ information technology extensively or effectively. Prescriptions and physician orders are frequently hand-written. Records are often maintained in hard copy and scattered among multiple locations. Few providers use e-mail to communicate with consumers. Public and private entities have worked to develop and introduce electronic medical records and computerized physician order entry, but commentators and panelists agreed that much remains to be done.

D. *Cost, Quality, and Access: The Iron Triangle of Trade-offs*

Health policy analysts commonly refer to an "iron triangle" of health care.[2] The three vertices of the triangle are the cost, quality, and accessibility of care. The "iron triangle" means that, in equilibrium, increasing the performance of the health care system along any one of these dimensions can compromise one or both of the other dimensions, regardless of the amount that is spent on health care.

Such tradeoffs are not always required, of course. For example, tying payments to health care providers to the quality of services provided could improve providers' incentives to contain costs and improve quality. Better quality also could be achieved at less cost by reducing unnecessary services and managing consumers with chronic conditions more cost-effectively. Competition has an important role to play in accomplishing these objectives.

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[2] WILLIAM L. KISSICK, MEDICINE'S DILEMMAS: INFINITE NEEDS VERSUS FINITE RESOURCES (1994).

Nonetheless, trade-offs among cost, quality, and access can be necessary. Those trade-offs must be made at multiple levels by multiple parties. Some consumers may prefer a "nothing but the best" package of medical care, but others are willing to trade-off certain attributes of quality for lower cost, or trade-off one attribute of quality for another. For example, some consumers will be more willing than others to travel in exchange for lower prices, while others may be more willing to travel in exchange for higher quality care. Good information about the costs and consequences of each of these choices is important for competition to be effective.

E. Societal Attitudes Regarding Medical Care

For most products, consumers' resources constrain their demand. Consumers and the general public do not generally expect vendors to provide services to those who cannot pay for them. Few would require grocery stores to provide free food to the hungry or landlords to provide free shelter to the homeless. By contrast, many members of the public and many health care providers view health care as a "special" good, not subject to normal market forces, with significant obligational norms to provide necessary care without regard to ability to pay. Similarly, many perceive risk-based premiums for health insurance to be inconsistent with obligational norms and fundamental fairness, because those with the highest anticipated medical bills will pay the highest premiums. A range of regulatory interventions reflect these norms.

F. Agency Relationships

A large majority of consumers purchase health care through multiple agents – their employers, the plans or insurers chosen by their employers, and providers who guide patient choice through referrals and selection of treatments. This multiplicity of agents is a major source of problems in the market for health care services. Agents often do not have adequate information about the preferences of those they represent or sufficient incentive to serve those interests.

III. HOW THE HEALTH CARE MARKETPLACE CURRENTLY OPERATES

Competitive pressures for cost containment have spurred the development of new forms of health care financing and delivery. Government payors have adopted new forms of payments for health care providers to slow health care inflation. Private payors have adopted systems, such as managed care and preferred provider organizations, to encourage or require consumers to choose relatively lower-cost health care. Physicians have tried new types of joint ventures and consolidation, and hospitals have consolidated through merger and the creation of multi-hospital networks. These new organizational forms offer the potential for reducing costs and increasing provider bargaining power. More recently, strategies for improving the quality of health care have gained attention. Health care markets remain in flux.

A. How Consumers Pay for Health Care

Most Americans pay for health care through health insurance. Most Americans under the age of 65 obtain health insurance through their employer or the employer of a family member. Some Americans under the age of 65 obtain coverage through a government program or purchase an individual insurance policy. Americans aged 65 and over are almost always covered by Medicare. In 2002, the Census Bureau estimated that approximately 85 percent of the total U.S. population had health insurance coverage.

1. Publicly Funded Programs

Medicare. Medicare provides coverage for approximately 40 million elderly and disabled Americans. Medicare Part A covers most Americans over 65, and provides hospital insurance coverage. Although Medicare Part B is optional, almost all eligible parties enroll, given substantial federal subsidies to the program. Medicare Part B provides supplementary medical coverage for, among other things, doctors' visits and diagnostic tests. Many Medicare beneficiaries also purchase Medicare Supplemental Insurance (Medigap) policies or have coverage from a former employer. Medigap policies are federally regulated and must include specified core benefits.

In 1997, Congress enacted Medicare + Choice (M+C). M+C encouraged Medicare beneficiaries to join privately operated managed care plans, which often offer greater benefits (*e.g.*, prescription drug coverage) in exchange for accepting limits on choice of providers. In 2003, Congress renamed M+C Medicare Advantage, and enacted prescription drug benefits for Medicare beneficiaries.

Medicaid. Medicaid provides coverage for approximately 50 million Americans. Although the federal government sets eligibility and service parameters for the Medicaid program, the states specify the services they will offer and the eligibility requirements for enrollees. Medicaid programs generally cover young children and pregnant women whose family income is at or below 133 percent of the federal poverty level, as well as many low-income adults. Most states have most of their Medicaid population in some form of managed care. Medicaid pays for a majority of long term care in the United States.

Payments to Health Care Providers: Past and Present. Prior to 1983, Medicare, as well as most other insurers, reimbursed providers under a "fee-for-service" (FFS) system based on the costs of the number and type of services performed. Despite some restraints on how much a provider could claim as its costs, the result was to reward volume and discourage efficiency. Commentators argued that the combination of FFS payment, health insurance, and consumers' imperfect information about health care created incentives for providers to provide, and consumers to consume, greater health care resources than would be the case in competitive markets. In addition, FFS payment dampened the potential for effective price competition, because FFS guaranteed reimbursement for claimed charges. Thus, providers lacked incentives to lower prices.

Hospitals and Ancillary Services. In response to increasing health care expenditures, Congress directed the Center for Medicare and Medicaid Services (CMS) to adopt the inpatient prospective payment system (IPPS) as a means to create a more competitive, market-like environment for hospital reimbursement by Medicare. The IPPS took effect in 1983. The diagnosis-related group (DRG) for the diagnosis at discharge determines the amount that the hospital is paid. Each DRG has a payment weight assigned to it, which reflects the average cost of treating patients in that DRG. Hospitals receive this predetermined amount regardless of the actual cost of care, although adjustments are made for extraordinarily high-cost cases ("outlier payments"), teaching hospitals, and hospitals that serve a disproportionate number of low-income patients.

Similarly, Congress directed CMS to change its payment system for hospital-based outpatient care provided to Medicare beneficiaries. On August 1, 2000, the payment system changed from a cost-based system to the outpatient prospective payment system (OPPS), under which CMS reimburses hospitals based on one of about 750 ambulatory payment classifications (APCs) in which an episode of care falls. Each APC has a general weight based on the median cost of providing the service.

Congress also directed CMS to adopt prospective payment systems for skilled nursing facilities and home health care services, and those systems are currently in effect. As of 2007, Medicare is scheduled to begin a competitive bidding system to determine which providers will offer durable medical equipment to Medicare beneficiaries.

Both the IPPS and the OPPS have constrained expenditures more effectively than the cost-based systems they replaced. With the introduction of IPPS, the increase in hospital expenditures slowed, and average length of hospital stay declined. The adoption of prospective payment for home health care services also had an immediate impact on the number of beneficiaries that received services and the average number of visits.

Any administered pricing system inevitably has difficulty in replicating the price that would prevail in a competitive market. Not surprisingly, one unintended consequence of the CMS administered pricing systems has been to make some hospital services extraordinarily lucrative and others unprofitable. As a result, some services are more available (and others less available) than they would be in a competitive market.

Physicians. Medicare pays for physician services using the resource-based relative value scale (RBRVS), a system for calculating a physician fee schedule. CMS calculates the fee schedule on the basis of the cost of physician labor, practice overheads and materials, and liability insurance, as adjusted for geographic and yearly differences.

2. Employment-Based Insurance

Employers offer insurance to their employees and retirees through various sources, including commercial insurance companies, employers' self-funded plans, or various combinations of the two. Employers

that offer health insurance through commercial insurers usually negotiate on behalf of their employees for a package of benefits at a specified monthly premium per person or per family. Some employers choose to self-fund (self-insure) by assuming 100 percent of the risk of expenses from their employees' health care coverage. Some employers create self-insured plans, but contract with commercial insurance companies to act as a third-party administrator for claims processing, for access to a provider network, or to obtain stop-loss coverage. The applicability of federal and state laws and regulations varies, depending on the source of health care coverage an employer makes available to employees and retirees.

Not all employers offer health coverage, and some employers offer coverage only to full-time employees. In some sectors of the economy, employment-based health insurance is less common. The larger the employer, the more likely it is to offer health insurance. Premiums and coverage vary widely. The number of people with employment-based insurance fluctuated throughout the 1990s but has currently stabilized at approximately 61 percent of the U.S. population.

The federal government subsidizes employment-based health insurance through the tax code. Employer contributions for health insurance coverage are deductible to employers, but are not considered taxable income to employees and retirees. The result is that employees can obtain health care coverage through their employer with pre-tax dollars. Although it is common parlance to speak of "employer contributions" to the cost of health care coverage, employees and retirees ultimately bear these costs in the form of lower salaries and benefits.

Payments to Providers. In some instances, private payors have copied the payment strategies of the Medicare program or have used Medicare payments as a reference price for negotiation with providers. For example, some payors negotiate either a specified discount or a specified premium relative to the payment the Medicare program would make for a specific episode of hospitalization or service. To be sure, many payors do not rely on these strategies, and instead structure their own payment arrangements with providers, including discounted per diem payments to hospitals and negotiated discounts off charges for other providers.

3. Individual Insurance

In 1999, approximately 16 million working-age adults and children – almost 7 percent of the population under 65 – obtained health insurance coverage through individually issued, non-group policies. Commentators suggest that this small market share is due, in part, to the tax subsidies provided for employment-based coverage. Individual insurance policies are generally more expensive and less comprehensive than group policies.

4. The Uninsured

Approximately 15 percent of the population, or 44 millions Americans, lacked health insurance at some point during 2002. A study by the Congressional Budget Office found that 45 percent of the uninsured were without coverage for four

months or less, and that only 16 percent of the uninsured (or approximately 6.9 million Americans) remained so for more than two years. The uninsured are more likely to be younger and less likely to have a regular source of care, less likely to use preventive services, and more likely to delay seeking treatment. Studies indicate a variety of adverse health consequences are associated with being uninsured.

Medical treatment for the uninsured is often more expensive than care of the insured, because the uninsured are more likely to delay treatment and receive care in an emergency room. Hospitals typically bill the uninsured full price for the services they received, instead of the discounted prices that hospitals offer insured patients pursuant to negotiated contracts with their insurers. The uninsured bear some of the costs of treatments themselves and often cannot fully pay for the care they receive. The burden of providing this uncompensated care varies significantly among providers and regions. For example, the burden of uncompensated care is greater in the South and West, where a higher percentage of the population is uninsured, than in the rest of the United States. The costs of uncompensated treatments for the uninsured are either paid by taxpayers, absorbed by providers, or passed on to the insured.

B. How Consumers Receive Health Care: The Rise and Decline of Managed Care

Burgeoning health care expenditures in the 1960s and 1970s led to numerous proposals to provide better incentives to contain costs. Some commentators argued that organizations that agreed to meet the health care needs of a consumer at a set price for a set period of time offered a solution to this problem. Such prepaid group practices existed in some parts of the United States beginning in the early part of the 20th century, but Congress took a significant step in this direction with passage of the Health Maintenance Organizations Act of 1973 (HMO Act). The HMO Act provided start-up funds to encourage the development of HMOs, overrode State anti-HMO laws, and required large firms to offer an HMO choice to their employees. These forces set the stage for the development of managed care organizations (MCOs). Managed care means different things to different people, and it has meant different things at different times. There is general agreement, however, that MCOs integrate the financing and delivery of health care services, albeit to varying degrees. In global terms, managed care offers a more restricted choice of (and access to) providers and treatments in exchange for lower premiums, deductibles, and co-payments than traditional indemnity insurance.

MCOs historically relied on three strategies to control costs and enhance quality of care. One is selective contracting with providers that must meet certain criteria to be included in the MCO's provider network. Selective contracting can intensify price competition and allow MCOs to negotiate volume discounts and choose providers based on a range of discounts. When MCOs and other insurers have a credible threat to exclude providers from their networks and send patients elsewhere, providers have a powerful incentive to bid aggressively to be included in the network. Without such credible threats, providers have less incentive to bid aggressively, and

even MCOs with large market shares may have less ability to obtain lower prices.

Another strategy is to use incentives that shift some of the financial risk to providers. Capitation, for example, pays providers a fixed amount for each of the patients for whom they agree to provide care, regardless of whether those patients seek care or the costs of their care exceeds the fixed amount. Some physician groups participating in capitation arrangements underestimated these risks and went bankrupt, and providers have become increasingly reluctant to accept the risks of capitation in recent years. Direct financial incentives for providers in the form of bonuses (or withholding a percentage of payment) based on meeting clinical or financial targets remain fairly prevalent, with considerable variation in their details.

A third strategy is utilization review of proposed treatments and hospitalizations. This strategy involves an appraisal of the appropriateness and medical necessity of the proposed treatment. Many MCOs and other insurers use utilization review in a variety of forms.

In recent years, many MCOs have adopted a fourth strategy: increased cost-sharing. Cost sharing creates direct financial incentives for consumers – through varying co-payments and deductibles – to receive care from particular providers or in particular locations.

By the late 1990s, managed care had grown so unpopular that commentators began to refer to a "managed care backlash." Providers complained that their clinical judgments were second-guessed; consumers complained that managed care was restricting choices, limiting access to necessary medical care, and lowering quality. These concerns resulted in a number of federal and state legislative and regulatory initiatives, as well as private litigation against MCOs.

Commentators report a substantial gap between consumer and provider perceptions, on the one hand, and managed care's actual impact, on the other. They point to surveys and studies showing that consumers are generally satisfied with their own MCOs, that MCOs do not provide poorer quality care than FFS medicine, and that "managed care horror stories" are often exaggerated or highly unrepresentative.

In recent years, more restrictive forms of managed care have been eclipsed by offerings with more choice and flexibility. These offerings include point-of-service (POS) plans, which allow patients to select a primary care gatekeeper, yet use out-of-plan physicians for some services. Preferred provider organizations (PPOs) are similar to POS programs, but generally do not require a coordinating primary care physician. Instead, PPOs have a panel of "preferred providers" who agree to accept discounted fees. Some physicians who wish to avoid managed care entirely have begun "concierge practices," where they provide personalized care, including house calls, to patients willing and able to pay out of pocket for health care costs.

Public and private payors are also experimenting with payment for performance (P4P) initiatives. Commentators and panelists generally agreed that P4P should be more widely

employed in health care. Many payors have yet to adopt P4P programs, and some providers have resisted such programs. The development of P4P programs will require better measurement of, and information about, health care quality.

IV. HEALTH CARE PROVIDERS: NEW DELIVERY SYSTEMS, NEW FORMS OF ORGANIZATION, AND COMPETITIVE PRESSURES

A. Physicians

Spending on physician services accounts for approximately 22 percent of the $1.6 trillion spent annually on health care services. Total spending on physician services increased at an average annual rate of 12 percent from 1970-1993, and at 4 to 7 percent a year since then. In response to increased competitive pressures from MCOs and other payors to lower their prices, some physicians have attempted to respond procompetitively, while others have engaged in anticompetitive conduct.

Multiprovider Network Joint Ventures. Historically, physicians were predominantly solo practitioners, but many physicians implemented network joint ventures in response to managed care. The 1980s saw the emergence of two types of joint ventures with physician members (Independent Practice Associations (IPAs) and Physician Hospital Organizations (PHOs)). In general, IPAs are networks of independent physicians that, among other things, may contract with MCOs and employers. PHOs are joint ventures between a hospital (or more than one hospital) and physicians who generally have admitting privileges there; hospital and physician members sometimes contract jointly through the PHO with MCOs to provide care to a population of patients.

IPAs and PHOs are often integrated to varying degrees financially (sharing financial risk) or clinically (using various strategies to improve the quality of care they provide) or both. Such joint ventures may provide various cost savings, such as reduced contracting costs, and clinical efficiencies, such as better monitoring and management of patients with chronic illnesses. IPAs and PHOs can also represent attempts by providers to increase their bargaining leverage with insurers. Some contend that the primary advantage for physicians and hospitals in forming a PHO is that the member hospital(s) and physicians present a united front for bargaining with payors. In recent years, the use of IPAs and PHOs has decreased, as MCOs and providers have abandoned capitation arrangements.

One antitrust issue that physician joint ventures confront with respect to their contracting practices is how to avoid summary condemnation under the antitrust laws. The *Health Care Statements* outline the key factors the Agencies will consider in determining whether to apply the per se rule or more elaborate rule of reason analysis to particular conduct.[3] These factors include the degree of integration that the venture achieves to obtain efficiencies and the extent to which joint pricing is reasonably

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[3] DEP'T OF JUSTICE & FEDERAL TRADE COMM'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (1996), *available at* http://www.ftc.gov/reports/hlth3s.pdf.

necessary to achieve those efficiencies.

The "Messenger Model." Arrangements to allow networks of providers to contract with payors, while avoiding any agreement on price among the providers, sometimes use a "messenger" to facilitate contracting. The payor usually submits a proposed fee schedule to an agent or third party, who transmits this offer to the network physicians. Each physician decides unilaterally whether to accept the fee schedule, and the agent transmits those decisions to the payor. Providers may also individually give the messenger information about the prices or other contract terms that the provider will accept, and the messenger aggregates this information and markets it to payors. *Health Care Statement* 9 describes how to avoid antitrust problems when using a messenger model, and provider networks have used the model successfully. Nonetheless, physician networks using so-called "messengers" to orchestrate or participate in price-fixing agreements have resulted in considerable antitrust enforcement activity in recent years.

Physician Collective Bargaining. Some physicians have lobbied heavily for an antitrust exemption to allow independent physicians to bargain collectively. They argue that payors have market power, and that collective bargaining will enable physicians to exercise countervailing market power. The Agencies have consistently opposed these exemptions, because they are likely to harm consumers by increasing costs without improving quality of care. The Congressional Budget Office estimated that proposed federal legislation to exempt physicians from antitrust scrutiny would increase expenditures on private health insurance by 2.6 percent and increase direct federal spending on health care programs such as Medicaid by $11.3 billion.

Licensing Regulation and Market Entry. State licensing boards composed primarily of physicians determine, apply, and enforce the requirements for physicians to practice within a particular state. Various state licensing boards have taken steps to restrict allied health professionals and telemedicine. Some states have limited or no reciprocity for licensing physicians and allied health professionals already licensed by another state. The Report discusses the anticompetitive potential of such restrictions, as well as their rationales.

B. Hospitals

As with physicians, some hospitals have responded to competitive pressures by finding ways to lower costs, improve quality, and compete more efficiently. Some commentators contend, however, that a number of hospital networks are exercising market power to demand price increases from payors, and seeking to forestall entry by new competitors, such as single-specialty hospitals.

Hospital Networks. Over the past 20 years, many hospitals have merged or consolidated into multi-hospital networks or systems. Although the Agencies had considerable early success in challenging certain hospital mergers, the Agencies and state enforcers have lost all seven hospital merger cases they have litigated since 1994. Courts in these cases typically disagreed with the Agencies on how to measure relevant antitrust markets, how to assess the prospects for entry to remedy any

anticompetitive effects, how to determine the magnitude of any likely efficiencies, and the relevance of the hospital's nonprofit status. The Commission has undertaken a retrospective study to evaluate the market results in several consummated mergers, and one case is currently pending in administrative litigation.

Initially, national systems acquired hospitals throughout the United States, but recent acquisitions have been more localized. Some believe that hospital consolidation generally has promoted the development of efficiencies and instilled life back into failing hospitals. They point to the savings from consolidated operations that hospital networks may make possible. Others believe that a primary result of consolidation has been to create hospital market power, thus allowing hospitals to increase their prices. Hospitals claim that rising prices result not from market power, but from a multitude of pressures they confront, such as shortages of nurses and other personnel, rising liability premiums, the costs of improved technology, and the obligations of indigent care.

Most studies of the relationship between competition and hospital prices have found that high hospital concentration is associated with increased prices, regardless of whether the hospitals are for-profit or nonprofit. Some studies have found that merged hospitals experienced smaller price and cost increases than those that have not merged, except in highly concentrated markets, where the pattern was reversed. Another study found that some systems' acquisition of hospitals did not produce efficiencies, because of a failure to combine operations. Some have pointed out that studies typically do not differentiate among transactions that occur within local markets and those that occur across markets, such as national system acquisitions; different types of consolidations might reflect very different hospital strategies and could have different efficiency effects.

Entry: Specialty Hospitals. Specialty hospitals provide care for a specific specialty (*e.g.*, cardiac) or type of patient (*e.g.*, children). Newer single-specialty hospitals (SSHs) tend to specialize in cardiac or orthopedic surgery, and participating physicians often have an ownership interest in the facility, for reasons described *infra*. Some contend that SSHs have achieved better outcomes through increased volume, better disease management, and better clinical standards.

Others disagree, suggesting that physician-investors send healthier, lower risk patients to their SSH and sicker patients to a general hospital to enable the SSH to produce service less expensively yet still be reimbursed at the same rates as the general hospital. These commentators fear that SSHs will siphon off the most profitable procedures and patients, leaving general hospitals with less money to cross subsidize socially valuable, but less profitable care.

Some general hospitals facing competition from SSHs have removed the admitting privileges of physicians involved with the SSH or otherwise acted to limit physician access to the general hospital; other general hospitals have established their own single-specialty wing to prevent physicians from shifting their patients to a new entrant. Some commentators state that general hospitals have used certificate of

need (CON) laws to restrict entry by SSHs. There are relatively few SSHs, and the vast majority are in states without CON programs. Debate about SSHs continues. A recently imposed Congressional moratorium on physician referrals to SSHs in which they have an ownership interest and two Congressionally mandated studies on SSHs and general hospitals will likely affect the future of SSHs.

Entry: Ambulatory Surgery Centers. Ambulatory surgery centers (ASCs) perform surgical procedures on patients who do not require an overnight stay in the hospital. Technological advances in surgery and anesthetic agents have made it possible for ASCs to perform a wide range of surgical procedures. Medicare reimbursement has had a profound effect on the number of ASCs and the amount and types of surgery performed in them.

