IDEAS TO IMPROVE COMPETITION IN THE MEDICARE PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

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IMPROVING COMPETITION IN MEDICARE: REMOVING MORATORIA AND EXPANDING ACCESS

TUESDAY, MAY 19, 2015

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to call, at 9:59 a.m., in Room 1100, Longworth House Office Building, the Honorable Kevin Brady [chairman of the subcommittee] presiding.

[The advisory announcing the hearing follows:]

COMMITTEE ON
WAYS AND MEANS
CHAIRMAN PAUL RYAN

Chairman Brady Announces Hearing on Ideas to Improve Competition in the Medicare Program

Congressman Kevin Brady (R-TX), Chairman of the Subcommittee on Health, today announced that the Subcommittee will hold a hearing titled, "*Improving Competition in Medicare: Removing Moratoria and Expanding Access.*" **The hearing will take place on Tuesday, May 19, 2015, in Room 1100 of the Longworth House Office Building, beginning at 10:00 A.M.**

Oral testimony at this hearing will be from the invited witness only. However, any individual or organization may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

Details for Submission of Written Comments:
Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, http://waysandmeans.house.gov, select "Hearings." Select the hearing for which you would like to make a submission, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Tuesday, June 2, 2015**. For questions, or if you encounter technical problems, please call (202) 225-3625 or (202) 225-2610.

Formatting Requirements:
The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.
1. All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses and submitters are advised that the Committee relies on electronic submissions for

printing the official hearing record.
2. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.
3. Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available at http://www.waysandmeans.house.gov/.

Chairman BRADY. Welcome to today's hearing on improving competition, within the important Medicare program. This is the first in a series of hearings this summer and fall on identifying solutions to saving Medicare for the long term. Today we are going to explore how much competition exists in Medicare, its impact, its benefits and savings for Medicare patients, as well as potential for improving Medicare access in choices through more competition.

We are also going to hear about two ideas to make Medicare more responsive to seniors' needs, while also driving down costs and expanding access. Competition is a good thing, it drives down costs and increases access while improving quality. Most importantly it empowers consumers. Competition and the choices it offers is how we discover information on the prices and quality.

It gives families the power to decide what they want to buy and how to stretch their dollars further. Competition is a critical component of virtually every sector in our economy save one, Medicare. While more often than not, Medicare stifles competition and choices through legislative action and agency enforcement. Medicare sets prices and sets the standards by which it determines quality. Rather than empowering consumers, Medicare program limits choices.

This system is set up so that providers are more likely to fight rulemaking decisions handed down from government agencies than they are to compete with each other, to offer better services to Medicare patients. The Medicare fee-for-service program is a perfect example. This fiscal year, Medicare's projected to pay $375 billion for Part A and Part B services, that is doctor and hospital services. The vast majority of that spending the Centers for Medicare & Medicaid Services is directly responsible for setting, implementing and managing these payments. In other words, the massive bureaucracy picks winners and losers among countless health care providers. Competition and choice and the preferences of Medicare seniors play little role in the administration of all that spending. It shows the program unfortunately is going insolvent.

By contrast, competition choices for seniors play a proven critical role in two successful programs, Medicare Advantage program, and Medicare Part D, which provides prescription drugs. In these two extremely popular programs Medicare seniors are the ones in control, not the government. Plans compete fiercely for the health care businesses, offering services and benefits to fit the needs of Medicare patients, not Washington. If consumers are unhappy with their service, they can they can say no thanks and change their plan to one that meets their needs. It is that simple, and it works.

Right now, seniors have accessed more than 3,600 Medicare Advantage plans tailored to meet their specific needs. Competition is robust, and not surprisingly, patient satisfaction is high. The same is true of the Part D prescription drug program, which is one of the few government health programs to actually come in under budget projections, and whose average base monthly premiums are as low today at $33, as when the program began in 2006 at $32.

Preventive care prescription plans seniors have dozens of choices in each State and can pick a plan that works for them. Studies show this very fact has led to a decrease in their out-of-pocket costs which is great news for seniors. Competition has proven to work in Medicare Advantage and it works on the Part D prescription

drug program. So how can it work in the larger Medicare fee-for-service system?

Today we will look at two proposals that do just that. The first is expanding seniors' access to local physician-owned hospitals. This is an issue Mr. Johnson of Texas has been working on for quite some time. Physician-owned hospitals are full service community hospitals that serve both rural and urban communities, they specialize and providing essential health services in areas that are considered underserved. But since 2005, these hospitals have been prevented from growing to meet the needs of their communities. As a consequence, there are just over 230 of these kinds of hospitals in operation around the country compared to 3,400 national acute care hospitals.

The questions before us include should seniors continue to be blocked from access to these high-performing hospitals? What are the impacts pro and con of this discrimination against one model of acute care? And is the current ban based on quality of service, or desire to restrain competition? At this point, a decade into the temporary moratorium, it is the right time to have a thoughtful discussion on this issue.

The second idea seeks to improve the way Medicare currently administers the durable medical equipment benefit, Dr. Tom Price of Georgia has spent a significant amount of time looking at this issue, as well as other members of this panel and the Ways and Means Committee. He has been working on a reform that would inject a more market-based approach to help address some of the more serious concerns Members of Congress from both parties have all heard about from our constituents.

These two proposals have the potential for improving competition, end the benefits within Medicare. But ultimately, Congress needs to examine how we administer the Medicare program overall. The current program is critical, but unsustainable. It went from the program's own actuaries to nonpartisan scorekeepers like the Congressional Budget Office. Outside watchdog groups have worried about this, and warned us about this growing problem. Members of both Parties in Congress have a responsibility to save Medicare for the long term, improve and protect Medicare for today's seniors and for future generations.

We recently took the first important step by solving the way Medicare pays its doctors. The second step, we must turn immediately exploring how we improve the way Medicare pays its other health care providers, from the testing and evaluation leading into the hospital, to inpatient and outpatient care, and post-acute care after leaving the hospital.

The Health Subcommittee will continue to hold hearings on this topic over the course of this year. Developed reforms will put Medicare on a sustainable path.

So to help us get started, I would like to welcome today's witnesses, Joe Antos, from the American Enterprise Institute; Joe Minissale, president of Methodist McKinney Hospital in Texas; Robert Steedley, president of Barnes Health Care Services in Georgia; and Richard Umbdenstock, president and CEO of the American Hospital Association.

And before I recognize the ranking member, Dr. McDermott, for the purposes of an opening statement, I ask unanimous consent that all members' written statements be included in the record. Without objection, so ordered.

I now recognize Dr. McDermott for his opening statement.

Mr. MCDERMOTT. Thank you, Mr. Chairman. We are here today to talk about the second part of health care reform, that is, control of cost. Access under the Affordable Care Act is rising clearly where people have access to health care supposedly. The question is about how do you get control of costs? And we are talking today about improving competition in Medicare. Now I can't help but wonder, having sat here for a number of years, what this hearing is really going to accomplish. If this hearing were about competition, we would look carefully about how to drive down prices and get a handle on health care costs. That would mean reducing wastes and overpayment to industries that are profiting at the expense of the American public. The more the American medical industrial complexes enter the government pocket, the more it becomes our issue here.

Unfortunately, the proposals we will hear this morning won't control costs; instead, they are designed to appease the very interest that benefit from the waste in the system and contribute to higher health care spending. A hearing like this would make us ask ourselves, are we serious about controlling costs or would we rather just want to talk about it?

We are going to discuss ways to revise Medicare's competitive bidding program for durable medical equipment. Specifically, we will hear a proposal that will put a halt to the existing program, reduce competition and ultimately increase cost for Medicare and beneficiaries. The real irony of this hearing is, because I remember when it was Republicans who were the champions of competitive bidding. I have been on this committee long enough to listen to all of this, and the problem of health care costs in devices has been there. It was a Republican Congress that first introduced the concept to Medicare as a demonstration project in the Balanced Budget Amendment Act of 1997. And it was a Republican Congress that expanded the program in 2003 as a part of the prescription drug legislation.

Now despite some hiccups along the way, the programs it had remarkable success or at least measurable success. First round of competitive bidding saved over $580 million in 2 years, and HHS projects that over 10 years, we will save over $43 billion. Of course, we should continue to carefully oversee the implementation of competitive bidding, but proposals like the one that is before us today, to delay or undermine signals to the American people that Congress is more concerned about appeasing an industry than it is about controlling costs.

We are also going to discuss the moratorium on new and expanded physician-owned hospitals. For many years, specialty hospitals enjoyed a loophole in the STOCK Act that allowed doctors to make referrals to hospitals in which they had an ownership interest. As long as the ownership interest was in the whole hospital rather than subdivision of it—you couldn't have just one department—physicians could make referrals that otherwise would have

been illegal. The result was a rapid growth in physician-owned hospitals which skewed the market in troubling ways. Nonpartisan experts of MedPac, GAO, the Office of Inspector General, for years have expressed serious concerns that these hospitals increased utilization of services and drive up healthcare costs.

Now, closing this loophole is a cost saving measure that has always had bipartisan support. We pass temporary moratoriums during the Republican-controlled Congresses, and we made it permanent as a part of the Affordable Care Act. This reform will save the American people $500 million according to the CBO. There is simply no good reason to reverse course and undue this progress. It will make the industry happy, but it will bring needless waste back into the healthcare system and ultimately harm the hardworking families of this country who are paying for this system.

Getting serious about controlling costs is more important now than ever. The Affordable Care Act continues to expand access, more and more people cover, everybody is clapping their hands and popping the corks on champagne bottles about how many more people. When all is said and done, more than 30 million additional people have been brought into the system. As this happens, the healthcare system is rapidly changing, medicine is transforming from a profession into a business. Market powers consolidating in fewer and fewer hands as hospitals merge and swallow up independent doctors' practices. This raises a number of questions about competition, cost, and patient care that we need to answer. Until we take a careful look at what this trend means, we are sending a message to the American people that appeasing wasteful industry actors is more important than controlling costs.

I sent a letter to the chairman earlier about my concerns about consolidating hospitals and having less and less competition in various parts of the country, and I would ask unanimous consent to have that put into the record.

Chairman BRADY. Without objection, so ordered.

[The information follows: The Honorable Jim McDermott Submission]

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CONGRESSIONAL TASK FORCE ON INTERNATIONAL HIV/AIDS

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Congress of the United States
House of Representatives
Washington, DC 20515

March 3, 2015

The Honorable Kevin Brady
Chairman
Subcommittee on Health
Committee on Ways and Means
1135 Longworth House Office Building
Washington, DC 20515

Dear Chairman Brady:

The legislative process does not stop once a bill is signed into law. A functional Congress will thoughtfully revisit legislation in the years following enactment in order to ensure that the law is implemented efficiently and correctly. If changes are necessary, it is the responsibility of the Congress to make those changes. To that end, I draw to your attention two important issues that I believe the Subcommittee on Health should examine through hearings during the 114th Congress.

The first issue is the trend of consolidation in the health care system. As the country transitions toward payment models that rely upon integration of care and increased coordination between providers, the risk of unintended consequences warrants increased scrutiny. In particular, the growing number of acquisitions of small physician practices by major health systems has concentrated enormous market power in the hands of fewer and fewer entities. Some hospitals have even acquired – or have themselves been acquired by – insurance companies, raising numerous questions regarding the delivery of patient care. Many issues remain unresolved, and there is evidence that such consolidation may have negative consequences, potentially leading to decreased competition, fewer choices, and increased costs for patients.

It is essential that we learn more about how this trend affects the health care system. To begin this conversation, I have called on the Government Accountability Office to study the implications of increased hospital consolidation. I also believe that this is an area that the Subcommittee on Health should examine carefully. I encourage you to hold a hearing that would allow Congress to take a look at the impact that consolidation is having on patients, providers, and taxpayers. By working together to constructively address this issue, I believe that we can find legislative solutions that strike the proper balance between harnessing the efficiencies of care coordination and preserving competition in health care markets.

The second issue that the Subcommittee on Health must address is the future of the premium tax credits, which are making health insurance affordable for millions of American families. This is particularly important as the Supreme Court considers the case of King v. Burwell, a lawsuit

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seeking to rewrite the text of the Affordable Care Act and take tax credits away from millions of Americans who live in states that rely on the federal exchange. Although I fully expect the Court to uphold the subsidies, the majority has a responsibility to prepare for the opposite result.

A number of Republicans have recently criticized the Administration for not announcing a contingency plan in the event that the Court hands down an unfavorable decision. However, despite enjoying complete control of both chambers of the Congress, the majority has provided few details as to its own contingency plan. In the American system of government it is the responsibility of the Congress – not the president – to write the laws. The party that controls the legislative branch owes the American people a clear explanation as to how it intends to preserve access to affordable coverage and ensure stability in the insurance market if the Court dismantles this key provision of the law. Accordingly, I recommend the Subcommittee on Health hold a hearing to examine proposals to help the millions of families whose health security would be jeopardized in the event of an adverse Supreme Court decision.

Thank you for your consideration of these recommendations. I look forward to discussing the importance of both of these issues with you in the near future.

Sincerely,

Jim McDermott

cc: Chairman Paul Ryan
Committee on Ways and Means

Mr. MCDERMOTT. I yield back the balance of my time.

Chairman BRADY. Thank you. Mr. Antos, welcome today and you are recognized for the 5 minutes.

STATEMENT OF JOE ANTOS, WILSON H. TAYLOR SCHOLAR IN HEALTH CARE AND RETIREMENT POLICY, AMERICAN ENTERPRISE INSTITUTE

Mr. ANTOS. Thank you, Chairman Brady, and Ranking Member McDermott and Members of the Committee. Competition is central to obtaining good value for the dollars spent by beneficiaries and taxpayers in the Medicare program. Congress must avoid the temptation to smother competitive markets in Medicare through overregulation. Private plans must follow rules—private plans and private providers must follow rules designed to protect consumers and ensure access to all necessary health services covered by the program, but the regulation should not be drawn so narrowly that healthcare delivery innovations cannot be adopted, or once adopted, cannot be altered or dropped. The rules should neither prevent the entry of new competing firms nor protect firms already in the market from competition. A competitive Medicare program must welcome change, while ensuring that beneficiaries and taxpayers are well served.

As the chairman said, the two leading examples of competitive markets in the Medicare program are Medicare Advantage and Part D. Medicare Advantage is an increasingly popular alternative to fee-for-service Medicare. Even with payment reductions mandated by the Affordable Care Act, Medicare Advantage enrollment has grown from 11.9 million people in 2011 to 16.2 million this year. More than 30 percent of Medicare beneficiaries are enrolled in Medicare Advantage plans. Clearly, for a growing number of beneficiaries, competitive Medicare Advantage plans are a better deal compared to fee-for-service Medicare combined with separate Medigap and prescription drug plans.

Part D, as the chairman said, has also been a remarkable success, and its cost has fallen hundreds of billions of dollars below CBO estimates. I am going to focus my remarks on the Medicare Advantage, my written statement has more detail about both programs.

There is growing evidence that Medicare Advantage—have I run out of time? The lights aren't lit.

Chairman BRADY. I think you are in good shape on time.

Mr. ANTOS. Sorry, so evidence that Medicare Advantage plans provide higher value services, less cost to society than traditional fee-for-service. First of all, Medicare Advantage plans are more efficient in delivering care than fee-for-service. According to the Medicare Payment Advisory Commission, the average MA plan bid in 2014 was 98 percent of fee-for-service spending. In 2015, the average bid was 94 percent. That means that MA plans are willing to pay to deliver standard benefits, 6 percentage points cheaper than fee-for-service can on average over the country.

HMO plans were, of course, more efficient, their bids averaged 90 percent for fee-for-service spending. Now why are they being paid more than that? Well, the answer is the payment formula, of course. The plans are paid their bid, unless they bid below the

benchmark. The benchmark was set to ensure that essentially everyone would have access to Medicare Advantage plans, so it tends to be higher than fee-for-service. Benchmark this year is 107 percent of fee-for-service, so the amount that MA plans are paid based on their quality performance is about 102 percent of fee-for-service spending. That doesn't tell you anything about the efficiency of delivering health care, that says something about the peculiarities of the payment system.

Second, MA plans have a spillover effect that lowers health care costs more generally. Turns out that studies have shown that for every 1 percent increase in Medicare Advantage enrollment in the market, there is a nine-tenths percent reduction in fee-for-service Medicare spending, and a general overall reduction in spending as well as on a per-person basis in the community.

Third, MA plans provide higher quality care. Beneficiaries in Medicare HMOs, for example, are consistently more likely than those in traditional Medicare to receive appropriate risk cancer screening, diabetes care, cholesterol screening, and so on.

And finally, the problem with favorable selection, which we have all been concerned about for many years, has largely been solved. This isn't just my opinion, this is Professor Joseph Newhouse at Harvard University and his colleagues pointed out the changes Congress made have improved the accuracy of payments in Medicare Advantage, and the lock-in procedure, the new method of risk adjustment, these are things that have largely eliminated favorable selection so that the payments to MA plans are not—aggregately reflect the costs to providing care to beneficiaries.

Competing private plans are strong incentives to provide health care efficiently and effectively to tailor the coverage and services of the needs and demands of their customers. By necessity, private plans are more flexibility and responsive to changing market conditions and consumer demands than fee-for-service Medicare. Satisfying your customers is a matter of survival. Doing so efficiently is the difference between a successful health plan and one that has failed.

[The prepared statement of Mr. Antos follows:]

Thank you, Chairman Brady, Ranking Member McDermott, and members of the Committee for the opportunity to discuss the importance of competition to Medicare and the need to eliminate restrictions on competition if we are to maintain the proper balance between cost, quality, and access to care.

I am Joseph Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute (AEI), a non-profit, non-partisan public policy research organization based in Washington, D.C. I was formerly the Assistant Director for Health and Human Resources at the Congressional Budget Office (CBO), and I was a member of CBO's Panel of Health Advisers for 7 years. My comments today are my own and do not necessarily reflect the views of AEI, CBO, or other organizations with which I am affiliated.

Competition is central to obtaining good value for the dollars spent by beneficiaries and taxpayers in the Medicare program. The two best-known examples of competition in Medicare are Medicare Advantage (MA) for a comprehensive package of benefits and Part D for prescription drug benefits. Under both MA and Part D, Medicare beneficiaries do not have to be satisfied with "one size fits all." Instead, they can choose the plans they prefer at prices that are based on market bids.

