OBAMA-BIDEN TRANSITION PROJECT

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Physician Owned Hospitals – An Overview

BACKGROUND

Physician ownership of hospitals has a long and distinguished history in the United States. Physicians and surgeons often opened and owned the first hospitals in their communities. Some of these evolved into important medical centers that set new standards of excellence. The current resurgence of interest in physician ownership of hospitals comes from the medical community's realization that medical care was no longer under the control of the people who provided that care, but was dominated by administrators and medical conglomerates who had lost sight of the real task – taking care of people who were sick or injured. Physicians have also found themselves to be the buyers of last resort of hospitals that have been abandoned by their corporate owners as unprofitable, even though there was still a strong need in those communities for the hospitals to remain open.

Legislation, starting with the Hill Burton act of 1946 and continuing with cost based reimbursement under Medicare, encouraged the growth of larger and more bureaucratic institutions. Size and breadth of services, rather than efficiency and effectiveness, became measures of success. Lost in the expansion of physical plant and layers of corporate bureaucracy were patient care, attention to the working conditions of nurses, the efficiency needs of physicians and the cost needs of payers.

These factors, along with dissatisfaction with the deterioration in quality of care that has accompanied the managed care era, have motivated many physicians to again demand a greater say in the care of their patients and the operation of their workplace - the hospital. In its federally mandated report to Congress in 2005, MedPAC stated that the most common reason for physicians to establish hospitals was governance. "Physicians wanted to control decisions made about the patient care areas of hospitals so they could improve the quality of care provided, improve their productivity, and make the hospital more convenient to them and their patients." Report to Congress, Physician-Owned Specialty Hospitals, March 2005, Medicare Payment Advisory Commission (MedPAC), pgs.7-8. Patients are also demanding a greater say in their own care and want choices. The one-size-fits-all approach of the traditional hospital is frequently not the patient friendly way to deliver health services.

Physician ownership of hospitals puts control where it belongs – with doctors and their patients. Physicians take an oath to do everything in their power to care for their patients. When physicians are directly involved in every aspect of the delivery of healthcare, patients benefit.

THE PHYSICIAN HOSPITAL INDUSTRY

What types of hospitals do physicians own? There really is no single model. Physicians have invested in full service community hospitals, rural hospitals, specialized surgical hospitals, rehab hospitals, and psychiatric facilities. Physician Hospitals of America (PHA), the national association representing the

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industry, is a great example of the melting pot that is the physician hospital industry. PHA currently represents specialty hospitals (such as single specialty orthopedic, heart, and multi-specialty surgical hospitals), women's hospitals, children's hospitals, rehabilitation hospitals, and general hospitals located both in cities and in rural areas. In addition, the industry is made up of joint ventured hospitals working with larger non-profit or for-profit hospital systems, joint ventured hospitals partnering with development/management companies or other investors, and one-hundred percent physician owned hospitals.

The industry continues to grow as patients and physicians increasingly see this model as one that is preferable to the community hospital offerings in many communities. At this time, there are approximately 198 physician owned hospitals in the country. In addition, PHA is currently aware of at least 35 hospitals scheduled to open within the next two years. An interesting trend in hospital growth patterns is that a larger percentage of new hospitals are general acute care hospitals. In addition, a majority of the ongoing development projects are following the joint venture model, choosing to partner with a non-profit or for-profit hospital system or with an independent development/management company.

Another exciting trend is the growth of physician hospitals in Certificate of Need (CON) states. At this time, a majority of physician owned hospitals continue to be located in states without CON laws. However, due to the increasing inclination of hospital systems to offload smaller, less profitable hospitals, physicians are entering the CON market by purchasing those discarded hospitals and keeping them alive. This trend has particular application in rural and inner city markets.

COMMUNITY BENEFIT AND ECONOMIC IMPACT

Not only do physician hospitals deliver high quality medical care to the patients they serve, they also provide much needed jobs, pay taxes, and generate significant economic activity for local businesses. In 2005 HHS concluded that, considering uncompensated care and tax payments, physician hospitals returned a net community benefit almost 8 times higher than non-profit hospitals, averaging 7.23% in net benefit as compared to .87% for non-profit hospitals. *HHS Study, pg. 58.*

Physician hospitals have a huge economic impact at the national, state and local levels. At the national level the following has been determined*:

- Physician hospitals employee just over 40,000 full and part time employees.
- Over 15,000 physicians practice at physician owned hospitals.
- There are currently approximately 2800 physicians who own a percentage of a hospital in the United States.