Commentators express divergent views on ASCs, with some focusing on likely benefits to consumers including greater convenience, and others expressing concerns about ASCs similar to those regarding SSHs. Hospital reactions to deter ASC entry and restrict competition have been similar to those for SSHs.

Government Purchasing of Hospital Services. Government-administered pricing by CMS inadvertently can distort market competition. For example, CMS never decided as a matter of policy to provide greater profits for cardiac surgery than many other types of service, but the IPPS tends to do so. This pricing distortion creates a direct economic incentive for specialized cardiac hospitals to enter the market; such entry reflects areas that government pricing makes most profitable, which may or may not reflect consumers' needs and preferences. When the government is the sole or primary payor for a service, such as kidney dialysis or vaccines, paying too much wastes resources, while paying too little reduces output and capacity, lowers quality, and diminishes incentives for innovation.

Although CMS can set prices, its ability directly to encourage price and non-price competition is limited. With few exceptions, CMS cannot force providers to compete for CMS's business or reward suppliers that reduce costs or enhance quality with substantially increased volume or higher payments. CMS has limited ability to contract selectively with providers or use competitive bidding. Even straightforward purchasing initiatives, such as competitive bidding for durable medical equipment (DME), have generated considerable resistance, despite the success of a pilot project for DME competitive bidding that resulted in savings of 17 to 22 percent with no significant adverse effects on beneficiaries. Worse still, CMS's payment systems do not reward providers who deliver higher quality care or punish providers who deliver lower quality care. As the Medicare Payment Advisory Commission reported, the Medicare payment system is "largely neutral or negative towards quality . . . . At times providers are paid even more when quality is worse, such as when complications occur as the result of error."[4]

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[4] MEDICARE PAYMENT ADVISORY COMMITTEE, REPORT TO CONGRESS: VARIATION AND INNOVATION IN MEDICARE 108 (2003), *available at* http://www.medpac.gov/publications/congressional_reports/June03_Entire_Report.pdf.

CMS has worked to enhance quality through public reporting initiatives. For example, since CMS began public reporting of quality information on dialysis care in 1996, the number of patients receiving inadequate dialysis or experiencing anemia has declined substantially. Since 2002, CMS publicly reports on the quality of care provided in nursing homes and by home health agencies. Recently, CMS joined with hospitals and the Quality Improvement Organizations in Maryland, New York, and Arizona to design pilot tests for publicly reporting hospital performance measures. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 creates modest financial incentives for hospitals to report such information.

Examples of other government initiatives include New York State, which began to publicize provider-specific outcomes for cardiac surgery in 1989. By 1992, one study found risk-adjusted mortality had dropped 41 percent statewide, giving New York the lowest risk-adjusted mortality rate for cardiac surgery in the nation. Studies show the mortality rate has continued to fall. Pennsylvania reportedly experienced similar improvements when it began collecting and publishing risk-adjusted report cards.

Some have criticized these findings on methodological and policy grounds. For example, critics suggest that some of the improvement in mortality rates in New York resulted from the migration of high-risk patients to other states for surgery, and that data collection and risk adjustment methods were flawed. A general criticism of such "report cards" is that they discourage providers from treating higher risk patients. More research is required to determine the best methods for measuring and reporting on hospital quality.

Private Purchasing of Hospital Services. In recent years, contracting between hospitals and private payors has sometimes been controversial and contentious. Some contend that many hospital systems include at least one "must-have" hospital in each of the geographic markets in which they compete. A "must-have" hospital is one that health care plans believe they must offer to their beneficiaries to attract employers to the plan. Payors complain that hospital systems insist on including all or none of the hospitals in a system in the payor's coverage plan. Consumer pressure for open networks has made it more difficult for payors to exclude an entire hospital system, and the presence of a "must-have" hospital in the network also increases a hospital's bargaining power. Although some commentators believe that particular hospitals and hospital systems have the upper hand in bargaining in some markets, bargaining advantage varies substantially within and among different markets.

In a few markets, certain payors have experimented with "tiering" hospitals, which results in different consumer co-payments depending on the hospital. Hospital tiers may be established based on a variety of criteria. Tiering usually does not apply to emergency care and may depend on where routine and specialty services are offered. Tiering allows a payor to maintain a broad network and include a "must-have" hospital, yet still create incentives for consumers to use lower cost hospitals. Hospitals usually resist tiering, in some cases negotiating

contracts that prohibit tiering. Hospitals express concern that low-cost facilities will be mislabeled as low quality and high-cost facilities as inefficient, and that tiering might force poorer consumers to use only low-cost hospitals.

Private-sector efforts are underway to provide more information about quality. A number of private initiatives seek to make quality-related information available to employers, health plans, and consumers. The Health Plan Employer Data and Information Set (HEDIS), developed by the National Committee for Quality Assurance to assess health plans, uses more than 50 measures of provider and plan performance in areas such as patient satisfaction, childhood immunization, and mammography screening rates.

Hospital Purchasing. Some hospitals have joined group purchasing organizations (GPOs) to consolidate their purchases and achieve volume and other discounts. GPOs have the potential to assist hospitals in lowering costs. There have been complaints about certain GPO practices. The Agencies investigate GPO practices that appear to merit antitrust scrutiny. The market-share safety zones contained in *Health Care Statement* 7 do not constrain Agency enforcement in cases involving anticompetitive contracting practices.

Consumer Price and Quality Sensitivity: The Need for Better Information. Tiering represents an attempt to force consumers to bear some of the increased price associated with receiving care at a more expensive hospital. Medical savings accounts, which combine a high-deductible insurance policy with a tax advantaged fund for paying a portion of uncovered costs, are intended to accomplish the same goal for most health care purchasing decisions. For such strategies to work, however, consumers will need reliable and understandable information about the prices and quality of the services among which they must choose.

At present, most insured consumers are "rationally ignorant" of the price of medical services they receive, because insurance largely insulates them from the financial implications of their treatment. Even if consumers were interested in the price of their care, they would find it very difficult to obtain the information. The pricing of health care services is complicated and frequently obscure. Thus, proposals to increase consumer price sensitivity must develop strategies to increase the transparency of pricing.

An analogous finding emerges for quality measures. Although consumers typically express interest in report cards, they often do not use such information to select health plans and providers. If the information is usable, consumers will select treatments that accord with their preferences. Publicly available report cards can motivate providers to address quality deficiencies, even when it does not appear that many consumers rely on that information. Not all consumers must be well-informed for the market to deliver an efficient level of quality.

Pricing: Bulk Purchasing, Price Discrimination, Cost-Shifting, and Cross-Subsidies. Understanding health care pricing requires an understanding of four terms: bulk purchasing, price

discrimination, cost shifting, and cross subsidies. The terms have distinct meanings, although there is some overlap between cost shifting and cross subsidies. Bulk purchasing occurs when large organizations receive purchasing discounts because of the volume of their purchases. Price discrimination involves charging different consumers different prices for the same services, based on differential demand. Cost shifting refers to raising the price charged to one group of consumers as a result of lowering the price to other consumers. Cross subsidizing is the practice of charging profit maximizing prices above marginal costs to some payors or for some services and using the surpluses to subsidize other payors or other clinical services.

Some panelists stated that cost-shifting is common in the medical marketplace, but most commentators and panelists disagreed, and stated that bulk purchasing discounts and price discrimination explain observable pricing patterns. Panelists and commentators agreed, however, that there are a range of subsidies and cross-subsidies in the medical marketplace. For example, providers lose money by treating the uninsured, but make money by treating the well insured. Any administered pricing system has difficulty replicating competitive prices. Thus, not surprisingly, under Medicare's administered pricing system, some services are much more profitable than others.

Congress has also created direct subsidies for certain hospitals. CMS pays more to teaching hospitals (approximately $5.9 billion in 1999) and to hospitals that provide a disproportionate share of care to the poor (approximately $5 billion per year). The existence of subsidies and cross-subsidies complicates any plan to give consumers better price information and increase their price sensitivity. Cross-subsidies can distort relative prices and makes access to care contingent on matters such as the number of uninsured that seek care, the wealth of the community, and the degree of competitiveness of the market for medical services.

C. Pharmaceuticals

Competition between Brand-Name and Generic Drug Manufacturers. The availability of patent protection creates innovation incentives for brand-name pharmaceutical companies by excluding others from making, using, or selling a claimed invention for a specified period of time. This protection helps ensure revenues to pharmaceutical firms that they can use for more research. Patent law also requires the disclosure of information about the patented invention that otherwise would remain a trade secret and thus encourages competition to design around brand-name patents.

In 1984, Congress passed the Hatch-Waxman Act, which has encouraged competition from lower-priced generic drugs. Hatch-Waxman has shaped substantially the legal environment governing Food and Drug Administration approval of generic drug products, and established a framework to balance incentives for continued innovation by brand-name firms with entry by generic drug firms.

The Commission has pursued several enforcement actions to remedy actions by particular firms to game certain Hatch-

Waxman provisions and deny consumers the benefits of generic competition that Congress intended. The Commission also issued a study in July, 2002 that addresses strategies among drug companies to affect the timing of generic drug entry prior to patent expiration. Congress has adopted the two major recommendations proposed in this study to preclude certain abuses of Hatch-Waxman.

Current Policy Debates. Concern about pharmaceutical prices in the United States has received much attention, and discussion continues about how best to address this issue. Certain policy choices currently under debate might lead to problems similar to those that this Report identifies in other health care sectors. For example, price regulation to lower prescription drug prices could lead to problems with administered pricing similar to those described above. Government purchasing that reflects monopsony power would likely reduce output and innovation.

PBMs. The use of pharmacy benefit managers (PBMs) as intermediaries between pharmaceutical managers and payors has raised questions whether PBMs increase the costs of pharmacy benefits. Pursuant to Congressional direction, the Commission is examining one aspect of these concerns: whether costs are higher if a payor uses a mail-order pharmacy integrated with a PBM rather than retail pharmacies or non-integrated mail-order pharmacies. This study is due in June, 2005. To date, empirical evidence suggests that PBMs have saved costs for payors.

Direct-to-Consumer Advertising. Some suggest that direct-to-consumer advertising has increased prices for consumers or caused them to consume inappropriate prescription drugs. The available evidence does not support these allegations. Indeed, competition can help address these information problems by giving market participants an incentive to deliver truthful and accurate information to consumers. Nobel Laureate George Stigler once observed that advertising is "an immensely powerful instrument for the elimination of ignorance."[5] Studies by the FTC's Bureau of Economics have confirmed that advertising provides a powerful tool to communicate information about health and wellness to consumers – and the information can change people's behavior. Thus, good information is a necessary building block both for consumer empowerment and enhanced health.

V. RECOMMENDATIONS TO IMPROVE COMPETITION IN HEALTH CARE MARKETS

Competition has affected health care markets substantially over the past three decades. New forms of organization have developed in response to pressures for lower costs, and new strategies for lowering costs and enhancing quality have emerged. Nonetheless, competition remains less effective than possible in most health care markets, because the prerequisites for fully competitive markets are not fully satisfied. This list of recommendations focuses on how to encourage the development of prerequisites to competition such as good information about price and quality. The Agencies recognize that the work remaining

[5] George J. Stigler, *The Economics of Information*, 69 J. POL. ECON. 213, 220 (1961).

to be done is complex and difficult and will take time. A renewed focus on the prerequisites for effective competition, however, may assist policymakers in identifying and prioritizing tasks for the near future.

Recommendation 1:

> **Private payors, governments, and providers should continue experiments to improve incentives for providers to lower costs and enhance quality and for consumers to seek lower prices and better quality.**

> ***a) Private payors, governments, and providers should improve measures of price and quality.***

As noted above, health care pricing can be obscure and complex. Increased transparency in pricing is needed to implement strategies that encourage providers to lower costs and consumers to evaluate prices. Achievement of this goal will likely require addressing the issue of cross-subsidization, which encourages providers to use pricing that does not reveal the degree to which the well-insured may be subsidizing the indigent, and more profitable services may be subsidizing less well-compensated care.

A great deal of work already has been done on measuring quality. Quality measures exist for a considerable number of conditions and treatments. The Agencies encourage further work in this area. The Agencies suggest that particular attention be paid to the criticism that report cards and other performance measures discourage providers from treating sicker patients. If it is not addressed, this criticism could undermine the perceived validity and reliability of information about quality.

> ***b) Private payors, governments, and providers should furnish more information on prices and quality to consumers in ways that they find useful and relevant, and continue to experiment with financing structures that will give consumers greater incentives to use such information.***

Information must be reliable and understandable if consumers are to use it in selecting health plans and providers. Research to date indicates that many consumers have not used the price and quality information they have received to make decisions about health plans and providers. Additional research into the types of price and quality information that consumers would use for those decisions appears to be necessary. Further experiments with varying co-payments and deductibles based on price- and quality-related factors such as the "tier" of service that consumers choose can help give consumers greater responsibility for their choices. Such responsibility will also likely increase consumer incentives to use available information on price and quality.

> ***c) Private payors, governments, and providers should experiment further with payment methods for aligning providers' incentives with consumers' interests in lower prices, quality improvements, and innovation.***

Payment methods that give incentives for providers to lower costs, improve quality, and innovate could be powerful forces for improving competition in health care markets. Although payors have experimented with some payment methods that provide incentives to lower costs, no payment method has yet emerged that more fully aligns providers' incentives with the interests of consumers in lower prices, quality improvements, and innovation. At present, for example, most payments to providers have no connection with the quality of care provided.

A focus on the degree to which providers' incentives are compatible with consumers' interests is important. Compatible incentives and interests are more likely to yield better results; incompatible incentives and interests are more likely to have unintended consequences that can lead to worse results. Initiatives that address the use of payment methods to align providers' incentives with consumers' interests are necessary. These experiments should be carefully analyzed to evaluate their consequences, both intended and unintended.

Recommendation 2:

States should decrease barriers to entry into provider markets.

a) States with Certificate of Need programs should reconsider whether these programs best serve their citizens' health care needs.

The Agencies believe that, on balance, CON programs are not successful in containing health care costs, and that they pose serious anticompetitive risks that usually outweigh their purported economic benefits. Market incumbents can too easily use CON procedures to forestall competitors from entering an incumbent's market. As noted earlier, the vast majority of single-specialty hospitals – a new form of competition that may benefit consumers – have opened in states that do not have CON programs. Indeed, there is considerable evidence that CON programs can actually increase prices by fostering anticompetitive barriers to entry. Other means of cost control appear to be more effective and pose less significant competitive concerns.

b) States should consider adopting the recommendation of the Institute of Medicine to broaden the membership of state licensure boards.

State licensing boards are disproportionately composed of licensed providers, although some states require broader representation. Many state licensing boards have taken steps, such as restricting allied health professionals (AHPs) from independent practice and direct access to consumers, that significantly reduce certain forms of competition. State licensure boards with broader membership, including representatives of the general public, and individuals with expertise in health administration, economics, consumer affairs, education, and health services research, could be less likely to limit competition by AHPs and new business forms for the delivery of health care, and are less likely to engage in conduct that unreasonably increases prices or lowers access to health care.

c) States should consider implementing uniform licensing standards or reciprocity compacts to reduce barriers to telemedicine and competition from out-of-state providers who wish to move in-state.

When used properly, telemedicine has considerable promise as a mechanism to broaden access, lower costs, and improve health care quality. When used improperly, telemedicine has the potential to lower health care quality and to increase the incidence of consumer fraud. To foster telemedicine's likely pro-competitive benefits and to deter its potential to harm consumers, states should consider implementing uniform licensure standards or reciprocity compacts. Uniform licensure standards and reciprocity compacts could operate both to protect consumers and to reduce barriers to telemedicine. State regulators and legislators should explicitly consider the pro-competitive benefits of telemedicine before restricting it. Similar considerations apply to the potential for licensure to restrict competition from out-of-state providers who wish to move in-state.

Recommendation 3:

Governments should reexamine the role of subsidies in health care markets in light of their inefficiencies and potential to distort competition.

Health care markets have numerous cross-subsidies and indirect subsidies. Competitive markets compete away the higher prices and supra-competitive profits necessary to sustain such subsidies. Such competition holds both the promise of consumer benefits and the threat of undermining an implicit policy of subsidizing certain consumers and types of care.

Competition cannot provide resources to those who lack them; it does not work well when certain facilities 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, rather than to obscure cross subsidies and indirect subsidies in transactions that are not transparent. Governments should consider whether current subsidies best serve their citizens' health care needs.

Recommendation 4:

Governments should not enact legislation to permit independent physicians to bargain collectively.

Physician collective bargaining will harm consumers financially and is unlikely to result in quality improvements. There are numerous ways in which independent physicians can work together to improve quality without violating the antitrust laws.

Recommendation 5:

States should consider the potential costs and benefits of regulating pharmacy benefit manager transparency.

In general, vigorous competition in the marketplace for PBMs is more likely to arrive at an optimal level of transparency than regulation of those terms. Just as competitive forces encourage PBMs to offer

their best price and service combination to health plan sponsors to gain access to subscribers, competition should also encourage disclosure of the information health plan sponsors require to decide with which PBM to contract. To the extent the Commission's Congressionally mandated study of PBMs provides relevant information to the issue of PBM transparency, it will be discussed in the Commission's study report.

Recommendation 6:

> **Governments should reconsider whether current mandates best serve their citizens' health care needs. When deciding whether to mandate particular benefits, governments should consider that such mandates are likely to reduce competition, restrict consumer choice, raise the cost of health insurance, and increase the number of uninsured Americans.**

State and federal governments mandate numerous health insurance benefits. Proponents argue that mandates can correct insurance market failures, and that the required inclusion of some benefits in all health insurance plans can be welfare enhancing. Opponents argue that the case for many mandates is anecdotal, and that mandates raise premium costs, leading employers to opt out of providing health insurance and insured individuals to drop their coverage. Opponents also note that providers of the mandated benefit are usually the most vigorous proponents of such legislation, making it more likely that the mandated benefits may constitute "provider protection" and not "consumer protection." The Commission has submitted numerous competition advocacy letters on this issue in the last fifteen years, focusing on any willing provider and freedom of choice provisions.

For mandates to improve the efficiency of the health insurance market, state and federal legislators must be able to identify services the insurance market is not currently covering for which consumers are willing to pay the marginal costs. This task is challenging under the best of circumstances – and benefits are not mandated under the best of circumstances. In practice, mandates are likely to limit consumer choice, eliminate product diversity, raise the cost of health insurance, and increase the number of uninsured Americans.

State and federal policy makers should consider ways of evaluating these risks in their decision making processes and reconsider whether current mandates best serve their citizens' health care needs.

VI. AGENCY PERSPECTIVES ON ISSUES IN ANTITRUST ENFORCEMENT IN HEALTH CARE

The Agencies have been active for nearly 30 years in health care markets, challenging anticompetitive conduct and providing guidance to consumers and industry participants. This section outlines the Agencies' perspective on several issues in antitrust enforcement in health care markets.

A. Perspective on Physician-Related Issues

Physician Joint Ventures and Multi-provider Networks. Health Care Statement 8 provides that "physician network joint ventures . . . will not be viewed as per se illegal, if the physicians' integration through the network is likely to produce significant efficiencies that benefit consumers, and any price agreements (or other agreements that would otherwise be per se illegal) by the network physicians are reasonably necessary to achieve those efficiencies." *Health Care Statement* 8 further notes that financial risk-sharing and clinical integration may involve sufficient integration to demonstrate that the venture is likely to produce significant efficiencies.

1st Observation:

Payment for performance arrangements among a group of physicians may constitute a form of financial risk-sharing.

In determining whether a physician network joint venture is sufficiently financially integrated to avoid *per se* condemnation, the Agencies will consider the extent to which a particular payment for performance (P4P) arrangement constitutes the sharing of substantial financial risk among a group of physicians, and the relationship between the physicians' pricing agreement and the P4P program.

2nd Observation:

The Agencies do not suggest particular structures with which to achieve clinical integration that justifies a rule of reason analysis of joint pricing, but the analysis of whether a physician network joint venture is clinically integrated may be aided in some circumstances by asking questions like those outlined in Chapter 2.

Attempts to achieve clinical integration were discussed at length at the Hearings. Panelists described a wide variety of factors as possibly relevant to evaluating clinical integration. Panelists and commentators asked the Agencies to define the criteria that the Agencies will consider sufficient to demonstrate that a particular venture is clinically integrated. The Agencies do not suggest particular structures with which to achieve clinical integration that justifies a rule of reason analysis of joint pricing, because of the risk that it would channel market behavior, instead of encouraging market participants to develop structures responsive to their particular goals and the market conditions they face. As an aid to analysis, Chapter 2 of the Report includes a broad outline of some of the kinds of questions that the Agencies are likely to ask when analyzing whether a physician network joint venture is clinically integrated.

B. Perspective on Hospital-Related Issues

Hospital Mergers. The Agencies will continue carefully to evaluate proposed hospital mergers and to challenge those with likely anticompetitive effects. Certain issues addressed in hospital merger cases are discussed below.

3rd Observation:

Research on hospital product markets is encouraged.

In most cases, the Agencies have analyzed hospital product markets as a broad group of acute, inpatient medical conditions where the patient must remain in a health care facility for at least 24 hours for treatment, recovery or observation. The Agencies continue to examine whether smaller markets exist within the traditional cluster product market definition or other product market adjustments might be warranted, and encourage research on these matters. For example:

- The percentage of total health care spending devoted to outpatient care is growing. The Agencies encourage research on whether services provided in outpatient settings may constitute additional relevant product markets, and if so, whether those services might be adversely affected by a hospital merger.

- In recent years, single-specialty hospitals have emerged in numerous locations. The Agencies encourage further research into the competitive significance of SSHs, including whether payors can discipline general acute care hospitals by shifting a larger percentage of patients to SSHs.

- The Agencies encourage additional research to validate or refute the analytical techniques for defining product markets suggested by various commentators and panelists.

4th Observation:

Hospital geographic markets should be defined properly.