Congress must avoid the temptation to smother competitive markets in Medicare through over-regulation. Private plans must follow rules designed to protect consumers and ensure access to all necessary health services covered by the program. But the regulations should not be drawn so narrowly that health care delivery innovations cannot be adopted or, once adopted, cannot be altered or dropped. The rules should neither prevent the entry of new competing firms nor protect firms already in the market from competition. A competitive Medicare program must welcome change while ensuring that beneficiaries and taxpayers are well served.[1]

Choice and Competition in Medicare Advantage

Medicare Advantage is the private plan alternative to traditional Medicare. In 2015, 16.2 million people enrolled in MA, or about 30 percent of the Medicare population.[2] Two-thirds of the 1,945 MA plans available nationwide are health maintenance organizations (HMOs).[3] Preferred provider organizations account for about a quarter of the plans, and the remainder consists of private fee-for-service and other types of plans. Beneficiaries have an average of 18 MA plans to choose from.

Despite payment reductions instituted by the Affordable Care Act, enrollment in MA has risen in recent years, partly reflecting the greater familiarity of younger Medicare beneficiaries to managed care plans. For many, MA is a better deal compared to traditional Medicare combined with separate Medigap and prescription drug plans. MA plans offer the full Medicare benefit, and may offer additional coverage as well. MA plans expose beneficiaries to a less confusing and less risky benefit structure than traditional Medicare, which requires separate deductibles and varying copayments and coinsurance depending on the type of service that is provided.

Critics of MA argue that private plans are overpaid compared to traditional Medicare. The way MA capitation rates are determined is flawed, typically leading to MA payments that

exceed fee-for-service costs. That defect of the payment system does not tell us whether MA plans can deliver the same level of benefits more efficiently than traditional fee-for-service Medicare.[4]

MA bidding process. MA plans bid against a benchmark payment for the cost of providing traditional Medicare benefits in each geographic region. The benchmark is the maximum amount Medicare can pay a plan. The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, which renamed and modified what was then called Medicare+Choice, set the benchmarks to ensure that even the most remote geographic areas would have access to an MA plan.[5] Benchmarks were generally set above fee-for-service cost.

The Affordable Care Act (ACA) revised the MA payment method and reduced the benchmarks. By 2017, they will range from 95% of traditional Medicare costs in the top quartile of counties with relatively high per capita Medicare costs (e.g., Miami-Dade), to 115% of traditional Medicare costs in the bottom quartile of counties with relatively low Medicare costs (e.g., Boise).

Because it sets an upper limit on payment, plan bids tend to cluster around the benchmark. If an MA plan bids higher than the benchmark, enrollees must pay the difference in the form of a higher premium. If the bid is lower than the benchmark, the plan must rebate most of the difference to enrollees in the form of additional benefits or lower premiums. Under the MMA, that rebate was 75% of the difference between the bid and the benchmark. The ACA now requires that the rebate vary between 50 percent and 70 percent of the difference, with high-performing plans under the "star" performance rating system receiving the higher rebates.

MA plan efficiency. Can MA plans operate more efficiently than traditional Medicare? The Medicare Payment Advisory Commission (MedPAC) reports that the average benchmark for 2014 was 112% of fee-for-service cost.[6] The average MA plan bid for 2014 was 98% of fee-for-service costs. In other words, the average MA plan could deliver the standard benefits 2 percentage points cheaper than traditional Medicare. HMOs could deliver the standard benefits for 95% of fee-for-service costs.

Because of flawed methodology, the average plan payment was 106% of fee-for-service costs; for HMOs, the payment averaged 105%. In other words, plans received on average between 8% and 10% of fee-for-service costs more than they asked for.

Much of that additional payment covers services that seniors want but cannot get from traditional Medicare. HealthPocket found that 97% of MA plans offered at least one vision, dental, or hearing benefit in 2014.[7] All three benefits were offered by 49% of HMOs in MA.

Recent analyses of premium support proposals suggest that private plans could become even more efficient relative to fee-for-service, reducing costs for Medicare and cutting premiums paid by beneficiaries. CBO projects that the average bid from MA plans will be 6 percent lower than average fee-for-service spending even with no change in law.[8] If Medicare shifted to a premium support model, which sets the government's contribution toward coverage based on

bids from MA and fee-for-service Medicare, CBO expects that MA plan bids will fall by an additional 4% relative to fee-for-service.[9]

Spillover effects and improved quality. Several studies find that greater enrollment in MA plans has a positive spillover on the rest of the local health sector, reducing costs for traditional Medicare and commercial health insurance. Chernew, DeCicca, and Town found that a 1% increase in MA enrollment in a market was associated with a 0.9% reduction in Medicare fee-for-service spending per enrollee.[10] Baicker, Chernew, and Robbins found that greater MA enrollment led to reductions in hospital costs for both seniors and commercially insured younger populations.[11] This suggests that more efficient practice styles of private plans become adopted as a kind of community standard of performance.

Enrollees in MA plans also receive higher quality care than their counterparts in fee-for-service Medicare. Ayanian and colleagues found that beneficiaries in Medicare HMOs were consistently more likely than those in traditional Medicare to receive appropriate breast cancer screening, diabetes care, and cholesterol testing for cardiovascular disease.[12] For example, women were about 20 percent more likely to receive a screening mammogram if they were enrolled in a Medicare HMO instead of fee-for-service.

Risk selection. There has long been a concern that MA plans attract a younger, healthier population which is not adequately accounted for in determining capitation payments. Studies conducted by Newhouse and McGuire and by Newhouse and colleagues conclude that policies adopted by Medicare have largely resolved this problem of risk adjustment.[13,14]

Until 2000, MA payments were only adjusted based on age, sex, and eligibility category of the beneficiaries, not their underlying health conditions. Beginning in that year, the Centers for Medicare and Medicaid Services (CMS) started to phase in a more accurate risk adjustment system. By 2007, the CMS Hierarchical Condition Categories system based on inpatient and outpatient diagnoses was in place.

In addition, the MMA phased in a "lock-in" that limits the ability of beneficiaries to disenroll outside of annual open enrollment periods. Previously, beneficiaries could disenroll from MA plans on a monthly basis, and could move freely between MA and traditional Medicare. Those changes, combined with a wider array of plan offerings (including MA plans offering a prescription drug benefit), made private plans more attractive to the Medicare population and has greatly reduced favorable selection.

Newhouse and colleagues find some evidence that beneficiaries who switched to MA were expected to cost less than the average fee-for-service enrollee.[15] In 2004, those who switched cost about 10 percent less. By 2008, favorable selection remained but dropped by a factor of 3. The researchers argue that this does not translate into a measure of federal overpayment to MA. Risk selection is only one factor affecting federal cost. Newhouse and McGuire point out that other factors, including higher quality care and positive spillovers, argue for maintaining the level of MA payment at or above the level for traditional Medicare.[16]

Improving competition. Actions should be taken to take better advantage of the efficiencies and better performance of a more competitive Medicare program.[17] Options include changing the default enrollment, which under current policy presumes that beneficiaries prefer traditional Medicare unless they specify MA. Once in a plan, Medicare beneficiaries tend to stay there. Consequently, the current rules are biased toward greater enrollment in fee-for-service Medicare. Random assignment among MA plans (possibly limited to low-cost plans) rather than automatically placing a new enrollee in fee-for-service is one possible solution.

Flaws in the current bidding system also should be addressed. Bids should reflect the actual cost of providing benefits. MA plans bid on the basis of the cost in their specific markets for their specific enrollees. Fee-for-service Medicare has a single national premium despite the variation in actual costs from market to market. That gives fee-for-service an advantage in high-cost markets that have the most to gain from fair competition and efficient private plans. Moving to a system of regional fee-for-service bids based on actual cost experience would reduce this bias.

The payment benchmark could be changed to reflect actual cost conditions in competitive markets rather than remaining tied to fee-for-service costs. Basing the benchmark on the second-lowest bid in the region would likely place greater downward pressure on MA bids and provide greater incentive for plans to seek efficiencies in delivering care.

Even without such changes, there is a growing body of evidence that MA plans provider higher value services at less cost to society than the traditional Medicare program.

Choice and Competition in Medicare Part D

Medicare Part D provides prescription drug coverage to about 38 million beneficiaries this year through competing private plans. About 61 percent (23.2 million) are in prescription drug plans (PDPs); the others are enrolled in Medicare Advantage drug plans.[18] The program has been consistently popular with seniors. A recent survey shows that 86 percent of seniors who have Part D are satisfied with their plans.[19]

Although there is a minimum benefit requirement, PDPs are able to modify the cost-sharing requirements, additional benefits, and pricing structure. Because of this flexibility, beneficiaries have numerous plans to choose from. In 2015, there are 1,001 stand-alone PDPs available nationally. Medicare beneficiaries have a choice of 30 stand-alone PDPs, on average.[20]

Premiums and subsidies are based on the national average of plan bids, which reflect each plan's expected benefit payments and administrative costs. Medicare provides plans with a subsidy that averages 74.5 percent of standard coverage for all types of beneficiaries, with higher subsidies for those with low incomes or who are at risk for higher costs.[21] Enrollees in a Part D plan pay the difference, if any, between the plan bid and the federal subsidy.

There is no cap that limits the allowable growth in federal subsidy amounts from year to year. Instead, the cost of Part D depends solely on the strength of plan competition and the responsiveness of consumers to changes in their costs.

Competition yields savings. Part D's cost experience has been far better than initially anticipated.[22] At the start of the program, the CBO estimated that the prescription drug program in full operation would cost $768 billion between 2006 and 2013.[23] In contrast, the Medicare trustees report that federal outlays for Part D totaled $473 billion through 2013—38 percent less than the CBO estimate.[24]

Part of this difference is undoubtedly the result of faulty assumptions in the original estimate. Enrollment in Part D has been lower than expected, and the slower introduction of new drugs, coupled with the movement of branded drugs to off-patent status, contributed to the slower cost growth.[25] But we also saw seniors exhibit considerable price sensitivity and pharmaceutical manufacturers discount aggressively as plans fine-tuned their formularies and steered patients toward lower-cost drugs.

This conclusion might surprise some skeptics. Behavioral economists have pointed out that individuals often make poor consumer decisions due to inertia, confusion, limited attention, and confusion associated with age or illness. Some argue that "health insurance is too complicated a product for most consumers to purchase intelligently….[It] is unlikely that most individuals will make sensible decisions when confronted with these choices."[26] This thinking has led to calls for stronger consumer protection rules and simplification rules, including limiting the number of options available to seniors.

A recent study of more than 71,000 Medicare beneficiaries who enrolled in stand-alone PDPs in both 2006 and 2007 concluded that seniors found ways to reduce their costs over time as they gained experience with Part D.[27] Overspending—measured as the difference between the beneficiary's actual out-of-pocket costs (including the insurance premium) and the cost of the cheapest alternative—declined an average of $298. These savings were achieved primarily by switching to a lower-cost plan. For some beneficiaries, that could mean switching to a plan that charges a higher premium but offers their prescriptions on more favorable terms.

These results demonstrate what one would expect: Once seniors understand their plan options, they are apt to enroll in a prescription drug plan that offers what they need at a lower total cost. Not surprisingly, those who had overspent the most in 2006 experienced the greatest savings. This helped keep the cost of prescription drugs in check for Medicare beneficiaries and taxpayers alike.

The competitive design of Part D also enables prescription drug plans to adapt flexibly to changing conditions. CBO's analysis of program data from 2006 to 2010 found that spending and premiums were lower when more plan sponsors competed for beneficiaries.[28]

The impact could be substantial. For example, the drop in the average number of competing drug plans fell from 22 per region in 2007 to 18 in 2008, and remained at that level through 2010. CBO estimates that had that decline not occurred, the program would have saved between $30 million and $70 million in 2010 alone.[29]

Impact of price controls. Would the imposition of price controls in Part D reduce the cost of the program? CBO also considered the impact of implementing Medicaid's statutory rebates for

Part D beneficiaries with low income. Those rebates are a minimum 23.1 percent rebate off the average manufacturer's price and an additional rebate if the brand-name drug price rises faster than general inflation.

According to CBO, applying those rebates would initially cause the prices of drugs purchased by low-income Medicare beneficiaries to drop to levels close to Medicaid prices.[30] However, manufacturers would raise the launch prices of new brand-name drugs, in time largely offsetting the statutory rebates in Part D. Those higher prices will affect all purchasers, including Medicaid and private payers. Moreover, the statutory rebates would reduce prospective returns from drug development and discourage the scientific research necessary to find the next generation of cures.

Conclusion

Medicare spending has slowed dramatically in the last few years. That is good news, but we cannot relax. If we expect Medicare to meet the needs of 76 million baby boomers—and eventually their children—we must modernize the program and put consumers in charge. Medicare Advantage and the Part D prescription drug program have proven the value of competition in providing essential benefits in a cost-effective way. Future reforms will build on that performance, allowing beneficiaries to choose the kind of coverage that best meets their needs at a price that is affordable to them and to the country.

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Chairman BRADY. Thank you, Mr. Antos, very much. Mr. Minissale, you are recognized for 5 minutes. I know as a constituent of St. Johnson, our colleague here you have great representation here now.

STATEMENT OF JOE MINISSALE, PRESIDENT, METHODIST MCKINNEY HOSPITAL

Mr. MINISSALE. Chairman Brady, Ranking Member McDermott, members of the Ways and Means Health Subcommittee, thank you for having me here today to testify. I am the President of Methodist McKinney Hospital, which is in McKinney, Texas. Methodist McKinney Hospital opened in February of 2010 just prior to the Accountable Care Act prohibition on physician ownership in hospitals.

Our hospital is a partnership with Methodist Health System, Nueterra Healthcare and local physicians.

Methodist Health System is a nonprofit health system that has for decades taken care of the underserved in Dallas, the indigent in the south part of the community. Over 51 percent of our profits go back to Methodist Health System to serve those in those communities. We accept almost all insurances, including Medicare, Medicaid, TRICARE, workers comp, most managed care plans, Medicare supplements. Our hospital employees are over 119 full-time employees. We have over 230 members on our medical staff, and only 22 of those members on the medical staff are physician investors.

We paid over $2.5 million in taxes last year, something that not for-profit hospitals do not share the burden in. Our services include inpatient care, internal medicine, emergency medicine, imaging, surgery, pain management, physical therapy, among many other things. We have a broad range of specialties that include pain management, gastroenterology, ENT, general surgery, medicine and more.

We have an ER average waiting time of just 76 minutes compared to over 2 hours at our competitors. The primary reason Methodist McKinney Hospital was developed was due to frustration with the local physicians over administration and health system management with the local hospitals. They wanted a hospital where patient care was always put first, not just the bottom line. So they decided to take matters into their own hands and build a hospital that was driven by the principles that physicians who spent their lives taking care of patients held dearly.

Having spent my career managing hospitals, I know one of the keys to success in hospital administration is to have good alignment between the hospital and the physicians. In a physician-ownership model, I feel like we have that much more than I enjoyed when I worked in other ownership models.

This culture has allowed us to endear ourselves to local physicians, nurses and other clinical caregivers because we care about the patient first and bottom line second. But we also care deeply about our employees and our community. We have won some good achievements and accolades to represent that. We received a 4 out of 5 star rating on CMS' Hospital Star Program. We are consistently above the 90th percentile on the HCAHPS, patient satisfac-

tion surveys. We have been named a Dallas, Fort Worth, top 100 employer in 2013, 2014. We have consistently been over 100 percent of baseline on the CMS value based purchasing program. And we receive the Joint Commission Gold Seal of Approval on Accreditation.

Thanks to strong support from the community, our hospital has been getting close to capacity in some areas. That is a good problem and a bad. We are in a growing community, Collin County in McKinney, Texas, have been expanding rapidly by growing more than 70 percent since 2000.

Patients can choose to go to a lot of good health care providers in our community, but many are choosing us. As a result, we are now at a crossroads where our board and our partners are going to have to decide, do we leave Medicare, Medicaid and TRICARE patients behind so we can grow the hospital and meet the growing demand and the growing community? Or do we just stop growing and stay where we are and just tell people we can't serve any more than we already are?

Twenty-seven percent of our current patient base has those insurances. It is very discouraging to think that we could spend years trying to meet the exceptions, and I am not sure anybody can meet the exceptions in accountable care. Even if you can meet it, it is going to be hard to prove and you are going to have to jump through a lot of hoops, yet our competitors do not have to do that. We don't want to leave the seniors and the military families behind so I would ask you to repeal Section 6001 of the Accountable Care Act so we don't have to make decisions to not have access to those seniors and military families. Thank you.

[The prepared statement of Mr. Minissale follows:]

House Ways and Means Subcommittee on Health
Testimony by Joe Minissale
President, Methodist McKinney Hospital

Chairman Brady, Ranking Member McDermott, members of the Ways and Means Health Subcommittee – thank you for inviting me to testify today. My name is Joe Minissale and I am the President of Methodist McKinney Hospital in Texas.

Hospital Overview

Methodist McKinney Hospital opened in February 2010, just months prior to the ACA prohibition on physician-owned hospitals. Our physician-owned hospital is a partnership with Methodist Health System, Nueterra Healthcare, and local physicians.

Our majority partner is Methodist Health System, a local non-profit system based in south Dallas. Over 51% of our profits go back to Methodist Health System, where they can be used to support the charitable missions of that health system, including caring for the underserved and indigent.

We accept Medicare, Medicaid, Tricare, Workers Compensation, and most managed care plans.

Our hospital employs over 119 full-time employees and has over 230 credentialed physicians, yet only 22 are physician investors.

We paid over $2.5 million in taxes in 2014 alone, taxes not paid by non-profit hospitals.

Our hospital is also very active in the community. We support several local charitable organizations with volunteer time and/or donations.

Services provided include inpatient care (21 beds), emergency department (4 beds), surgery (8 OR's), imaging (MRI, CT, US, X-ray, mammography), physical therapy/occupational therapy, laboratory, pharmacy, sleep studies, GI, and pain management.

Our hospital offers a vast variety of specialties such as anesthesiology, cardiology, colo-rectal surgery, emergency medicine, ENT, family practice, gastroenterology, general surgery, gynecology, infectious diseases, internal medicine, neurosurgery, orthopaedics, pathology, plastic surgery, radiology, urology, and vascular surgery.

We have an average ER waiting time of just 76 minutes, compared to over 2 hours at our competitors.

We also have an incredibly low mortality rate, thanks in part to our inpatient nurse to patient ratio of 1 to 4.

Our hospital mission is to provide quality and compassionate care for our patients, incomparable service to our physicians, and an empowering workplace for our employees.
Our vision is to be recognized as the hospital of choice in the communities we serve by creating a destination medical center that sets the standard for superior healthcare delivery.