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- Average payroll at each physician hospital is approximately $8,200,000 with just over $1.6 billion being distributed in payroll by physician hospitals in the country.
- In aggregate, physician hospitals spend over $1.9 billion per year on trade payables.
- As for profit entities, physician hospitals pay federal, state and local taxes including property, federal and state income (paid by hospital and by individual physicians depending upon corporate setup), sales, franchise and excise taxes, etc. On average, not including individual income tax paid by individual physicians, physician hospitals pay $2,715,000 in various taxes on an annual basis.
- Physician hospitals provide charity and write off bad debt at rates higher than many non-profit hospitals. On average, 4.53% of physician hospitals net revenue is provided in charity care and bad debt write-offs.

**Data obtained from an internal PHA survey of 198 existing physician hospitals in the United States.*

In addition, physician hospitals strengthen the local medical community. The opportunity to be involved with a physician-owned hospital, as either an investor or credentialed user, provides a means of recruiting and retaining top quality doctors to communities that may otherwise find it difficult to attract and retain the physicians they need. Physician hospitals report that after opening their doors physician practices in the area were able to recruit an average of 10 new physicians to the market in a period of 5 years or less.

In summary, physician hospitals allow communities to become centers for healthcare excellence. The excellent quality services provided by physician-owned hospitals often attract patients from an expanded service area broadening the community healthcare market.

THE PHYSICIAN HOSPITAL POLITICAL DEBATE

The federal government regulates physician ownership and investment primarily through the Stark laws. When these laws were debated in Congress in the 1980's and 1990's, the reality of physician ownership and its importance were acknowledged. For example, physician owned ambulatory surgical centers are not covered by the law. Ownership of medical equipment and services, like labs and imaging, was given special consideration so that physician practices could continue providing these important services to their patients. Most importantly, Congress included the whole hospital exception, which explicitly recognized the fact that physician ownership of hospitals was even then an important and valued element in the medical care system of this country. This provision is also a tacit acknowledgement that physician hospitals would continue to play a role in the future.

However, since at least 2001, opponents of physician hospitals have encouraged legislation that would alter the current Stark law exception. It is important to note that these opponents have almost always

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been competing hospitals and their political allies. Although these opponents have attacked physician ownership in many ways, extensive government studies have failed to substantiate their claims, thus proving that the attacks are simply based on greed and fear of competition.

In the beginning of the debate, attention was focused on specialized hospitals owned by physicians, such as cardiac or surgical facilities. However, since 2007 the attack has been against physician ownership of any kind of hospital in any location. Apparently the opponents of physician ownership are so fearful that they want to shutter all physician owned facilities, even though these opponents have often abandoned the very community facilities that physicians have invested in.

The following is a bulleted list of the federal legislative and political challenges physician hospitals have faced in the last 5 years:

June 2003 – Senator John Breaux (D-LA) adds physician owned specialty hospitals to Medicare legislation

December 2003 – the Medicare Modernization Act passes with an 18 month moratorium on the ability of physician hospital owners to refer Medicare patients to new hospitals, an effort to stop the growth of specialty hospitals (existing hospitals and those under development are exempt from this provision)

May 2005 – Senators Charles Grassley (R-IA) and Max Baucus (D-MT) introduce stand-alone legislation to shut down specialty hospitals

June 8, 2005 – the 18-month moratorium enacted in the MMA expires

June 9, 2005 – CMS enacts a “moratorium-lite” on new physician owned hospitals applying for Medicare certification after June

October 2005 –Senator Grassley adds anti-specialty hospital language to the Budget Reconciliation Package

February 2006 – the Deficit Reduction Act passes including additional study and strategic plan requirements for CMS and confirming the “moratorium lite” affecting only hospitals applying for licensure after June 9, 2005

May 17, 2006 – Senators Grassley and Baucus call a Senate Finance Committee Hearing on specialty hospitals

August 8, 2006 – CMS issues its final report and strategic plan as required by the Deficit Reduction Act and lifts the moratorium on certification of specialty hospitals

July 25, 2007 – Physician hospital language added to CHAMP Act in the House

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September 2007 – general Medicare language removed from CHAMP Act by Senate

December 2007 – after threat of being added to a separate Medicare package, clean Medicare bill passes

March 2008 – Physician hospitals added to the Mental Health Parity Bill by Senator Baucus

April 2008 – Physician hospitals added to the Farm Bill by Senator Grassley. The language was removed the same month.

May 2008 – Physician hospitals added to the Supplemental Appropriations Bill by Senator Baucus

June 2008 – Senate adopts House version of Supplemental Appropriations Bill, not including physician hospital language

July 2008 – After threat of being added to a separate Medicare package, clean Medicare bill passes

July 2008 – Physician hospitals added to stand alone rural health bill by Senator Grassley

September 2008 – Physician hospitals removed from Mental Health Parity bill and threat of being added to Alternative Minimum Tax/Tax Extenders bill was eliminated

FEDERAL STUDIES

Over the course of this multiyear debate, a number of government studies were conducted in response to the complaints of opponents to physician ownership of hospitals. These reports fail to substantiate in any significant way the challenges offered to physician ownership.