The definition of hospital geographic markets has proven controversial. In connection with this Report, the Agencies undertook a substantial analysis of how best to determine the contours of the relevant geographic market in which hospitals operate, consistent with the process described in the *1992 Horizontal Merger Guidelines* (*Merger Guidelines*). The Agencies' conclusions are:

a) The "hypothetical monopolist" test of the *Merger Guidelines* should be used to define geographic markets in hospital merger cases. To date, the Agencies' experience and research indicate that the Elzinga-Hogarty test is not valid or reliable in defining geographic markets in hospital merger cases. The limitations and difficulties of conducting a proper critical loss analysis should be fully considered if this method is used to define a hospital geographic market.

b) The types of evidence used in *all* merger cases – such as strategic planning documents of the merging parties and customer testimony and documents – should be used by Courts to help delineate relevant geographic markets in hospital merger cases. Evidence regarding the willingness of consumers to travel and physicians to steer consumers to less expensive alternatives should also be considered by Courts.

c) The Agencies encourage additional research to validate or refute the analytical techniques for defining geographic markets suggested by various commentators and Hearings participants.

5th Observation:

Hospital merger analysis should not be affected by institutional status.

The best available evidence shows that the pricing behavior of nonprofits when they achieve market power does not systematically differ from that of for-profits. The nonprofit status of a hospital should not be considered in determining whether a proposed hospital merger violates the antitrust laws.

6th Observation:

The resolution of hospital merger challenges through community commitments should be generally disfavored.

The Agencies do not accept community commitments as a resolution to likely anticompetitive effects from a hospital (or any other) merger. The Agencies believe community commitments are an ineffective, short-term regulatory approach to what is ultimately a problem of competition. Nevertheless, the Agencies realize that in some circumstances, State Attorneys General may agree to community commitments in light of the resource and other constraints they face.

C. General Issues

7th Observation:

The safety zone provision of *Health Care Statement* 7 does not protect anticompetitive contracting practices of group purchasing organizations.

Health Care Statement 7 and its safety zone aim to address monopsony and oligopoly concerns with the formation of a GPO. This statement does not address all potential issues that GPOs may raise. The Agencies believe amending the statement to address some, but not all potential issues, is likely to be counterproductive. *Health Care Statement* 7 does not preclude Agency action challenging anticompetitive contracting practices that may occur in connection with GPOs. The Agencies will examine, on a case-by-case basis, the facts of any alleged anticompetitive contracting practice to determine whether it violates the antitrust laws.

8th Observation:

Countervailing power should not be considered an effective response to disparities in bargaining power between payors and providers.

Although there appear to be disparities in bargaining power between some payors and some providers, the available evidence does not indicate that there is a monopsony power problem in most health care markets. Even if it were assumed that providers confront monopsony health plans, the Agencies do not believe that allowing providers to exercise

countervailing power is likely to serve consumers' interests.

9th Observation:

Private parties should not engage in anticompetitive conduct in responding to marketplace developments.

The permissibility of unilateral and collective provider conduct in response to marketplace developments (including P4P, tiering, SSHs, and ASCs) is raised in several different settings in the Report. Generally speaking, antitrust law permits unilateral responses to competition. If there is specific evidence of anticompetitive conduct by individual providers or provider collusion in response to marketplace developments, the Agencies will aggressively pursue those activities.

10th Observation:

The state action and Noerr-Pennington doctrines should be interpreted in light of the principles that justified those doctrines in the first place.

The state action and Noerr Pennington doctrines curb competition law to promote important values such as federalism and the right to petition the government for redress. Inappropriately broad interpretations of these doctrines can chill or limit competition in health care markets. It is important to recognize both the genuine interests these doctrines serve as well as the anticompetitive consequences that result from an overly expansive interpretation of their scope.

11th Observation:

Remedies must resolve the anticompetitive harm, restore competition, and prevent future anticompetitive conduct.

Remedies are a critical issue in implementing an effective competition policy. Optimal enforcement must steer between over-deterrence and under-deterrence. Over-deterrence may occur if conduct that is not, in fact, anticompetitive is challenged, or if excessive sanctions are imposed on anticompetitive conduct. Under-deterrence may occur if anticompetitive conduct is not identified and addressed, or if inadequate remedies are imposed in response to such conduct. The Agencies must avoid both of these extremes to effect optimal deterrence, while recognizing that bringing cases helps create a "compliance norm."

The Agencies view all anticompetitive conduct as serious, and will seek appropriate sanctions. In general, much more stringent measures are necessary against those who violate the antitrust laws repeatedly or flagrantly and those who facilitate anticompetitive conduct by multiple parties. The Division will also pursue criminal sanctions in appropriate cases. Disgorgement and/or dissolution will be sought in appropriate cases.

VIII. CONCLUSION

The fundamental premise of the American free-market system is that consumer welfare is maximized by open competition and consumer sovereignty – even when complex products and services

such as health care are involved. The Agencies play an important role in safeguarding the free-market system from anticompetitive conduct, by bringing enforcement actions against parties who violate the antitrust and consumer protection laws. To be sure, in some instances compelling state interests may trump or limit free-market competition. The Agencies play an important role here as well, by making policy makers aware of the costs of impediments to competition, and by advocating for competitive market solutions.

The Agencies do not have a pre-existing preference for any particular model for the financing and delivery of health care. Such matters are best left to the impersonal workings of the marketplace. What the Agencies do have is a commitment to vigorous competition on both price and non-price parameters, in health care and in the rest of the economy. Much remains to be accomplished to ensure that the market for health care goods and services operates to serve the interests of consumers. This Report identifies concrete steps to improve competition in the health care marketplace, and improve the application of competition law to health care.

CITIZENS HEALTH CARE ASSOCIATION

COMMENTS IN OPPOSITION OF KANSAS SENATE BILL 235

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- **Introduction**

- **Opposition to S.B. 235 – A CON Law in Disguise**

- **Double Standards – Perception vs. Reality**

(a) Excess Capacity. When traditional hospitals complaint about duplication, about too many providers, or excess capacity, they are actually expressing their contempt for competition. In the absence of sustained competition, a provider has little incentive to offer the highest quality service at the lowest price. Who decides the correct number of beds?

(b) Name Calling.

(i) Specialty hospitals are now referred to as "niche" or "limited service" providers. Hospitals refer to themselves as "community hospitals"

(ii) Physicians who invest in specialty hospitals are called "cherry pickers" or "profiteers" – what should we call investors and managers of for-profit hospitals?

(c) Self-Referral. Hospitals are now referring to the laws under which specialty hospitals were built as "loopholes" which allow physicians to profit at the expense of patients. What about employed physicians? Who has taken Hippocratic oath?

(d) Patient Choice. The words that you do not hear from hospitals are "patient choice".

(e) Hidden Truth. Under the smokescreen of duplication, excess capacity, cherry picking and profiteering, lies the truth of the general hospitals' concern: Who will control the new facilities? Who will control the delivery of healthcare services?

Senate Health Care Strategies Committee
Date: March 3, 2005
Attachment 3

► **Reasons for Development of Specialty Hospitals**

(a) Greater control over patient care delivery

(b) Greater control over health care environment and productivity

(c) Better quality with specialization and volume

(d) Greater control over management decisions

(e) Additional source of income

► **Fundamental Questions**

(a) How do general hospitals plan to use their tax-exempt margins (profits)? For additional services to the indigent? For programs to enhance the quality services to all patients in the community?

(b) Will profits be used for better technology? Or for buying and controlling more physicians and physician practices? Or for eliminating competition and reducing patient choice? Or for funding massive legislative efforts to stamp out competition through prohibitions on any facilities that compete with traditional hospitals?

(c) By eliminating competition through the acquisition of physician practices, or by blocking new, competitive inpatient services, hospitals undermine the primary system of checks and balances in health care – patient choice. When patient choice vanishes, control shifts from patients to committees of business executives and general hospital administrators who claim to have community health as their primary interest while, at the same time, often demonstrate contempt for competition.

► **Conclusions**

Proponents of the moratorium on specialty hospital development are willing to sacrifice cost-effective improvements through innovation; investment in new technologies; quality services; and, patient choice and convenience which, as the technology of healthcare advances, offer a true and valid opportunity to provide cost-effective quality healthcare.

The ideal healthcare delivery system seeks value by considering all-important components: access, quality, beneficial outcomes, the appropriate cost benefit relationship, as well as *patient choice*.

Oligopoly and *monopoly* impede the pursuit of the value ideal in the U.S. healthcare delivery system.

MEMORANDUM

TO: CHAIRMAN WAGLE AND MEMBERS OF THE HEALTH CARE STRATEGIES COMMITTEE

FROM: CITIZENS HEALTH CARE ASSOCIATION

SUBJECT: KANSAS SPECIALTY HOSPITAL MORATORIUM (S.B. 235) CONFLICTS WITH MEDICARE/MEDICAID LAWS

DATE: FEBRUARY 25, 2005

BACKGROUND

A proposed Kansas Specialty Hospital Moratorium, Senate Bill 235, was introduced in the Kansas Legislature on February 9, 2005. Generally, Senate Bill 235 imposes a moratorium on the construction of specialty hospitals within the State of Kansas. This memorandum responds to your request for preliminary research and discussion regarding the potential conflicts with Medicare and Medicaid guidelines (and related federal program funds available to the State of Kansas under said programs). Said conflicts may arise in that a state moratorium may conflict with and effectively extend the scope and time of the federal specialty hospital moratorium imposed by the Medicare Prescription Drug Improvement and Modernization Act of 2003 ("MMA").

FEDERAL SPECIALTY HOSPITAL MORATORIUM

Under Section 1877 of the Social Security Act (42 U.S.C. §1395nn), a physician cannot refer a Medicare patient for certain designated health care services ("DHS") to an entity with which the physician (or an immediate family member of the physician) has a financial relationship unless an exception applies. Section 1877 also prohibits the DHS entity from submitting claims to Medicare, the beneficiary, or any other entity for DHS that are furnished as a result of a prohibited referral. The statute, however, enumerates various exceptions, including an exception for physician ownership in hospitals (herein referred to as the "whole hospital exception") that allows physicians to refer Medicare patients to a hospital in which they have ownership or investment interests, as long as the

physicians are authorized to perform services at the hospital and their ownership or investment interests are in the whole hospital and not a subdivision of the hospital.

Section 507 of the MMA added an additional criterion for the whole hospital exception, specifying that for the 18-month period beginning on December 8, 2003 and ending on June 8, 2005 (the "federal moratorium"), physician ownership and investment interests in "specialty hospitals" would not qualify for the whole hospital exception. In other words, for this 18-month period only, a physician may not refer a patient to a hospital in which he or she has an ownership or investment interest if the hospital is a "specialty hospital".

For purposes of the MMA, a "specialty hospital" is defined as a hospital that is "primarily or exclusively engaged in the care and treatment of one of the following: (a) patients with a cardiac condition; (b) patients with an orthopedic condition; (c) patients receiving a surgical procedure; or (d) patients receiving any other specialized category of services designated by the Centers for Medicare & Medicaid Services ("CMS"). Certain specialized hospitals, however, were expressly excluded from the definition of "specialty hospital" (including psychiatric hospitals, rehabilitation hospitals, children's hospitals, long-term care hospitals, certain cancer hospitals, and existing specialty hospitals that satisfy the grandfathering provisions in Section 507 of the MMA).

FRAMING THE ISSUE

Senate Bill 235, proposed February 9, 2005, in the Kansas Legislature, attempts to establish a state law moratorium on the construction of specialty hospitals within the State of Kansas. Concern has been raised regarding policy and federal preemption conflicts between the federal specialty hospital moratorium and any Kansas state moratorium that is inconsistent in either scope or time with the federal moratorium. Particularly in the event that Congress allows the federal moratorium to expire (a possible outcome, in our opinion, in light of the findings of the Medicare Payment Advisory Commission ("MedPAC") study regarding benefits of specialty hospitals), conflict will

almost certainly arise between any Kansas moratorium that would deny licensing or limit reimbursement to Kansas hospitals that are otherwise fully Medicare certified under federal law. Thus, a Kansas specialty hospital moratorium that varies in any respect (scope, time, application, enforcement, etc.) from the federal specialty hospital moratorium will clearly contravene federal public policy by interfering with established federal statutes and policies allowing provider reimbursement for Medicare services. Of even greater concern may be the similar effects of these conflicts on provider and State access to federal Medicaid funds, as explained in the following section.

MEDICAID / MEDICARE PREEMPTION

Title XIX of the Social Security Act, also known as Medicaid, is a federal-state matching entitlement program which provides medical assistance for certain individuals and families with low incomes and resources. Within broad national Medicaid guidelines imposed by the federal government, each state (a) establishes eligibility standards for participating beneficiaries; (b) determines the type, amount, duration and scope of services; (c) sets the rate of payment for services; and (d) administers its own program. The federal government also shares in the states' expenditures for administration of the Medicaid program. Most administrative costs are matched at fifty percent (50%) for all states, but, depending on the complexities and the need for incentives for a particular service, higher matching rates are authorized for certain functions and activities. Federal Medicaid payments to states have no set limit; rather, the federal government matches the state payments for mandatory services plus the optional services that the individual states decide to provide for eligible recipients. However, these matching funds are only available if the state is in compliance with the broad national guidelines imposed by the federal government as a condition to state participation in the Medicaid program.

Specialty hospitals typically provide inpatient and outpatient hospital services which are among the mandatory services that states must provide to Medicaid beneficiaries. In addition, to be eligible for federal Medicaid funds, states are required to provide Medicaid coverage for groups which include certain Medicare beneficiaries who have low income and limited resources (sometimes known as "dual eligibles"). Effectively, for Medicare recipients who also are eligible for Medicaid coverage, the Medicaid program supplements Medicare coverage by providing services and supplies that are available under the state's Medicaid program.

To comply with federal guidelines, states must communicate and obtain approval for the design of their Medicaid plan with CMS by delivery and approval of their state Medicaid plan. When a state desires to change Medicaid benefits it offers, or change the way in which they are offered, it must submit a state plan amendment ("SPA") for prior formal approval by CMS. Not surprisingly, CMS has an intricate system for evaluating proposed SPA's and ensuring that any changes in state Medicaid plans are consistent with both the national Medicaid conditions of participation and federal public policy.

Any change in the Kansas State Medicaid plan relating to a state specialty hospital moratorium that differed in any respect from the federal moratorium, therefore, would require an attempted SPA that would openly conflict with the national Medicaid guidelines and federal public policy. Thus, any Kansas specialty hospital moratorium SPA could properly by rejected by CMS or, if allowed in some respect, could cause the Kansas State Medicaid plan to fall out of compliance with the national Medicaid plan requirements and lose federal funding. Further, and in either event, any Kansas statute or related SPA attempting to limit access to specialty hospital providers that are otherwise fully Medicare and/or Medicaid licensed would be in direct contravention to the federal public policy supporting the national guidelines: ***unlimited access for the Medicaid patient population to all***

providers properly licensed under federal law to provide healthcare services and receive reimbursement from the Medicaid program.

ADDITIONAL ISSUES AND CONCLUSION

Proposed Senate Bill 235 creates a number of potential state problems, both from a policy-standpoint and from a Medicare-Medicaid participation standpoint, that, in our view, are wholly unnecessary given the intensive federal public policy analysis regarding participation by specialty hospitals in the Medicare programs that is being properly conducted by MedPAC and reported to Congress. Further, any conclusions in this regard, as they relate the federal Medicare and Medicaid programs, should be properly implemented through Congress and are within the jurisdiction of CMS. Beyond these clear federal public policy issues, we also believe there are several additional technical problems likely to be barriers to any state specialty hospital moratorium.

First, competing and inconsistent federal and state moratoriums create potential jurisdictional nightmares for enforcement, particularly for states, because Medicare and Medicaid enforcement falls under the exclusive jurisdiction of the Secretary of the U.S. Department of Health and Human Services ("HHS"). Second, establishment of a state moratorium that extends beyond the federal moratorium, either in scope or time, effectively reduces the number of available Medicaid providers and otherwise impairs the state's ability to provide mandatory inpatient and outpatient hospital services to beneficiaries, as required by federal Medicaid guidelines. Moreover, the Kansas Medicaid Manual contains a "free choice provision" (implemented under 42. U.S.C. §431.51) which requires that Medicaid recipients be allowed the same opportunities to choose among available providers of covered health care services as are normally offered to the general population. Permitting states to limit construction of facilities that may otherwise be allowed under federal law and certified to be in compliance with federal guidelines would clearly be a restriction in available Medicaid services by the state. Again, Kansas changes to its Medicaid plan to implement a Kansas specialty hospital

moratorium would necessarily result in lack of compliance with the nationally mandated Medicaid program and potentially result in the loss of matching federal Medicaid funds. There is simply no reason for Kansas to take this risk when it simply flies in the face of the federal public policy to make willing and qualified providers available to Medicare and Medicaid program beneficiaries.

3-8

A New Concept in Hospitals

A few years ago a small number of physicians sat down to ask how they could continue to have a voice in the care of their hospitalized patients. Also could we give them another and yes a better option? With large insurance companies, layers of administrators in large city hospitals and vertical integration, both control and the ability to influence were gone.

Reborn was the idea of physician run hospitals where they made both the clinical and the business decisions. They were personally at risk financially and yes as part of the investor pool could make a financial gain. Speciality hospitals arrived first as there were already models already in existence and they was simpler to develop. Strategy- spend the money on patient care! Best people, best working conditions, salaries , technology; give the patients the best care possible. Results: phenomenal patient satisfaction, best morbidity-mortality rates for all severities of illness, best length of stay and best cost performance in the county. The first year we sent money back to medicare!

As time evolved we saw that this same mindset needed to reach out to broader range of patients; they often have more than one body system that needs help; beyond a speciality hospital. A new and probably more enduring model of a small physician run hospital was developed in this case for Andover. It based on the lack of a local general hospital.

The Andover project will start with a staff of 40-50 selected physicians and offer services in anesthesiology, blood bank, cardiology, dentistry, 24hour emergency room, family practice, gastroenterology, general surgery, hematology and cancer care, infectious disease, internal medicine, laboratory medicine, nephrology and dialysis, neurology, plastic surgery, pulmonary medicine, radiology with full CT service, thoracic surgery and urology. There will be 60 beds with onsite outpatient clinics soon to follow. If our previous numbers and projections hold we will give uncompensated care at a rate slightly greater than the not for profit hospitals do as a percentage of overall revenue.

Senate Health Care Strategies Committee
Date: March 3, 2005
Attachment 4

In my own speciality the majors still struggle with long wait times for urgent diagnostic and surgical services. One of the majors has had an unofficial review by a recent VP of Medical Staff of unacceptably high mortality rates with myocardial infarction , the other has had chronically poor outcomes at bypass surgery for decades. I won't send my family there now that there is a better option. Who will you send there?

Freedom. The right to choose. Improving service. A community hospital. Is this still not America? Just what might we destroy with Bill 235?

Dear Senator:

I am writing with regard to Senate Bill #235. As a Kansas native and practicing anesthesiologist, I have some interest in this legislation. I was born and raised in Pratt Kansas, attended Pratt County Community College, Pittsbrug State University, Kansas State University and the University of Kansas where I received my MD. After medical school I did my internship and residency in anesthesiology at the University of Utah in salt Lake City where I was appointed Chief Resident in 1982. As Chief resident I was involved in the world's first artificial heart transplant and other research project. I was subsequently offered a faculty position at the University of Utah. I declined this opportunity and returned to Kansas to start a practice in anesthesiology in 1983. Since then I have performed anesthetics at all of the major hospitals, most of the specialty hospitals, and many of the surgery centers in Wichita. In addition I have performed anesthesia at Central Kansas Medical Center in Great bend, St Joseph in Larned, Susan B. Allen in Eldorado, Newton Memorial in Winfield and Mercy Hospital in Independence. Experience has taught me that each hospital has its own special bond with the patient population that it services.

I now practice anesthesiology at Via Christi, St Francis in Wichita, the largest hospital in Kansas. I do not mean to portray these large hospitals as uncaring or impersonal but they are, by their very nature, tertiary care centers. As such, they are not perceived by most patients in the same light as the "hospital back home". Patients are often confused by the shear immensity of the building and it is not uncommon to find families wandering the halls in search of the correct bank of elevators to get to the parking garage. Families and friends also find Wichita traffic to be an obstacle when trying to be with a patient. It is often hared for patients to feel at home during their treatment and recovery from illness.

I am against Senate Bill # 235 because I believe that it is important not to limit the building of any hospital in this State. As we "baby boomers" age, Kansas is going to need more health care availability not less. Furthermore, I truly believe that patients prefer the intimacy of a "small town" hospital, where family and friends can be there for them. Bigger is not always better. Small, efficient, and friendly is the way of the future in health care.

I have known Dr Badr Idbeis and Colleagues for over 22 years and consider it an honor to

Senate Health Care Strategies Committee
Date: March 3, 2005
Attachment 5

be invited to provide anesthesia services at the new hospital that is planned for Andover this year. Dr Idbeis is a visionary for health care and a man of his word. I have seen the plans for this amazing new facility and it will be truly worthy of its name, the Kansas Medical Center. It will bring the very best of what medicine has to offer to the people of Andover. It will serve Butler County as an educational center for Nurses and others in training at the Community College. Not only will it bring "State of the Art" technology to Andover but it will be an economic force for the entire area. It will be a hospital that the town will speak of with pride and enthusiasm. The physicians involved with this project are compassionate and competent: they will do whatever it takes to provide the very best care for their patients. It would be a travesty to not allow this facility to be built.

I know something of a small town hospital, I was born in one. Growing up in Pratt, every time I needed stitches or a tetanus shot the hospital was there for me and my family. My father passed away two years ago and was able to be surrounded by his family and friends up to the end because of that hospital. My family and I will always be grateful for the compassion and care that the hospital has provided. This is the essence of health care in our State and I hope we never lose sight of that. Please vote no on Senate Bill #235.

Sincerely:

Edward J. Wade, MD
14554 SW 60th St
Andover, KS 67002

I had initially expected my correspondence with this committee to end with the letter that I just read. However, something happened to me last week that needs to be presented. It seems that the administration at Via Christi learned of my letter, and, subsequently, my employer was severely admonished for my position on Senate Bill 235. On Thursday February 24th I was instructed to resign my position as a staff anesthesiologist with Anesthesia Consulting Services because **"Via Christi would not tolerate my involvement with this other hospital".** My contract with Anesthesia Consulting Services has never restricted my participation in planning and/or investing in other health care entities, nor do my medical staff privileges at Via Christi. For the record, I have been involved in planning, investing and providing anesthesia services at other hospitals and surgery centers in Wichita. I helped to start the Cataract Surgery Center (aka Team Vision Network), the Center for Same Day Surgery, and the Kansas Surgery and Recovery Hospital. It should also be noted that Via Christi is the majority owner of all of these other health care entities.