And we operate under our core values of S.E.R.V.E:

Servant Leadership – the service to others guides our actions
Enthusiasm – the celebration of our work as caregivers and healers
Respect – the courtesy extended to our employees and patrons
Visionary – embracing the changing needs of the community
Integrity – conducting our business in an honest and ethical manner
Compassion – providing service in a welcoming and caring environment
Excellence – the commitment to high standards of quality and performance

Why was Methodist McKinney Hospital Developed?

I think it is important to discuss why Methodist McKinney Hospital was developed. There are a lot of reasons, but I believe the primary reason was physician frustration and dissatisfaction with the existing local hospitals, their administration, and the health systems that owned them. The group of physicians who started Methodist McKinney wanted a hospital where patient care is the top priority, not the bottom line. They also wanted higher nurse to patient staffing ratios and grew tired of hearing patient complaints about quality and service. So they decided to take matters into their own hands and build a hospital which was driven by their values and principles.

The second reason is because of a demand for greater efficiency. Some doctors, especially surgeons, spend much of their time at a hospital. Having competent staff and high efficiency, especially in the peri-operative areas, significantly increases the quality of patient care and physician satisfaction with their job. Inefficiency in the peri-op department not only adds cost to healthcare delivery, but it directly affects a physician's ability to do more procedures in a given day. Because our hospital has higher staffing ratios and responds to the needs of our doctors and patients, we are able to operate more efficiently. This ultimately results in higher patient satisfaction.

Lastly, the doctors also believed that the future of healthcare was going to demand a higher quality, lower cost delivery model than the current big box hospitals provide. They knew that Value Based Purchasing (VBP) was coming and they wanted to respond to that need. Since the ACA's implementation of VBP, our hospital has consistently scored well for providing high quality, low cost care – yet the ACA simultaneously prohibits us from expanding.

Hospital-Physician-Employee-Community Alignment is Good for Care

Having spent my career managing hospitals, I know that the key to success is having a good alignment of goals between the physicians, staff, partners, patients, and the community. It is the philosophy of our partners and the MMH Board to operate the hospital based on the guidance of our local physicians and doing whatever is best for patient care at whatever the cost. This culture has endeared us greatly to local physicians, far beyond the 22 investors, because that is what they also want in a hospital. It is our physician ownership that makes this possible.

But we also care deeply about making sure we are addressing the needs of our staff, patients, and community. As a result, we have received many awards and achievements, including:

- receiving 4 out of 5 stars under CMS' Hospital Star Rating Program;
- scoring above the 90th percentile nationally for HCAHPS;
- exceeding 100% of the baseline for the CMS Value Based Purchasing Program;
- being awarded the Joint Commission's Gold Seal of Approval for accreditation;
- earning the recognition as a Dallas Forth Worth Top 100 Workplace in 2013 & 2014;
- receiving a score of 99 out of 100 on our lab survey (COLA 2014);
- being awarded a perfect survey with no findings noted on our 2014 Joint Commission Pathology Survey;
- earning a perfect survey with no findings noted on our 2015 Texas Department of State Health Services Mammography Survey; and
- being recognized as a 2014 Texas Hospital Quality Improvement Silver Award by the Texas Medical Foundation.

Methodist McKinney Hospital Expansion Dilemma

Thanks to strong support from the community, MMH is getting very close to the point where we have outgrown our facility and need to start expanding. McKinney and Collin County are growing at an incredible pace with a population increase of 70 percent since 2000. Patients can choose to receive their health care services at any one of many facilities in our area, but many chose MMH because of the quality of care provided by our hospital.

As a result, our board and partners are being forced by the ACA prohibition on expansion to make a very tough decision. Do we stop serving Medicare, Medicaid, and Tricare so that we can expand to meet the growing community demand or do we stop growing? If we are forced to drop out of the Medicare and Medicaid program, it will not only decrease competition and increase costs at other hospitals, but the 27% of our patients who are covered under those programs will be forced to receive care elsewhere.

While we have just started the process of discussing expansion, it is extremely discouraging to even consider undertaking the sometimes years long process to prove we meet the stringent requirements as a high-Medicaid facility or applicable hospital. As of today, only one – yes one – physician-owned hospital has been approved for expansion. But even if we did meet the

requirements for expansion, we would still be limited to the number of beds we could add. The arbitrary expansion exception under the ACA is not linked to quality of care or lower costs. Yet at the same time, lower quality, higher cost, for-profit and non-profit hospitals can expand without any limitations or hoops to jump through.

The Changing Healthcare Landscape in the McKinney, TX Area

Since MMH opened in February 2010 and after the ACA was passed, the healthcare landscape in and around McKinney has been changing at a rapid pace. For instance:

- Baylor, Texas Health Resources (THR), HCA, and Tenet have all begun buying up independent physician practices and recruiting new physicians to the market in a hospital employment model;
- THR purchased Medical Edge physician group (300+ physicians);
- THR bought 2 physician owned surgery centers near MMH;
- THR also bought Envision Imaging Centers;
- HCA bought CareNow urgent care centers; and
- Baylor Health System partnered with Select Medical (OP Physical Therapy Centers).

This is not nearly a comprehensive list, but a good example of consolidation that is occurring with the big hospitals in and around McKinney. Yet while these hospitals are consolidating practices, our hospital is unable to even add one bed because we have 22 physician investors.

Why does this matter? Data has shown that physician employment by hospitals and hospital consolidation is one of the biggest drivers of cost increases. So while we strive to reduce costs and provide care in the most cost-effective manner, we are being punished because of our physician-owners.

Emergency Department Myth

One of the main arguments against physician-owned hospitals is that they shouldn't be allowed to open or expand because they don't have EDs. I would like to set that record straight. Medicare does not require hospitals to have EDs. For instance, rural hospitals do not have EDs. What Medicare does require is that all Medicare providers comply with EMTALA. Not only does Methodist McKinney comply with EMTALA, we also have an ED.

Physician-Owned Hospitals and Cherry Picking Myth

There are those that argue physician-ownership of hospitals leads to cherry picking patients. But I can tell you based on my many years of working in hospitals, all hospitals and health systems, regardless of the ownership makeup, make decisions on which services to provide based in part on financial sustainability. So I'd like to take a moment to share a few experiences I have had in my career that touch on this point.

I previously worked for Rockwall Hospitals, a company that purchased Doctors Hospital Tidwell/Parkway in north Houston out of bankruptcy in 2007 with a group of physicians. This hospital is in a very underserved and economically disadvantaged area. It used to be owned by HCA, but they abandoned it despite maintaining a large presence in the Houston market. The local doctors felt it was essential to maintain service to this area and put their own capital up to do so. This hospital still serves that community today and is still physician owned. The question here is did the doctors at Tidwell/Parkway cherry pick or did HCA?

Second, I also worked for a county hospital and for-profit hospitals, including HCA and Community Health Systems. In every instance at those hospitals, our boards made decisions on what services to provide. We added new service lines and closed some service lines and in every case, a financial analysis was a major part of the decision process.

I am not sharing these examples to argue one ownership model is better than another. I mention them to show the inherent unfairness in saying because physicians have an ownership interest in a hospital, they act in bad-faith compared to for-profit or non-profit hospitals.

Conclusion:

In closing, I want to urge Congress to repeal Section 6001 of the ACA so that our hospital can meet the demands of our community. We believe that competition should be allowed in America and the market will decide who should survive and thrive based on cost, quality, service, etc. It should be the market and patients that chose winners and losers – not the federal government.

Chairman BRADY. Mr. Minissale, 5 minutes goes fast, but we have all your testimony for the record. So Mr. Steedley you are recognized for 5 minutes.

STATEMENT OF ROBERT STEEDLEY, PRESIDENT, BARNES HEALTHCARE SERVICES, ON BEHALF OF THE AMERICAN ASSOCIATION FOR HOMECARE

Mr. STEEDLEY. Good morning. My name is Robert Steedley, and I am the president for Barnes Healthcare Services, a regional home care provider based in Georgia. I also serve as the voluntary chairman of the board of directors for the American Association of Homecare, which is the national trade association for home medical equipment, providers, manufacturers and other stakeholders in the home care community.

I would like to thank Chairman Brady, Ranking Member McDermott and members of the House Ways and Means Subcommittee on Health for holding this hearing on improving competition and Medicare. I would also like to thank Congressman Tom Price and Congressman John Larson for introducing legislation that would create a state-of-the-art, market-driven auction system, an alternative to the competitive bid program.

I am here today to talk about flaws in the current bids program, how those flaws impact noncompetitive bid areas and offer a better budget neutral solution. Both the association and I fully support healthy and fair competition. My testimony also comes from firsthand experience with the bidding program at Barnes Healthcare. Opening in 1909, Barnes Healthcare Services has 106 years of experience, employs more than 300 people across 14 locations and serves 4 States. Experts in the past explain in great detail why CMS bidding program lacks transparency and restricts patient choice and access to the prescribed home medical equipment they need. I have also detailed these in my written testimony.

Fortunately, Congress recently passed legislation to help fix one of those issues of the program, the lack of a binding bid. AA Homecare would like to thank Congressmen Tiberi and Larson for introducing legislation that require binding bids. I would also like to thank the Ways and Means Committee for its consideration and approval of this bill which was included in the file SGR bill.

Requiring binding bids is a key provision in the Congressman Price and Congressman Larson's Market Pricing Program legislation, which is also known as MPP. The issues with the competitive bid program are not just limited to round 1 and 2. In October 2014, CMS also issued a final rule that applies the artificially low competitive bid raise to all non-bidding areas, including rural and underserved.

The artificially low competitive bid rates are only part of the problem of this final rule. The application of payment rates to nonbid areas is flawed and will disrupt Medicare beneficiary access to the home medical equipment items that they need.

In competitive bid areas, the suppliers try to make up for drastic cuts through increased volume. As a result of the CMS final rule, suppliers outside of those bid areas will receive the same drastic cuts without the exclusive contracts or increases in the volumes of business.

There is a better budget neutral way to achieve market prices for home medical equipment known as the Market Pricing Program. I have included more detailed information in my written testimony, but following are a few components of MPP. MPP includes the same items that are currently in the CMS bidding program, and it is also nationwide. There are two categories bid per geographic area, eight additional categories in that same area, would have prices adjusted based on auctions conducted simultaneously in comparable geographic markets.

Bid areas are smaller than the Metropolitan Statistical Areas, also known as MSAs and more homogeneous. Finding bids are required to ensure only serious bidders participate. The bid price is based on the clearing price rather than the median price of the winners. And finally, the same areas that are exempted from bidding under competitive bidding program from CMS will be exempted under MPP.

As committee members can see from my written testimony, MPP is simply a much better auction system than the current CMS competitive bid system. MPP uses auction principles supported by economists and auction experts. It is more transparent and efficient in the current program and it will achieve the goal of Congress to have true market prices for home medical equipment in Medicare.

AA Homecare was very thankful when Congressman Price and Larson introduced MPP, the Medicare DME Post Market Pricing Program Act in 113th Congress. This legislation has received strong bipartisan support with 180 cosponsors. AA Homecare strongly supports this commonsense legislation and urges the subcommittee and Congress to do the same.

I would like to thank the committee again for the opportunity to provide this testimony. AA Homecare and I look forward to working with the subcommittee to improve competition in Medicare while protecting patients' access to the needed home care equipment. Thank you.

Chairman BRADY. Thank you, Mr. Steedley. I was just told that our normal lighting system that gives you the yellow light and the one-minute warning to wrap up isn't working today, so I apologize for that. We will get that back on track soon.

Mr. Umbdenstock, thank you for your leadership of AHA and you are recognized for 5 minutes.

[The prepared statement of Mr. Steedley follows:]

Testimony of Robert Steedley

President, Barnes Healthcare Services, Valdosta, GA

on behalf of the American Association for Homecare

before the Subcommittee on Health

House Committee on Ways and Means

on

Improving Competition in Medicare: Removing Moratoria and Expanding Access

May 19, 2015

Good morning, my name is Robert Steedley, I am the President of Barnes Healthcare Services. Barnes Healthcare Services is a regional post-acute homecare provider offering home medical equipment, infusion therapy and products, specialty pharmacy services and products, as well as in-home chronic-care telemedicine services. Our headquarters are in Valdosta, Georgia and our service area includes Georgia, Florida, Alabama, and Tennessee. I would like to thank Chairman Brady, Ranking Member McDermott, and members of the House Ways and Means Subcommittee on Health for holding this hearing on improving competition in Medicare.

Barnes Healthcare opened one hundred and six years ago in 1909, and today employs more than 300 people across 14 locations. Barnes' owner and CEO is Charles Barnes, III; a third generation pharmacist. Barnes Healthcare Services has a long tradition of caring for our community, and in that tradition I am coaching Charles Barnes IV, who will eventually inherit the company from his father. I have been at Barnes for a little over nineteen years, a registered nurse for more than twenty years, and I began my career in healthcare as an EMT.

I am pleased to share my experience with the Medicare competitive bidding program and make recommendations on how Congress can create a state-of-the art auction program that achieves market pricing, is sustainable over the long term, will not reduce quality and access to home medical equipment, and can be used as a model for other sectors of healthcare. I would like to thank Congressman Tom Price and Congressman John Larson for their legislation that would establish a true market driven auction process for home medical equipment (HME).

As a proud member of the American Association for Homecare (AAHomecare), I also serve as volunteer Chairman of the Board of Directors. AAHomecare is the national trade association for HME providers, manufacturers and other stakeholders in the homecare community. AAHomecare members serve the medical needs of Americans who require home oxygen therapy, mobility assistive technologies

(standard and complex wheelchairs), hospital beds, diabetic testing and medical supplies, inhalation drug therapy, home infusion and other home medical products, services and supplies.

Most of these services and products are already included or will be included in the Medicare competitive bidding program, some without any precedent for doing so. We believe that home medical equipment is a vital component of the continuum of care and is a fundamental component to controlling health care costs by keeping beneficiaries in the most cost-effective and patient preferred setting—their homes—rather than providing acute care in emergency departments and extended care institutional settings. We have grave concerns about the way in which the current bidding program is being implemented and operated.

For its 100 plus years, and through my 19 years with the company, Barnes takes our commitment to our customers seriously. We have customers with serious physical illnesses and disabilities that are enormously dependent on the services we provide. I, Barnes, and AAHomecare members pride ourselves on providing high quality service along with equipment; the current competitive bidding program has jeopardized our ability to provide high level, or even the most basic level of service. Not being able to surpass expectations for quality service runs counter to my nature and the nature of my colleagues. During the last Round 2 bid, Barnes Healthcare bid on the wheelchair category, and we were awarded the contract. However, we declined that contract because we knew that at the contract price, which was lower than what we had bid, we could not in good faith take care of our customers. We declined the wheelchair contract because we feel strongly that every Medicare beneficiary we serve deserves a specific service and standard of practice. In order to do that for wheelchairs, we must assess the unique needs of the individual. We visit the home, talk with the patient, and do things like measure hallways and turnaround space in the bathroom so that the patient has what they need. Ultimately, we feel it is our duty to ensure that the patient has exactly what they need and can use their chair freely in their home.

Contrary to the official program report, patients are receiving less service and lower quality care because of CMS' competitive bidding program. At Barnes, and many other companies, beneficiaries call-in consistently to report problems with the companies that won the bids. Conversely, we hear from many companies that were awarded bids that simply could not keep up with the demand created by the holes left in the market by competitive bidding. In sum, we hear from both sides that there are holes in the system that results in patients receiving care that is not up to the quality they demand. With each round of bidding it has been a race to the bottom.

My goal before this Subcommittee is not to argue against competition. Both the Association and I support healthy and fair competition. HME providers compete every day to provide quality health care items and services to Medicare beneficiaries and embrace the opportunity to continue to compete to better serve our patients. My testimony will highlight the problems of the current competitive bidding program and recommend a sound, budget neutral alternative—the Market Pricing Program (MPP).

The competitive bidding program distorts the marketplace by not using the pricing methodology implemented in the original demonstration projects in Florida and Texas, which goes against the original

intent of Congress when it voted to implement the program in 2003. It radically reduces the number of providers (competitors), thereby creating oligopolies in the marketplace at a time when our senior population is growing rapidly. Given the gaming and irresponsible speculation by unscrupulous players, providers who truly want to serve their patient populations must reduce supportive services in order to meet drastically lower reimbursement rates.

My testimony is not the first reporting of these deficiencies–speculators and gaming—to Congress. In fact, I have met with my own Congressional delegation to report on my experiences with the program, both at Barnes and in my capacity with AAHomecare. Meanwhile, costs are shifted to Part A due to longer hospital stays and increased readmissions and beneficiaries are forced to pay cash or go without needed medical equipment.

AAHomecare does not stand alone in raising concerns with the current program. In fact, well over 200 economists, computer scientists, statisticians and auction experts from around the world have advised CMS that significant modifications need to be made to the bidding program to make it sustainable over time. Additionally, more than 30 consumer and beneficiary groups believe that the bidding program is flawed and needs to be changed.

AAHomecare worked with Congressman Price, Congressman Larson, and auction experts on the creation of an alternative to the current model that would give CMS a sustainable market-based pricing program for home medical equipment. This alternative preserves the concept of competition and ensures future beneficiary access. AAHomecare was very pleased when Congressman Price and Congressman Larson introduced the Medicare DMEPOS Market Pricing Program Act. This legislation received strong bipartisan support. In the 113th Congress, the legislation had 180 cosponsors. We believe that this legislation will achieve true market prices, while not impeding patient access to the equipment they need.

AAHomecare seeks to be a partner with Congress and CMS to develop a market-based pricing program that is sustainable over the long term and which may serve as a model for other health care sectors. As Congress looks for ways to control health care spending through new and innovative delivery and payment models, I believe we have an obligation to listen to the auction experts who understand auctions best and thereby "get it right."

If we do not address the flaws in this program now, the hidden cost to beneficiaries will be exorbitant and translate into extended hospital stays, an inability to obtain services when needed in the home and unnecessary trips to the emergency department. It is time to look at a different approach to having competition in Medicare.

Cost Effectiveness of Homecare

HME offers an efficient and cost-effective way to allow patients to receive care they need at home. The need for HME and HME providers will continue to grow to serve the ever-increasing number of older Americans. Homecare represents a small but cost-effective portion of the more than $2.3 trillion national health expenditures (NHE) in the United States, and approximately 15.5 million Medicare

beneficiaries require some type of home medical equipment annually, from bedside commodes for people who have hip replacements to high-tech ventilators for quadriplegics.