Government Accountability Office (GAO)

GAO has provided Congress three reports on physician owned specialty hospitals since 2003. The first report, released in May 2003 pursuant to a request by Members of Congress, was largely descriptive of the industry as it existed in 2002. The report provided initial data on the prevalence of specialty hospitals and their characteristics in terms of ownership and patients treated. GAO found that physician owned specialty hospitals made up a very small portion of Medicare hospital costs. They also determined that the average share of ownership per physician was between 2-4%. GAO identified modest differences in the acuity of the patients treated in specialty hospitals and general hospitals.

A more extensive analysis was provided to Congress in October 2003, expanding on the findings of the earlier report. GAO found that hospitals that specialize in treating cardiac, orthopedic, or women's conditions or in performing surgery tended to be concentrated in certain geographic areas where state policy or local demographic conditions were favorable to hospital growth. Although 28 states had at least one specialty hospital, approximately two-thirds of the 100 specialty hospitals that GAO identified

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were located in seven states: Arizona, California, Kansas, Louisiana, Oklahoma, South Dakota, and Texas. Counties with populations that grew the fastest from 1990 through 2000 were somewhat more likely than slower growing counties to have had a specialty hospital open since 1990. Relative to general hospitals, specialty hospitals, as a group, were much less likely to have emergency departments, treated smaller percentages of Medicaid patients, and derived a smaller share of their revenues from inpatient services. The results were more mixed for Medicare patients. Cardiac hospitals in the sample treated a higher percentage of Medicare patients relative to area general hospitals, while the percentage of Medicare patients at other specialty hospital types was lower or about the same relative to area general hospitals. Differences also appeared in the mix of inpatient and outpatient services. Cardiac and women's hospitals derived the majority of their revenues from inpatient services, while orthopedic and surgical hospitals derived the majority of their revenues from outpatient services. GAO also found that many physicians who had no ownership in these hospitals also used them, suggesting that the attractiveness of the model went beyond any possible opportunity for financial gain.

In the most recent GAO study, released in May 2006, the agency was asked to provide information on the competitive response of general hospitals to specialty hospitals. GAO surveyed approximately 600 general hospitals in markets with and without specialty hospitals to provide information on the extent to which these two groups of general hospitals reported implementing operational and clinical service changes to remain competitive. Nearly all general hospitals responding to GAO's survey reported making operational and clinical service changes to remain competitive in what they viewed as increasingly competitive healthcare markets; however, there was little evidence to suggest that general hospitals made substantially more or fewer changes or different types of changes if some of their competition came from a specialty hospital. There were no substantial differences in the average number of operational and clinical service changes made by general hospitals in markets with and without specialty hospitals and, for the vast majority of the potential changes included on GAO's survey, there was no statistical difference between the two groups of hospitals in terms of the specific changes they reported implementing.

Medicare Payment Advisory Commission (MedPAC)

In the Medicare Modernization Act of 2003 (MMA), Congress directed MedPAC to study several questions related to the impact of physician owned specialized hospitals on general hospitals. That report was provided to Congress in March 2005. MedPAC demonstrated that specialty hospitals may reduce the volume of patients treated by traditional hospitals in certain specialties. However, the Commission also found that community hospitals remained profitable over time despite competing with a new specialty facility. According to MedPAC, "The financial impact on community hospitals in the markets in which physician-owned specialty hospitals are located has been limited, thus far. Those

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community hospitals competing with specialty hospitals have demonstrated financial performance comparable to other community hospitals."

In addition, a MedPAC analyst reported that competition provides community hospitals with a stimulus for change; and that community hospitals often responded to the presence of surgical hospitals by "improving their own performance." The MedPAC staff reported that the most common reason for physicians to establish surgical hospitals was governance. "Physicians wanted to control decisions made about the patient care areas of hospitals so they could improve their productivity, improve the quality of care provided and make the hospital more convenient to them and their patients."

MedPAC concluded that specialty hospitals have a small patient mix advantage leading to a 5-10% advantage in profitability over general hospitals. However, the Commission pointed out that this difference in case mix was not based on improper incentives but rather on the fact that specialty hospitals realize they do not have the resources to treat certain more severe patients. The Commission recommended modifications to Medicare's DRG payment system that would eliminate the incentives for hospitals to specialize in certain types of care and patients by basing payments on patient acuity and cost of care for more complex patients. Basically, hospitals treating sicker patients and providing more complex services would receive higher payments than those that took care of healthier, less difficult patients. The Centers for Medicare and Medicaid Services (CMS) started implementing these recommendations in 2007.