I was told that my employment is to be terminated because Via Christi does not want me to be involved specifically with the Kansas Medical Center in Andover. I was told that the administration at Via Christi was angry that I wrote a letter to try to stop Senate Bill 235. I was not given the opportunity to explain my position nor divest any interest that I might have … I was summarily instructed to resign. There are literally hundreds of physicians in Wichita who have, in one form or another, invested planned and assisted in the building of other health care entities without such reprisals. Why should Via Christi be so upset with my actions?

It seems to me the largest health care providers in Kansas want to have protection from any competition what-so-ever. Why else would a 60 bed hospital in another County worry them so much? It's like WalMart asking the city council to shut down the local "Five & Dime" or Microsoft demanding protection from a start up software company … It just isn't right.

In the final analysis, I feel that it comes down to "basic fairness". It is not fair to prevent a smaller competitor from entering the marketplace. It is not fair to the patients in our State to limit the competition among hospitals. And, it is not fair to the citizens of Andover, or any other town, to tell them they can't have a hospital of their own, no matter who builds it. If Senate Bill # 235 is successful then the people of Kansas will have to rely on the large hospital systems to provide this "basic fairness". By recent actions toward myself and others I'm not sure these large hospitals understand the meaning of "fair play" … but I am certain that the people of Kansas do! Please vote no on Senate Bill # 235.

Sincerely:

Edward J. Wade, MD

Mid America Surgical Associates
Cardiothoracic and Vascular Surgery

Gary Benton, M.D., F.A.C.S.
Robert Fleming, M.D., F.A.C.S.
Badr Idbeis, M.D., F.A.C.S.
John D. Rumisek, M.D., F.A.C.S.
Richard S. Toon, M.D., F.A.C.S.

March 2, 2005

Dear Senators:

My name is Gary Benton. I was born and raised in Arkansas City, Kansas. I attended Washburn University as an undergraduate and completed my medical school education at Tulane School of Medicine in New Orleans. I completed my surgical residency at the Medical College of Virginia, Richmond, in general surgery, cardiothoracic surgery, and transplant in 1992. That year I returned home to Kansas to practice medicine. I currently am a cardiothoracic surgeon who works in Wichita and resides in Andover.

For 25 years, many in Kansas including the legislature, have spent a great deal of time and money to improve medical care and medical access in Kansas, especially rural Kansas. These efforts have largely gone unrewarded. In the past five years regional medical centers have developed in Hutchinson, Hays, and Salina delivering tertiary care to rural folks that might not otherwise seek it in urban centers. Hospitals in these areas had the foresight to invest in capital improvements and doctors, some of which would be prohibited by Bill 235. These programs have been very successful in attracting new specialists, improving the overall quality of medical care in the community, and dramatically improved medical access in rural Kansas.

If the above statements are true, and they are, then this committee must ask itself why those that have benefited from Kansas' efforts to improve rural care and access are for Bill 235. I am referring to the large urban hospitals that are greatly benefited from extra state and federal payments for participating in resident training, in part to provide doctors for rural Kansas. There are more rural medical centers in the planning phase in Kansas. If these centers are developed, health care for rural Kansas will improve.

To illustrate this, I want to provide you with once scenario that occurs daily in Kansas. A rural Kansan suffers an acute myocardial infarction in a town of 15,000 (or 500) people 2 1/2 hours from the nearest urban tertiary center. He or she is transported to the local hospital emergency room. At this point the patient's care diverges depending upon your vision for Kansas health care. The

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first scenario is the status quo. The patient is given a thrombolytic, which may or may not abort his myocardial infarction and can complicate further care. He is then transported by air or land ambulance to an urban tertiary center, delaying his care 2 to 4 hours. Or, the patient can be transferred from his local ER upstairs to his local heart catheterization lab and have definitive therapy within an hour.

Finally, I would like to address two points that were raised by the proponents of this bill. The first is that those that were involved in the Kansas Heart Hospital project early on realized that resident training was important in the process. Dr. Idbeis approached the University of Kansas and offered to sponsor a resident at the Kansas Heart Hospital, and the offer was declined. Finally, yesterday, a great deal was said about profitability or nonprofitability in charitable care to this committee by the proponents. Unfortunately, terms like "patient care", "patient access", "patient satisfaction", and "patient outcome" were not addressed. These are really the categories that need to be evaluated when looking at the overall quality of the health service line. All of these categories were outstanding at the Kansas Heart Hospital. If I were a member of this committee concerned about health care costs in Kansas I would have to ask myself how a group of physicians produced a better product line at a lower cost. Indeed, these regional medical health centers may be the answer to some of Kansas' health care costs instead of the problem. I believe that Senate Bill 235 is not in the public interest. Thank you.

Sincerely yours,

Gary S. Benton, M.D.
GSB/mjs

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The City of
EST. 1957
ANDOVER
KANSAS

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Andover, Kansas 67002

Phone (316) 733-1303
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02-28-05

Senate Healthcare Strategies Committee Members,

On behalf of the City of Andover, I would like to offer the following comments regarding proposed Senate Bill 235.

Economics of Free Trade- This bill is in direct contradiction to a market driven economy in the State of Kansas. Protectionist legislation has never served our state well, nor should we expect it to. Competition is the cornerstone of our economy and when theories of state governmental interference are forcibly applied to capitalistic markets, they simply create separate interests in a struggle against each other. Simply put, Bill 235 appears to be a formation of theory, creating in its possible wake, an unjust device for realizing it. While this bill may provide the Legislature additional time to consider the effect of *specialty* hospitals, the proposed moratorium would in reality be, a restriction of free enterprise.

Health Care Matters- The absence of local healthcare for residents of the City of Andover is of great concern to us. This is not to say we do not have access to acute hospital care, but there are no local alternatives currently available. Market research indicates Western Butler County can support additional hospital capacity, a fact Bill 235 proponent Susan B. Allen Hospital in El Dorado has alluded to. I find it ironic however, that no area or regional hospital, including Susan B. Allen, had expressed an interest to accommodate our rapidly growing population until this recent hospital proposal was introduced. With a growth rate of approximately one thousand people a year, a *general* hospital in Andover will fill the current void and will allow residents the opportunity to seek and receive medical services within their own community. Healthcare is supposed to revolve around a patient's right to choose their doctor and how and when they will be treated. It is enough that large insurers govern most all of these decisions already, but Bill 235 will deny our citizens of their last vestige of choice: Where. One of the essential functions of government is to create an environment that enables people to live better. I do not see this bill as an opportunity to do so.

Economic Impact- The proposed general hospital will be tax paying entity; unlike the regional hospitals that support this bill. In its current design, it will employ almost 150 people and have an assessed valuation of around $22 Million. The tax benefit to Butler

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County, the City of Andover, U.S.D. 385 and Butler Community College will be profound. The successful completion of this hospital will lessen the tax burden across the area and given the severity of non-funded mandates by the State and Federal government, coupled with the one-hundred percent elimination of LAVTR and the city-county revenue sharing, it will be a welcome relief. Private party, tax paying businesses like this, enable municipalities and other agencies to provide for themselves, without leaning on the State for assistance. It makes reasonable sense for the State of Kansas to promote and foster this type of activity, rather than to thwart it through legislation.

We are opposed to Senate Bill 235 for the aforementioned reasons and would encourage the committee to explore other avenues in their efforts to ensure affordable and available care for all of the citizens of Kansas. In lieu of discarding the Bill and if there is a desire by the committee, a certain amendment may allow all parties to reach a satisfactory conclusion in this matter. I would be pleased to discuss this at the hearing.

With respect,

Ben Lawrence-Mayor
City of Andover

Cc: Andover City Council

The City of

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To the Chair and Members of the Kansas State Senate Committee on Health Care Strategies

Testimony by Jeff Bridges, City Administrator, City of Andover, KS as an opponent to Senate Bill 235

Contrary to many of the remarks by the proponents, this facility is not in Wichita, it is not even in Sedgwick County, this project is in the City of Andover located in Butler County and it is not a limited service hospital but a full service general hospital. Since the closing of the Augusta Hospital several years ago, Butler County has only one hospital serving a land area larger than the State of Rhode Island. That hospital, although well respected, cannot and does not provide a full range of services. The new general hospital in Andover will help fill the voids in Butler County such as cardiac care and provide additional emergency room operations.

Currently Butler County has only four ambulances on duty at any one time with one stationed in the Andover Fire Station. If that ambulance has to transport a patient into El Dorado or Wichita, we loose the services of that unit for over an hour. In that time other units throughout the County must shift to cover the out of service unit. Having a full service community hospital in Andover would decrease the time that these ambulance units are out of service and keep them available for emergency operations in Butler County a higher percentage of the time. Emergency service personnel in Andover respond to calls on US 54, I35 and 254. It only makes sense to have emergency care in Andover at what is basically the crossroads of these three interstate highways.

We heard from some of the proponents of the bill that this facility is not necessary to service the hospital needs of the community. If that is so, why does Susan B. Allen Hospital in El Dorado, a proponent of this bill, have plans to open a facility in Andover? If the Andover Community has a choice between a not-for-profit, non tax paying hospital, and a-for profit, tax paying, full service hospital, I would expect we would want the one that will pay almost $800,000 per year in property taxes. I find it difficult to believe that in this rapidly growing community there is not a need for additional hospital services nor can I believe that this full service hospital will disrupt the billion dollars a year health care systems represented by the proponents of the bill.

There has been some discussion regarding the term "established" and what that actually means in the bill. In the City of Andover's view, this project is established. The City started construction of a $750,000 sewer line in early January to serve this project and the adjacent properties. If this project is halted, the City tax payers will have to pick the share of the costs for this line which would have been the responsibility of the hospital. Not a very good position to put the 9,000 people of Andover in.

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South Central Kansas
Regional Medical Center

Chief Executive Officer
Joe Jirinec, CHE

March 2, 2005

My name is Aaron Watters and I am a rural Family Physician residing in Ark City, KS.

Kansas was settled by hardworking individuals seeking the possibilities and independence that the prairie had to offer. From the earliest Kansans an attitude of self-reliance, fortitude, and hard work were passed down for generations. Today the same pioneering spirit is found in the rural healthcare system.

As rural healthcare providers, we find ourselves in a unique and challenging position compared to our urban counterparts. We are continually challenged to provide "state of the art" healthcare while being able to keep our doors open for business. Unfortunately, more and more rural facilities are being forced to close their doors due to financial, procedural and structural problems. Instead of complaining and shutting down our services in such great adversity, together our medical staff, our hospital and our community are trying to thrive.

Our current facility is not unlike dozens of others in Kansas aged to the point of dilapidation. However, we are in the process of obtaining a FHA HUD 242 insured mortgage loan so we may build a replacement hospital. This loan came as the last and only available option because our city, our community and our physicians could not afford to build a new facility.

Our community and our physicians have been completely dedicated to ensure healthcare to our citizens, in a timely and efficient manner. Our physicians have invested countless time and money and have agreed to invest in the future of our community by taking partial ownership of the hospital. Through this pulling together as a community, as a hospital, and as a medical staff we feel that we may have a prototype that the rest of rural Kansas might follow in order to ensure rural healthcare in their community.

It is our great concern that Senate Bill 235 could stop or severely impact our project negatively, along with the future of rural Kansas. Any state issued moratoriums would have to be considered as HUD deliberates the funding of the SCKRMC replacement facility. After 1.6 million dollars, countless hours, and a tremendous effort over the last 4 years, a delay in this process would be a

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South Central Kansas
Regional Medical Center

Chief Executive Officer
Joe Jirinec, CHE

deathblow to the project. Without a replacement facility, we will not be able to be competitive with larger urban hospitals for physician recruitment, state of the art services and equipment.

In turn, a community without local healthcare providers is not at all likely to experience any growth or prosperity. In the event we lose our hospital, we lose our physicians. The local economy is heavily dependent upon the jobs provided by the local healthcare industry. The physicians rely upon timely intervention when dealing with patients who may not survive the "golden hour" while being transferred to an urban facility. Our urban counterparts would love to see us more and more dependent on them as our rural community hospitals continue to close down but we are desperate to continue striving towards our goal.

Essentially, rural hospitals and rural providers are crucial to every aspect of survival to a rural community. Therefore, we respectfully request that you do not support Senate Bill 235 and allow our community and hopefully other rural Kansas communities to continue to progress. This will enable your physicians to provide the exceptional quality healthcare that all Kansans deserve.

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CITY OF ARKANSAS CITY

March 2, 2005

Senate Committee on Health Care Strategies
Honorable Committee Chair Wagle
Honorable Committee Vice Chair Brungardt
Honorable Members of the Committee:
Barnett, Jordan, Journey, Palmer, V. Schmidt, Haley, Gilstrap

Re: Testimony Regarding Senate Bill #235

Ladies and Gentlemen:

The City of Arkansas City is currently owner of the South Central Kansas Regional Medical Center hospital in Arkansas City. The hospital was built over 50 years ago, and currently serves residents in Arkansas City and southern Cowley County, and in northern Oklahoma. The hospital not only provides essential medical care for our citizens, but it is a key to the economic future of our community in our ability to retain and attract employers and families to live in our community, to continue to attract top quality physicians, as well as to serve members of our senior population. In addition, the hospital is a significant employer for our community.

For nearly ten years, the City and its hospital Board of Trustees have been looking for solutions to provide for either significant renovation of the facility or a replacement facility. For the last five years, the effort has focused primarily on a private replacement hospital that would be spearheaded and owned by the local physicians in our community. Much work has been accomplished to date towards this project, including completion of the plans and specifications, acquisition of the site, and application for various financing mechanisms to finance the project. We think that we may be within a few weeks of actually getting underway with construction of our new hospital.

The City is concerned that the bill currently being considered could in some way be construed as being applicable to the replacement hospital in Arkansas City. After all of the years of effort, and over a million dollars of expense that has gone into getting this project to its current point, it would be a devastating blow to our community if the new private replacement hospital could not proceed.

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P.O. BOX 778 • 118 W. CENTRAL • ARKANSAS CITY, KANSAS 67005-0778 • PHONE (620) 441-4400 • FAX (620) 441-4426
www.arkcity.org

We would like for the committee to consider whether or not a moratorium on privately funded and operated hospitals is a wise move for the State of Kansas in terms of providing adequate medical care to the State's citizens. Many times moratoriums disrupt natural market forces which, while seeming to have a good effect, actually work in a disruptive and inappropriate manner. Aside from that, we would like to request that the committee consider specifically exempting the Arkansas City replacement hospital by adding language to that effect in the bill or the record of the committee, so that there is not any question at some future point in time as to whether this law, should it become effective, would be applicable to the replacement hospital project in Arkansas City.

We also want to make it clear that the City of Arkansas City fully supports the efforts of the South Central Kansas Regional Medical Center Board of Trustees and the medical staff in Arkansas City to develop this private replacement hospital. There is not a competing interest between the City, who is the current owner of the hospital in our community, and this project. We respectfully request your consideration of our testimony.

Sincerely,

Wayne a Short

Wayne Short
Mayor

WS/nc

Kansas Senate March 4, 2005

Good afternoon Senators,

My name is Douglas Palzer; I am the CEO of Physicians General Hospital in Lenexa, KS. I am here today to express my opposition to Senate Bill 235. I provided a statement to the committee yesterday that I had intended to read today. That letter outlines the critically needed services that Physicians General Hospital will provide and the impact that this full service hospital will have on the community that it will serve. Please review that document at your leisure. I have decided however, not to read that document today. But rather to address some of the issues discussed in this committee yesterday.

The statement was made yesterday that the main purpose of bill 235 is to stop the uncontrolled development of specialty and limited service hospitals in Kansas. By doing so, the two largest hospital systems in the state wish through legislation, to keep the status quo and thereby protect their financial positions. Unfortunately, although Physicians General Hospital falls outside of the intent of this bill, it is none-the-less adversely impacted by this legislation and will by default negatively impact the communities that this hospital will serve. The spokesperson from Via Christi stated yesterday that he welcomes competition from other hospitals as long as it is on a level playing field. That is what I am asking to do, but this bill, in the way that it is written, will prevent me from having that opportunity. I intended to speak only of the positive impact to my community that Physicians General Hospital will provide and how this hospital will address critical needed medical services. I was hoping to avoid having to address the specialty hospital issue and allow others to address this topic. I now find myself unable to do this.

The solution to this problem is **not** through legislation, but rather through cooperation between physicians and hospitals and by these entities partnering to build facilities that meet the communities' needs. I am not aware of a single specialty hospital that would not welcome the opportunity to allow hospital investment. The largest obstacle that I have seen to date in the limited hospital partnerships with current specialty hospitals; is not money, but rather the issue of operational control of these facilities. Physicians feel and rightfully so, that if they have operational control they can manage the costs and thereby, generate larger profits. The second issue is that they do not want to continue to be under the thumb of hospital administrators.

Let there be no doubt in your minds, this bill is truly about greed and control. Healthcare and hospitals in particular are big business representing hundreds of millions of dollars in Kansas every year. Why should the large hospitals share these massive revenues with physicians if they don't have to? As long as there is such a drastic difference between what physicians are paid verses what the hospitals receive, there will be an overwhelming desire by physicians to participate on more equitable bases.

The proponents of this bill asked you to overlook the adverse economic impact that this bill will have on the communities that you represent. They said don't take into consideration the loss of tax dollars to the communities or the negative impact of high paying jobs that would be lost by passage of this bill. They ask that you disregard the negative impact to these communities that

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will continue to occur because of the lack of new and expanded critical needed medical services. They say you should only be concerned about protecting the status quo and their financial interests.

I am sadden to say that I did not hear yesterday how this bill will; improve the quality of care to our patients, or how it will lower hospital infections rates, or how we will continue to retain qualified nurses or increase the number of nurses compared to patients. I did not hear how this bill will improve the level of health services to the community or increase services to the low income populations.

I share this committees concern about the current status of healthcare in Kansas today as well as into the future. The healthcare system needs to be overhauled. Unfortunately, this overhaul will not be accomplished by legislation. Change must come from within the system based upon pressures applied by outside sources. This pressure to be effective will need to come from one of two sources. Either from direct competition by other hospitals or by local community outcry demanding change. This bill will not bring about these changes and will by its design further delay their implementation.

I strongly recommend that you oppose this bill while it is still in committee. Thank you for your attention.

Douglas C. Palzer, CEO
Physicians General Hospital
9300 Renner Blvd.
Lenexa, KS 66219
913-492-0160

Kansas Senate March 3, 2005

Good afternoon Senators,

My name is Douglas Palzer, I am the CEO of Physicians General Hospital and am here today to express my opposition to Senate Bill 235. This bill is anti-business in nature and is self serving in design. No other business sector in the state would be allowed to unilaterally stop competitors from building facilities that may create fair competition.

Physicians General Hospital is currently in the process of building a $60 million hospital in Lenexa, KS. If this bill is allowed to pass, it would severely delay this project and would cause a severe set-back to the economic development of the City of Lenexa and both Wyandotte and Johnson Counties. Since we are anticipating constructing up to 15 separate businesses on this site, to include 4 hospitals (General Hospital, Psychiatric Hospital, Long Term Acute Care Hospital (LTACH), and a Bariatric Hospital), passage of this bill would mean a loss to the community of over 500 new high paying healthcare jobs. This hospital, by default will be the community hospital for the City of Lenexa and the surrounding area. There currently are no hospitals between Overland Park Regional Hospital in Overland Park, KS and Lawrence Memorial Hospital in Lawrence, KS. There are also, no hospitals between our location in Lenexa and Providence Hospital in Wyandotte County. By default this hospital will be the principle facility providing the majority of in-patient health care to these geographic areas.

Our hospital will also have in-patient psychiatric beds. As I am sure you are aware, there are less than 100 in-patient psychiatric beds in the Greater Kansas City area. With a population in Greater Kansas City nearing 2 million, the lack of psychiatric services and lack of concern by the existing hospitals to meet these needs is unconscionable. There is also a critical need for in-patient psychiatric beds throughout the state of Kansas. Our hospital, along with a proposed free standing in-patient psychiatric hospital to be co-located on our site, would go a long way in trying to meet the critically underserved healthcare needs of the community.

We are also currently in discussion with a developer of Long Term Acute Care Hospitals. This developer would like to build an LTACH on the same site that Physicians General Hospital is to be built. This bill would also place a hold on that proposed hospital. There also is a critical shortage of LTACH facilities and beds in the Kansas City area.

SB 235 is sponsored by greedy health systems that do not want competition from any source anywhere in the state of Kansas. This bill is discriminatory in nature and is not to the benefit of your constitutes, nor to the communities in which these facilities would serve.

I strongly recommend that you oppose this bill and kill it while it is still in committee. I would be more than happy to meet with you or someone from your offices at your leisure to discuss the impact of this bill. Thank you for your attention.

Douglas C. Palzer, CEO
Physicians General Hospital
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From: "Shelly Baldwin" <sbaldwin@ksspine.com>
To: <MargaretC@senate.state.ks.us>
Date: 3/8/2005 8:41:25 AM
Subject: Testimony Information at Last Week's Senate Committee Hearing on Proposed Senate Bill 235

-----Original Message-----
From: Daryl Thornton [mailto:dthornton@ksspine.com]
Sent: Monday, March 07, 2005 5:07 PM
To: MargaretC@senator.state.ks.us
Cc: Robin Crawford; sbaldwin@kansasspinehospital.com; Sheila Whiston-Fox
Subject: Testimony Information at Last Week's Senate Committee Hearing on Proposed Senate Bill 235

Margaret:

This is Daryl Thornton, COO of the Kansas Spine Hospital in Wichita. I was the 16th individual to testify last Thursday, March 3, as an opponent to SB 235. The following represents a summary of my comments:

As a long time resident of Augusta, Kansas, which is located in the mid central area of Butler County, I indicated that there is a definite and urgent need for another acute care hospital for Butler County. I referred to the fact that for approximately 30 years, a full service general acute care hospital was located in the neighbor city of Augusta. The Augusta hospital closed in the fall of 2002. I indicated that for several years, efforts were made by the Augusta City and Hospital leaders to partner with either Wesley Medical Center or Via Christi Regional Medical Center to provide much needed primary and emergency care services to Augusta and surrounding residents. Both Wesley and Via Christi said no to any type of partnership arrangements. I also indicated to the Senate Committee, that the same type of effort by the Augusta City and Hospital leaders was made to Susan B. Allen Hospital which is located in El Dorado.