Yet, not all products are equal: some require licensed or credentialed clinicians to be on staff or cost $15,000 just to procure. While past reports from Congress and the Office of Inspector General (OIG) shed light on products they believe to be overpaid, many others are unprofitable for providers to provide even before the bidding program. The high cost of fuel, labor, rent and utilities, and regulatory compliance associated with billing and collections, HIPAA privacy, identity theft, IT security, Sarbanes-Oxley, waste disposal, beneficiary and employee safety, OSHA, DOT and FDA regulations continues to escalate year after year. Anyone who has ever required HME or had a relative who needed it can attest that our service includes much more than just the equipment.

With greater access to quality equipment and services at home, beneficiaries and Medicare will spend less on hospital stays, emergency room visits, and nursing home admissions. Home medical equipment is an important part of the solution to the nation's healthcare funding crisis. The facts bear this statement out as private health care plans have contracted for our services for decades and reaped the cost-savings along the way. Even the current Administration is trying to develop programs to manage chronically ill Medicare patients in the home through new demonstration projects and the Innovation Center.

One key fact that is sometimes lost in this debate is that HME represents about one percent of annual Medicare spending. So while this program appears to reduce HME expenditures when simply comparing past and current Medicare Part B expenditures, CMS has not examined the cost shifting that occurs as a result of the program as more beneficiaries will be forced to receive care in hospitals, nursing homes, and emergency treatments. The alternative auction program ensures that competitive market pricing is still derived while promoting increased access, transparency, fairness and confidence in the program.

Flaws in the Competitive Bidding Program

As I stated, 244 experts from across the world have weighed in identifying problems with CMS's bid program. AAHomecare shares these concerns, which include:

1. **Providers' Bids Were Not Binding Commitments**

In the first 3 rounds of Medicare's bidding program, bidders were not bound by the prices they bid. Any HME provider could decline to accept an offered contract from CMS after the prices, called Single Payment Amounts, are announced by the government. Because of CMS' decision about pricing, 50 percent of all bidders' prices will be lower than their best submitted bid. Medicare's rule undermines the credibility and integrity of bids, and, without binding commitments, the program encourages low-ball bids from providers.

To add insult to injury, if HME providers turn down contracts, their bid prices are still included in Medicare's calculation of bid amounts, and other bidders invited to participate are forced to choose between accepting the low price which they did not influence, or losing their business altogether by not

participating. CMS states that 92 percent of contract awardees accepted their contract offer. While CMS claims this is a very high acceptance rate, it still means that 8 percent of contract awardees did not accept a contract, which skewed the single payment amount.

Fortunately, Congress recently passed legislation to address this flaw. AAHomecare was very pleased that the Ways and Means Committee marked up and reported binding bid legislation (H.R. 284) introduced by Congressmen Tiberi and Larson. Requiring binding bids is a key provision in Congressman Price and Congressman Larson's market pricing program legislation. This legislation passed on the House Floor by voice vote and was ultimately included in the SGR bill, which passed into law in April, 2015. AAHomecare would like to thank the Ways and Means Committee for supporting and passing this important legislation.

2. The Pricing Calculation Is Flawed

Rather than paying contracted providers the clearing price (the last-accepted bid) which is the standard in bidding and reverse auction programs, Medicare's bidding program establishes prices at the unweighted median among the winning bids, resulting in 50 percent of the winning bidders being offered a contract price less than their bids. We know of no other auction or bidding program that has such a perverse rule where bidders are offered contracts at less than the amount they submitted during the bidding process.

3. Composite Bids Are Distorted

A composite bid is an average of a bidder's bids across many products weighted by the government's estimated demand. The composite bid methodology used in the program provides strong incentives to distort bids away from market prices. Only heavily weighted (based on utilization) products within a category will impact the composite bid. Providers can "game" the system by bidding very little off the current Medicare allowable for certain products with little weight, while bidding more aggressively on other items with a higher weight. This creates a program where individual products are not closely related to costs and providers participating in the program can "game" the system in order to manipulate the single payment amount. In addition, Medicare set a maximum for all items bid—again distorting the bidding process by not permitting bidders to fairly bid based on their true, fully-loaded costs.

4. Lack of Transparency

CMS has shared virtually no data with the public on the selection of contracted providers, calculation of historical demand (capacity), calculation of the single payment amount for products and services covered by bidding and outcomes-related findings to evaluate the program. Instead, CMS has made generalized statements that point to the so-called success of the program.

Moreover, the savings numbers recently quoted by CMS appear to "double-count" savings resulting from anti-fraud and abuse initiatives that were implemented concomitantly with this program. For example, new provider screening tools, real-time claims monitoring and an avalanche of incremental

pre- and post-payment audit activity have been implemented since the program began in 2011. It is surprising and shocking to us that Medicare has elected to audit contract winners in Round One markets so heavily when, in fact, CMS has stated that the program should, on a stand-alone basis, root out fraud and abuse. If this is the case, why deluge contract winners with thousands of audits when those precious resources might be applied to other high-risk healthcare segments and markets?

Under the current program, pricing can be easily manipulated through subjective adjustments to the capacity that a provider lists on its bid forms. During the announcement of the Round One Rebid pricing a CMS official stated the following about contract winners' financial stability. During a press call on July 2, 2010, the CMS official stated –

> *"We do screen bids that are on the low side (to) determine whether or not the provider can actually provide the service or the item at that price," the CMS official said. "That includes looking at invoices...and the provider's financials, including their liquidity and credit, and their ability to expand into a market area. Where we do not feel comfortable, we may not count their capacity at all, or to the degree that they wish us to, in determining the number of winning providers. In fact, we did that 30% of the time. So we have been very careful in selecting providers and in scrutinizing these bids, in terms of prices and sustainability. I think we're comfortable, when we look at the prices that we see."*

This fact calls into question the validity of the payment rates established by the program and the supposed objective process in the program and published in its original Final Rule. The above public comment confirms that CMS may adjust a provider's stated capacity if it questions the provider's bid because it was considered low. By adjusting capacity, CMS manipulated the single payment amount and subjectively decided how many winners were needed. This is completely counter to the more quantifiable rules CMS published initially for the program. The bidding program then just becomes another way to apply administered pricing rather than letting the market set reimbursement rates. The subjectivity is playing with the very viability of numerous family-owned businesses across the country.

5. The Bidding Program Is Designed to Be "Gamed"

Due to the methodology concerning how payment rates are calculated, the impact of non-binding bids and the ability to manipulate the capacity that a provider self reports, the program can be "gamed." CMS even appears to acknowledge this fact in its first annual report on the bidding program when they state that, "we are strengthening our bona fide bid review process…to check that very low bids are sustainable by checking more of those bids." Questioning the sustainability of very low bids implicitly brings into question a program where the SPA offered by CMS is, by definition, lower than 50 percent of the accepted bids presented. If the bid amounts represent the lowest pricing while maintaining quality service, how can a program that reduces the pricing additionally be sustainable over the long term?

Under a "win at any cost" program, providers would do well to submit an unreasonably low bid—"a suicide bid"— in order to win a contract. These providers then would be assured of a contract but they must hope that other providers bid more rationally so that the SPA would be higher than their submitted bid. From here, providers facing low reimbursement rates could agree to furnish

competitively bid items but subsidize their revenue from non-Medicare or non-competitive bidding patients. CMS has never shared with the public how many contract providers have sold their businesses, gone out of business or simply did not bill Medicare for competitively bid items.

6. CMS Monitoring Is Weak and Non-Transparent

When the bidding program was first implemented, CMS required HME providers to provide the exact brand and model of equipment they were providing to Medicare beneficiaries. CMS also stated that it would begin to measure the patient satisfaction of beneficiaries who received HME services. This equipment report was intended to allow the Agency to determine if contracted providers began to substitute lower quality equipment under the program than was previously furnished to beneficiaries. However, CMS modified this requirement after one quarter into the pilot so there is no way to monitor the quality of equipment Medicare beneficiaries are receiving. And to date, we have seen no beneficiary satisfaction data.

7. No Due Process

Currently, there are no due process protections or appeals processes in place for providers to appeal CMS' methodology for establishing payment rates, making contract awards, designating bidding areas, deciding on the phased-in implementation approach, selecting items and services or the bidding structure and number of contractors. Numerous companies were initially qualified due to a technical error on CMS' fault, and yet it took over 120 days to resolve the issue.

Flawed Competitive Bidding Rates Will Impact Non-Competitive Bidding Areas

The issues with the competitive bidding program are not just limited to Round 1 and 2 areas; they will impact suppliers and beneficiaries in non-competitive bidding areas as well. On October 31st, 2014, the Centers for Medicare & Medicaid Services (CMS) released the final rule on "Medicare Program: End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies," which establishes the methodology for making national price adjustments to payments for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) paid under fee schedules based upon information gathered from the DMEPOS competitive bidding programs (CBPs) and phase in special payment rules in a limited number of competitive bidding areas (CBAs) under the CBP for certain, specified DME and enteral nutrition.

For qualified DME items, the final rule phases in, over 6 months, a new reimbursement rate for non-competitive bidding areas. On January 1, 2016, the reimbursement rate for these claims (with dates of service from January 1, 2016 through June 30, 2016) will be based on 50 percent of the un-adjusted fee schedule amount and 50 percent of the adjusted fee schedule amount which will be based on the regional competitive bidding rates. Starting on July 1, 2016, reimbursement rates will be 100% of the adjusted fee schedule amount which will be based on regional competitive bidding rates. The following are example of these drastic cuts –

HCPCS Code	Region	Current	1/1/16 rate	7/1/16 rate
E1390 (O2 concentrator)	Mideast	$178.23	$134.21 (-25%)	$90.18 (-49%)
EO470 (BiPAP)	Rocky MT	$241.85	$178.50 (-26%)	$115.14 (-52%)
K0003 (standard wheelchair)	Great Lakes	$97.98	$68.78 (-30%)	$39.58 (-60%)

The artificially low competitive bid rates are only part of the problem with this final rule. The application of payment rates to non-competitive bid areas is flawed and will disrupt Medicare beneficiaries' access to the DME items they need. In competitive bid areas, suppliers accept contracts for DME items at a lower rate because there will be a reduced number of suppliers that can operate in that bid area. Suppliers try to make up for the drastic payment cuts through increased volume of beneficiaries served. As a result of CMS' final rule, suppliers in non-competitive bid areas will receive the same drastic payment cuts set in competitive bid areas, without exclusive contracts or increases in volume of business. The industry also has data that indicates providing DME items in rural areas have a higher cost than in urban areas.

Fixing the Bidding Program

Congress' objective in requiring Medicare to use a competitive bidding model was to establish market prices for HME and ensure that beneficiaries have access to quality items and service. This objective cannot be met because the program does not ensure that bidders are qualified or capable to provide the products in the bid markets, and, due to the arbitrary nature of the capacity analysis, has produced bid rates that are financially unsustainable.

Unfortunately, the recommendations of auction experts, beneficiary and consumer groups, the Medicare Program Advisory and Oversight Committee (PAOC)—the panel created by Congress to advise CMS on the design and implementation of the program—and AAHomecare and other interested groups have not been acted upon beyond Congressional action to require binding bids. We now look to Congress to fix systemic problems so that Congressional intent is followed.

To fix the flaws in the CMS designed program, an alternative market-based pricing program for HME has been developed, which has been specifically tailored to the HME marketplace. The proposal, known as the Market Pricing Program (MPP), would require changes to ensure a financially sustainable program. The MPP uses an electronic state-of-the-art reverse auction to establish market-based reimbursement rates for HME around the country. These changes are consistent with Congress' original intent: to create a program that is based on competition while maintaining beneficiary access to quality items and services. The MPP would apply to the same product categories as the current program and will achieve the same cost savings for HME item nationwide. It is intended to be budget-neutral.

The following are key features of the MPP:

1. **Timeline**

The design of MPP would allow CMS to implement it quickly. The program would be developed through a collaborative, transparent process, involving all stakeholders (HME providers, CMS, beneficiaries), with

the guidance of an auction expert and the oversight of the market monitor, to establish market rules, to set market-based and sustainable reimbursement rates, and protect beneficiary access to, and choice, of quality HME products, services, and supplies. The use of an auction expert to help the Secretary of the Department of Health and Human Services design the auction program and a market monitor to help the Secretary ensure that the program is operating effectively and efficiently are common among public auctions.

2. Auction Operation

The MPP would auction a representative 20 percent of the market (counties eligible for bidding) with two-year contracts. The remaining market areas eligible for the program would be served by any eligible providers furnishing HME at the reimbursement rates determined by the auction. The reimbursement rate established through the auction would apply to similar geographic areas (i.e., urban to urban, suburban to suburban) and be adjusted for regional characteristics.

Each year thereafter, the MPP would auction a representative 10 percent of the market (counties eligible for bidding) with two-year contracts starting on July 1 of the year of auction.

An additional 10 percent of eligible market areas would be subject to auction each subsequent year until market pricing programs are occurring in 100 percent of eligible market areas throughout the United States. The process would continue and the Secretary, in consultation with the auction expert, would continue to select additional eligible market areas on an ongoing and rotating basis. **This design would create the most accurate competitive market payment methodology in the Medicare program.**

3. Market Areas

Market Areas established by the Secretary would be composed of a county, an aggregation of counties or parts of counties that together form an economically interdependent area. Large counties would be permitted to be subdivided. The current program's geographic areas are too large to be effective because not all HME providers are able to service an entire area. Smaller contract winners need to subcontract to serve large MSAs and lose quality control since another provider is furnishing the prescribed equipment and related services.

4. Rural Exemption

The same areas that are exempted from auctions under the competitive bidding program would be exempted by the MPP.

5. Transparent Process Required

In establishing the MPP, the Secretary would utilize an open and transparent process that includes all relevant stakeholders in the market. Provider and beneficiary education would be required in consultation with the auction expert and market monitor.

6. Market Design

The Secretary would conduct an auction and ensure that the market has these basic features:

- In each Market Area, two product categories would be auctioned, producing the clearing price and limiting supplying rights to bid winners. The "lead product" would be submitted for bid in the auction.
- Bidders must provide a cash deposit or irrevocable letter of credit (LOC) (from a qualified institution) of 10 percent of expected annual volume as a bid guarantee and winning bidders must provide same as a performance guarantee. Winning bidders must accept a contract (binding bid).
- For each product category, a "lead product" is determined by the auction expert on the basis of cost and utilization. Only the "lead product" is bid. The "lead product" sets the pricing for the category and the pricing of all other products in the product category is set relative to the "lead product". The "lead product" is the baseline pricing for the category, and establishes the clearing price. The auction expert will aggregate the various price weighting percentages reported for each product to adopt a single capacity-weighted average. This relative price index will be publicly disclosed in advance of the auction so that each bidder will know how each product price will be determined in the auction.
- In the Market Area subject to the auction, the reimbursement rates of the other "non-lead products" subject to the MPP would be established by reference to reimbursement rates established in economically similar areas in which that product category was subject to auction and all qualified providers able to accept that price would have the right to provide products and related services.
- The MPP would use the market "clearing price" (the first excluded bid in each product area) for each product area.
- HME providers whose bid is below the "clearing price" would be offered a contract for a two-year period. HME providers whose bids are below the clearing price must accept the contract.

How MPP Auctions Actually Work

I am not an economist or auction expert, but as a supplier I can recognize the simplicity of the MPP auction process. My understanding is that the MPP is an electronic auction system, which takes place over a few days. During the auction, suppliers know where their bids stand and they can make adjustments to stay competitive. At the end of the auction, suppliers know if they have won or lost contracts. This is vastly different than the current competitive system, in which suppliers are notified a year later after the bid window closes about the results of the auction. When suppliers are finally offered contracts under competitive bidding, the reimbursement rate may be significantly lower, which happened to my company. Suppliers are usually only given 10 days to decide to accept or decline the contract.

Unlike the CMS program, MPP was developed with the input of auction experts. Consistent with many other successful auction systems, MPP is a reverse clock auction with some special features for the HME application. According to Dr. Peter Craton's working paper on MPP, all HME items that are subject to auction are offered simultaneously. The MPP auction proceeds in rounds and each round is associated with a price range for each lead product in each region. The lead product is one of the major products within the product category. Prices for all non-lead products are set from a price index for the product category. By stating a lowest price the bidder is willing to supply a product, the bidder indicates whether it is willing to stay in the auction in the current round or drop out. Once the bidder drops out for a product-region, the bidder may not bid for that product-region again. Prices start high and are reduced each round at a rate depending on excess supply for each product–region. This process continues until supply for a region has dropped below or equal to the demand. At this point, the price for the HME item is set, also known as the clearing price.[1] Immediately following the auction, winning bidders are announced.

Days after the auction, contracts are offered to suppliers. Within 30-60 days, the beneficiaries are educated about the winning suppliers and contracts are implemented.

As committee members can see, MPP is a much better auction system than CMS' current competitive bidding program. MPP uses auction principles supported by economists and auction experts; it is more transparent and efficient than the current program; and will achieve the goal of Congress to have true market prices for home medical equipment in Medicare.

Conclusion

AAHomecare strongly supports the MPP legislation introduced Congressmen Price and Larson. We urge this Subcommittee and Congress to support this common sense legislation. To protect Medicare beneficiaries, Congress must change the current, flawed bidding system to a sustainable market pricing program at the earliest legislative opportunity.

[1] An Auction for Medicare Durable Medical Equipment: Evidence from an Industry Mock Auction Peter Cramton , Ulrich Gall , and Pacharasut Sujarittanonta 25 June 2011

STATEMENT OF RICH UMBDENSTOCK, PRESIDENT AND CEO, AMERICAN HOSPITAL ASSOCIATION

Mr. UMBDENSTOCK. Chairman Brady, Ranking Member McDermott, Members of the Subcommittee. On behalf of our nearly 5,000 member hospitals, health systems and other healthcare organizations I thank you for the opportunity to testify today. Community hospitals embrace fair competition where facilities compete over quality, price and patient satisfaction. However, we are strongly opposed to the practice of self-referral, which skews the marketplace in favor of physician owners who self-refer the healthiest and wealthiest patients to their own facilities. Therefore, the AHA urges Congress to current law preserving the ban on physician self-referral to new physician-owned hospitals and retaining the restrictions on the growth of existing physician-owned hospitals.

Physician self-referral is contrary to competition. It allows physicians to steer the most profitable patients to facilities in which they have an ownership interest or potentially devastating the healthcare safety net in vulnerable communities.

Changing the current law would not foster competition. Instead, it would only allow these physicians to increase their profits. Current law represents a compromise that protects the current physician ownership of hospital arrangements and allows these arrangements to grow where increased hospital capacity is needed. However, some have proposed weakened significantly Medicare's prohibition on physician self-referral to new physician-owned hospitals and loosened the restrictions on the growth of grandfathered hospitals.