A subsequent study released to Congress in August 2006 reexamined these same questions, using a larger Medicare claims database. The conclusions reached in the earlier work were substantiated by the follow up review.

Centers for Medicare & Medicaid Services

In the MMA Congress also instructed CMS to conduct a separate study of specialty hospitals. CMS found that specialty hospitals provide high patient satisfaction, high quality of care, improved patient outcomes, as well as greater predictability in scheduling and services. Regarding referral patterns, CMS reported that physician owners do not refer their patients exclusively to the specialty hospitals that they own. They also refer patients to local community hospital competitors. CMS found that there were no consistent patterns of preference for referring to specialty hospitals by physician owners. Finally, CMS found that, "Overall, the proportion of net revenue that specialty hospitals devote to both uncompensated care and taxes significantly exceeds the proportion of net revenues that community hospitals devote to uncompensated care. Real estate and property tax payments stay in the local community, as does a share of sales tax payments in most areas."

CMS also recognized flaws in the inpatient payment system and outlined several steps it planned to take to correct them. These changes closely mirrored the recommendations that MedPAC had made to Congress. CMS undertook a review of emergency care policy to evaluate whether changes to

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EMTALA rules were warranted. CMS also said that it would scrutinize more closely whether facilities met the definition of the term "hospital", and would overhaul the payment system for ambulatory surgical centers (ASCs) to reduce the incentives for those facilities to convert to hospitals. Revision of the ASC payment structure was proposed in 2006 and went into effect in 2008.

In 2005 CMS reported to Congress that no changes to EMTALA rules were required, except for clarification of the responsibility of all hospitals to accept appropriate transfers. The agency decided not to make any changes in the definition of "hospital", but would instruct Fiscal Intermediaries to carefully examine applications to participate in Medicare from new hospitals to ensure that the facilities had real inpatient capacity, thus demonstrating intent to provide a realistic volume of inpatient care.

In the Deficit Reduction Act, Congress told CMS to develop a strategic plan to address the growth of specialty hospitals. In 2006 CMS reported to Congress that it would begin collecting data on ownership, investment and compensation arrangements from all hospitals to make sure that all such financial ties met federal standards. CMS also indicated that it will propose rules to address concerns that smaller hospitals may not be properly equipped or staffed to handle patient emergencies.

Department of Justice and Federal Trade Commission Report--Improving Health Care: A Dose of Competition

In November 2002, FTC Chairman, Timothy J. Muris, announced that the FTC would hold joint hearings with the DOJ on competition in healthcare. On July 23, 2004, following the conclusion of hearings lasting over six months, the FTC and DOJ issued a joint report in which the agencies recommended that states decrease barriers to entry into provider markets. The agencies encouraged states to reconsider whether CON programs "best serve their citizens' health care needs." The agencies stated that, "On balance, the DOJ and FTC believe that such programs are not successful in containing health care costs, and they pose serious anticompetitive risks that usually outweigh their purported economic benefits."

The report further states that, "the American free-market system is built on the premise that open competition and consumer choice maximize consumer welfare – even when complex products and services such as healthcare are involved." A further observation was made stating that "Private parties should not engage in anticompetitive conduct in responding to marketplace developments. … 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." According to the report, "Healthy competition equals healthy consumers. Consumers want high-quality, affordable, accessible health care, and the challenge of providing it requires new strategies." The report specifically considered the emergence of physician owned specialized hospitals and concluded that no special enforcement action was required because of any suspect behavior by these facilities.

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Office of the Inspector General

In January 2008 the HHS Office of Inspector General (OIG) issued a report regarding the emergency care policies at physician-owned specialty hospitals. This report was requested in 2006 by Senators Charles Grassley and Max Baucus. The OIG interviewed and obtained documents from 109 hospitals in preparing the report. The OIG suggests that certain policies regarding emergency response and patient transfers might violate Medicare's conditions of participation. The OIG further concluded that 37 of these hospitals allegedly use 911 as a substitute for the hospital's ability to stabilize its patients. In addition, the OIG listed 8 hospitals which had supposedly violated Medicare conditions of participation due to improper staffing.

However, the conclusions and suggestions of the OIG are without merit. Specifically, 29 of the 37 hospitals the OIG claimed use 911 as a substitute for stabilizing patients have challenged this conclusion and provided documentation that supports this reaction. Similarly, all 8 of the named hospitals have come forward with documentation showing that they were, in fact, properly staffed according to CMS guidelines during the times in question. The OIG's conclusions were wrong and the agency erred in forwarding these hospitals to CMS for further investigative review.