I acknowledged and applauded the effort and entrepreneurship that was being demonstrated by both Dr. Idbeis and his fellow business partners. I indicated that Butler County is the largest of counties in terms of land size. I also indicated to the Committee that Butler County has had in years past and is still projected to have the second highest increase in population growth in the State (2nd to that of Johnson County). I also reported that Butler County is tremendously underserved in terms of the ratio of physicians per thousand population. I compared the population of Butler County to that of other neighboring counties such

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as Lyons, Reno, Riley, etc. However, Butler County has a significant discrepancy in terms of the ratio of physicians per thousand population. Butler County's ratio is approximately .53 as compared to that of Harvey County's ratio of 2.34, Lyon County's ratio of 1.42, Reno County's ratio of 1.60, Riley County's ratio of 1.33 and Saline County's ratio of 2.06. These are statistics from the KHA report of Year 2000. If the number of primary care physicians practicing in Butler County, grew another 50 in number from 33 in Year 2000 to 83 in Year 2005, the ratio of physicians per thousand population would still be at 1.30. A new hospital in Butler County would bring much needed primary care physicians.

On a final note, I explained that the only general acute care hospital, with acute care, diagnostic and emergency services, was located in the northeast portion of the county at Susan B. Allen Hospital in El Dorado. This part of the county is simply not growing in population. However, the areas of Rose Hill, Andover, and Augusta, are growing significantly. I also stressed the fact that in the middle of the night, when seconds count, the nearest emergency room for the communities of Augusta and Andover are from 25 to 30 minutes away.

In conclusion, I indicated that a 2nd general acute care hospital, with emergency services, is extremely needed in the eastern to middle part of the county. This is the high population growth concentration of the county. I also stressed to the Senate Committee members that it simply would be doing an injustice by trying to pass this type of legislation. I thanked the Senate Committee members present for their time and the opportunity to present as a long time resident of Augusta and Butler County.

Margaret, I sincerely hope that this information will be shared in Senator Wagle's report to the other Senate Committee members. Best wishes. Daryl

Kansas Spine Hospital, L.L.C.

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E-Mail: dthornton@ksspine.com <mailto:dthornton@ksspine.com>

LTACH Ventures of Kansas
Alan L. Burke
2021 N. Amidon
P.O. Box 781838
Wichita, KS 67278

March 2, 2005

Dear Senate Committee Members:

I am submitting to you today our company's concerns regarding Senate Bill 235: A moratorium on the establishment of any new hospitals in the state of Kansas. Our concern is that this proposed legislation casts a broad net across all forms of health delivery systems, some of which include Long Term Acute Care Hospitals. Admittedly, LTACH's are specialty hospitals that deliver a very high level of care targeting to Medicare patients.

But, unlike other specialty hospitals, LTACHs are a creation of the Federal Government specifically designed to form a symbiotic relationship with community and regional hospitals to provide service to medically complex patients, typical after a surgical stay in an acute care hospital where the hospital has exhausted its reimbursements: i.e. the hospital's ability to produce revenue. In lieu of an LTACH, the acute care hospital continues to provide care for these patient profiles, without reimbursements, for extended periods of time. The LTACH is designed to provide care for these patients under a special fee schedule not available to the acute care hospitals.

The hospitals are unique in many ways, but it is important to note that in the creation of LTACHs, the Federal Government, in its wisdom and with intent, restricted to a great degree the ability of the acute care hospital to build and own these forms of health care systems. The intent, due to the dependent relationship between these two entities, was to restrict common ownership of these two types of hospitals. LTACH are very new forms of patient care delivery systems. The first business model was most exclusively hospitals within hospitals: Special areas within acute care hospitals that were owned by totally separate entities, many of which are publically traded, publically owned companies. In the last several years the Federal regulators have reviewed and revised this business model to bring even more separation between these two mutually beneficial hospital types. This was done, in part, due to the perceived rapid growth of LTACHs to meet the needs of the coming "Baby Boomers" demographics.

The expected need over the next few years is estimated to bean increase of more than 300% or up to an additional 800 hospitals nationwide. In Kansas, currently only 4 of these hospitals exist, all owned by one out-of-state company. Bill 235 effectively State sanctions a monopoly within the state of Kansas. Almost all of the existing LTACHs are of the original business model which has now fallen out of favor with the Federal Government, yielding to the new model which was finalized with the new regulations published just this last summer.

Senate Health Care Strategies Comm.
Date: March 3, 2005
Attachment 13

This is a newly announced LTACH business model which the Federal Government is incentivizing to be constructed, separate from, but mutually beneficial to, existing acute care hospitals that would, under proposed Senate Bill 235, be restricted from coming into existence. LTACHs are not "cherry picking" facilities and actually assist in producing additional profits and capital directly to community and regional-based acute care hospitals.

I am presenting this information to the committee for your review and consideration in reference to proposed Senate Bill 235. This topic before the Health Care Strategies Committee is a very complex issue and I am confident you will be exposed to a spectrum of positions and opinions. I believe it is important to note that in the first release of directives from the Federal Government's study under the moratorium on specialty hospitals was to issue an exemption for LTACHs at the Federal level so as to not inhibit the implementation of the newly defined LTACH business model.

In a truly free market, the open exchange of ideas and competition leads to innovation and improvements not only in cost reductions and profitability, but as it concerns healthcare, the most important index of which our company is singularly focused, a true real value improvement in patient care. Sometimes in the complex issues of today's healthcare delivery, the patient is all but assumed and not *fully appreciated.*

Our company request is that this committee consider the currently enacted Federal moratorium exemption of LTAC hospitals and we request that Bill 235 be amended to reflect a consistency with the Federal moratorium language.

Your consideration is greatly appreciated. If I may be of service in your deliberations I make myself available at your discretion.

Respectfully Yours,

Alan L. Burke, Director
LTACH Ventures of Kansas, L.L.C.

Long Term Acute Care Hospital

A long-term acute care hospital focuses on extended hospital care for the medically complex patient. Long-term acute care hospitals were established to fill the gap in services between short-term acute care hospitals and skilled nursing homes or sub-acute facilities. Treatment programs center around providing the highest level of care required to maximize clinical outcomes for patients and to give them the best quality of life possible.

Catastrophically ill or severely injured patients usually require a long period for recuperation. A Long Term Acute Care Hospital, or LTACH, is a hospital designed for specialized care for patients that require this longer recovery period. In fact, in today's health care continuum, no other type of hospital can provide an acute level of care that is more cost effective and offers services appropriate to each patient's individual needs. The federal regulations require a minimum of 25 days length of stay for these patients.

A long term acute care hospital is Medicare designated hospital. Patients typically are ventilator-dependent, technology-dependent (requiring services such as IV therapy or dialysis) or have medically complex conditions such as pulmonary disease, cardiac disease, pressure wounds or post-operative complications.

LTACHs serve a specific niche market in U.S. healthcare. Up until Diagnosis Related Groups (DRGs) were introduced into the health system, there were approximately 90 LTACHs in the country. Mostly, these 90 were the county hospital or the old tuberculosis hospitals. After DRGs were introduced limiting the reimbursed stay in the short tem acute hospital, LTACHs began to multiply. In 2002, the Federal Government established a Prospective Payment System for LTACHs. The PPS for LTACHs mirrors the system set in place for short tem acute care hospitals. This PPS system lifted the final concerns as to the viability of LTACHs. LTACHs are now a necessary component of the health care continuum.

Patients are referred to a long term acute care hospital by a variety of sources; physicians, social workers, case managers, nursing homes, even the patient, care giver or family member. Any licensed physician on the medical staff of the long term acute care hospital can admit a patient. Physicians may follow their patients, or may refer the attending physician role to any member of the long term acute care hospital's medical staff. If the care is transferred to an attending physician, the referring physician may resume the role of primary care upon the patient's discharge from the hospital. During the time that the patient is under the care of the LTACH physician a bi-weekly report will be sent to the referring doctor.

Patients transferred to a long term acute care hospitals are medically stable and do not require the critical care resources found in the short-term acute care hospital. The most expensive portion of a patient's diagnostic work-up is completed prior to transfer, therefore minimizing expenses. In addition, the LTACH is specialized and focused on the delivery of medically complex care, and does not have the higher overhead of additional programs such as OB/GYN suites or emergency rooms. This allows cost containment and results in minimized patient expense. LTACHs are Federally created specialty hospitals.

In contrast, a skilled nursing home/sub-acute facility is limited in the range and frequency of services provided, and does not offer a complete healthcare delivery system. This often results in a patient being discharged from a skilled nursing home/sub-acute facility, and being readmitted to a short-term acute care hospital. In this situation, the patient is impacted clinically, financially and psychologically.

Based on the clinical needs of the patient and the capabilities of at-home support systems, a patient may be discharged to a rehabilitation center, skilled nursing home/sub-acute facility, or can be sent home, typically with home healthcare.

The growth rate of LTACHs in the United States has been impressive. From 206 LTACHs in October 1998, the numbers have risen to 270 in 2002, a 33% rate of growth that exceeds all other post-acute venues, such as rehabilitation units (7.1%), rehab hospitals (10.1%), and freestanding skilled nursing facilities (1.7%). In the past year alone, from January 2001 to January 2002, the number of LTACHs jumped from 251 to 270, a rate of 7.5%. One of the reasons for this proliferation is an increased demand for the services LTACHs provide that cannot be fully met by other levels of care.

Center for Medicare and Medicaid Services (CMS) studies found that patients in LTACHs are more functionally impaired than patients in rehabilitation hospitals or units. They often arrive from intensive care units with severe and complex conditions that require extensive medical and rehabilitation services and clinical expertise using high-tech equipment. Rehab facilities, by comparison, have a less acute population that must be able to tolerate at least 3 hours of therapy daily. The rehab facility is designed to rehabilitate and help patients compensate for loss of independent physical or mental functioning, while the LTACH focuses on the patient's medical recovery and then addresses functional recovery. The large majority of LTACH cases, based on clinical profile and functional status, would not qualify for acute rehab at the time of acute care discharge.

Acute care hospitals have been under constant and relentless pressure to reduce costs. To do so, hospitals must move patients to a lower cost setting as soon as the patient can tolerate the transfer and the associated clinical outcomes will not be compromised. With a greater number of LTACH beds coming into the market, acute care providers may accelerate earlier referrals to the LTACH rather than acute rehab.

Long term acute care hospitals typically offer the acute care hospital and referring physician the finest patient care through:

Medically Complex Program - Designed for patients requiring multidisciplinary medical services, this program includes treatment for cancer and infectious disease, dialysis and post surgical recovery. Many patients have complications that may require long-term antibiotic therapy or isolation.

Pulmonary/Ventilator Program - Provides services to patients who are intubated, whether orally or by tracheostomy, are ventilator dependent, or who require mechanical support to maintain breathing. Patients are evaluated by board certified pulmonologists and respiratory care practitioners, and protocols are developed to meet individual disease-process needs.

Complex Wound Care Program - Comprehensive wound care program is designed

for patients recovering from serious wound complications or extensive surgery, and for patients requiring the management of pressure ulcers. A multidisciplinary team of physicians, physical therapists, registered dietitians and enterostomal nursing professionals provide individualized patient care.

Low Tolerance Rehabilitation Program - Focused on patients unable to tolerate or participate in more than three hours of therapy a day, rehabilitation services include physical, occupational and speech therapy. Diagnoses include, but are not limited to, cerebral vascular accidents (CVA), chronic obstructive pulmonary disease (COPD), degenerative disease and cardiovascular disease.

Review:

1. How Do You Define "Long Term Acute Care?"
Long term acute care is defined as medical care provided to patients that meet acute care criteria, and that require hospitalization for a period of time generally greater than 25 days.

2. What Is A LTAC Hospital?
A long term acute care hospital like is a hospital with an acute care license that provides specialized extended acute care for the medically complex/chronically ill patient. Our patients typically require hospitalization for an average length of stay of 25 days or more.

3. Has The Need For LTAC Hospitals Increased?
Yes. LTACHs focus entirely on providing quality care and aggressive therapies to medically complex patients and are able to deliver a complete continuum of care at an overall cost that is substantially lower than traditionally short-term acute care hospitals. The savings are passed on directly to the patient, families, and third party or government payors, providing a cost-effective alternative for the critically ill patient. As the patient's health status improves, they no longer require acute care, and are discharged to appropriate facilities (SNF, nursing homes,) that can continue to provide the current level of care needed - or to Home Health Care when appropriate.

4. What Is The Difference Between Skilled Nursing Home/Subacute Care And Long Term Acute Care?
Patients requiring long term acute care require a hospital environment. This environment provides the patient with daily physician visits, a critical care and medical/surgical experienced nursing staff, a complete respiratory department (24 hours a day, 7 days a week), an in-house rehab department, case management, and social services, an in-house pharmacy, radiology, an operating room, an I.C.U., and a complete healthcare system designed to meet the needs of high acuity patients. This acute care environment promotes timely and effective responses to maximize the recovery potential of the patient, and prevents the need for discharge when complications arise.

In contrast, a skilled nursing home/sub-acute facility is limited in the range and frequency of services provided, and does not offer a complete healthcare delivery system. This often results in a patient being discharged from a skilled nursing home/sub-acute facility, and being readmitted to a short term acute care hospital. In this situation, the patient is impacted clinically, financially and psychologically.

5. What Types Of Patients Does a Long Term Acute Care Hospital Admit?
Long Term IV Therapies (three weeks or longer)
Ventilation/Pulmonary Care
Hemodialysis or Peritoneal Dialysis
Post CVA
Post Surgical
Low Tolerance Rehabilitation
Wound Care
Complicated Infectious Process

6. What Is The Referral Process?
Patients are referred to a long term acute care hospital by a variety of sources; physicians, social workers, case managers, nursing homes, even the patient, care giver or family member.

7. Who Can Admit Patients To A Long Term Acute Care Hospital?
Any licensed physician on the medical staff of the long term acute care hospital can admit a patient. Physicians interested in having staff privileges may apply for review by the medical staff team. Temporary privileges may be given while completing the standard application process, to assure a continuity of care.

8. How Often Do Physicians Visit Their Patients?
Daily

9. Where Do Patients Go After Discharge?
Based on the clinical needs of the patient and the capabilities of at-home support systems, a patient may be discharged to a rehabilitation center, skilled nursing home/sub-acute facility, or can be sent home, typically with home healthcare.

10. What Is The Average Length Of Stay?
The average length of stay is 25 days or more.

11. Does A Referring Physician Follow His/Her Patients Upon Transfer To A Long Term Acute Care Hospital?
Physicians may follow their patients, or may refer the attending physician role to any member of the long term acute care hospital's medical staff. If the care is transferred to an attending physician, the referring physician may resume the role of primary care upon the patient's discharge from the hospital.

12. How Can A Long Term Acute Care Hospital Be Less Expensive Than A Short Term Acute Care Hospital?
Patients transferred to a long term acute care hospitals are medically stable and do not require the critical care resources found in the short term acute care hospital. The most expensive portion of a patient's diagnostic work-up is completed prior to transfer, therefore minimizing expenses. In addition, the hospital is specialized and focused on the delivery of medically complex care, and does not have the higher overhead of additional programs such as OB/GYN suites or emergency rooms. This allows cost containment and results in minimized patient expense.

13. Is The Referring Hospital's DRG Reimbursement Affected When A Medicare

Patient Is Transferred To A Long Term Acute Care Hospital?
No. The referring hospital is under the Prospective Payment Service (PPS) system and received Diagnosis Related Group (DRG) payments. The long term acute care hospital has special Medicare DRG's specific to medically complex patients.

On October 1, 2002, the federal government mandated that long-term acute care hospitals (LTACHs) participate in the Long-term Care Hospital Prospective Payment System (PPS) to receive Medicare reimbursement. LTACHs changed their Medicare reimbursement systems to conform to the final published rules, which are updated twice a year (July and October).

The patient classification system used by this PPS is Long Term Care Diagnosis-Related Groups (LTC-DRGs), which are based on:

1 Principal diagnosis

2 Up to eight additional (secondary) diagnoses

3 Up to six procedures performed during the stay

4 Age

5 Sex

6 Discharge status

LTACHs handle patients with extended LOS and high levels of acuity who struggle with a host of complications. If

LTAC Hospitals- Answering A Need
Short-term acute care hospitals face clinical and economical challenges when treating longer term, acutely ill patients. Not only do these patients require intensive, aggressive clinical care for recovery, but also Medicare's Prospective Payment System (PPS) severely limits reimbursement for services rendered. The result is often financial loss for the hospital and medically compromised recovery for the patient, caused by multiple discharges and readmits.

As a solution, Congress enacted an exemption from the Medicare PPS system for hospitals with a facility-wide average length of stay of 25 days or more - commonly called long-term acute care (LTAC) hospitals.

Redefining Competition in Health Care

by Michael E. Porter and Elizabeth Olmsted Teisberg

The wrong kinds of competition have made a mess of the American health care system. The right kinds of competition can straighten it out.

THE U.S. HEALTH CARE SYSTEM has registered unsatisfactory performance in both costs and quality over many years. While this might be expected in a state-controlled sector, it is nearly unimaginable in a competitive market – and in the United States, health care is largely private and subject to more competition than virtually anyplace else in the world.

In healthy competition, relentless improvements in processes and methods drive down costs. Product and service quality rise steadily. Innovation leads to new and better approaches, which diffuse widely and rapidly. Uncompetitive providers are restructured or go out of business. Value-adjusted prices fall, and the market expands. This is the trajectory common to all well-functioning industries – computers, mobile communications, banking, and many others.

Health care could not be more different. Costs are high and rising, despite efforts to reduce them, and these rising costs cannot be explained by improvements in quality. Quite the opposite: Medical services are restricted or rationed, many patients receive care that lags currently accepted procedures or standards, and high rates of preventable medical error persist. There are wide and inexplicable differences in costs and quality among providers and across geographic areas. Moreover, the differences in quality of care last for long periods because the diffusion of best practices is extraordinarily slow. It takes, on average, 17 years for the results of clinical trials to become

standard clinical practice. Important constituencies in health care view innovation as a problem rather than a crucial driver of success. Taken together, these outcomes are inconceivable in a well-functioning market. They are intolerable in health care, with life and quality of life at stake.

We believe that competition is the root of the problem with U.S. health care performance. But this does not mean we advocate a state-controlled system or a single-payer system; those approaches would only make matters worse. On the contrary, competition is also the solution, but the nature of competition in health care must change. Our research shows that competition in the health care system occurs at the wrong level, over the wrong things, in the wrong geographic markets, and at the wrong time. Competition has actually been all but eliminated just where and when it is most important.

There is no villain here. Poor public-policy choices have contributed to the problem, but so have the bad choices made by health plans, hospitals, and the employers who buy their services. Decades of "reform" have failed, and attempts to reform will continue to fail until we finally get the right kind of competition working.

The health care system can achieve stunning gains in quality and efficiency. And employers, the major purchasers of health care services, could lead the transformation.

Zero-Sum Competition

In any industry, competition should drive up value for customers over time as quality improves and costs fall. It is often argued that health care is different because it is complex; because consumers have limited information; and because services are highly customized. Health care undoubtedly has these characteristics, but so do other industries where competition works well. For example, the business of providing customized software and technical services to corporations is highly complex, yet, when adjusted for quality, the cost of enterprise computing has fallen dramatically over the last decade.

Health care competition, by contrast, has become zero sum: The system participants divide value instead of increasing it. In some cases, they may even erode value by creating unnecessary costs. Zero-sum competition in health care is manifested in several ways: First, it takes the form of cost shifting rather than fundamental cost reduction. Costs are shifted from the payer to the patient, from the health plan to the hospital, from the hospital to the physician, from the insured to the uninsured, and so on. Passing costs from one player to another, like a hot potato, creates no net value. Instead, gains for one participant come at the expense of others – and frequently with added administrative costs.

Second, zero-sum competition involves the pursuit of greater bargaining power rather than efforts to provide better care. Health plans, hospital groups, and physician groups have consolidated primarily to gain more clout and to cut better deals with suppliers or customers. But the quality and efficiency gains from consolidation are quite modest.

Third, zero-sum competition restricts choice and access to services instead of making care better and more efficient. As the system is currently structured, health plans make money by refusing to pay for services and by limiting subscribers' and physicians' choices. Health plans and care providers restrict patients' access to medical innovations or limit the services that are covered. Many health plans pay hospitals a set amount per admission for a given ailment rather than for a full treatment cycle. This creates an incentive for hospitals to use cheaper treatments rather than more effective, innovative ones – and if patients consequently must be readmitted, the hospitals are paid again.

Fourth, zero-sum competition relies on the court system to settle disputes. Yet lawsuits compound the problem. They actually raise costs directly (through legal fees and administrative expenses) and indirectly (through the practice of unnecessary, defensive medicine) – none of which creates value for patients. Moreover, of the billions of dollars that doctors and hospitals pay annually for malpractice insurance, less than 30% goes to injured patients or their families.

What Happened?

Zero-sum competition in health care is the consequence of a series of unfortunate strategic choices made by nearly all the actors in the system – encouraged, and in some cases reinforced, by bad incentives introduced through government regulation. These include:

The Wrong Level of Competition. The most fundamental and unrecognized problem in U.S. health care today is that competition operates at the wrong level. It takes places at the level of health plans, networks, and hospital groups. It should occur in the prevention, diagnosis, and treatment of individual health conditions or co-occurring conditions. It is at this level that true value is created – or destroyed – disease by disease and patient by patient. It is here where huge differences in cost and qual-

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ity persist. And it is here where competition would drive improvements in efficiency and effectiveness, reduce errors, and spark innovation. Yet competition at the level of individual health conditions is all but absent.

The fundamental economics of health care are driven at the level of diseases or conditions. Numerous studies show that when physicians or teams treat a high volume of patients who have a particular disease or condition, they create better outcomes and lower costs. (For more on this concept, see the exhibit "Experience Matters.") The renowned Texas Heart Institute (THI), for example, prides itself on having surgical costs that are one-third to one-half lower than those of other academic medical centers despite taking on the most difficult cases and using the newest technologies. Because of its specialization, THI attracts the most complex and demanding patients, whose needs produce even more rapid learning. In health care, as in most industries, cost and quality can improve simultaneously as providers prevent errors, boost efficiency, and develop expertise. As we have learned in many businesses, "doing it right the first time" not only improves outcomes but can dramatically cut costs. The trade-off between cost and quality in health care, then, is significantly reduced by competition at the right level.