The AHA strongly opposes these changes, any changes that would expand the use of the whole hospital exception, beyond grandfathered hospitals or that allow grandfathered hospitals to expand or increase their capacity beyond what is allowed in current law for three primary reasons: First, physician-owned hospitals provide limited or no emergency services, relying instead on publicly funded 911 services when their patients need emergency care. HHS's Office of the Inspector General reported that, quote, "two-thirds of physician owned specialty hospitals use 911 as part of their emergency response procedures." And, quote, "most notably, 34 percent of specialty hospitals use 911 to obtain medical assistance to stabilize patients, a practice that may violate Medicare requirements."

Second, physician self-referral leads to greater utilization of services and higher costs, CPO, MedPac and independent researchers all have concluded that physicians self-referral leads to greater per capita utilization of services and higher costs to the Medicare program.

Third, physician-owned hospitals tend to cherry-pick the most profitable patients and services, jeopardizing communities' access to full service care. GAO, CMS and MedPac have all found that physician-owned hospital patients tend to be healthier than patients with the same diagnosis of general hospitals. Further, MedPac and GAO found that physician-owned hospitals treat substantially fewer Medicaid patients. This trend creates a destabilizing environment that leaves sicker and less affluent patients to

community hospitals. These selection practices place full service hospitals at a competitive disadvantage because they depend on a balance of services and patients to support the broader needs of the community.

The current payment system does not explicitly fund standby capacity for emergency trauma, burn services or the like, nor does it fully reimburse hospitals for the care provided to Medicaid and uninsured patients. Community hospitals rely on cross subsidies from better reimbursed services, the very services targeted by physician-owned hospitals to support these and other essential, but under-reimbursed health services. Resident loss to specialty hospitals can lead to staff cuts and reductions in subsidized services.

In addition, many of the physicians profiting from limited service hospitals will not serve on-call in the community's emergency department, or participate in wider quality improvement projects that benefit the community. These facilities duplicate services, further exacerbating the shortages of physicians and allied health professionals in some communities.

Furthermore, closing the whole hospital exception loophole in the Stark law reduced the Federal deficit by $500 million over 10 years, according to the CBO. Proposed changes to the current law would erase those savings and raise the deficit at a time when our Nation is trying to control increases in health care costs.

True, our competition could be fostered by making commonsense changes to law to allow greater care coordination and new delivery models. The health care field is rapidly changing, moving toward new payment delivery models that emphasize value over volume. As part of that change, hospitals are actively exploring clinical integration, a move away from working in silos toward emphasizing teamwork to coordinate care.

However, hospitals attempting to seize these opportunities to improve care and care coordination for Medicare beneficiaries and other patients face significant legal barriers. Chief among these are the outdated rules governing compensation relationships between hospitals, physicians and other caregivers. Portions of the anti-kickback statute, the Stark law and civil monetary penalty law.

Congress recently acknowledged the need for change to the CMP law through the work of this committee in the recent SGR bill, which limited the scope of this prohibition so that a hospital is only subject to CMPs for making payments that will reduce or limit medically-necessary care. We advocated for this change and are pleased that Congress lifted this barrier.

Chairman BRADY. Mr. Umbdenstock, I apologize.

Mr. UMBDENSTOCK. No problem, sir. Thank you very much.

[The prepared statement of Mr. Umbdenstock follows:]

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Testimony

of the

American Hospital Association

before the

Health Subcommittee

of the

Committee on Ways and Means

of the

U.S. House of Representatives

"Improving Competition in Medicare: Removing Moratoria and Expanding Access"

May 19, 2015

I am Rich Umbdenstock, president and CEO of the American Hospital Association (AHA). On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, I thank you for the opportunity to testify.

Community hospitals embrace fair competition where facilities compete over quality, price and patient satisfaction. However, we are strongly opposed to the practice of self-referral, which skews the marketplace in favor of physician owners who self-refer the healthiest and wealthiest patients to their own facilities. Therefore, the AHA urges Congress to maintain current law preserving the ban on physician self-referral to new physician-owned hospitals, and retaining restrictions on the growth of existing physician-owned hospitals.

Our specific objections to changing current law on physician-owned hospitals follow, along with our ideas for how the government can help foster true competition while improving care for patients and preserving the health care safety net for our communities.

BACKGROUND

For decades, the Ethics in Patient Referrals Act ("Stark law") has shielded the Medicare program from the inherent conflict of interest created when physicians self-refer their patients to facilities and services in which they have a financial stake. But the Stark law's "whole hospital" exception permitted physicians to refer patients to those hospitals where they had an ownership interest in the entire facility rather than just in a subdivision, such as imaging or surgery.

In 2010, Congress limited the use of the "whole hospital" exception to existing physician-owned hospitals that had a Medicare provider number as of Dec. 31, 2010. The law imposed growth restrictions on "grandfathered" hospitals but allowed for limited exceptions if such hospitals can demonstrate that their communities need additional capacity. For example, if a physician-owned hospital can show that it has the average or a higher number of Medicaid inpatient admissions and is located in an area with significant population growth and high bed occupancy rates, it may apply to increase its number of beds. Congress added the need criteria because the proliferation of physician-owned hospitals was focused in those states without certificate-of-need laws and restricted physician self-referral to new physician-owned hospitals.

THE WRONG PRESCRIPTION FOR COMPETITION

Physician self-referral represents the antithesis of competition. Instead it allows physicians to steer the most profitable patients to facilities in which they have an ownership interest, potentially devastating the health care safety net invulnerable communities. Changing current law would not foster competition. Instead it would only allow these physicians to increase their profits.

Current law represents a compromise that protects current physician ownership of hospital arrangements and allows these arrangements to grow where increased hospital capacity is needed. However, some members of Congress propose to weaken significantly Medicare's prohibition on physician self-referral to new physician-owned hospitals and loosen restrictions on the growth of grandfathered hospitals. The so-called Patient Access to Higher Quality Care Act (H.R. 976) would allow many more physician-owned hospitals to open and permit unfettered growth in all grandfathered hospitals.

The AHA opposes any changes that would expand use of the whole hospital exception beyond grandfathered hospitals or that allow grandfathered hospitals to expand or increase their capacity beyond what is allowed in current law. We oppose such changes for three primary reasons. First, physician-owned hospitals provide limited or no emergency services, relying instead on publicly funded 911 services when their patients need emergency care. The Department of Health and Human Services' (HHS) Office of Inspector General reported that "[t]wo-thirds of physician-owned specialty hospitals use 911 as part of their emergency response procedures," and "[m]ost notably, 34 percent of [specialty] hospitals use 911 to obtain medical assistance to stabilize patients, a practice that may violate Medicare requirements."

Second, physician self-referral leads to greater utilization of services and higher costs. The Congressional Budget Office (CBO), the Medicare Payment Advisory Commission (MedPAC) and independent researchers all have concluded that physician self-referral leads to greater per capita utilization of services and higher costs for the Medicare program.

And third, physician-owned hospitals tend to cherry-pick the most profitable patients and services, jeopardizing communities' access to full-service care. The Government Accountability Office (GAO), the Centers for Medicare & Medicaid Services and MedPAC have all found that physician-owned hospitals' patients tend to be healthier than patients with the same diagnoses at general hospitals. Further, MedPAC and GAO found that physician-owned hospitals treat fewer Medicaid patients. This trend creates a destabilizing environment that leaves sicker and less-affluent patients to community hospitals. These selection practices place full-service hospitals at a disadvantage because they depend on a balance of services and patients to support the broader needs of the community. The current payment system does not explicitly fund standby capacity for emergency, trauma and burn services, nor does it fully reimburse hospitals for care provided to Medicaid and uninsured patients.

Community hospitals rely on cross-subsidies from the well-reimbursed services targeted by physician-owned hospitals to support these and other essential but under-reimbursed health services. Revenue lost to specialty hospitals can lead to staff cuts and reductions in subsidized services such as inpatient psychiatric care, as well as lower operating room utilization, which decreases efficiency, strains resources and increases costs. In addition, many of the physicians profiting from limited-service hospitals will not serve "on call" in the community's emergency department or participate in wider quality improvement projects that benefit the community. Furthermore, the nation is experiencing shortages in many physician and other allied health professions. These facilities duplicate services, further exacerbating these shortages. Siphoning off the most financially rewarding services and patients threatens the ability of community hospitals to offer comprehensive care – and serve as the health care safety net for all patients.

Furthermore, closing the "whole hospital" exception loophole to the Stark law reduced the federal deficit by $500 million over 10 years, according to the CBO. The ill-advised Patient Access to Higher Quality Care Act would erase those savings and raise the deficit at a time when our nation is trying to control increases in health care costs. We strongly oppose any attempt to expand the number of physician-owned hospitals and support tight restrictions on the growth of existing facilities.

ENCOURAGING COMPETITION TO BENEFIT PATIENTS AND COMMUNITIES

The health care field is rapidly changing, moving toward new payment and delivery system models that emphasize value over volume. As part of this change, hospitals are actively exploring clinical integration – a move away from working in silos toward emphasizing teamwork to coordinate care. Increasingly, public and private payers are holding hospitals accountable for reducing costs and improving quality in ways that can be accomplished only through teamwork with physicians and other health care professionals within and across sites of

care, including the alignment of financial incentives. This is opening up new opportunities for partnership, joint ventures and new types of health care organizations.

However, hospitals attempting to seize these opportunities to improve care and care coordination for Medicare beneficiaries and other patients face significant legal barriers. Chief among these are outdated rules governing compensation relationships between hospitals, physicians and other caregivers – portions of the Anti-kickback Statute, the Stark law and the Civil Monetary Penalty (CMP) law.

Congress recently acknowledged the need for change to the CMP law through the work of this committee to remove impediments to improving care for beneficiaries and other patients and remedy the government's problematic interpretation of the law. The recently passed Medicare Access and CHIP Reauthorization Act of 2015 limits the scope of this prohibition, which had prevented hospitals from offering physicians incentives to follow evidence-based care guidelines, so that a hospital or critical access hospital is only subject to CMPs for making payments to reduce or limit *medically necessary* care. The AHA advocated for this change and is pleased that the Congress has lifted this significant barrier to hospital "gainsharing" arrangements with physicians. Additional commonsense changes like this would allow hospitals and other caregivers, including physicians, to work together to better coordinate care for beneficiaries and other patients and would spur increased competition for the benefit of patients and payers, chief among them Medicare.

Congress itself has promoted change by fostering new care delivery models through the Center for Medicare and Medicaid Innovation and the Medicare Shared Savings Program (MSSP). However, it too recognizes the barriers currently in place. For example, when crafting the MSSP, Congress expressly granted the HHS Secretary authority to waive provisions of the Anti-kickback, Stark and CMP laws to remove these impediments to the successful implementation of Medicare accountable care organizations (ACOs). It did the same to enable new models to be tested under the Innovation Center.

All federal health program beneficiaries should have the same opportunity to benefit from the quality and care coordination improvements that clinically integrated organizations can provide. Specifically, the AHA recommends three statutory changes to enhance hospitals' ability to improve health and health care: creating an Anti-kickback safe harbor for clinical integration programs; refocusing the Stark law on ownership arrangements; and standardizing the merger and review process between the two federal antitrust agencies.

Creating an Anti-kickback Safe Harbor for Clinical Integration Programs. The Anti-kickback law's main purpose is to protect patients and federal health programs from fraud and abuse. The law states that anyone who knowingly and willfully receives or pays anything of value to influence the referral of federal health program business – including Medicare and Medicaid – can be held accountable for a felony. Today, the law has been stretched to cover any financial relationship between hospitals and doctors. For example, if a hospital rewards a physician for following evidence-based clinical protocols, the reward could be construed as violating the Anti-kickback law, since technically such a reward could influence a physician's order for treatment or services. In acknowledgement that there are cases where the Anti-kickback

statute thwarts good medical practices, Congress has periodically created "safe harbors" to protect those practices. Congress should create a safe harbor for clinical integration programs. The safe harbor should allow all types of hospitals to participate, establish core requirements to ensure the program's protection from Anti-kickback charges, and allow flexibility in meeting those requirements so the programs can achieve their health goals.

Refocusing the Stark Law on Ownership. The Stark law was originally enacted to ban physicians from referring patients to facilities in which they have a financial stake (i.e., self-referral). However, prohibitions that have grown around the law now prevent arrangements that encourage hospitals and physicians to work together to improve patient care. Specifically, they prohibit hospitals from making payments to physicians that are tied to achievements in quality and efficiency – rather, payments must be for hours worked only. For example, if a hospital pays a physician to help patients manage their diabetes according to a well-designed medical protocol, both the hospital and physician risk being in violation of the Stark law. Congress should return the Stark law to its original focus of regulating self-referral to physician-owned entities by removing compensation arrangements from the definition of "financial relationships" subject to the law.

Standardizing the Merger and Review Process between the Two Federal Antitrust Agencies. The Department of Justice's Antitrust Division (DOJ) and the Federal Trade Commission (FTC) are the two federal agencies with antitrust oversight. FTC has frequently used its own internal administrative process to challenge a hospital transaction, an option not available to DOJ, which increases the time and expense of defending a transaction and the likelihood of an outcome that favors the agency. The Standard Merger and Acquisition Reviews through Equal Rules (SMARTER) Act of 2014 sought to eliminate FTC's ability to challenge a transaction without going to court and to require FTC to meet the same preliminary injunction standards as DOJ. The bill was approved by the House Judiciary Committee. The AHA urges Congress to reintroduce and pass the SMARTER Act. Hospital integration and realignment is essential if the field is to be successful in its drive to build an efficient and effective continuum of care that delivers care to communities in innovative ways and in new, more convenient settings. Both antitrust agencies should be required to prove their case before a neutral judge in the federal courts and not just internal proceedings in which the agency has a decided advantage.

CONCLUSION

Conflict of interest is inherent in self-referral. To again allow for the proliferation of self-referral to physician-owned facilities would prove to be a giant step backward for both health care consumers and taxpayers. We urge you to reject efforts to change the carefully crafted compromise contained in law and help protect community hospitals and access to care for all who need it. Common sense changes in current law to allow providers to work more closely together would go much further toward fostering competition and improving health and health care.

Chairman BRADY. Thank you very much. Mr. Antos, in Washington, we like to talk a lot of about cost control, Washington sort of setting prices and then determining whether it is the right amount, or if you deserve this. You talked about competition as a more patient-centered way to find savings and efficiency. Can you talk about briefly—I have questions for our witnesses—can you talk briefly about which one better serves seniors while creating savings?

Mr. ANTOS. Well, thank you, Mr. Chairman. It certainly is the case that the fee-for-service incentives are to expand volume of services and to focus only on the part that you as the specific provider, whether it is a hospital or a physician or some other provider, but only your part of the patient's health care. So, in fact, I found that Mr. Umbdenstock's point about expanding services, I believe that that is endemic in the Medicare fee-for-service system. If you don't provide services, you don't get paid.

So as far as a competitive program doing a better job of serving patients and giving patients what they want, which is not only a good financial deal, but also good patient outcomes, then you really have to go to private plans, that I think we see in much of Medicare Advantage where they look at the whole patient.

Now short of that, fostering real competition, avoiding having CMS or Congress set prices, when, in fact, we don't know what the prices are, all we know is what the charges are. We need to introduce more competitive approaches in traditional Medicare, but ultimately, I think we are going to have to move to a more coordinated system, Medicare Advantage is not that way.

Chairman BRADY. Mr. Antos, thank you. I notice in the prescription drug program, the Democratic alternative to the Republican plan set a monthly premium of $35 for Medicare Part D. Here we are 10 years later after, and through cost increases, prices all that, the average price is still below the cost control price that originally buy the alternative through competition.

Mr. ANTOS. Well, that comes from several factors, perhaps the biggest factor is the competitive effect. The different drug plans know that if they are going to make money, they have to attract customers. If they are going to attract customers, they have to offer a good balance of access to drugs, including expensive drugs and low cost.

The remarkable thing about this program really, is, as you say, we have seen premiums basically stay level for the last 10 years or so. That is partly due to the fact that we have seen a slowdown in the introduction of expensive new drugs. But importantly, Part D plans have really encouraged Medicare beneficiaries to use generic alternatives that has been very effective.

Chairman BRADY. Thank you, Mr. Antos. Mr. Minissale, thank you for being here. We are told the problem with physician-owned hospitals is that they don't have an ER, that they self-refer so there is greater utilization among themselves at a higher cost, and that you cherry-pick the patients who come through your door. Can you talk a little bit about your experience? I think you served both in for-profit and nonprofit in our position on the House bill so you have seen the operations in all those models. Your thoughts?

Mr. MINISSALE. Yes, sir. First, I want to mention in terms of cherry-picking, it should be pointed out that we serve TRICARE, we are a TRICARE provider, our facility, and one of two largest health systems in Dallas-Fort Worth area, is not a provider, and I guarantee you, we are not doing that because of the high TRICARE payment levels. So that would be one example of cherry-picking.

We do have an ER, and we have advertised it since we have been open on an ongoing basis to try and get more people to come in and open those doors up.

Also, as you mentioned in previous positions, I have been responsible for facilities in the southwest side of San Antonio where we had physician ownership, and it was a very large indigent population there, underserved, the same situation in Congressman Eddie Bernice Johnson's district in north Houston where we had physician ownership, in Port Arthur, in Odessa. These are full service hospitals with physician ownership that were—didn't have the opportunity to cherry-pick.

Chairman BRADY. You are 4 star rated?

Mr. MINISSALE. Yes, sir. Yes, sir.

Chairman BRADY. That star rating takes into effect the complexity of the patients you are serving, correct? So if you are cherry-picking, in fact, you are punished in that star rating, correct?

Mr. MINISSALE. Yes, sir. I would point out that many of the physicians that work at our hospital bring most of their patients to our facility. Obviously we are a 21-bed facility, so they can't bring 100 percent, but, yes, I think the—in our circumstance, the cherry-picking is greatly exaggerated.

Chairman BRADY. How many times have you called, your hospital called 911 for emergency services.

Mr. MINISSALE. Actually, we have a process for strokes, we have a code STEMI, which those are the situations where, like, there are certified stroke centers and certified heart centers where time is of the essence where we would need to get that patient transferred to the highest level of care possible. In fact, there are not a lot of stroke certified centers even among the larger hospitals in our area.

Chairman BRADY. So when you dial 911, it is to get the patient to the highest certified and qualified local provider?