The OIG also reported the number of hospitals with emergency rooms and the size of those emergency rooms. However, the report made no mention of the fact that these issues are controlled by state law. The OIG failed to include a statement that each of these hospitals met their state law requirements, thus inferring impropriety where none exists.

Many of the hospitals named by the OIG are five-star ranked and/or listed by independent quality authorities (such as HealthGrades) as the #1 hospital in their specialty and state. In its 2008 Report, the OIG did a disservice both to the medical professionals at these hospitals and, more critically, to the patients who are served by them.

QUALITY

The Federal government has reported that structural measures of quality, such as staff specialization, clinical staff per patient, and complication rates, all suggested good performance on the part of physician-owned hospitals and demonstrated very high quality of care. *"Study of Physician-Owned Specialty Hospitals Required in Section 507(c) (2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003," (HHS Study) by Michael O. Leavitt, Secretary of Health and Human Services, 2005, p. 53.* Mortality rates are significantly lower in physician hospitals than in other community hospitals– for all medical procedures analyzed by the U.S. Department of Health and Human Services (HHS) there was a measurable statistical significance. HHS Study, pg.42 (in reaching these conclusions, HHS adjusted for acuity). In addition, complication rates at physician hospitals are measurably lower than at general hospitals. According to the HHS study, patients are 3 to 5 times more likely to experience complications at general hospitals than at specialty hospitals. HHS Study, pg.

44-45 (Again, the results of the HHS Study were adjusted for acuity.) One factor that helps to bring about these better patient outcomes is that nurse to patient ratios are significantly better at physician hospitals than general hospitals. At physician hospitals, nurse to patient ratios average 1 nurse to 4 patients; however, nurse to patient ratios at general hospitals are typically 1 to 8 or higher.

The heightened quality present at physician hospitals comes with a cost-savings to the public. A study was recently conducted by healthcare economist John Schneider using quality data from the HHS Study, above. In this study, it was concluded that "if we were to move all specialty (physician) hospital patients into general hospitals, where they will face higher mortality rates and higher rates of patient safety events, there will be an additional 225 deaths and an additional 351 cases involving medical errors. The costs of these deaths and medical errors are conservatively estimated to be $605,920,876 per year. In other words, in purely monetary terms, a hypothetical shift of specialty hospital patients back to general hospitals would cost society at least $606 million, all else equal. This estimate is most likely an underestimate since it does not fully capture the indirect costs associated with mortality and medical errors." Specialty Hospitals and Quality: Potential Savings, John E. Schneider, PhD, HECG, November 12, 2007.

The quality present at physician owned and controlled hospitals has also attracted the attention of independent quality analysts. In a quality ratings summary compiled by HealthGrades, a number of hospitals specializing in Cardiac or Orthopedic services received a 5 Star Rating (functioning in the top 15% of hospitals in the nation), were ranked as the #1 or #2 hospital in the state for the type of care provided, or were in the top 5-10% in the nation for the type of care provided. In November 2008, Thomson Reuters released its list of the Best Community Hospitals for Cardiovascular Care - 10 of the 30 hospitals named as are owned and operated by physicians. (Thomson Reuters – www.thomsonreuters.com).

SCIP Measures Summary

Finally, the better quality of care provided at physician hospitals as compared to other hospitals is clearly demonstrated by an ongoing federal quality improvement initiative. The "Surgical Care Improvement Project" (SCIP) is a national quality partnership sponsored by the Federal government and made up of organizations committed to improving the safety of surgical care through the reduction of post-operative complications. The data below compares key performance metrics captured for physician-owned hospital and national hospital SCIP measures. All national hospital data was pulled directly from the Hospital Compare CMS website.

Percent of Surgery Patients Who Received Preventative Antibiotic(s) One Hour Before Incision

Physician Hospital Mean – 91.80%

National Hospital Mean – 84.00%

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Percent of Surgery Patients Who Received the Appropriate Preventive Antibiotic(s) Before Their Surgery

Physician Hospital Mean – 97.12%

National Hospital Mean – 91.00%

Percent of Patients Whose Preventive Antibiotic(s) Were Stopped Within 24 Hours After Surgery

Physician Hospital Mean – 90.27%

National Hospital Mean – 82.00%

Percent of Patients Whose Doctors Ordered Recommended Venous Thromboembolism Prophylaxis

Physician Hospital Mean – 91.83%

National Hospital Mean – 80.00%

Percent of Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis

Physician Hospital Mean – 91.83%

National Hospital Mean – 77.00%

In summary, the quality of care provided at physician hospitals is very high.