As we have learned in many businesses, "doing it right the first time" not only improves outcomes but can dramatically cut costs.

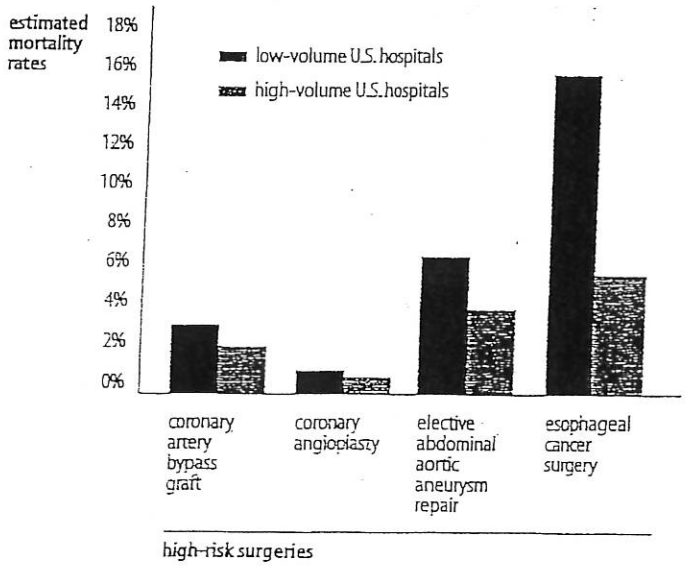
Competition at the level of individual diseases and conditions is getting even more important as medical research reveals that diagnoses and treatments should be increasingly specialized. Prostate cancer, for example, is now understood to be six different diseases that respond to different treatments. Providers should compete to be the best at addressing a particular set of problems, and patients should be free to seek out the providers with the best track records given their unique circumstances. In the current environment, where patients' treatments are determined by the networks they are in, network providers are all but guaranteed the business.

The Wrong Objective. Competition at the wrong level has been exacerbated by pursuit of the wrong objective: reducing cost. Even worse, the objective has often not been to reduce the total cost of health care but to reduce the cost that is borne by the system's intermediaries – health plans or employers. The right goal is to improve value (quality of health outcomes per dollar expended), and value can only be measured at the disease and treatment level. Competing on cost alone makes sense only in commodity businesses, where all sellers are more or less the same. Clearly, that is not true in health care. Yet that perverse assumption – which neither buyers nor sellers really believe – underlies the behavior of the system participants. Payers, employers, and even providers pay insufficient attention to achieving better outcomes and improving value over time, which are what really matter.

The Wrong Forms of Competition. Instead of competing to increase value at the level of individual diseases or conditions, the players in health care have entered into four unhealthy kinds of competition, all of which have unhappy consequences. One is the annual competition among health plans to sign up subscribers. Because of strong network restrictions, however, signing up for a health plan blocks most of the competition at the level

Experience Matters

The more experience physicians and teams have in treating patients with a particular disease or condition, the more likely they are to create better outcomes – and, ultimately, realize lower costs. By performing particular procedures over and over, teams increase their learning opportunities and thereby reduce mortality rates.



Source: John D. Birkmeyer, *Leaping Patient Safety Standards: The Potential Benefits of Universal Adoption*, November 2000.

of diseases and treatments. And because the commitment between the subscriber and the health plan is for just one year, both payers and employers are motivated to engage in short-term thinking rather than invest in practices and therapies that will improve value over time.

Another form of unproductive competition occurs when providers compete to be included in health plan networks by giving deep discounts to payers and employers that have large patient populations. There is little or no economic rationale for such discounts. It does not cost less to treat a patient employed by a large company than a patient who is self-employed. Health care delivery does not become more efficient from treating twice as many patients with a random distribution of diseases; patients are still treated one at a time and according to their particular circumstances. Large discounts in return for increased overall patient flow simply shift revenue from providers to health plans or to large employers. This creates artificial benefits for large groups and shifts costs to small groups, unaffiliated individuals, patients seeking out-of-network care, and the uninsured—with little, if any, compensating value. Such cost shifting ultimately drives

How Reform Went Wrong

Attempts to reform the U.S. health care system have failed because they have been based on the wrong diagnosis of the problem.

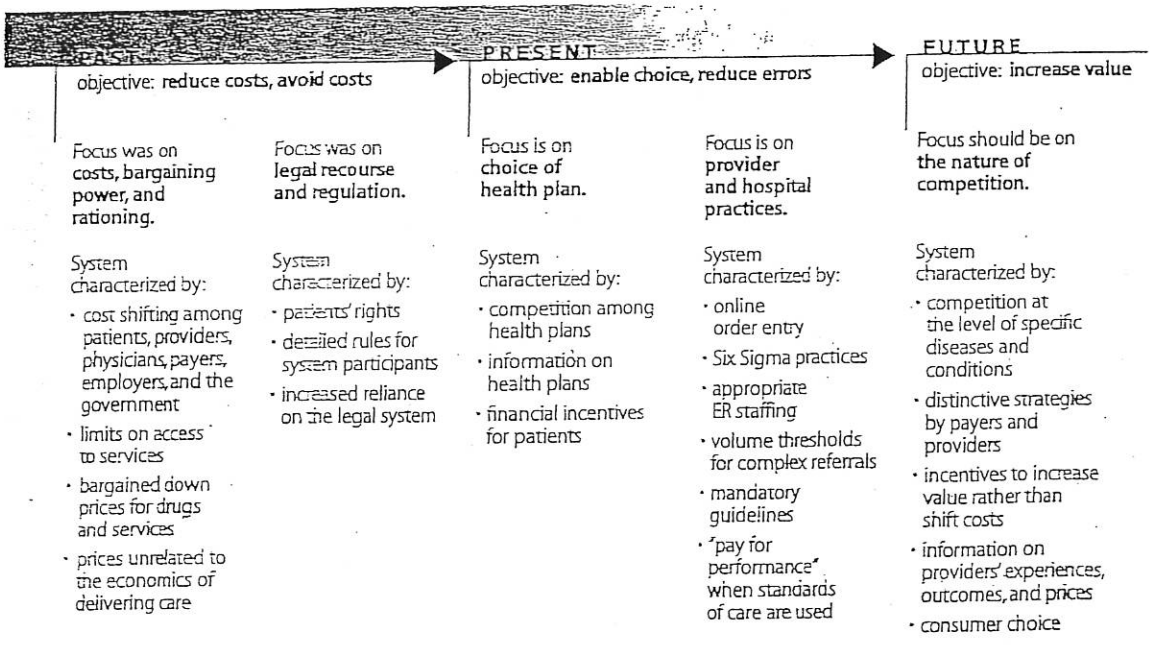
These reform efforts have not resulted in meaningful competition at the level of specific diseases and conditions—the level at which value is created in medicine. With competition at the wrong level, all the system participants—consumers, providers, employers, and insurers—have acted counterproductively. Some historical perspective appears in the exhibit, "The Evolution of Reform Models."

The managed care era was focused largely on cost; reformers treated health care as if it were a commodity. To cut their expenses, payers shifted costs and aggressively pursued bargaining power. Providers did the same. Services were rationed, and there were few true improvements in efficiency. Ironically, costs continued to rise.

In reaction to managed care, reformers tried to give patients more legal rights. Those efforts ended up saddling health care providers with extra regulatory layers—and increased costs. Requiring hospitals and doctors to adhere to a patients' bill of rights did eliminate some of the more egregious examples of cost-driven rationing by providers, but it also left untouched the fundamental cause of providers' behavior—namely, competition structured to compel players to focus on cost. Costs rose even higher.

When their attempts to fix the system through legal and regulatory means proved futile, reformers began to focus on consumer choice—a good topic to examine, but subscribers' choice of health plan is not the choice that really matters. Consumers today have little choice about providers and treatments and are in no position to make informed decisions given the limited information available to them.

The Evolution of Reform Models



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up overall costs – even to large groups – by increasing the number of uninsured patients who must be treated in expensive settings (emergency rooms, for instance) and hence the amount of free care that must be subsidized.

Providers also compete to see who can form the largest, most powerful group, able to offer a complete array of services. Here, too, there are few efficiencies to be gained, apart from modest opportunities to share overhead. Hospital mergers often result in two departments in the same specialty rather than one department, even when the facilities are close to one another. Provider groups are formed not to create value but to boost bargaining power vis-à-vis health plans and other system participants. Throughout Florida, for example, large hospital networks have won price increases far above the rate of inflation and unconnected to any improvements made in quality of care after threatening to cut off one of the region's largest health plans. And because their referrals are heavily skewed toward affiliated physician groups and institutions, large provider groups further limit competition at the level of diseases and treatments.

Finally, there is always a squabble over who pays. This struggle takes many forms. Providers and payers try to shift costs to each other. Payers raise rates on subscribers who become ill. Providers boost their list prices so Medicare discounts will not cut so deep. Patients seek coverage for optional or cosmetic care. And employers allow health plans to deny payment to their employees. All of this is costly. None of it creates value for patients.

The Wrong Geographic Market. Competition should force providers to equal or exceed the value created by the best in their region or even nationally. For the most part, however, health care competition is local. Such competition insulates mediocre providers from market pressures and inhibits the spread of best practices and innovations. Throughout the United States, there is an almost threefold variation in annual costs per Medicare enrollee – from less than $3,000 per patient in some areas to more than $8,500 in others. According to studies by Dartmouth Medical School's John Wennberg and the school's Center for the Evaluative Clinical Sciences, the higher costs are not associated with better medical outcomes and cannot be explained by differences in age, sex, race, rates of illness (which affect the need for care) or cost of living (which affects the cost of delivering care). These studies did find, as have several others, major differences across regions in outcomes and in delivery of care at the disease or treatment level. Such differences are sustained by the absence of competition.

Localized competition is institutionalized by health plan policies that require subscribers to pay most of the costs of out-of-network care – discouraging them from seeking providers outside their immediate area – or that penalize physicians for making out-of-network referrals. Medicare, for its part, computes HMO capitation payments at the county level, creating little incentive for hospitals in different counties to compete, even if they are only a few miles apart. Localized competition is also the result of habit, inertia, and information; as a matter of course, physicians refer their patients to nearby doctors – even their Medicare patients, who have no geographic restrictions.

Recent thinking on health care reform has migrated to improving quality and reducing medical errors. Employer consortia are attempting to improve hospital practices by requiring that facilities, for instance, enter treatment orders into a computerized system, maintain appropriate coverage in intensive care units and emergency rooms, and meet volume thresholds for some referrals. These are useful requirements, but they do not change the underlying incentives for zero-sum competition. Similarly, employer-proposed "pay for performance" initiatives will help in the near term to get more providers to comply with current accepted medical standards. But this will not be enough to reform the system because the incentives are to conform to specific processes, not to achieve real results. Effective incentives need to be tied to goals rather than means.

Some recently proposed reforms will even exacerbate zero-sum competition. For instance, some employer groups advocate "system to system" competition, in which physicians are forced to commit to one closed network or another. This actually limits competition at the level of diseases and treatments while accentuating the power of a few full-line systems to completely avoid competing at this level. Meanwhile, other proposed reforms, such as the migration of some consumers from Medicare to private insurance and the purchase of prescription drugs from Canada, are not reforms at all. Shifting Medicare patients to a private system that is not working is not a solution. And buying drugs from Canada is the system's latest attempt to shift costs rather than create value.

Missing in the discussion about health care reform is an understanding of the role competition plays in driving quality, safety, and efficiency improvements and the type of competition that will best do so. If the objective is to create value, then competition to improve outcomes and increase efficiency in specific medical conditions is essential. Getting the level of competition right will reduce error and encourage the spread of new, excellent practices. Reform must focus on the rules, incentives, information, and strategies that will enable positive-sum competition where it counts – at the level of individual diseases and treatments.

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Though many health care services should be provided locally, health care competition should take place regionally, or even nationally, especially for more complex or uncommon conditions. In this way, all providers would be subject to competitive pressures to improve. And providers treating less common conditions, drawing from a wider area, could serve enough patients to develop the expertise and efficiency that come with repeated experience and learning.

An ideal health care system would encourage close working relationships between local providers (for most routine and emergency services and follow-up care) and a wide array of leading providers (for definitive diagnoses, treatment strategies, and complex procedures in certain areas). These relationships would speed up the diffusion of state-of-the-art clinical care and would help to increase quality and efficiency throughout the system – but they are often resisted today.

Pitfalls and Potential:
An Overview of What's Plaguing U.S. Health Care

In any industry, competition should drive up value for consumers over time. In health care, competition is zero sum – value is divided (sometimes destroyed) instead of increased. The system can change if the participants strive for positive-sum competition.

The Wrong Strategies and Structure. Although value is created by developing deep expertise and tailored facilities in a set of areas where providers can truly excel, most hospitals and networks have instead pursued wide service lines to negotiate better with health plans. Hospitals and physician groups have broadened their services by merging with or acquiring other institutions, resulting in roughly 700 hospital mergers between 1996 and 2000 and very high levels of local industry concentration. In North Carolina, for instance, only 18 of 100 counties had multiple hospital systems in 2000. Rivalry is severely limited as a result.

This reduction in competition produces few offsetting benefits. As we have discussed, consolidation has led to few efficiencies. Nor is it at all clear that quality is better when the breadth of services is wider. Though some patients have multiple diseases, focused institutions can easily cope with this. The M.D. Anderson Cancer Center in Houston, for example, has staff cardiologists but does not maintain a full-line cardiology practice. When difficult cases arise or heart surgery is required, the physicians at M.D. Anderson consult with outside colleagues or refer their cancer patients to leading cardiac centers.

The Wrong Information. Information is integral to competition in any well-functioning market. It allows buyers to shop for the best value and forces sellers to compare themselves to rivals. In health care, though, the information really needed to support value-creating competition has been largely absent or suppressed. There is plenty of information about things that have a modest impact on value – health plan coverage and subscriber satisfaction surveys, for instance. But much more relevant is information about providers' experiences and outcomes in treating particular conditions. Even this basic information is unavailable. For example, most hospitals and physicians do not even provide data on how many patients

The Features of ZERO-SUM Competition in Health Care

The Wrong Level of Competition
Competition is among health plans, hospitals, and networks.

The Wrong Objective
Cost reduction; participants try to reduce their own costs by transferring them to someone else without reducing the total cost.

The Wrong Forms of Competition
Competition is to sign up healthy subscribers. Methods include discounting prices to large payers and groups, consolidating to increase bargaining power, and shifting costs.

The Wrong Geographic Market
Competition is local.

The Wrong Strategies and Structure
Participants build full-line services, form closed networks, consolidate with others (thereby reducing rivalry), and match their competitors.

The Wrong Information
Information is about health plans and subscribers' satisfaction surveys.

The Wrong Incentives for Payers
Payers try to attract healthy subscribers and raise rates for unhealthy subscribers. They restrict treatments and out-of-network services, shift costs to providers and patients, and slow down innovation.

The Wrong Incentives for Providers
Providers offer every service, but often below prevailing medical standards. They refer patients within the network, if at all; spend less time with patients and discharge them quickly; and practice defensive medicine.

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with a particular diagnosis or condition they have treated. Instead, available information about medical experiences and outcomes is largely word-of-mouth, even among physicians, and may be unsupported by evidence.

There have been efforts to collect the right kind of information – among them, Cleveland Health Quality Choice, the Pennsylvania Health Care Cost Containment Council, and New York State's Cardiac Surgery Reporting System. But these have been small-scale experiments. Providers argue that data on the outcomes of treatments – appropriately risk-adjusted to reflect the complexity or severity of the patients' initial conditions – are complex and difficult to measure in meaningful ways. Indeed, the collection of outcome information has been actively opposed by some system participants – sometimes for good reasons (the difficulty of performing risk adjustments, for instance) and sometimes for not so good reasons (fear of comparison and accountability, for instance).

Some observers have tried to discredit the attempts that have been made so far to collect relevant information. But these experiments demonstrate both the critical value of having the right information and the feasibility of developing it. In Cleveland, the information collected was not disseminated to patients or referring doctors.

The Features of POSITIVE-SUM Competition in Health Care

The Right Level of Competition

Competition is to prevent, diagnose, and treat specific diseases or combinations of conditions.

The Right Objective

Improve value – quality per expended dollars over time.

The Right Forms of Competition

Competition is to create value at the level of diseases or conditions by developing expertise, reducing errors, increasing efficiency, and improving outcomes.

The Right Geographic Market

Competition is at the regional or national level.

The Right Strategies and Structure

Participants define their distinctiveness by offering services and products that create unique value. The system has many focused competitors.

The Right Information

Information is about providers, treatments, and alternatives for specific conditions.

The Right Incentives for Payers

Payers help subscribers find the best-value care for specific conditions. They simplify billing and administrative processes and pay bills promptly.

The Right Incentives for Providers

Providers succeed by developing areas of excellence and expertise. They measure and enhance quality and efficiency. They eradicate mistakes; they get it right the first time. They meet, exceed, and improve standards.

The Ingredients for Change

No Restrictions to Competition and Choice
- No preapprovals for referrals or treatments
- No network restrictions
- Strict antitrust enforcement against collusion, excessive concentration, and unfair practices
- Meaningful co-payments and medical savings accounts with high deductibles, all of which will give consumers incentives to seek good value

Accessible Information
- Appropriate information on treatments and alternatives is formally collected and widely disseminated.
- Information about providers' experience in treating particular diseases and conditions is made available immediately.
- Risk-adjusted outcome data are developed and continually enhanced.
- Some information is standardized nationally to enable comparisons.

Transparent Pricing
- Provider sets a single price for a given treatment or procedure.
- Different providers set different prices.
- Price estimates are made available in advance to enable comparison.

Simplified Billing
- One bill per hospitalization or per period of chronic care
- Payer has legal responsibility for medical bills of paid-up subscribers.

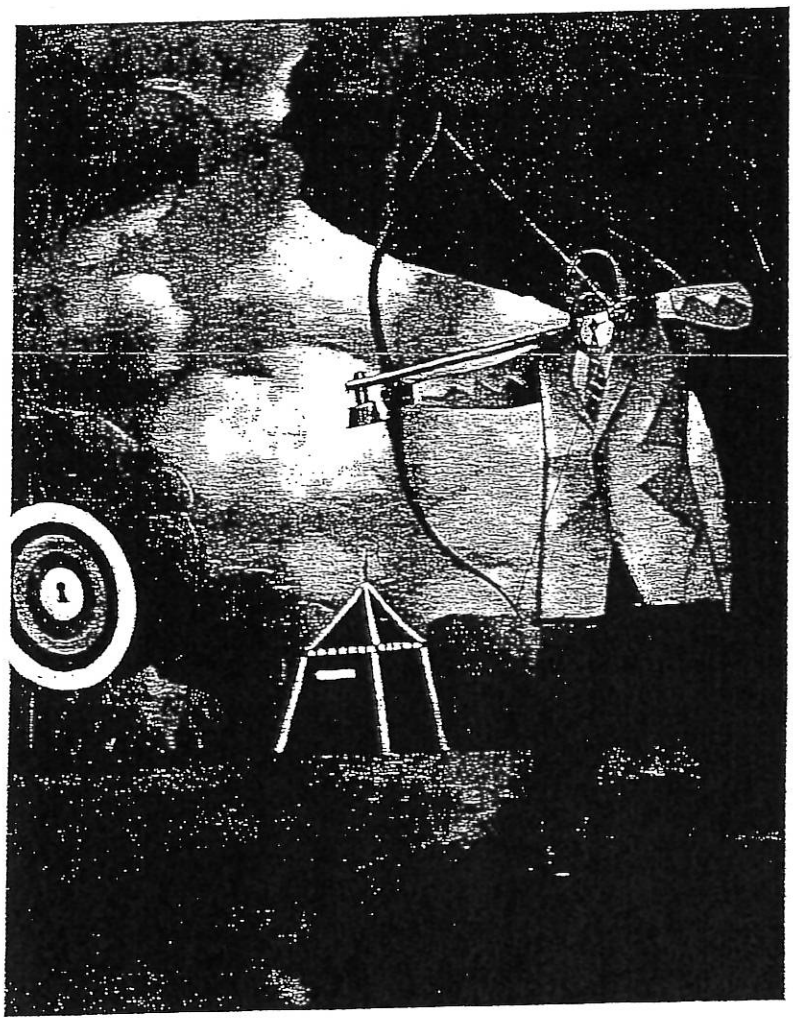
Nondiscriminatory Insurance
- No re-underwriting
- Assigned risk pools for those who need them
- Required health plan coverage, which would create equity and value throughout the system

Treatment Coverage
- National list of minimum required coverage
- Additional coverage results from competition, not litigation.

Fewer Lawsuits
- More information means more disclosure of risks and better-informed choices by patients.
- Lawsuits address use of obsolete treatments and carelessness.

Employers, faced with short-term cost pressures, did not use the data to select high-quality providers. Patients and doctors were left in the dark. Meanwhile, in New York, information was collected on risk-adjusted mortality rates following cardiac bypass surgeries performed statewide, and the data were made more widely available. In response to the data, cardiac surgery groups pursued process improvements, and some hospitals revoked the privileges of cardiac surgeons with low volume and high mortality rates. After four years of published data, New York had the lowest risk-adjusted mortality following bypass surgery of any state in the country.

Encouraging competition at the level of specific diseases or conditions will speed the development of the right kind of information. For instance, insurer Preferred Global Health (PGH) helps its subscribers choose among the world-class providers and treatments it offers for the 15 critical diseases it covers. To find the highest-quality providers, PGH identifies those with the most experience in the most advanced treatments, documents their effectiveness and outcomes, and asks them to participate in quality-improvement processes. PGH's experience belies the argument that there is too little information available for meaningful consumer choice in health care. America cannot afford to wait for perfect information to be developed before it can be disseminated. Nothing will drive improvements in information faster than making the existing data widely available.