Mr. MINISSALE. Correct, correct. And that has been very rare, but that has happened a few times I would say probably three times in 5 years, maybe for us.

Chairman BRADY. Thank you. Mr. Umbdenstock, you raised points. We have heard as concerns, that these hospitals don't have functioning ERs, they self-refer to each other as physicians and they cherry-pick. Looking for common ground, in recognizing in the decades since this temporary moratorium was put in place, before profit and nonprofit hospitals have increased their beds easily more than double all the position on hospital beds in America. So you are allowed to grow to meet the needs of the community, which seems to me to make good sense.

So the common ground here with physician-owned hospitals, I can guarantee you they are not all in the best parts of town, while I have noticed nonprofit and for-profit do grow to meet the needs

of the community. So would a compromise be if physician-owned hospitals had a functioning ER, that they are shown to not self-refer in high utilization like CMS, and their stars rating proved that they are not cherry-picking, but meeting the needs of their community. Is that an area where this discrimination against one model could end and we could have competition among all the hospitals? Is this a common ground you would consider?

Mr. UMBDENSTOCK. Mr. Chairman, thanks for the question. Just a couple of points, first of all. As recently as the cab ride over here this morning, I double-checked the Web site for Methodist McKinney Hospital relative to the ER, and it says that our emergency department offers quick care for all of your bumps, sprains and minor injuries, 365 days, 7 days a week. That may be a very important urgent care function that is good for that community, but that doesn't sound like an emergency department to me.

Chairman BRADY. Mr. Minissale, since this was raised, so you only treat bumps, scrapes and bruises in your ER?

Mr. MINISSALE. Absolutely not, sir. As I mentioned, we are not a stroke center, we are not a heart center.

Mr. UMBDENSTOCK. From their own Web site. From the Medicare cost reports in 2012 and 2013, the percentage of Medicaid, talking to the question of patient and payment selection, in 2012, the Medicare cost report showed zero patient, Medicaid patient discharges and accrued to 0.4 percent in 2013. So a very, very skewed payment system.

So, that is the issue, sir. And that is what we are here to urge Congress to stay with, stay with a program that limits the growth of these hospitals where they are highly selective and picking off the most profitable services. You notice the services on which hospitals like this are focused. And I understand why. That is where the payment is.

Chairman BRADY. Well let me ask you this.

Mr. UMBDENSTOCK. Many hospitals don't have that opportunity.

Chairman BRADY. One, I respect your opinion. Thank you so much for being here. But the stars rating program takes into account the types of patients these hospitals treat. So are they incorrect in their assessment, or are they fairly accurate?

Mr. UMBDENSTOCK. No. Number 1, the stars rating program focuses on the HCAHPS scores, the experience of care or patient satisfaction as we commonly refer to it. If you have the opportunity to identify which patients are going to come to your hospital in advance, you can prepare those patients for that experience. A hospital, a general service community hospital, full service community hospital receive over 60 percent of their admissions through the ER; that is not a predictable source of who the patient is, number one.

Number two, if you are not treating a full array of patients from all socioeconomic strata, you are not likely—you are likely to have a much higher satisfaction rate.

Chairman BRADY. Is that the criteria for adding new beds, is that hospitals of all models should only go to areas that have broad, certain percentage of Medicare, Medicaid patients, that that ought to be a criterion to supplied, to physician-owned hospitals,

for example? Should that be—should this moratorium be applied to all hospitals equally to ensure that each facility meets a broad range of patients?

Mr. UMBDENSTOCK. The current criteria for an exception recognizes several factors, but one is that the particular hospital in question serves at least the average or greater proportion of Medicaid patients as other hospitals in its area, that is already there.

Chairman BRADY. I agree. Would that be a fair restriction on all hospital increases?

Mr. UMBDENSTOCK. Well, it is not a matter of whether or not it has to be a requirement. Every——

Chairman BRADY. But it is for a physician-owned hospital—I am just trying to find again common ground, because hospitals are serving both areas of town that don't have necessarily good culture of health care, and they can serve areas, perhaps, with higher private pay. They do that as systems, again, to try to make ends meet and try to meet their missions, either nonprofit or for profit. The question is, why shouldn't this model be able to do the same thing?

Mr. UMBDENSTOCK. I think you will find that if you look across the Nation's full-service community hospitals, on average, they have about 15 percent of their patients, plus or minus, that are Medicaid; about another 25 or more that are Medicare; probably about 10 percent prior to the ACA expansion and coverage—admittedly, that number is going down—but about 10 percent no pay. So those hospitals are already taking that type of mix of patients. I don't see a need to require it; they are already experiencing it.

Chairman BRADY. So you would be comfortable with a requirement for those types of services for new beds in all hospitals? Should we apply this gold community, broad community service to all hospital beds?

Mr. UMBDENSTOCK. I would like to go back to your context that you used to set up this point, sir, if I might. Which was that hospitals nationally have, I believe, you said opened more beds than the total number of beds in the 250 or so physician-owned specialty hospitals. Number one, that is a very small percentage of the National bed complement. Number two, that may be true that some hospitals have grown at that rate, but we have also seen hospital closures across the full-service hospital spectrum in many areas, including in Texas, sir, as I know you are very familiar with. So I don't think that that is a rampant problem of hospitals adding more beds.

In fact, hospitals are trying to figure out how to skinny down their inpatient complement so that they can focus more and get more patients served in outpatient, and out into the community. So we are actually seeing the reverse phenomenon of the description. They are actually de-emphasizing inpatient care, particularly as they are more at risk.

Chairman BRADY. I recognize that. I hope you will come to Houston some time and see the growth of hospitals. We are thrilled, in my community and throughout the area, and it tells a little different story. So again, looking to find common ground, I know what the concerns are, and I think we need to have a discussion on this.

Ranking Member McDermott, you are recognized.

Mr. MCDERMOTT. Thank you, Mr. Chairman. It is an interesting discussion we are having here, this is not to pick on one hospital, but it is an example we have in front of us here today, McKinney Hospital. Why would a hospital want to be a specialty hospital? Why would they just want to do certain things? Mr. Umbdenstock, I mean you have 5,000 hospitals, so why would a hospital specialize in only doing orthopedics or only doing cardiac or whatever?

Mr. UMBDENSTOCK. Well, I assume there are several reasons, one of which might be that the focus of energy and resources, volume in order to improve technique and outcomes, but also, I would say that you have to recognize that the particular services that limited service hospitals focus on are the profitable services. I don't have a lot of competition for the non-profitable services inside full service hospitals.

Mr. MCDERMOTT. What are the profitable services for hospitals?

Mr. UMBDENSTOCK. Well, certainly you see procedure oriented services, so surgeries, speaking broadly, other forms of procedures as opposed to medical services, certainly your own specialty of psychiatry would be at the other end of that spectrum.

Mr. MCDERMOTT. So if a hospital had 83 percent of its patients in for surgery, somehow they would be skewing it in that direction so that is not the average in most hospitals across the country?

Mr. UMBDENSTOCK. That would not be reflective of the average complement, the average balance of services, that is correct.

Mr. MCDERMOTT. So in some way, they selected who comes in by the services that they offer; is that correct? Is that how a specialty hospital works?

Mr. UMBDENSTOCK. With that kind of imbalance, one would have to assume.

Mr. MCDERMOTT. And if you talked about the emergency room. Now I, like you, use the Internet and I think all modern people use the Internet, it says here that for Methodist McKinney, if you were experiencing any of these conditions, please call 911, immediately: Life threatening conditions, heart attack or stroke, open fractures, severe bleeding, signs of heart attack or chest pain, head injury or other major trauma, one-sided weakness or numbness, loss of consciousness, severe abdominal pain, uncontrolled pain or bleeding, poisoning, call the poison control center.

Now, if an emergency room is not going to deal with those issues, can that be called full service—what it says is they do take care of our stitches and staples for cuts, gashes and wounds, X-rays, fractures and sprains, abdominal pain for maladies such as appendicitis, colitis, pancreatitis. And general illness treatment virus, flu and dehydration. So it is kind of a doc in the box, it sounds to me. They say they have a doctor on call. Is that how that sounds to you when you listen to that description?

Mr. UMBDENSTOCK. I would say, Mr. McDermott, that full service community hospitals run toward problems, trauma, emergencies, and want to be of immediate service to people. They have that type of condition; that is exactly the type of person we expect to see at our ER. That is our purpose and that is why we are there.

Granted, we often have to then transfer the most acutely ill to the higher levels, full service hospitals or teaching centers. But yes, those are the kinds of things that we would expect to see and that we do see in full-service community hospital ERs.

Mr. MCDERMOTT. Explain to me how the Stark law operates in a specialty hospital? The doctors own everything, they own the MRI, they own the CAT scan, they own all the machinery. They can refer every patient they want to their own CAT scan or their own MRI; is that correct?

Mr. UMBDENSTOCK. That is correct. They are free to do——

Mr. MCDERMOTT. And that Stark law prevents you from doing that if you are in another hospital where you have an MRI that is away from it that you own or own a piece of, you can't refer your patients to that MRI; isn't that correct?

Mr. UMBDENSTOCK. That is right, it is called the whole hospital exception as was pointed out earlier. You have to own a share in the whole hospital.

Mr. MCDERMOTT. You have to own the whole thing. That is really what we are trying to stop. And have successfully stopped and saved a half billion dollars.

Mr. UMBDENSTOCK. According to the CBO.

Mr. MCDERMOTT. According to the CBO. By the way, I want to say, I know this may be your last appearance before this committee, you have been working as CEO for AHA for us for 8 years, and we thank you for your service in this tough job that you had and we appreciate your work.

Mr. UMBDENSTOCK. Thank you and thank you to the chairman as well for the sentiment.

Chairman BRADY. I appreciate it. Thank you very much. Mr. Minissale, we are 1,200 miles from your ER, your and Mr. Johnson's witness. Do you want to address the claims you just heard about your ER.

Mr. MINISSALE. Yes, sir. First of all, I would certainly appreciate any ideas or support from Representatives McDermott or Mr. Umbdenstock on how we could grow our ER business. As I have stated, we have not been very successful. We have advertised and advertised and advertised, and that is how a lot of those admissions do come into the larger hospitals. We have also seen a proliferation of free-standing ERs open up in our community, HCA opened two in the area, there are several others. So anything we could do to grow the ER and get more admissions, medical or otherwise would be great.

Chairman BRADY. Thank you. Mr. Johnson, recognized for 5 minutes.

Mr. JOHNSON. Thank you, Mr. Chairman. Mr. Minissale, thank you so much for testifying today. I appreciate hearing all the great things Methodist McKinney is doing back home. I want to ask, given your unique experience, what do you believe the biggest difference is between physician-owned and other hospitals?

Mr. MINISSALE. I think, really, the directive is when we are making decisions, there is kind of a hierarchy in a physician-owned hospital. Where I am at is patient care is first; physician desire is second; employees are third; and profits fourth. In previous experi-

ences where I worked for other company, we were usually driven by corporate health system goals and profits.

Mr. JOHNSON. Thank you. Mr. Umbdenstock, thank you for your testimony today. I have a handful of questions so in the interest of time, I ask you to please keep your answers to a yes or no, if you would. First, are you aware that your testimony refers to the GAO, MedPac and HHS reports that are 8 to 10 years old, and only studied specialty hospitals, not all physician-owned hospitals. Is that a yes or no?

Mr. UMBDENSTOCK. This debate has been going on that long, and we try to reference all sources that we can find throughout the last.

Mr. JOHNSON. Well, you didn't answer my question. So in your testimony, you argue that physician-owned hospitals cherry-pick patients, but did you know that after the GAO and MedPac reports were released, CMS changed how hospitals are reimbursed so a hospital is paid based on the severity of the specific patient, which means you can't cherry-pick. Is that true or false?

Mr. UMBDENSTOCK. You can't necessarily——

Mr. JOHNSON. You can't do that either. Thank you. I would also like to——

Mr. UMBDENSTOCK [continuing]. From the way you refer patients, not in the way a particular patient is paid for, sir.

Mr. JOHNSON. Okay. I would also like to refer you to the first quote on the screen from a Health Affairs study stating, "Physician ownership is not a driving force in referring patients to specialty hospitals." I request that the full article be submitted for the record along with additional references.

Chairman BRADY. Without objection.

[The information follows The Honorable Sam Johnson 1:]

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Specialty Versus Community Hospitals: Referrals, Quality, And Community Benefits

Physicians' commitment to and pride in their specialty hospitals are powerful positive forces.

by Leslie Greenwald, Jerry Cromwell, Walter Adamache, Shulamit Bernard, Edward Drozd, Elisabeth Root, and Kelly Devers

ABSTRACT: In this paper we compare physician referral patterns, quality, patient satisfaction, and community benefits of physician-owned specialty versus peer competitor hospitals. Our results are based on evidence gathered from site visits to six markets, 2003 Medicare claims, patient focus groups, and Internal Revenue Service data. Although physician-owners are more likely than others to refer to their own facilities and treat a healthier population, there are rationales for these patterns aside from motives for profit. Specialty hospitals provide generally high-quality care to satisfied patients. Uncompensated care plus specialty hospitals' taxes represent a greater burden, in percentage terms, than community benefits provided by nonprofit providers. [*Health Affairs* 25, no. 1 (2006): 106–118]

As part of the Medicare prescription drug, Improvement, and Modernization Act (MMA) of 2003, Congress established an eighteen-month moratorium on the development and expansion of new physician-owned specialty hospitals. The central concern among policymakers is whether these hospitals enjoy an unfair competitive advantage relative to other community hospitals. During the moratorium, Congress required the Medicare Payment Advisory Commission (MedPAC) and the Centers for Medicare and Medicaid Services (CMS) to report on two different aspects of this issue. At issue is whether specialty hospitals' physician-owners are able to control the referral of patients, choosing between their own facilities and other hospitals in the community, in a way that results in favorable selection. Other related issues are whether specialty hospitals provide high-quality care, how their patients perceive care, and what types of community benefits they contribute in their markets. Although the con-

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gressional moratorium focuses largely on whether or not physician-ownership contributes to an unfair competitive advantage for specialty hospitals, at stake is the level of competition that will be allowed in hospital markets, or whether greater regulation of hospital markets is a likely policy direction of the future.

We conducted a study that focused on these issues, under contract to the CMS to support the secretary of the Department of Health and Human Services' (HHS') required report to Congress. In this paper we apply our findings to four policy questions: (1) Do specialty hospitals enjoy an "unfair" competitive advantage in their markets, driven by the incentives of physician-ownership? (2) Does physician-ownership result in favorable referral patterns to specialty hospitals? (3) Do specialty hospitals provide lower quality of care to less satisfied patients than local community hospitals? (4) Do specialty hospitals fail to bear an equal burden in providing community benefits compared with community hospitals?

Methods: Definitions And Analytic Approach

A critical first task in our study was to determine which facilities we should define as *specialty hospitals.* Section 507(a) of MMA defines them as "primarily or exclusively engaged in the care and treatment of one of the following categories: (i) patients with a cardiac condition; (ii) patients with an orthopedic condition; (iii) patients receiving a surgical procedure," and any other category deemed to a be a "specialty" and subject to the eighteen-month hospital-building moratorium. Unfortunately, a Medicare designation of "specialty hospitals" (other than certain specialized hospitals, such as children's or psychiatric facilities) does not exist. Recent studies have investigated the effects of specialty hospitals on other providers, each using a somewhat different definition and different numbers of "specialty hospitals" in their analyses.[1]

■ **Study sample.** Given the lack of a well-defined list of specialty hospital facilities, we generated a list of physician-owned specialty hospitals based on Medicare data. We adhered generally to the MedPAC definition of *specialty hospital* in which at least 45 percent of discharges were in one of three clinical groups: diseases and disorders of the circulatory system (major diagnostic category, or MDC, 5), diseases and disorders of the musculoskeletal system and connective tissue (MDC 8), or surgical diagnosis-related groups (DRGs).

Our goal was to identify all such hospitals in existence in mid-2004 using the most recently available data, because, as the earlier studies have noted, the number of specialty hospitals has increased dramatically during the past few years. To this end, we identified physician-owned specialty hospitals in two stages. In the first stage we identified a set of physician-owned hospitals that were "potential" specialty hospitals using an Internet search and listings provided by relevant associations. In the second stage we used Medicare claims data from January–June 2004 to determine the specialization (if any) of the hospitals identified in the first stage. This method yielded ninety-two specialty facilities—a much larger and

more current study sample than previous studies have used. Once we identified specialty hospitals using this approach, we identified competitor hospitals in the same markets (defined as located within twenty miles). The Medicare Provider of Services (POS) File, issues of the American Hospital Association (AHA) Guide, and full calendar year 2003 Medicare claims were used for many of the analyses.[2]

■ **Site-visit data.** Because most of the policy issues involve physicians' behavior and motivations, we felt that it was important to observe and interview staff in specialty and competitor hospitals. Therefore, to complement the Medicare claims data analyses and to help interpret these empirical findings, project staff conducted site visits at hospitals in six cities. Cities were selected based on the number and types of specialty hospitals in operation (cardiac, orthopedic, and surgical) (Exhibit 1). A potential city had to have at least one specialty hospital in operation for two years, and final choices were based in part on a requirement that we locate areas that would allow site visits in all three types of specialty hospitals. Our choice of sites also represented a range of census regions. Through the site visits, we collected information on physician-specific ownership percentages in specialty hospitals. These data allowed us to analyze referral patterns based on actual, not proxy, ownership stakes. Additionally, the site visits facilitated the collection of detailed financial information on specialty hospitals, to enable an analysis of community benefits. Finally, to evaluate patients' satisfaction and experiences with care, we conducted a series of six focus groups with seventy-six Medicare patients in three site-visit cities—Oklahoma City, Fresno, and Dayton—who were treated for similar conditions at either a specialty hospital or a local peer competitor hospital in 2004.