PATIENT SATISFACTION

In a survey conducted in 2008 by Lake Research Partners, an independent 3rd party, it was determined that "The American public believes doctors would do a good job running hospitals in their community, and they want doctors to make decisions about patient care and how hospitals are run. They believe doctors should be allowed to own hospitals where they work and that Congress ought to vote to allow this practice to continue." Two-thirds (67%) of the American public believes physicians would do an excellent or good job running a hospital in their community. And, physicians are the American public's first choice (over hospital administrators) of the person(s) they would prefer to see in charge of

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hospitals in their communities. (March 2008 telephone survey of 1,000 adults nationwide, conducted by Celinda Lake of Lake Research Partners).

The patient satisfaction rates at physician hospitals are unbeatable. According to the federal government, patients and their families value greatly the patient centered care provided by physician hospitals, including a quiet environment, private rooms, family accommodations, accessibility and attentiveness of nursing staff, specialized training of nursing staff, and specialized treatment and procedures offered by physician-owned hospitals. HHS Study, pgs. 48-53. These conclusions are supported by the internal patient satisfaction rates reported by many physician hospitals. For instance, Stanislaus Surgical Hospital in Modesto, California, Siouxland Surgery Center in Dakota Dunes, South Dakota and Kansas City Orthopaedic Institute in Kansas City, Kansas all report patient satisfaction rates of 98% or higher, with the same percentage of patients stating that they would recommend care at this physician hospital to a relative or friend. Such patient satisfaction rates are very common for physician owned and controlled hospitals.

This result is corroborated by the latest federal study. In order to measure patient satisfaction at hospitals around the country, the Federal Government initiated the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) program. The first set of results was published in March 2008. The data below compares key performance metrics captured for physician hospital and national hospital HCAHPS measures. All data was pulled directly from the Hospital Compare CMS website.

<u>HCAHPS Measures Summary</u>

Nurses "Always" Communicated Well With Patients

Physician Hospital Mean – 84.95%

National Hospital Mean – 74.00%

Doctors "Always" Communicated Well With Patients

Physician Hospital Mean – 84.95%

National Hospital Mean – 80.00%

Patients "Always" Received Help As Soon As They Wanted

Physician Hospital Mean – 82.49%

National Hospital Mean – 63.00%

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Patients' Pain Was "Always" Controlled Well

Physician Hospital Mean – 77.70%

National Hospital Mean – 68.00%

Staff "Always" Explained Medicines Before Giving to the Patient

Physician Hospital Mean – 67.33%

National Hospital Mean – 59.00%

Patients Were Given Information on What to do During Their Recovery at Home

Physician Hospital Mean – 83.56%

National Hospital Mean – 80.00%

Patients' Rooms and Bathrooms Were "Always" Kept Clean

Physician Hospital Mean – 79.50%

National Hospital Mean – 70.00%

Area Around Patients' Room Was "Always" Quiet at Night

Physician Hospital Mean – 79.04%

National Hospital Mean – 56.00%

Patients Who Gave Their Hospital a Rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)

Physician Hospital Mean – 85.10%

National Hospital Mean – 64.00%

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Patients Would Definitely Recommend the Hospital to Family and Friends

Physician Hospital Mean – 88.42%

National Hospital Mean – 68.00%

CLAIMS AGAINST PHYSICIAN OWNERSHIP

Over the course of the debate, opponents of physician ownership have made many claims, which, as previously noted, have not been substantiated by government studies. This section addresses the major arguments

Self-Referral/ Conflict of Interest

Physician ownership of hospitals is attacked by many general hospitals as a conflict of interest – it is assumed that physicians who invest in hospitals to which they refer patients have an automatic conflict with the best interest of their patients. Ironically, those in opposition to physician ownership see no conflict when they reverse the tables and own physician practices. Large hospitals, especially in the past 10 years, have been buying large medical groups and clinics. By purchasing a group or clinic, they virtually prohibit a return to private practice by the physicians. These doctors become beholden to the hospital that issues their paycheck. Their loyalties and livelihoods belong to the hospital. Under such circumstances, hospital employers of physicians have been known to monitor employed physicians' referrals and insist on referrals to "loyal" physicians who are then expected to send those patients to the designated hospital. The ultimate conflict of interest is not physician ownership of hospitals, but rather hospital "ownership" of physicians.