The Wrong Incentives for Payers. Health insurers should be rewarded for helping their customers learn about and obtain care with the best value; for simplifying administrative processes; and for making participants' lives easier. Instead, payers benefit financially from enrolling healthy people and from raising premiums for or denying coverage to sick people. Payers have incentives to complicate billing; they can shift costs by issuing incomprehensible or inaccurate invoices and by delaying or disputing payment. They also have incentives to shift costs or reduce services by putting roadblocks between patients and care providers, restricting patients' access to expensive treatments and most out-of-network treatments. (Although out-of-network care is not inherently more expensive, hospitals charge out-of-network patients list prices that may be twice as high as negotiated in-network prices. The difference between the amount the payer will reimburse and the artificially high list prices essentially makes out-of-network care prohibitively expensive for many patients.) Finally, payers benefit from slowing down innovations that do not show immediate, short-term cost savings. All these incentives reinforce zero-sum competition and work against value creation in health care.

A single-payer system, which has been proposed, would end the practice of excluding high-risk subscribers. But it would only exacerbate all the other skewed incentives by eliminating competition at the level of health plans and giving the payer more bargaining power with which to shift costs to providers, patients, and employers. A single payer would have greater incentive to reduce its costs by restricting or rationing services and by slowing the diffusion of innovation. The only real solution is to change these incentives and open up competition, not to make health insurance a government monopoly.

The Wrong Incentives for Providers. Providers should be rewarded for competing regionally and nationally to deliver the best-value care for particular conditions or diseases. Instead, providers' incentives, just like the payers' incentives, reinforce zero-sum competition in health care. Hospitals and physicians have incentives to not refer patients to other providers who may be more experienced or to make referrals

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only within their network. Reimbursement practices encourage physicians to spend less time with patients, discharge them quickly, and readmit them if there is a problem. While many physicians resist the pressure to undertreat their patients, this conflict between good medicine and economic self-interest demoralizes physicians and slows the diffusion of best practices.

The threat of malpractice suits creates opposing incentives for physicians to overtest, overtreat, and overrefer their patients. Unfortunately, these incentives to overtreat do not cancel out the reimbursement incentives to undertreat. Instead, the result is less effective clinical practice and mountains of paperwork that drain doctors' time. Worse still, the threat of malpractice suits creates risks for providers who try to learn from bad outcomes by measuring and analyzing them. Ironically, while technology has made knowledge diffusion faster and easier than ever before, the social and economic structures of the health care sector work against the rapid dissemination of learning.

Positive-Sum Competition

In a healthy system, competition at the level of diseases or treatments becomes the engine of progress and reform. Improvement feeds on itself. For that process to begin, however, the locus of competition has to shift from "Who pays?" to "Who provides the best value?" Getting there will require changes in the strategies of providers and payers and in the behaviors of employers purchasing health plans. In addition, some important system infrastructure needs to be put in place – rules and regulations that shift the incentives and create the right types of information. Let's look at each needed reform in turn.

Provider Strategies: Distinctiveness. Under positive-sum competition, providers would not attempt to match competitors' every move. Instead, they would develop clear strategies around unique expertise and tailored facilities in those areas where they can become distinctive. Most hospitals would retain a wide array of service areas, but they would not try to be all things to everyone. In most businesses, it is common sense to develop products and services that create unique value. For many hospitals, developing uniqueness is a significant change in mind-set and deciding what *not* to do is an even more radical idea.

No Restrictions to Choice. Under positive-sum competition, all restrictions to choice at the disease or treatment level would disappear, including network restrictions and approvals of referrals. Reasonable co-pays and large deductibles combined with medical savings accounts would let patients take some financial responsibility for their choices. But co-pays would be the same inside and outside of the network. Antitrust authorities would scrutinize system participants so that one hospital system or health plan did not unfairly dominate an important market.

> Providers should compete to be the best at addressing a particular set of problems.

Transparent Pricing. Prices would be posted and readily available. Providers would charge the same price to any patient for addressing a given medical condition, regardless of the patient's group affiliation. Providers could and would set different prices from their competitors, but that pricing would not vary simply because one patient was insured by Aetna, another covered by Blue Cross, and another self-insured. Payers could negotiate, but price changes would have to benefit all patients, not just their own. The cost of treating a medical condition has nothing to do with who the patient's employer or insurance company is.

Price discrimination not related to costs imposes huge burdens on the system today. Having multiple prices drives up administrative costs. Patients covered by the public sector are subsidized by private-sector patients. And within the private sector, patients in large groups are subsidized by the uninsured, members of small groups, and out-of-network patients, who pay list prices. Artificially high list prices make more patients unable to pay, driving up uncompensated care expenses, which leads to ever higher list prices and bigger discounts for large groups. The price disincentives for care outside of the network stifle competition, which in turn slows quality and efficiency improvements that would otherwise benefit all patients. Without service-by-service competition, costs spiral ever higher while quality lags. The cost of dysfunctional competition far outweighs any short-term advantages system participants get from price discrimination – even for those firms that currently get the biggest discounts.

Paradoxically, the most practical way to eliminate price differentials for favored groups might be to temporarily institutionalize them. The federal government could limit the spread between the most discounted price and the highest price charged by a provider for any service and then reduce this spread each year over a five-year period. Ending the price anomalies would put a short-run burden on the biggest beneficiaries of the current system – master cost shifters like Medicare and the largest health plans. But over time, all participants would benefit from the enormous improvements in value and efficiency.

Simplified Billing. A fundamental function of pricing is to convey information to consumers and competitors.

Current billing practices obscure that information. Unnecessarily complex billing contributes to cost shifting, drives up administrative costs, and makes price and value comparisons virtually impossible. Under positive-sum competition, providers would have to issue a single bill for each service bundle, or for each time period in treating chronic conditions, rather than a myriad of bills for each discrete service. Many other industries have solved the problem of how to issue a single bill for customized services; among them aerospace, construction, auto repair, and consulting. A competitive health care industry could figure it out, too. Competing providers would also figure out how to give price estimates in advance of service. Such estimates would not only improve consumer choice but would also spur providers to learn about their real costs.

> The locus of competition has to shift from "Who pays?" to "Who provides the best value?"

The other major source of billing problems is that currently, the patient bears the legal responsibility for bills, even with fully paid-up insurance. In positive-sum competition, payers would bear full legal responsibility for the medical bills of paid-up subscribers. If providers bill once and payers cannot shift costs to patients or providers, much of the confusion in billing will end.

Accessible Information. Under positive-sum competition, both the providers and the consumers of health care would get the information they need to make decisions about care. The government or a broad consortium of employers could jump-start the collection and dissemination process by agreeing on a standard set of information that would be collected nationally on a regular basis. Indeed, medical information is not unlike the corporate disclosures overseen by the SEC. The benefits of national comparisons are compelling and will unleash a tidal wave of improvements in quality and efficiency.

An obvious – and relatively uncontroversial – starting point would be to collect information on specific providers' experience with given diseases, treatments, and procedures. The data would be made publicly available after a waiting period during which providers could correct any errors. Over time, information about providers' risk-adjusted medical outcomes also would need to be collected and disseminated, allowing consumers to evaluate the providers' areas of expertise. This information would be specific to particular diseases or medical conditions, not aggregated across different areas of medical practice. A productive system would also collect or disseminate pricing information, enabling comparisons for specific treatments or procedures.

Nondiscriminatory Insurance Underwriting. Two anomalies mar the pricing of health plans. First, people who are included in large risk pools (such as those who work for big companies) can get a reasonably priced health plan even if someone in the family has medical risks. But those without access to such a pool (such as people who work for small firms or are self-employed) will pay very high prices if a family member has medical risks. Realistic reform efforts need to assume that health care coverage will continue to come mostly from employers. However, risk-pooling solutions need to be developed for those who are self-employed, employed by small firms, employed part-time, or unemployed. For example, smaller companies are joining consortia for health plan purchases. For high-risk people unable to buy health plans, assigned risk pools, like those used in automobile insurance, will need to be developed.

In addition, people in small groups or with individual insurance policies face the likelihood that their premiums will rise sharply if someone in the family actually develops an expensive medical condition, even if the family has paid premiums for years without making large claims. This practice, known as "re-underwriting," negates the purpose of health insurance and must be eliminated.

Fewer Lawsuits. Malpractice litigation and the associated defensive medical practices inflict huge costs on everyone, and they have done little to raise the quality of health care. Indeed, the threat of malpractice creates incentives for physicians and hospitals to hide their mistakes rather than own up to and eliminate them. Standards for malpractice litigation need to change. Lawsuits are appropriate only in cases of truly bad medical practice, such as negligence, the use of obsolete treatments, or carelessness, not when a patient had a bad outcome despite receiving appropriate, up-to-date treatment. With better information and no restrictions on choice, many lawsuits will be averted. The money spent on enabling information and choice is an investment in removing billions of dollars of administrative and legal costs from the system.

National List of Minimum Coverage. The current system of individual negotiation and litigation over coverage is expensive. A better system would mandate a minimum level of coverage with a national list (such as the one used in the Federal Employees Health Benefits Program). Health plans could choose to cover more services and treatments for competitive reasons, but they could not be forced to do so by lawsuits. This change would refocus health care expenditures from malpractice premiums to delivery of care for more people.

Payer Strategies: Choice and Efficiency. Positive-sum competition would induce payers to compete to create value, not just to minimize cost. They would simplify

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billing and administrative processes. They would serve subscribers by identifying treatment alternatives and providers with excellent outcomes. They would help subscribers to know when and where it is appropriate to travel outside of their immediate areas for quality care. (Some payers have begun to post information about treatments and providers on their Web sites, but the information is often only about those treatments and providers within a small radius around the subscriber's ZIP code.) The best payers would be able to recommend effective disease-management options for subscribers with chronic conditions. Competition would shift to providing information and excellent service. Attempts to limit patients' choices or to control physicians' behavior would end.

Accelerating the Transformation. Two other steps would accelerate the transformation in health care – one a transitional change and the other a larger, more controversial one. The transitional step, with major symbolic importance, would be the creation of a short-term mechanism to encourage the diffusion of promising new approaches to care that are initially expensive. One model would be for Medicare, traditionally slow to adopt new treatments, to create an Adoption of Innovation Fund to support the spread of promising FDA-approved therapies to patients. Providers, working with technology suppliers, pharmaceutical companies, and payers, would compete to win the funding under well-defined standards for institutional review and informed patient consent. In time, such a fund may not be needed as positive-sum competition takes hold. As a transitional device, however, it would speed treatments toward lower cost and wider adoption.

The larger, more controversial step would be for the government to require health coverage for all, with subsidies for low-income people. With required health care coverage, everyone would be a paying customer concerned with the value of health care. While subsidies to low-income people would drive up health care expenditures, there would be offsetting cost savings and revenues. The huge cost of free care would be eliminated, and providers would no longer have to raise their prices to cover it. Cost savings would result from more care delivered at the right time rather than after complications have developed, and in cost-effective settings rather than in emergency rooms. Additional revenues would come from people who can afford coverage but who choose not to buy it and become part of the uncompensated care pool if they become ill or injured.

Employers Should Lead the Way

Companies have a lot at stake in how the U.S. health care system performs. Businesses' health care costs have outpaced inflation in 13 of the last 17 years, reaching more than $6,200 per employee in 2003. Double-digit increases the last three years, projected to continue in 2004, have caught senior management's attention. A Hewitt Associates study of 622 major U.S. companies found that 96% of CEOs and CFOs are significantly or critically concerned about health care costs for 2004, and 91% voiced the same concern for the impact health care costs will have on their employees.

As major purchasers of health care services, employers have the clout to insist on change. Unfortunately, they have also been part of the problem. In buying health care services, companies have forgotten some basic lessons about how competition works and how to buy intelligently. Ignoring differences in quality, companies have bought health plans based on price rather than value. They have delegated the management of their health plans to parties whose incentives were not well aligned with the companies' attempts to maximize value or with the well-being of employees. Hence, employers have become unwitting conspirators in a troubled system.

They should have known better. Few products or services are really commodities – especially not complex services like providing quality health care. The relevant standard should be value, not cost. Companies know that experience and expertise simultaneously improve quality and reduce cost. They know that innovation is crucial to progress, not an expense to be suppressed. And they know that relevant information is essential to good decision making.

Some employers have started to purchase health care services differently. And consortia like the Leapfrog Group (a coalition of 150 public and private organizations that provide health care benefits) are working to improve the quality of health care; Leapfrog's focus is on reducing the high incidence of errors in U.S. medical care. These efforts are important,

What Employers Can Do Immediately

- ☐ Select plans that do not restrict employees' access to treatments or out-of-network providers.
- ☐ Expect from providers information about their experience, their use of prevailing standards, and their outcomes.
- ☐ Ensure employee access to information on diagnoses and alternative treatments. Share collected information regionally and nationally.
- ☐ Insist that employees be treated by experienced providers.
- ☐ Require a single posted fee for each service.
- ☐ Require one bill per hospitalization or treatment cycle.
- ☐ Eliminate billing of employees by health plans or providers.

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but they will be even more effective when they focus on the power of competition. Rather than approve hospitals or tell them how to run their operations, employers need to insist that choice and information be made truly available at the level of specific diseases and treatments so that patients and referring physicians can choose providers that use efficient, state-of-the-art methods of care. Leapfrog is moving in this direction with its efforts to promote regional referrals for high-risk surgeries to highly experienced providers. Honeywell is also moving in this direction by hiring Consumer's Medical Resource, a decision-support service that provides independent information on diagnoses and treatments to employees.

The newest employer initiatives, known as "pay for performance," set higher reimbursement rates for providers that comply with specified standards of medical care. These measures aim to prevent subpar care by encouraging widespread use of well-established standards that are too often ignored. Pay for performance could be an important transitional measure until experience and outcome data are widely available. However, it is an inadequate long-term solution because it rewards providers for following mandated practices, not for achieving excellent (risk-adjusted) outcomes. The system will improve much faster if providers face competitive pressure to produce truly good results, patient by patient and condition by condition.

By setting new expectations for health plans and providers and by purchasing health care services differently, employers can realize the power of positive-sum competition in health care. (The exhibit "What Employers Can Do Immediately" outlines what employers should demand from their health plans.) Most employers resist the idea of an end to volume discounts, but these discounts contribute to the vicious cycle of cost increases and cost shifting in health care. If employers take the lead in creating productive health care competition, insisting that competition take place at the right level, firms and their employees will benefit from the increased value of services and the broader information available. Pursued seriously, such changes would radically alter the health care system, instigating a transformation of historic proportions. The system can be fixed. ▽

Deeper Diagnosis

Improved health care delivery should be a top priority for corporate managers. Yet most companies continue to depend on government and industry "experts," whose reform efforts during the past decade have failed to create effective competition in health care. In "Fixing Competition in U.S. Health Care," professors Michael E. Porter and Elizabeth Olmsted Teisberg explain what's wrong with the system from a business perspective and what changes will be required to improve the value equation. This report features in-depth analyses and comprehensive facts and figures gleaned from the authors' exhaustive research. For more information, visit http://hcreport.hbr.org.

Reprint R0406D; HBR OnPoint 6964
To order, see page 139.

DAVE CARPENTER

February 25, 2005

Senator Susan Wagle, Chairman
Committee on Health Care Strategies
Other Committee Members: Phil Journey, V. Schmidt, Paul Brungardt, D. Haley, J. Barnett, M. Gilstrap, Peggy Palmer

Re: Senate Bill 235
Moratorium on Hospitals

Dear Senators,

This particular bill is totally absurd! I have just finished reading the language contained in it. I looked out my front window to make sure that I did wake up this morning in America! Ladies and gentlemen, this is a very bad bill and should be killed in committee!

I am sure from reading reports in newspapers, the large medical centers are probably behind this proposed legislation. The largest medical centers do not necessarily provide the best care due to their inadequate under staffing of health care workers to take care of patients.

This bill could have repercussions for health care and the state of Kansas. In small cities if we are to survive and get businesses to locate in our area, we must provide good health care, that is just as essential as good clean air, water, good food and good roads.

We have the best medial care in the world, yet, we don't try to protect our physicians and surgeons from sharks(trial lawyers). Malpractice crisis from this is outrageous. Why not put a damper on the percent these lawyers take in. That would put a stop to a large majority of the lawsuits. Let them earn an honest living as the rest of us have had to do. I will address some substandard care we personally have encountered later on. We have never filed a malpractice suit against any medical hospital, for their substandard care we received due to lack of staff on floor. The physician was not at fault in our cases.

We hope to have a new medical center built in Arkansas City and we are very excited about that. If I read your bill correctly, it would be a stumbling block to us. Kansas has a large number of senior citizen people who have worked and paid taxes all their life here. We would like to keep those medical facilities here. We will not get younger! It is an inconvenience to have to drive to Wichita for medical treatment plus waiting longer for appointments which could be a matter of life and death.

Kansas is not particularly a business friendly state, as you well know. Taxes are too high for corporations, as well as the rest of us. Jobs are important to all of us. This bill will only stop progress in the smaller cities. If we have investors or physicians that want to build a new

Senate Health Care Strategies Comm.
Date: March 3, 2005
Attachment 14

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hospital ,whether it be a regular medical center, speciality or otherwise, they should be allowed to do so. This is the American way. If we can stay in our own area, that would keep health care cost down. Traveling to the large cities, we have mileage, meals and motel costs. This could be eliminated.

I am only speaking for my family and myself, I am just a regular concerned 67 year old citizen. I grew up near Harrison, Arkansas. At that time, there was no college, hospital or vision for the brain drain on our town. Thank God! Someone had a vision. They now have both. I spoke with the hospital yesterday. They are a community about the size of Arkansas City. Perhaps about 12,000 population. They now have a staff of 57 physicians, 32 consulting physicians able to care for almost everything but serious accidents or extreme illnesses, which are then transferred to Fayetteville, approximately 60 miles away or Little Rock, 140 miles away. This small medical center has a very large volunteer group, as well. We have 9 very caring primary care physicians here. Why can't we work on offering some incentives for young Kansas doctors out of residency to come to rural communities until they can get practices established. That seems to me, it would also lower our health costs.

I would like to address some substandard care in the large medical centers as I stated above. My .husband has had a total of seven major surgeries, plus some minor ones. As you can see, I have personally spent a lot of time in hospitals. We have received very good care at Wesley and North Arkansas Medical Center, as well as our own South Central Regional Medical Center. They are as follows: Presbyterian Hospital in Pittsburgh, Pa.(The largest hospital in Pa. and of course not one that you would interested in:
My husband was sent there in 1997 for brain surgery that could not be done anywhere in our area. He started going down hill on a Friday night(weekend) It took 12 hours to get a doctor to come in to see him right in the hospital Substandard care right! Our regular surgeon was never notified. He was placed back in intensive care, his room cleaned out and I was never called! To walk into the hospital and see all his flowers, robe and other belongings on the counter of the nurse's station was very over whelming. I have very bad memories of that hospital.

VIA Christi in Wichita, my husband had cancer of the bladder surgery in early 1995, he was scheduled to be placed on the urology floor, someone decided the orthopaedic floor did not have as many patients and to balance the two, placed him on the orthopaedic floor. He had complications, started hemorrhaging and as a result, the nurse in charge, did not know how to care for him. He went back for emergency surgery that night. The nurses told us over and over that our surgeon had been called. Our surgeon said they never once called him. He was free for an hour and could have come back to the hospital. He sent another doctor in his office to stay with us until he could get there.
VIA Christi in Wichita, February 13, 2005, we were in emergency room waiting room with a friend. This area was dirty and needed cleaning, as well as the front door area outside.

I hope I have not rambled on too long and worn you out. This is from my heart. I care and love Kansas. I care and love Arkansas City, Kansas. I love and am proud to be an American.

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I see this very bad bill as an attack on my family and myself. Every rural town in Kansas has the right to have any investor or physician group to build a medical hospital, speciality hospital, or otherwise. Please have a vision as did the small town that I grew up near. I am a very optimistic person. I am truly convinced that we could make our state, city and counties very healthy by helping our rural people practice preventive medicine. It should help the bottom line by decreasing the states burden on medical care for the uninsured and children in need of medical care.

Senator Wagle, we are praying for your son Paul, as well, as your family. We have been there. He is also on our prayer list at my church.

Please, ladies and gentlemen, reject this bad bill before it goes further.

I hope to be at your committee hearing on March 2, providing there is not ice or snow.

Sincerely yours,

Mary L. Benton

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1519 North 8th St.
Arkansas City, Kansas 67005-1855
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AGC of KANSAS

Building a Better Kansas Since 1934

200 SW 33rd St. Topeka, KS 66611 785-266-4015

WRITTEN TESTIMONY OF
ASSOCIATED GENERAL CONTRACTORS OF KANSAS
BEFORE SENATE COMMITTEE ON HEALTH CARE STRATEGIES
SB 235

March 3, 2005

By Corey D Peterson, Associated General Contractors of Kansas, Inc.

Madame Chairman and members of the committee, my name is Corey D Peterson, Executive Vice President of the Associated General Contractors of Kansas, Inc. The AGC of Kansas is a trade association representing the commercial building construction industry, including general contractors, subcontractors and suppliers throughout Kansas (with the exception of Johnson and Wyandotte counties).

The **AGC of Kansas opposes Senate Bill 235 and requests that you not report it favorably for passage.**

AGC of Kansas opposes the state of Kansas issuing a moratorium on construction projects, especially during difficult economic times. Such a moratorium would be ill-timed as the commercial building construction industry continues to be very slow in most parts of the state.

A recent study showed that for each $1 million in construction 30.8 jobs are created (34.2 jobs for maintenance and repair construction). Legislation as outlined in SB 235 would work against Kansas' economic recovery as it attempts to rebound.

While AGC is not certain of the full intent of this bill, it feels questionable ground is entered when legislation is sought that would limit or restrict competition. AGC is concerned what precedent this may set.

The AGC of Kansas **respectfully asks that you not recommend SB 235 for passage**. Thank you for your consideration.

HUTTON
CONSTRUCTION

BUILDING BETTE
BUILDING SMARTER
BUILDING TRUST

March 2, 2005

Senator Susan Wagle
State Capital, Room 120-S
Topeka, Kansas 66612-1510

Re: Written Testimony on SB 235

Dear Senator:

Thank you for allowing me to submit my written testimony on SB 235. Under cover of this letter I am faxing you that testimony as well as numerous articles that we discuss that discuss the preliminary MedPAC report findings. At the very least I believe that these preliminary reports indicate that this is not the crisis that some would perceive it is. These reports provide ample reason to allow the MedPAC process to take its course so that the problem can be corrected at the appropriate level.

Thanks again and please call if you would like to discuss this issue further.