■ **Limitations of study design.** Despite the advantages of a large national sample of specialty hospital Medicare claims and direct data on physician ownership share, this study has a number of limitations. First, it is limited to Medicare patients and hospital inpatient claims. Second, we did not analyze Medicare claims for hospital outpatient departments or ambulatory surgery centers (ASCs). This is work

EXHIBIT 1
Characteristics Of The Site-Visit Areas, Study Of Specialty Hospitals

City	Census division	Area population	Medicare+Choice plan enrollment, 2003 (%)	Number of specialty hospitals
Dayton, OH	East North Central	848,153	12.0	1
Fresno, CA	Pacific	799,407	20.1	2
Hot Springs, AR	West South Central	88,068	0.1	1
Oklahoma City, OK	West South Central	1,095,421	7.8	6
Rapid City, SD	West North Central	112,818	0.1	2
Tucson, AZ	Mountain	843,746	33.0	1

SOURCE: RTI International analyses of the Medicare 2003 Annual County Enrollment File and the Medicare Provider of Services File, second quarter 2004.

that we are performing as a follow-up to our original analysis. Use of services in these facilities would likely be necessary to present a complete picture of competition in specialty hospital markets. Third, project time and financial resources limited our analysis to one year of Medicare claims data (2003), six case-study markets, and six patient focus groups in three markets. Finally, our findings (and those in the MedPAC study also mandated under MMA) consider the impact of specialty hospitals during a limited period. The dynamic nature of specialty hospital entrants into markets suggests that longer-range impacts might be different from the short-term analyses presented here.

Study Findings

■ **Hospital competition.** Because physicians generally drive the decision of which facilities their patients are referred to, physician-owners might have a financial incentive to direct the most profitable patients to specialty hospitals in which physicians have a financial interest. This is particularly true for Medicare beneficiaries, given the current case-mix adjustment limitations of the DRG-based prospective payment system (PPS) that has been shown to lead to differences in the relative profitability of various DRGs.[3]

From our analysis, we found that ownership by physicians is positively related to the likelihood of referring patients to a specialty hospital. However, the relationship between ownership and referrals varied by specialty hospital type and (nonlinearly) the size of the ownership stake (Exhibit 2). The correlation coefficients between ownership share and referral percentage were 0.17 (10 percent significance level), 0.62 (1 percent significance level), and 0.77 (1 percent significance level) for cardiac, orthopedic, and surgical hospital owners, respectively.

First, although we found that physician-owners do tend to favor their own specialty hospitals, they also refer patients to competitor hospitals; the size of the ownership share appears to be an important factor, not the fact of ownership per se. We also found that most physician-owners have very small shares in their specialty hospital and, possibly as a consequence, make few referrals to the facility. For example, only one of ten cardiac facility owners with shares less than 0.5 percent (one-third of all owners) referred more than half of their cases to their own specialty hospital. By contrast, one of two physician-owners with greater than a 1 percent share referred more than half of their patients to their own hospital. The relationship was similar for owners of surgical specialty hospitals but somewhat stronger for owners of orthopedic specialty hospitals.

Second, case-study interviews revealed that many local physicians invested in the specialty hospital either out of a personal relationship with the major physician owners or to ensure that they could refer patients to the facility if need be. These reasons might explain the relatively small ownership shares of many physicians; they can accomplish these goals without more sizable financial stakes.

That physician-owners sometimes refer sizable numbers of patients to their

EXHIBIT 2
Physician-Ownership And Medicare Referral Rates To Specialty Hospitals In Six Cities

Hospital type/individual MD ownership	Percent MD ownership[a]	Proportion of MD owners referring more than half their cases to specialty hospital
Cardiac		
<0.5%	33%	1 in 10
0.5–1.0%	32	1 in 2
>1.0%	35	1 in 2
Orthopedic		
<1%	41%	1 in 14
1–5%	39	1 in 5
>5%	19	4 in 5
Surgical		
<1%	22%	0 in 7
1–5%	56	1 in 5
>5%	22	1 in 2.3

SOURCES: Ownership information provided by specialty hospitals; referral rates based on 2003 Medicare inpatient prospective payment system (IPPS) claims.
NOTE: Based on ownership data from Tucson, Fresno, Hot Springs, Oklahoma City, Rapid City, and Dayton.
[a] Percentage of physician-owners with ownership shares in each given range.

hospitals is not inconsistent with physicians' behavior more generally. For example, an inspection of admission patterns of sixty-four competitor cardiologists in one of our site-visit cities (Oklahoma City) showed that all but nine admitted more than 90 percent of their patients to a single facility. Of sixty-one orthopedic surgeons, all but twelve admitted to a single facility. Detailed discussions with physician-owners uncovered a range of factors—other than ownership share—that affect physicians' referrals. An appreciation of these factors will help one interpret our quantitative findings.

■ **Insurance participation.** We found that insurance was a strong determinant in physicians' referral decisions. In several markets, community hospitals had entered into exclusive contracts with major insurers. We found no evidence that specialty hospitals were holding exclusive insurance contracts that would draw much business away from the community hospitals. In fact, a few specialty hospitals were lobbying for "any-willing-provider" legislation in their states, to be able to refer insured patients to their facilities.

■ **Emergency "call" in competing community hospitals.** We found that it was fairly common for physician-owners of specialty hospitals to take emergency department (ED) "call" in community hospitals; this practice also affected referrals. This occurred for a number of reasons. Physician-owners said that they needed to see patients in the larger EDs of community hospitals to serve the community and to make a living. Community hospitals reported that specialized expertise was needed to properly care for emergency patients entering their doors.[4] Thus, not only do most physician-owners see large numbers of patients at competitor hospitals, they

also tend to admit sicker patients coming in through the ED where they are taking call.

■ **Patients' preferences and service needs.** Patients' preferences were factored into referral decisions. Some patients might prefer a specialty over a general hospital because of its single rooms and hotel-like amenities or, conversely, might prefer to return to a local hospital where they had been treated in the past. Referring physicians also considered the service needs for a particular patient and where he or she would receive the highest-quality care. Physician-owners and nonowners using the specialty hospital felt that the overall quality of care was better because of higher procedure volumes, lower patient-to-nurse ratios, and more patient amenities (such as private rooms). In sharp contrast, physicians in community hospitals were concerned that patients in specialty hospitals lacked the necessary intensive medical care backup on site that was available in their facilities.

■ **Physicians' preferences and convenience.** Physicians working in specialty hospitals reported that they find it more convenient, on occasion, to admit a patient to a general hospital that is closer to their offices or that offers other conveniences. Physician-owners and nonowners at all sites we visited argued that specialty hospitals are better able to schedule patients in a way that is convenient to the physician and to complete procedures or operations on time.

■ **Favorable selection.** Patients with greater severity of illness require more-intensive and -expensive care; yet, under the current Medicare payment system, reimbursement is generally the same, regardless of severity. Therefore, profitable favorable selection occurs when one facility systematically admits Medicare patients with lower severity levels. Our results for specific MDC and DRG analyses in the six site-visit markets found that, consistent with findings from the GAO and MedPAC, physician-owned specialty hospitals treat less severely ill patients than their competitors, although not necessarily across every DRG and not systematically across all specialty hospital types.[5] These results suggest that physicians are referring less severe and therefore more profitable patients to specialty hospitals that they own.

We found that a range of rationales explain the existence of the clearly defined, narrow focus of specialty hospitals that go beyond physician-ownership and a motive for profit making. Our findings suggest that although profit might well be a motive for referral behavior in some hospitals and by some physician-owners, other explanations might apply in other hospitals and markets. It seems logical to ascribe their narrower service offerings, in fair part, to the dominant specialty of the major physician-owners—usually cardiologists and orthopedic surgeons.

If physicians' ownership and incentives for profit were the primary driving factors in referring healthier patients to specialty hospitals, we would expect to see different patterns of referrals among owners and nonowners. Nonowner referring physicians do not share physician-owners' profit incentives for specialty hospital referrals (Exhibit 3). We see, for example, that 41.9 percent of admissions by physician-nonowners to the Dayton Heart Hospital were major/extreme, compared

EXHIBIT 3
Proportion Of Cases Admitted To Specialty And Competitor Hospitals Of Major/ Extreme Intensity, By Physician-Ownership

	MD nonowners (%)		MD owners (%)	
City	**Specialty**	**Competitor**	**Specialty**	**Competitor**
Cardiac hospitals				
Dayton	41.9[a]	29.9	37.8[a]	29.9
Oklahoma City	20.4[a]	27.0	21.7[a]	25.6
Tucson	24.2	27.9	18.4	21.3
Orthopedic hospitals				
Fresno	1.2[a]	26.5	10.1[a]	19.6
Oklahoma City	4.5[a]	20.3	2.6[a]	21.1
Rapid City	37.5	33.1	8.6[a]	22.5

SOURCE: Ownership information provided by specialty hospitals; severity based on Medicare inpatient prospective payment system (IPPS) claims, 2003.
[a]Significant at the 1% level compared with competitors.

with only 29.9 percent of their admissions to other competitor hospitals.

Within each of the six site-visit markets, we observed little difference in referral patterns between owners and nonowners, which suggests that specialization of the hospital is potentially a primary issue, not ownership alone. The results for cardiac specialty hospitals in three cities (Fresno Heart Hospital was in operation only two months in calendar year 2003 and was excluded) show that in Dayton, both physician-owners and nonowners referred a higher percentage of severely ill patients to the cardiac specialty hospital. In Oklahoma City and Tucson, the trend was reversed, but only differences in Oklahoma City were significant. The Oklahoma Heart Hospital is majority-owned by a full-service hospital located next door that treats many heart patients with serious comorbid illness. Findings for orthopedic specialty hospitals show a more consistent pattern of less severely ill patients referred to specialty hospitals, but, again, the pattern is consistent for both owners and nonowners. Too few observations were available to test for percent-of-ownership effects on severity of referrals.

■ **Quality of care and patient satisfaction.** Our study also included a number of analyses to assess the quality of care and patient satisfaction for Medicare beneficiaries in specialty relative to community hospitals.[6] Specialty hospitals put forward the argument that by focusing on a limited range of diagnoses and procedures, they have the potential to increase the quality of care provided to their patients. This argument centers on the notion that focus, practice, and repetition are known to improve outcomes.[7] Competitor hospitals, however, argue that specialty hospitals, by offering a limited range of services, lack the ability to deal appropriately with complications and other complex problems.

In addition, specialty hospitals feature an all–registered nurse (RN) staff; low

patient-to-nurse ratios; high procedure volumes; electronic physician ordering; single rooms; and the latest equipment, structure, and process measures that are associated with quality. We examined three measures of quality using Medicare claims data: mortality rates (Exhibit 4); patient safety indicators (not discussed here); and readmission rates (Exhibit 5).

■ **Mortality rates.** Risk-adjusted thirty-day mortality rates were significantly lower for specialty hospitals than for community hospitals. Across both cardiac and orthopedic specialty hospital types (the small numbers of deaths made analysis of surgical specialty hospital unreliable), for both moderate (All Patient Refined, APR-DRG 1 or 2) and severe patients (APR-DRG 3 or 4), the proportion of patients who died while hospitalized or within thirty days of discharge was significantly less for specialty hospitals than for community hospitals for all DRG groupings. Although we controlled for admission type and severity, we did not stratify by specialty and community hospital volume, which has been found to account for differences in mortality.[8] Although mortality is a very rare event for the types of orthopedic condi-

EXHIBIT 4
Specialty Hospitals And Community Acute Care Hospital Competitors: Overall Mortality Stratified By Patient Severity And By DRG Groupings, Inpatient Plus Thirty-Day Mortality

	Specialty hospitals		Community hospitals	
	Number	Percent who died	Number	Percent who died
Cardiac				
Moderate severity				
Major heart	3,326	1.17****	8,934	1.65
PTCA etc.	8,046	0.90****	22,525	1.07
Other	6,690	1.91****	53,593	3.52
Severe severity				
Major heart	2,076	13.44****	7,810	15.94
PTCA etc.	1,125	5.87****	4,356	9.37
Other	1,912	15.64****	20,848	19.19
Orthopedic				
Moderate severity				
Major orthopedic	3,954	0.13****	40,192	1.64
Minor orthopedic	1,614	0.06****	13,960	0.69
Medical	79	1.27****	14,583	4.25
Severe severity				
Major orthopedic	346	1.16****	14,178	8.66
Minor orthopedic	24	0.00****	829	6.03
Medical	1	0.00	4,484	18.51

SOURCE: 2003 Medicare inpatient prospective payment system (IPPS) claims.
NOTES: All Patient Refined Diagnosis-Related Group (APR-DRG) classification was used primarily to stratify comparisons between specialty and acute general competitors into the four severity-level groups used in this system: minor, moderate, major, and extreme. PTCA is percutaneous transluminal coronary angioplasty.
****$p < .001$

EXHIBIT 5
Specialty Hospitals And Community Acute Care Hospitals: Readmission Rates Stratified By Patient Severity And DRG Grouping

	Specialty hospitals			Community hospitals		
	No. of readmissions	No. of hospitals	Percent readmissions	No. of readmissions	No. of hospitals	Percent readmissions
Cardiac						
Moderate severity						
Major heart	278	3,326	8.36	536	8,934	6.00****
PTCA etc.	403	8,046	5.01	1,080	22,525	4.79**
Other	594	6,690	8.88	3,902	53,596	7.28****
Severe severity						
Major heart	305	2,076	14.69	860	7,812	11.01****
PTCA etc.	169	1,125	15.02	477	4,356	10.95****
Other	317	1,912	16.58	2,270	20,849	10.89****
Orthopedic						
Moderate severity						
Major orthopedic	63	3,954	1.59	1,008	40,193	2.51****
Minor orthopedic	22	1,614	1.36	251	13,961	1.80****
Medical	1	79	1.27	638	14,584	4.37****
Severe severity						
Major orthopedic	17	346	4.91	843	14,179	5.95**
Minor orthopedic	1	24	4.17	54	829	6.51**
Medical	0	1	0.00	317	4,484	7.07

SOURCE: 2003 Medicare inpatient prospective payment system (IPPS) claims.
NOTES: Statistics representing cardiac specialty hospitals include cases where major diagnostic category (MDC) = 5; noncardiac patients are not included. Comparisons are limited to patients in MDC = 5 for cardiac and MDC = 8 for orthopedic. DRG is diagnosis-related group. PTCA is percutaneous transluminal coronary angioplasty.
$^{**}p < .05$ $^{****}p < .001$

tions treated at specialty hospitals, other measures such as return to functioning and improved mobility are not available in the claims data.

■ **Readmission rates.** The readmission analysis in Exhibit 5 showed mixed results. Patients treated at orthopedic specialty hospitals had lower readmission rates among the moderate-severity admissions. However, the number of specialty hospital admissions for the severe category, particularly for minor orthopedic procedures and medical admissions, is very small, and this analysis would benefit from having more years of data. On the other hand, readmission rates were higher among beneficiaries treated at cardiac specialty hospitals, particularly for the severe category, which suggests that specialty hospitals might not do as well as community hospitals with these very sick patients.

■ **Patient satisfaction.** Patient satisfaction is another dimension of quality. To better understand patients' perspectives on specialty and local competitor hospitals, we conducted a limited number of focus groups with Medicare patients in three of the six sites. Although focus groups are useful in providing uniquely detailed feedback on patients' perspectives, they are inherently limited, and their findings should be generalized only with caution. Focus groups do not provide statistically robust

findings. Still, focus groups are useful in identifying strong or prevalent patient perspectives when a survey is not feasible.

With these limitations in mind, we noted that Medicare patients' satisfaction was very high in specialty hospitals, as evidenced by numerous positive comments from patients who had been treated in specialty hospitals. Patients in our focus groups evaluated the limited clinical focus of specialty hospitals highly, particularly as this related to the perceived expertise of hospital staff. They thought that the level of knowledge and specialized skills of the nursing staff differed materially between specialty and community hospitals:

> I felt like the nurses were trained in that specific area and therefore we didn't have to do as much explaining to them about what we felt was going on with our bodies.

Those who had been hospitalized previously for a serious condition compared their experience to being in an intensive care unit (ICU) at a community hospital. One focus-group member remarked that the nurses' demonstrated confidence and knowledge helped relieve many of the fears he had when going into surgery:

> They made me feel so comfortable.... They talked to me.... They explained the procedure, and this one nurse told me they had 98 percent of people coming out okay.

Remarks about the specialized knowledge of nursing staff were not offered by Medicare patients treated at a community hospital, except in the ICU context.

When asked in our specialty-hospital focus groups if people knew that the hospital was partially owned by physicians, most stated that they had known prior to hospitalization. Most agreed that physician-ownership was a positive factor that probably contributed to how well they felt the hospital was run. One commented:

> I think they care more because their name's on it.... They own it.... It's just normal that they would put more into it.

Those receiving care at a specialty hospital had positive experiences with the hospital environment and commented on the private rooms, space, lower noise level, and treatment of family members, including pleasant waiting areas. Private rooms offered a quiet environment conducive to sleep and recovery:

> If you have a heart condition, it's extremely anxiety producing. If you are in a setting where there's a lot of ruckus or you are concerned about whether you are going to get the kind of attention you need or if there's just generally a sense of disorganization or noise...it just adds to that anxiety level.

In contrast, many Medicare patients who went to a community hospital expected the inconvenience associated with a shared room, a certain level of noise, fewer ways to accommodate family (including less plush waiting areas), and occasional teaching rounds of residents and interns. They also reported more delays after being admitted to the hospital when being transferred for tests, and so forth. This was generally considered part of the hospital experience.

■ **Community benefits.** Concerns have been raised that physician-owned specialty hospitals exist primarily to generate profits for their physician-owners. To the extent that this is true, specialty hospitals might contribute little to the overall community in which they exist. But based on the ten specialty and twenty-one community hospitals in the six cities we studied, we found that specialty hospitals incurred a greater net community benefit burden than their not-for-profit competitors did.[9] We estimated the sum of uncompensated care costs and taxes paid by these hospitals. We also computed the difference between uncompensated care costs and the value of the tax exemption received by nonprofits (this definition might better account for the value of unprofitable activities, since lower margins result in lower values of tax exemption). Equating uncompensated care cost with community benefit, for comparing to taxes or tax exemptions, is a standard approach in this literature.[10] Under both definitions, the specialty hospitals we studied provided more net community benefits than their not-for-profit competitors as a share of total revenues: 5.5 percent versus 2.5 percent under the first definition, and 1.0 percent versus −0.4 percent under the second. We did find particularly low uncompensated care percentages for not-for-profit hospitals in cities with a publicly owned hospital. On average, the low community benefit burden of not-for-profits did not justify the value of their tax exemption.

The higher net community benefits generated by specialty hospitals were attributable almost entirely to the taxes they paid as for-profit entities. Additionally, the cardiac hospitals in this study provided evidence of a nontrivial level of uncompensated care, but they were generally less profitable (and hence paid fewer taxes). Our results are also generally consistent with findings that uncompensated care in not-for-profits costs somewhat less than the value of their tax exemptions.[11] We also found that a large proportion of patients in cardiac specialty hospitals have Medicare coverage. Most specialty hospitals also treat Medicaid and self-pay patients, although as a smaller percentage of total patient revenues than their competitors—especially orthopedic and surgical specialty hospitals. Orthopedic specialty hospitals also treated patients with other forms of public insurance (for example, workers' compensation).