Some have suggested that doctors will be tempted to cheat, to perform unnecessary surgery, if they have an ownership interest in a physician hospital. A quick look at the realities of insurance pre-certification and approval for payment of surgical procedures quickly illustrate the virtual impossibility of this notion. Insurance companies require a great deal of justification in advance of a recommended surgical procedure before they authorize the procedure and approve the physician and facility fee. A very detailed account of the patient's medical history and physical condition, past operations, lab results, notes and diagnoses from primary care physicians, as well as the diagnosis and recommendations of the physician specialist are required. These are examined closely by the health care professionals in the insurance companies' auditing departments. Depending on the acuity of the procedure, as many as five to six health care professionals, employed by the insurance company, are required to judge the documentation and justification before approval is granted. In some cases, the final approval is given by a medical doctor employed or retained by the insurance company to ensure proper compliance and justification for each procedure.

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A more compelling argument comes from a simple examination of the financial influences on a physician's decision to recommend a procedure. There are three assumptions that reasonably represent a typical scenario of the financial facts of a given medical or surgical procedure:

- Assume that the physician in question has a typical ownership interest in a physician hospital, approximately 2%.
- Assume also that the average fee the physician earns for performing a given operation is $2,000.
- Assume the average hospital profit for a surgical procedure is $1000.

In this fairly typical example, the physician will receive $20 (2% of an average profit of $1000) because he/she has an ownership interest in the physician hospital, and will receive $2,000 for performing the surgery. If the physician is to behave unethically and recommend unnecessary surgery, it will be because of the $2,000 physician surgical fee NOT because the physician has an ownership interest in the physician hospital and stands to receive $20 in compensation due to that interest.

The ultimate conflict of interest is not physician ownership of hospitals, but rather hospital ownership of physicians. Large hospitals, especially in the past 10 years, have been buying large medical groups and clinics. By purchasing all of the assets (i.e. accounts receivables) of a group or clinic, they virtually prohibit a return to private practice by the physicians. These doctors become beholden to the hospital, whose foundation issues their checks. Their loyalties and livelihoods belong to the hospital. Under such circumstances, hospital employers of physicians have been known to monitor employed physicians referrals and insist on referrals to "loyal" physicians. That is not a problem when the loyal physician is the best in town but is certainly a problem when the loyal physician is not. Employed physicians are also expected to refer admissions to their employer. Again, this is not a problem when the employing hospital has the best service for the referral in question but is certainly a problem when the hospital service in question is not a strong as that of a nearby competing hospital.

The conflict of interest or "physician self-referral" issue, in reality, is a thinly veiled tactic being used by opposition to restrict competition. Hospital administrators, unaccustomed to being questioned or being forced to compete, are attempting to stifle any competition by spreading half truths and using the same scare tactics employed two decades ago in response to the growth of ambulatory surgery centers. The state hospital associations, though well funded and organized, are having difficulty balancing the interests of their own members, many of whom have seen the benefits of partnering with physicians and their development of focused care facilities. Nevertheless, their well funded efforts have found the receptive ears of some state legislators and United States Senators and Representatives.

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Cherry Picking

Physician hospitals accept all patients and treat everyone who can benefit from the care provided at those facilities. Contrary to the accusations of industry opponents, physician-owned hospitals treat Medicare and Medicaid patients; and in fact, approximately one-quarter of their annual revenue comes from Medicare and Medicaid. Due to their typically older patient population, Cardiac hospitals have much higher rates of Medicare. In addition, physician hospitals have charity care policies and meet the needs of patients who have no health insurance or are underinsured.

In 2007, CMS enacted a series of changes to the inpatient prospective payment system to adjust for variances in acuity of cases. These changes are intended to pay more for higher acuity cases and less for cases considered lower severity. These CMS payment system changes were enacted with the support of physician hospitals, and against the wishes of the general hospitals whose cost shifting practices did not fare well with such logical adjustments.

Harm to the Hospital Industry

Competition does not hurt general hospitals. This fact is more than evident even if looking only at the national growth of the healthcare industry. According to *Modern Healthcare*, "U.S. community hospitals enjoyed record profits in 2007, posting $43 billion more in revenue than expenses and creating the largest single-year jump in profit margins in at least 15 years, according to figures released by the American Hospital Association. [In 2007,] operating revenue at community hospitals topped $600 billion for the first time." *Modern HealthCare.Com, Joe Carlson, Posted: November 7, 2008 - 1:00 pm EDT.* And on January 3rd, 2006, USA Today reported that the industry is "in the middle of the biggest hospital-construction boom" in more than 50 years.