Sincerely
HUTTON CONSTRUCTION CORPORATION

Mark Hutton,
President

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WRITTEN TESTIMONY OF MARK E. HUTTON
BEFORE SENATE COMMITTEE ON HEALTH CARE STRATEGIES
SB 235
March 3, 2005

Madam Chair, and Members of the Committee my name is Mark Hutton. I am president of Hutton Construction Corporation, a mid-sized general contractor operating primarily in the Wichita and surrounding areas of Kansas.

Today I am speaking out in opposition to SB 235 and request that you not report it favorably for passage.

SB 235 is prescriptive in nature and is designed to block competition with the traditional hospitals in our State, specifically one that is being considered for the Andover, Ks. area. While I am certainly not an expert on the impact of private, physician owned hospitals on the large existing health care facilities I do believe strongly that it is very dangerous to start passing legislation in our State to block specific private initiatives.

It is my understanding that this bill is being considered so that KDHE has the time to review and revise the regulations governing the operations of hospitals in the State. I submit that if KDHE has a concern about strengthening their standards for hospitals that they have a year to get this done before the project in question would be open and even then they have the authority to add requirements to the facilities and operations at any time if they feel it is in the best interest of the public. If there is a question about low standards and the impact on our public health then I suggest that you consider strengthening KDHE's oversight abilities and not weaken our state by blocking private enterprise.

Imposing a moratorium on free enterprise sets a bad precedent for our State. In today's competitive market for attracting new industry and capital to our State we would be remiss if we react with legislation every time it threatens the status quo.

Last year the federal government commissioned MedPAC to prepare a report on exactly the issue that is before you today. Included in this mandate was a moratorium on the construction of new facilities until later this year. While this report is not yet complete the preliminary report found that the presence of specialty hospitals in a market has produced a higher level of healthcare and has not adversely affected the profitability or the ability of the larger hospitals to provide services. Last year this was born out in that while 4 specialty hospitals were operating in the Wichita area both of the large hospitals posted profits. The final analysis of the data is still pending. At the very least I believe you should wait for the final report on the impact of physician owned hospitals before you impose a moratorium that could prove to be unwarranted, unjust, and potentially damaging our States reputation and economy.

Thank you for allowing me the opportunity to address this important issue today and I again respectfully request that you not recommend SB 235 for passage.

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Comments FYI

From: "Michelle M. Freeland" <michellefreeland@surgicalhospital.org>
To: <info@surgicalhospital.org>
Sent: Monday, September 13, 2004 10:23 AM
Subject: ASHA - MedPAC Article Published in BNA Today

September 14, 2004
Hospitals Report Shows Little Financial Impact On Large Hospitals by Specialty Facilities

Specialty hospitals care for fewer low-income patients than larger community hospitals but overall have little negative financial impact on the competition, the Medicare Payment Advisory Commission found in a preliminary study issued Sept. 10.

The early study looked at specialty and community hospitals in three areas with a concentration of physician-owned, single-specialty facilities. The findings were released at a regular MedPAC meeting. A full report is due out in March 2005.

Congress mandated in the 2003 Medicare law that MedPAC look at a number of issues related to physician-owned specialty hospitals, specifically the financial effect the single-service facilities have on full-service acute care hospitals. Specialty hospitals, as defined by the law and MedPAC, are those that offer only cardiac, surgical, or orthopedic services. The law imposed an 18-month moratorium on Medicare payments to new specialty hospitals while MedPAC conducts its research.

Specialty hospitals have received much criticism from the larger hospital community and from some lawmakers for "cherry-picking" the most profitable patients from community hospitals, leaving the acute-care facilities to absorb the cost of caring for the sickest and most expensive patients. Critics also charge that specialty hospitals further handicap full-service facilities by not operating emergency departments.

The preliminary MedPAC study was conducted in Texas, Kansas, and South Dakota. It confirmed that, on the whole, doctor-owned specialty hospitals see fewer Medicaid patients, leaving community facilities to pick up cases with lower reimbursements.

However, the findings further showed that community hospitals remained profitable even as competing specialty hospitals attracted large volumes of profitable procedures, such as heart and other surgical procedures.

MedPAC also found that specialty hospitals prompted changes at competing community hospitals, such as extending patient hours, improving scheduling, and upgrading equipment.

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09/13/2004

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Sent: Monday, September 13, 2004 9:43 PM
Subject: ASHA Update

Pomattos
Tom Nestel
should have Rec'd
this also -
9/14/4

AMERICAN SURGICAL HOSPITAL ASSOCIATION
TRUTH CAMPAIGN

ASHA UPDATE

September 13, 2004

Dear ASHA Member:

On Friday, September 10, 2004, the Medicare Payment Advisory Commission (MedPAC) held its monthly meeting. At this meeting, MedPAC was presented with preliminary results of the study mandated by the Medicare

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Modernization Act of 2003 that was passed in November of last year. The initial findings of the study are very positive and show that specialty hospitals do not pose a serious threat to traditional hospitals, as some of our opponents have claimed. We are confident that the final report will show that there is no compelling need to extend, or make permanent, the moratorium on the development of specialty hospitals throughout the United States.

I would like to begin this letter by mentioning that our communications and advocacy efforts are succeeding because of the monetary contributions you have made. Your generosity has allowed us to hire Randy Fenninger, a Washington, D.C. based lobbyist and Carlos Vasquez, a public relations and political policy expert. Much of our recent success in the policy and public perception arenas can be attributed to these two individuals.

Mr. Fenninger has been responsible for executing ASHA's advocacy efforts on Capitol Hill. Due to his relationship with key staff members, Randy was instrumental in convincing MedPAC to expand the number of site of visits to our members' hospitals in order to gain a more wide-spread sample of specialty hospitals. He has also been ASHA's voice in the halls of Congress. From testifying at key committee hearings, to representing our organization at political fundraising events, Randy has successfully represented ASHA with key decision makers in Washington.

Mr. Vasquez is responsible for message development and continuity. He developed the ASHA Truth Campaign, our communications plan designed to educate Congress, key policy makers and the American public about the benefits specialty hospitals bring to our nation's health care system. In addition to general message development, Carlos is responsible for all of ASHA's media relations, policy development, creation and distribution of press releases, scripting responses to opposition attacks and authoring articles. Because of Carlos' efforts, ASHA has been frequently mentioned in nationally-published trade journals and newspapers and we have become a more recognizable organization in Congress and across the country.

Our opponents such as the American Hospital Association (AHA) and the Coalition of Full Service Community Hospitals claim that the growth of specialized hospitals threatens community access to acute care. However, according to MedPAC, this simply is not happening. MedPAC staff reported that when a specialty hospital enters a market served only by traditional hospitals, these facilities see a slight decline in the volume of patients treated, yet remain profitable over time despite the new competition brought on by the specialty hospitals.

MedPAC also reports that traditional hospitals are forced to find better efficiencies and improve service when faced with competition from specialized acute care facilities. For example, in order to respond to the increase in competition, traditional hospitals improve their hours of operation, thus making it more patient-friendly. This substantiates our claims that the competitive nature of the specialized model leads to improved patient care at a lower cost. In short, when competition is encouraged, patients and payers alike win.

MedPAC was very complimentary about our member facilities that were chosen for site visits by MedPAC. They were very impressed with our open-door policy and the access to information that we afforded them. We have stated time and time again that

we have nothing to hide and that the truth about specialty hospitals is one to be shared with the country, not covered-up, which the AHA would prefer.

Despite this encouraging news, it is too early to celebrate and claim victory. Although the ASHA Truth Campaign is working and our legislative efforts are bearing fruit, this is the first battle in a long war. We must remain diligent and committed to the programs we have implemented to fight the moratorium and our opponents' rhetoric. The AHA is on record stating that they will continue to push for a permanent moratorium on specialty hospitals despite the final results of the MedPAC and HHS studies. Regardless of the final outcome of these studies, our opponents will not quit until they have exhausted all of their resources in fighting to eliminate any form of competition in the health care industry.

We look forward to the final results of the MedPAC study, and are confident that they will be positive for the specialty hospital study. The preliminary information presented to MedPAC on Friday, as well the findings of ASHA's member survey, are consistent with earlier studies that show competition leads to lower costs, lower complication rates and improved patient satisfaction. America's patients demand the best health care possible and specialty hospitals have answered that call. ASHA will continue to work to ensure that facilities, like yours, have a voice in the health care debate. We have the truth. We have the facts. And we will use them to educate the American public and Congress about the necessity of specialization in acute care.

Thank you for your time regarding this important matter. If you have any questions, please do not hesitate to contact me at your convenience.

Sincerely,

Mike Lipomi, MSHA
President

p.s.
I have attached an article from Jeff Tieman of Modern Healthcare to whom I gave an interview regarding the preliminary findings of MedPAC's study for your information. I hope that you find the article of interest. Please note the AHA's position at the end of the article.

Specialty competition isn't all bad: MedPAC

By Jeff Tieman, Modern Healthcare / September 10, 2004

Physician-owned specialty hospitals may not pose as severe a threat to community hospitals as critics have suggested they do, according to preliminary results of a study being conducted by the Medicare Payment Advisory Commission.

Specialty hospitals -- which focus exclusively on providing cardiac, orthopedic or surgical care -- initially reduce the volume of patients treated by competing community hospitals, MedPAC researchers said. However, they added, most community hospitals remained profitable over time despite competing with a new specialty facility.

When specialty hospitals enter a market, they often serve as a "wake-up call" for

their traditional acute-care competitors to improve services and efficiency, according to early findings of MedPAC's study, which was mandated by the Medicare Modernization Act and will be completed in March 2005.

Specialty hospitals also serve fewer Medicaid and uninsured patients, and present possible conflicts of interest, MedPAC said.

The Medicare Modernization Act put in place a moratorium on the construction of new physician-owned specialty hospitals until June 2005. The American Hospital Association and other advocates of acute-care, community hospitals are lobbying to make the moratorium permanent.

Some lobbyists said MedPAC's early conclusions on specialty hospitals could take some of the wind out of their sails. The AHA, meanwhile, said it will continue to push for a permanent ban on the specialized facilities.

Article taken from Modern Physician, September 10, 2004

[redacted]

09/14/2004

Jim Barone

From: "Michelle M. Freeland" <michellefreeland@surgicalhospital.org>
To: <info@surgicalhospital.org>
Sent: Thursday, November 18, 2004 5:40 PM
Subject: ASHA MedPAC Press Release

FOR IMMEDIATE RELEASE

Date: November 18, 2004
From: Carlos Vasquez – ASHA Public Relations
Phone: (775) 852-9292x227
Email: carlos@artassociates.com

MedPAC: Specialty Hospital Competition Doesn't Harm Community Hospitals

The American Surgical Hospital Association (ASHA), the national trade organization representing more than seventy specialty hospitals nationwide, is gratified with the recent findings of the Medicare Payment Advisory Commission's (MedPAC) study on specialty hospitals. These findings show that allegations made by our opponents are without merit.

These findings contradict claims made by community hospital special interest groups such as the American Hospital Association (AHA) and Federation of American Hospitals (FAH), that competition from specialty hospitals leads to the closure of community hospitals or reduction in essential services. According to MedPAC staff, when community hospitals are faced with competition from specialty hospitals they continue to remain profitable. According to the MedPAC report, full service community hospitals that competed against specialty hospitals saw profits that "were in line with national averages through 2002."

Although some of these facilities see a minute decline in their revenue streams due to this new competitive threat, community hospitals are able to compensate for this reduction in revenue by streamlining operations and cutting costs. This is consistent with ASHA's position that competition reduces costs and improves delivery of care.

Today's report is another example of extensive, third party analysis, which illustrates the fact that the AHA and FAH's rhetoric is baseless and untrue. To date, our opponents have failed to substantiate any of their claims that specialty hospitals negatively impact healthcare. However, expert organizations such as MedPAC, after extensive site visits and data analysis, have found that specialization and competition in healthcare improves patient access and choice.

"Today's report proves that the attacks made by our opponents are untrue. I am pleased with MedPAC's findings that specialty hospital competition does not harm community hospitals. These conclusions are yet more examples of extensive studies and research that show that specialty hospitals are a valuable component of our nation's healthcare system," said ASHA President Jim Grant.

Mr. Grant concluded by saying, "ASHA is hopeful that Congress ignores the claims made by the AHA and FAH and moves forward to immediately lift the current moratorium on specialty hospital

11/19/2004

development. To date, there have been no studies or research that would cause Congress to extend, or make permanent, the moratorium. ASHA members want to continue to be a valuable part our nation's healthcare system and are confident Congress will allow us this opportunity."

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11/19/2004

Tom Hutton - FYI
As discussed - Share w/ 42
Judy Townsend Page 1 of 1
Barone 11-19-04

Jim Barone

From: "Michelle M. Freeland" <michellefreeland@surgicalhospital.org>
To: <info@surgicalhospital.org>
Sent: Thursday, November 18, 2004 5:02 PM
Subject: ASHA - Important MedPAC Mtg. Recap

Dear ASHA Member:
Recap of the MedPAC meeting November 17, 2004 attended by ASHA Washington Representative, Randy Fenninger.
Regards, Michelle Freeland, CMP, BS

MedPAC Meeting Recap
MedPAC met today and received the third report on specialty hospitals from the staff. The analysis and discussion focused on heart hospitals because there are far more Medicare claims from those facilities than from other
surgical hospitals, but the conclusions apply to all surgical hospitals.

The conclusion of the presentation: "Despite competition from heart hospitals, full service community hospitals that competed with heart hospitals continued to have profits that were in line with national averages through 2002."

2002 is the most recent year with complete data that MedPAC staff could review.

The specific questions that were addressed today were (1) do MD owned specialty hospitals have different transfer rates than other hospitals; (2) do costs differ between MD owned specialty and community hospitals; (3) do heart specialty hospitals affect Medicare per capita rates for heart procedures; and (4) do physician owned specialty hospitals affect
community hospitals' profitability. The basic answers are (1) yes; (2) yes, but the difference is not statistically significant; (3) no; and (4) no.

The discussion among the Commissioners was more muted than in the past. A few tried to find a hook to use to criticize specialty hospitals, but the staff would not bite, so the criticism fell flat. I think the staff were very careful to note the limitations of their data and the story the data tell. In the face of the conclusion, the debate just petered out, much
like a balloon deflating.

While we have many fights remaining before this issue is finished in Congress, today's report provides compelling evidence that the AHA and FAH have made allegations that are not supported by the data. We should not
underestimate their political power, but we now have a powerful argument for ending the moratorium.

This meeting completes the major data and analytic presentations. In December, the Commissioners will discuss draft recommendations to go to Congress in March. We have requested a meeting to discuss these next steps.

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From: "Michelle M. Freeland" <michellefreeland@surgicalhospital.org>
To: <info@surgicalhospital.org>
Sent: Thursday, November 18, 2004 5:31 PM
Attach: MedPAC Study Review 11.18.04.pdf
Subject: ASHA MedPAC Study Findings Report

Hello ASHA Member,
Enclosed is a review titled "MedPAC Study - A Review of Findings Released October 28-29, 2004, by ASHA Legal Counsel Scott Becker, JD, CPA.

Best Regards,
Michelle Freeland, CMP, BS

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11/19/2004

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Statement of the Kansas Medical Society on
SB 235; Concerning a moratorium on the establishment of certain hospitals
Senate Public Health and Welfare Committee
March 3, 2005

The Kansas Medical Society appreciates the opportunity to comment on SB 235, which would impose a moratorium on the establishment of certain hospitals until July 1, 2006. This legislation focuses attention on a complex and controversial issue – that of the growth of non-traditional, specialty or general hospitals and other medical facilities which are either owned in whole or in part by the physicians that work in such facilities. This legislation was apparently introduced specifically to prevent the establishment of a general hospital being planned in Andover, which will have at least partial physician ownership. Critics of physician-owned hospitals contend that such facilities damage existing community hospitals by reducing their volume of high-paying services which have typically been used to cross-subsidize their less profitable services.

As you are already aware, as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L.108-173), Congress imposed an 18 month moratorium on physician referrals to new specialty hospitals in which the physician had an ownership interest. The federal moratorium is scheduled to expire this June, unless Congress extends it, which is a possibility. That law required government agencies to conduct a study to, among other things, compare the costs and patient mix of specialty hospitals versus general hospitals, the financial impact of specialty hospitals on general hospitals, and whether the inpatient hospital payment system should be changed to better reflect actual costs of care. SB 235 would essentially continue the moratorium at the state level, and broaden it to include all hospitals, except critical access hospitals.

This issue is extremely complicated, and quite frankly, divides the physician community somewhat. Overall, physicians clearly understand and are very sensitive to the needs of traditional community hospitals, and the importance of keeping them financially viable. Critical community support services, such as caring for the uninsured, and delivering other safety net services require the services of both hospitals and physicians. Working together, both groups provide substantial amounts of uncompensated care to patients who must rely on these safety net functions.

On the other hand, there are a number of physicians who believe their ownership and operation of hospitals has provided an alternative that produces high quality care at less cost because they focus their mission and resources on a limited set of services and

Senate Health Care Strategies Committee
Date: March 3, 2005
Attachment 15

operate more efficiently than conventional hospitals. They are concerned that legislation such as this is really just the beginning of a broader effort by hospitals to prevent physicians from developing patient care facilities to provide any surgical, diagnostic or other medical services that traditionally have been provided by community hospitals. In response to criticism that it is a conflict of interest for physicians to own and operate hospitals, they point to the fact that hospitals and vertically integrated health systems have for years acquired physician practices to assure patient referral to their facilities. Why is it not a conflict of interest for hospitals to operate medical practices to compete with community physicians, but it is a conflict for physicians to have a role in the operation/ownership of a hospital?

One of the biggest criticisms of those in the health care system is that the system resists normal market forces which produce enhanced value by delivering higher quality at lower cost. There is great pressure from government, employers, and patients to interject competitive market forces into the health care equation, in order to bring about changes that produce greater value. Doesn't a moratorium send a mixed message - physicians and others are expected to compete, improve quality and find ways to lower costs, but not if it impacts existing facilities?

Clearly the growth of alternative facilities and their impact on community hospitals is a topic that needs thoughtful study and discussion. For example, a contributing factor in this equation is a flawed Medicare reimbursement methodology that underpays safety-net services such as emergency departments. Hospitals have been required to cross-subsidize those services with higher paying services. Congress and other payors need to change payment systems to more accurately reflect the relative costs of care and services provided in the hospital. Additionally, we should also look at ways to more adequately compensate the teaching hospitals for the critical medical education functions they provide the state's physician and nurse training programs. These are just a couple of the many cost, access, quality, system, and patient preference considerations that are important to the discussion of which model, or combination of the models, will best meet the needs of our state in the future. While it is understandable that parties in a particular local area may want the state to intervene to prevent the growth of competing facilities, we question whether this legislation is a necessary and appropriate response. Before our state imposes a broader moratorium than that which is already in effect nationally, we believe more study and information about the many facets of this overall problem is warranted. We would encourage the legislature to undertake a comprehensive study of this whole issue during the upcoming interim, taking into account the results of the federal study which is just about to be released, and any subsequent congressional activity. Thank you for the opportunity to offer these comments.

KANSAS

RODERICK L. BREMBY, SECRETARY

KATHLEEN SEBELIUS, GOVERNOR

DEPARTMENT OF HEALTH AND ENVIRONMENT

Testimony on Senate Bill 235

Presented to

Senate Committee on Health Care Strategies

By
Roderick L. Bremby, Secretary

Kansas Department of Health and Environment

March 2, 2005

Chairperson Wagle and members of the committee, my name is Roderick L. Bremby, Secretary of Kansas Department of Health and Environment. Thank you for the opportunity to discuss SB 235, which proposes to allow time to complete and/or review state and national studies evaluating the impact of limited service, or specialty hospitals on the health care system.

KDHE has not been involved in health facilities planning or control of health assets since the Certificate of Need law expired in 1985. As a result, we have insufficient data or criteria to evaluate facility growth. Senate Bill 235 would have its most significant impact on specialty hospitals; these hospitals are much like general hospitals, but provide diagnosis and treatment to patients with specified medical conditions. Currently there are 17 specialty hospitals in Kansas, a number that has held firm for about the last two years. We are aware of interest in two more being constructed.

KDHE and Kansas Health Institute (KHI) are currently studying the very issue of specialty hospitals and their impact on general, or full-spectrum hospitals. Accordingly, we do not have sufficient information at this point to either support or oppose a moratorium. We would like to take this opportunity to describe the specialty hospital study and bring to the committee's attention some technical issues with the bill as currently drafted.

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KDHE and KHI have proposed a study of the impact of specialty hospitals on communities across Kansas. The project is expected to take 6-9 months following successful collection of data by KDHE. The study would address four key sets of questions:

- How does the entry of a specialty hospital impact market competition?
- How does the entry of a specialty hospital affect utilization rates?
- How does the entry of specialty hospitals impact revenue and margins at community hospitals?
- How have specialty hospitals impacted the provision of community health services such as Medicaid, uncompensated care, and emergency room services?

When this study is completed we will have a much better idea what effects physician-owned limited service facilities have on Kansas communities and our state's health care service industry.

We should note that in December 2003, Congress suspended federal Medicare payments to new specialty hospitals until June 8, 2005 and commissioned studies from the Medicare Payment Advisory Commission (MedPAC) and the Center for Medicare and Medicaid Services (CMS) on the effect of specialty hospitals on cost, quality, financial impact, and impact on care provided to the uninsured.

MedPAC did not find that specialty hospitals have a negative financial impact on community hospitals, but wondered aloud whether the study period was too short to find such an effect. One of MedPAC's recommendations to Congress is that the payment moratorium be extended until January 2007.

At the present time, we do not believe we have sufficient Kansas-specific data that can be used to shape policy decisions on the moratorium issue. We believe after the conclusion of the KDHE/KHI specialty hospital study, we will be in a better position to inform the debate on this subject.

Should SB 235 progress, we believe there are some technical clarifications needed to express the intent of this bill. On page 1, line 23, we strongly recommend that the term "commenced" be clarified, as it could mean anything from providing notice of intent to build a facility to actually breaking ground. Because we become aware of construction in a variety of ways and at various time frames, we believe a more definitive threshold needs to be established to avoid misunderstanding, as well as programmatic and legal conflicts that may arise under the current language.

Thank you and I will be happy to respond to questions.