The Medicare Payment Advisory Committee (MedPAC) found specifically that the profitability of general hospitals remained stable overtime when faced with a physician-owned hospital in the same market area. According to MedPAC, "The financial impact on community hospitals in the markets in which physician-owned specialty hospitals are located has been limited, thus far. Those community hospitals competing with specialty hospitals have demonstrated financial performance comparable to other community hospitals." MedPAC Study, summary pg. vii. Furthermore, in a study completed in 2008, healthcare economist John Schneider stated, "We find that the presence of one or more new or established specialty hospitals in a market has a negative effect on general hospital costs and a positive effect on general hospital operating margins. Results, which were consistent across several different modeling approaches, imply that the presence of specialty hospitals encourages greater efficiency on the part of incumbent general hospitals, and the existence of profits attracts market entry." *Effects of Specialty Hospitals on the Financial Performance of General Hospitals, 1997-2004, John E. Schneider, et al, Inquiry 44: 321–334 (Fall 2007), Excellus Health Plan, Inc.*

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When competition exists in any industry, including healthcare, service is improved, efficiencies are heightened and costs are controlled. In fact, in its 2005 study, MedPAC reported that competition provides community hospitals with a stimulus for change; and that community hospitals often responded to the presence of surgical hospitals by "improving their own performance." MedPAC Study, pg. 10.

PARTICIPANTS IN HEALTHCARE REFORM

The current healthcare industry is made up, in large part, of vertically integrated delivery systems that have spawned huge bureaucracies unrelated to the care their patients need. On the other hand, physician hospitals are focused on the patient's immediate medical needs, and provide low cost, high quality, efficient medical care. The focus is on what the consumers want and need. This is the model for the future, patient choice – consumer oriented medical care. As hospitals already involved in the process of healthcare reform, there are several ways in which we can play a continued and important role in the future of reform under a new Administration and a new Congress.

Care Coordination, Efficiency and Effectiveness

First, in examining the issue of healthcare cost from the patient perspective, we must ask "how do we make the relationship and experience between a patient and physician as effective and efficient as possible?" A major step is to remove the barriers between physician and patient, thus reducing the administrative expense now associated with medical interaction and streamlining the process. By removing the barrier and putting the physician in charge of care coordination, preventative medicine can also be stressed and an overall health plan suited specifically for the individual patient can be achieved. The physician –owned hospital provides a perfect example of such care coordination and the quality and cost savings that result.

Another positive choice for patients is to provide care in the most efficient place possible, consistent with patient safety and good medical outcomes. Healthcare facilities do not necessarily need to provide every conceivable medical treatment or service – be all things to all people. Rather, there is a place for more efficient, specialized "focus factories" who treat medically appropriate patients and focus on one disease or one specialty. Both heightened efficiency and cost effectiveness can be realized in these types of facilities, of which physician hospitals are once again, great examples.

Implementation of New, Cost Effective Technologies

Second, implementation and use of modern tools of data collection and transmission certainly stand to positively impact healthcare spending over time. In a time when medical technology is rapidly improving, it is truly unfortunate that our healthcare system continues to rely on old technology that does not allow for the type of seamless connectivity needed to provide the safest, most efficient and cost effective care for our patients.

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The success of new technologies is measured not only by outcomes but also by the ensuing cost. New technologies may offer amazing advances in care. However, many may not be the most efficient or effective. As hospitals that believe in implementing the best and newest technologies, physician hospitals can demonstrate to the public and other healthcare players which technologies work, which don't work, and which are worth the expense.

Quality Improvements through Physician and Patient Involvement

Third, any discussion on health reform requires examination of the quality issues currently facing our healthcare industry. From the patients' perspective, considering what healthcare in America costs, we should be able to assure the highest quality care. Unfortunately, that is simply not being born out. In order to keep healthcare costs under control, there must exist a degree of individual patient responsibility balanced in conjunction with a level of social responsibility. Patients must have a stake in the game, so to speak.

Physician hospitals believe the patient can be an effective regulator or watchdog of quality care, but only if given the appropriate tools to make informed choices. Therefore, transparency, both of quality and cost, are an absolute necessity. Patient-centered care requires informed choice. It is completely unacceptable that patients do not currently have the tools they need to research the care options available. Physicians can play an important role at the local, state and national levels working collectively with hospitals to hold all parties accountable and assisting in the creation of a system of transparency and reporting that is logical and useful to patients. In addition, as smaller, more manageable hospitals, physician hospitals may volunteer as "beta-sites" or model facilities for purposes of testing transparency/reporting systems.

Physician/Hospital Partnerships

Finally, in order to accomplish the goal of achieving patient centered reform, it will be very necessary that all segments of the industry work together. Public/private partnerships, federal/state partnerships, and certainly hospital/physician partnerships are all in the best interest of the patient. Physician hospitals in partnership with larger hospitals or systems provide a valuable example of how healthy relationships can form between doctors and hospitals. The challenges facing the nation's healthcare system transcend the question of who owns what. All providers and participants in the healthcare industry must work together to navigate the issues, undertake a major industry renovation and ultimately, establish an effective and practical system that ensures the provision of high quality, efficient care, unequaled access, patient directed care and competition.