Discussion

We found that specialty hospitals treat Medicare patients with lower-severity illnesses, compared with the illness severity of patients treated in community hospitals. Furthermore, physician-owners do prefer to admit to their own facilities when possible. However, contrary to the notion that community hospitals are languishing passively on the perceived unfair playing field created by physician-owned specialty hospitals, we found in our site-visit discussions that community hospitals have responded vigorously to local competition and the entry of specialty hospitals in most markets by (1) purchasing "feeder" primary care practices committed to sending patients to their facilities; (2) providing valuable operating

"Favorable selection in many facilities arises from the flawed Medicare payment system that overpays for healthy surgical cases."

room time as an incentive for surgeon referrals; (3) negotiating exclusive managed care contracts with insurers; (4) providing lucrative "management" subcontracts with inpatient specialists in lieu of actual ownership stakes; (5) opening heart and orthopedic "centers of excellence" on campus for specialists; and (6) building physician offices on campus.[12] Any disadvantage that not-for-profit hospitals face from being prohibited in offering their physician staff an "ownership stake," while real, has been diminished somewhat through alternative financial arrangements.

Although the policy debate tends to focus on specialty hospitals' possible "unfair" competitive advantage, we found that they actually stimulate a competitive environment in some markets, which could have positive effects on quality of care. Cardiac specialty hospitals in general, and orthopedic specialty hospitals in small markets in particular, heightened local competition for patients. In no case were we aware of a specialty hospital opening in a market without at least one local competitor. Given the short-run nature of our evaluation, we were not able to evaluate specialty hospitals' long-run viability, but it was clear that not all of them were financially viable in the longer run.

Patient satisfaction among Medicare beneficiaries treated in specialty hospitals was very high. Contrary to allegations made by competing hospitals, we found very little evidence of poor quality of care in specialty hospitals relative to community hospitals; instead, we found many instances of high-quality care that should be encouraged. Physicians' commitment to and pride in their specialty hospitals are powerful positive forces that critics have underappreciated. Encouraging physicians' involvement in community hospitals' decision making could address many of the reasons why physicians choose to sponsor their own specialty hospitals.

Although specialty hospitals provide less uncompensated care, they do contribute substantial tax revenues, contrary to the notion that these facilities are simply a drain on community resources. For-profit hospitals are legitimate, legal entities and are not required by the Internal Revenue Service to provide uncompensated care because they pay taxes instead. Policy concerns regarding "unsupported" uncompensated care in U.S. hospitals should not focus on specialty hospitals alone; rather, the problem of uninsurance deserves a more fundamental solution, including broader coverage and better enforcement of community benefits when tax exemptions are granted.

Favorable selection in many facilities, including specialty hospitals, arises from the flawed Medicare payment system that overpays for healthy surgical cases. "Overpayments," not necessarily physician-ownership, encourage all types of investors to open specialized facilities and "unravel" care from full-service tertiary care hospitals. Physicians are able to take advantage of the profitability differences

created by the current Medicare payment system because they have a strong influence over where patients receive care. However, these incentives, and the resulting effects on favorable selection, do not seem to be unique to specialty hospitals. Changing "self-referral" incentives for physicians could be addressed much more directly and effectively through review and modifications to the Medicare DRG-based payment methodology than through policies that limit only referrals to specialty hospitals.

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NOTES

1. U.S. Government Accountability Office, *Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance,* Pub. no. GAO-04-167 (Washington: GAO, 2003); L. Casalino, K.J. Devers, and L.R. Brewster, "Focused Factories? Physician-Owned Specialty Facilities," *Health Affairs* 22, no. 6 (2003): 56–67; and Medicare Payment Advisory Commission, *Report to the Congress: Physician-Owned Specialty Hospitals* (Washington: MedPAC, 2005).
2. J. Cromwell et al., *Specialty Hospital Evaluation,* Report to the Centers for Medicare and Medicaid Services under Contract no. 500-00-0024, TO no. 12, section 3 (Waltham, Mass.: RTI, June 2005).
3. MedPAC, *Report to the Congress.*
4. While "call" arrangements worked reasonably well in some markets, in others there was tension between specialty hospital physicians and general hospital managers over compensation and hours.
5. GAO, *Specialty Hospitals;* and MedPAC, *Report to the Congress.*
6. J. Cromwell et al., *Specialty Hospital Evaluation,* Final Report to the CMS (Waltham, Mass.: RTI, September 2005).
7. H.S. Luft et al., *Hospital Volume, Physician Volume, and Patient Outcomes: Assessing the Evidence* (Ann Arbor, Mich.: Health Administration Press, 1990); and J. Cromwell, J.B. Mitchell, and W.B. Stason, "Learning by Doing in CABG Surgery," *Medical Care* 28, no. 1 (1990): 6–18.
8. P. Cram, G.E. Rosenthal, and M.S. Vaughan-Sarrazin, "Cardiac Revascularization in Specialty and General Hospitals," *New England Journal of Medicine* 352, no. 14 (2005): 1454–1462.
9. We compared specialty hospitals with not-for-profit competitors only, since not-for-profit hospitals receive special consideration (exemption from income, property, and sales taxes) in exchange for providing community benefits, particularly uncompensated care. For-profits receive no such special consideration.
10. N.M. Kane and W.H. Wubbenhorst, "Alternative Funding Policies for the Uninsured: Exploring the Value of Hospital Tax Exemption," *Milbank Quarterly* 78, no. 2 (2000): 185–212; J.L. Frizzell, "Nonprofit Hospitals and Charitable Tax Exemptions: Re-Examining the Quid Pro Quo," *New Hampshire Bar Journal* 39, no. 4 (1998): 30–35; and W.M. Gentry and J.R. Penrod, "The Tax Benefits of Not-for-Profit Hospitals," in *The Changing Hospital Industry: Comparing Not-for-Profit and For-Profit Institutions,* ed. D.M. Cutler (Chicago: University of Chicago Press, 2000), 285–324.
11. Ibid.
12. See also K.J. Devers, L.R. Brewster, and L.P. Casalino, "Changes in Hospital Competitive Strategy: A New Medical Arms Race?" *Health Services Research* 38, no. 1, Part 2 (2003): 447–469.

Mr. JOHNSON. Thank you.

Now, let me ask you: Do you believe that physician-owned hospitals destabilize community hospitals? Yes or no.

Mr. UMBDENSTOCK. Yes.

Mr. JOHNSON. Okay. I would like to now refer you to the second quote on the screen by the Federal Trade Commission on the importance of competition in Medicare.

I would also like to highlight that the August 2006 MedPAC report your testimony cites stated that, "Profit margins for community hospitals in markets with physician-owned hospitals were higher than those in markets without physician-owned hospitals."

Next question: Do you believe that physician-owned hospitals lead to greater utilization of service and higher costs? Yes or no.

Mr. UMBDENSTOCK. Yes.

Mr. JOHNSON. Thank you.

I would also like to submit for the record a list of cases with over $3 billion in fines paid by non-physician-owned hospitals for the very things you claim physician-owned hospitals do. I think you have those, Mr. Chairman.

[The information follows: The Honorable Sam Johnson 2]

Found Guilty or Settled (sometime admitting no fault but still settling)

Hospital	State	FAH Member	Specific Issue	Fine (in millions)	Year	Link	
Largest Cases:				$2.6 billion			
HCA	mult.	Yes	overbilling, anti-kickback, etc	1,700.00	2003	http://www.justice.gov/archive/opa/pr/2003/June/03_civ_386.htm	
Tenet Healthcare Corporation	Corp.	Yes	improper use of outlier payments, kickbacks to physicians for referrals, and upcoding procedures to increase reimbursements	900.00	2006	http://www.justice.gov/archive/opa/pr/2006/June/06_civ_406.html	
Since ACA				688.81			
Health Alliance of Greater Cincinnati	OH		Illegal compensation to Dr's for referrals	108.00	2010	http://www.justice.gov/opa/pr/health-alliance-greater-cincinnati-and-christ-hospital-pay-108-million-violating-anti	
Community Health Systems	mult.	Yes	overutilization by billing Inpatient which should have been inpatient	98.15	2014	http://www.justice.gov/opa/pr/community-health-systems-inc-pay-9815-million-resolve-false-claims-act-allegations	
Halifax Hospital	FL		illegal compensation agreements with Dr's for referrals and overutilization of inpatient admissions	85.00	2014	http://www.justice.gov/opa/pr/florida-hospital-system-agrees-pay-government-85-million-settle-allegations-improper	
Community Health Systems	NM	Yes	Illegal Medicaid contributions to local govt to increase state Medicaid funding to hospital	75.00	2015	http://www.justice.gov/opa/pr/community-health-systems-professional-services-corporation-and-three-affiliated-new-mexico	
King's Daughters Medical Center	KY		Over utilization of coronary procedures	40.90	2014	http://www.justice.gov/opa/pr/king-s-daughters-medical-center-pay-nearly-41-million-resolve-allegations-false-billing	
55 hospitals	21 states	Yes and No	billing inpatient spine procedures instead of outpatient for higher reimbursements Lifepoint:$2.52 million HCA: $7.14 million	34.00	2013	http://www.justice.gov/opa/pr/fifty-five-hospitals-pay-us-more-34-million-resolve-false-claims-act-allegations-related	
Detroit Medical Center	MI		Illegal compensation for referrals	30.00	2010	http://www.justice.gov/opa/pr/detroit-medical-center-pays-us-30-million-settle-false-claims-act-allegations	
Intermountain Health Care	UT		Illegal compensation for referrals	25.50	2013	http://www.justice.gov/opa/pr/intermountain-health-care-inc-pays-us-255-million-settle-false-claims-act-allegations	
Infirmary Health Systems	AL		Illegal compensation to Dr's for referrals	24.50	2014	http://www.justice.gov/opa/pr/alabama-hospital-system-and-physician-group-agree-pay-245-million-settle-lawsuit-alleging	
St. Joseph's Medical Center	MD		illegal compensation for DRr's	22.00	2010	http://www.justice.gov/opa/pr/st-joseph-medical-center-maryland-pay-us-22-million-resolve-false-claims-act-allegations	
Medical Center of Central Georgia	GA		overutilization by billing Inpatient which should have been inpatient	20.00	2015	http://www.justice.gov/opa/pr/georgia-hospital-pay-20-million-resolve-false-claims-act-allegations	
HCA	TN	Yes	False Claims Act and Anti-Kickback	16.50	2012	http://www.justice.gov/opa/pr/hospital-chain-hca-inc-pays-165-million-settle-false-claims-act-allegations-regarding	
Saint Joseph's Health System	KY		unnecessary cardiac care	16.50	2014	http://www.justice.gov/opa/pr/kentucky-hospital-agrees-pay-government-165-million-settle-allegations-unnecessary-cardiac	
Pacific Health Corporation	CA		Pay ambulences to bring patients in for unnecessary procedures	16.50	2012	http://www.justice.gov/opa/pr/pacific-health-corporation-and-related-entities-agree-pay-165-million-allegedly-engaging	
Adventist Health System	CA		Illegal compensation to Dr's for referrals	14.10	2013	http://www.justice.gov/opa/pr/adventist-health-pays-united-states-and-state-california-141-million-resolve-false-claims-act	
Cooper Health System	NJ		Illegal compensation to Dr's for referrals	12.50	2013	http://www.justice.gov/usao-nj/pr/major-new-jersey-hospital-pays-125-million-resolve-kickback-allegations	
Robinson Health Systems	OH		physician referrals in exchange for lower costs to Dr.	10.00	2015	http://www.justice.gov/opa/pr/ohio-based-health-system-pays-united-states-10-million-settle-false-claims-act-allegations	
Freeman Health Systems	MO		Illegal compensation to Dr's for referrals	9.30	2012	http://www.justice.gov/opa/pr/missouri-hospital-system-agrees-pay-93-million-resolve-false-claims-act-and-stark-law	
Memorial Hospital	OH		physician referrals in exchange for lower costs to Dr.	8.50	2014	http://www.justice.gov/opa/pr/memorial-hospital-ohio-pays-government-85-million-settle-false-claims-act-allegations	
Rhode Island Hospital	RI		Over utilization of inpatient and gamma knife	5.30	2012	http://www.justice.gov/usao/ri/news/2012/feb2012/rihos.html	
Tenet Healthcare Corporation	FL	Yes	Illegal compensation for referrals	5.00	2013	http://www.miamiherald.com/news/local/community/miami-dade/article1963695.html	
St. Vincent Healthcare and Holy Rosary Healthcare	MT		Illegal compensation to Dr's for referrals	3.95	2013	http://www.justice.gov/opa/pr/montana-hospitals-agree-pay-395-million-resolve-alleged-false-claims-act-and-stark-law	
St. James Healthcare and Sisters of Charity	MT and CO		Illegal compensation to Dr's for referrals	3.85	2013	http://www.justice.gov/opa/pr/colorado-health-care-organization-and-one-its-montana-hospitals-pay-385-million-allegedly	
Health Alliance of Greater Cincinnati	OH		illegal compensation for DRr's	2.60	2010	http://www.justice.gov/opa/pr/health-alliance-greater-cincinnati-two-ohio-hospitals-and-physician-group-pay-26-million	
Northampton Hospital Company	PA		Over billing for services or billing for services not provided.	0.662	2014	http://www.justice.gov/usao-edpa/pr/easton-hospital-agrees-pay-government-662000-resolve-false-claims-act-allegations	
Banks Jackson Commerce Medical Center	GA		Excess payments to Dr for referrals.	0.50	2014	http://www.justice.gov/usao/gan/press/2014/09-22-14.html	

More smaller cases can be found here: http://oig.hhs.gov/fraud/enforcement/cmp/kickback.asp

HealthSouth	Corp.	Yes	False Claims Act for defrauding Medicare	325.00	2004	http://www.justice.gov/archive/opa/pr/2004/December/04_civ_807.htm	
Tuomey Healthcare Systems	SC		Compensating Dr's to not refer patients outside hospital	70.00		http://www.aronovitzlaw.com/tuomey-healthcare-system-fork-70-million-false-claims-act-appeal/	Still being appealed
Tenet Healthcare Corporation	CA	Yes	Conducting unnecessary heart procedures and operations on patients	54.00	2004	http://www.nytimes.com/2003/08/07/business/tenet-healthcare-paying-54-million-in-fraud-settlement.html?pagewanted=print	
Tenet Healthcare Corporation	Corp.	Yes	Using Outlier payments to increase revenue and meet earning targets	10.00	2007	http://www.sec.gov/news/press/2007/2007-60.htm	
Sacred Heart Hospital	IL		Illegal bribes and compensation to Dr's for referrals.	Criminal		http://www.justice.gov/usao/iln/pr/chicago/2015/pr0319_02.html	

Mr. JOHNSON. I would also like to submit for the record a statement by the Federal Trade Commission saying that physician-owned hospitals increase competition and reduce prices.

[The information follows: The Honorable Sam Johnson 3]

FEDERAL TRADE COMMISSION
PROTECTING AMERICA'S CONSUMERS

FTC and Pennsylvania Attorney General Challenge Reading Health SystemsProposed Acquisition of Surgical Institute of Reading

Complaint Alleges Deal Would Reduce Competition, Lead to Higher Health Care Costs

FOR RELEASE

November 16, 2012

TAGS: Competition

The Federal Trade Commission today authorized an action to block Reading Health System's proposed acquisition of Surgical Institute of Reading L.P. (SIR), alleging that the combination of the two health care providers would substantially reduce competition in the area surrounding Reading, Pennsylvania, and lead to reduced quality and higher health care costs for the area's employers and residents.

The FTC, jointly with the Pennsylvania Attorney General, will file a complaint in federal district court next week seeking a preliminary injunction to stop the deal pending an administrative trial. The FTC has also issued an administrative complaint, initiating a proceeding that will determine the legality of the transaction following a full trial consisting of up to 210 hours of live testimony before an FTC Administrative Law Judge (ALJ). The ALJ's decisions and orders are reviewable by the Commission and ultimately a federal Court of Appeals.

"The FTC is challenging this acquisition because it would lead to higher overall health care costs for employers and patients in the Reading area," said Bureau of Competition Director Richard Feinstein. "While SIR is not a full-service general acute-care hospital, it has injected important price and quality competition into the Reading area. That competition will be lost if this deal goes forward."

Reading Health System is a comprehensive, not-for profit health care system located in Berks County, Pennsylvania. It operates the Reading Hospital, as well as accompanying teaching facilities on a 36-acre, 22-building campus in West Reading, Pennsylvania. The Reading Hospital, a 737-bed facility, is Reading Health System's main facility, providing inpatient general acute-care, tertiary services, and outpatient care. In all, Reading Health System has a staff of 970 doctors, had $47 million in operating income in 2011, and has over $1 billion in unrestricted cash and investments.

SIR, which opened in April 2007, is a for-profit physician-owned surgical specialty hospital located in Wyomissing, Pennsylvania, within Berks County. It has 15 licensed beds and provides a range of inpatient and outpatient surgical services, including ear, nose, and throat (ENT), orthopedic, spine, and general surgical procedures. Most of the

inpatient surgeries performed at SIR are orthopedic and spine procedures. SIR is owned by 16 physicians, has 11 independent doctors on staff, and employs about 100 nursing and support staff.

On May 21, 2012, Reading Health System agreed to acquire SIR. According to the FTC's administrative complaint, the proposed acquisition would be anticompetitive and would violate the FTC Act and the Clayton Act. The FTC, together with the Commonwealth of Pennsylvania, will seek a preliminary injunction in federal district court barring consummation of the transaction pending completion of the administrative proceeding and any appeals.

The FTC's administrative complaint alleges that the acquisition would reduce competition in four markets where Reading Health System and SIR compete: 1) inpatient orthopedic/spine surgical services; 2) outpatient orthopedic/spine services; 3) outpatient ENT surgical services; and 4) outpatient general surgical services. In each market, the FTC alleges, the proposed deal would lead to combined Reading Health System/SIR market shares ranging from 49 to 71 percent.

According to the complaint, the proposed transaction would decrease the number of meaningful competitors for inpatient orthopedic/spine surgical services in the Reading area from three to two. The markets for outpatient general surgical services and outpatient ENT services also would be left with only one other significant competitor, and the number of competitors for outpatient orthopedic surgical services would be reduced from four to three.

The complaint charges that the proposed deal would increase Reading Health System's already significant negotiating leverage, enabling it to raise the reimbursement rates it negotiates with commercial health plans. This would increase the health care costs of local employers, potentially forcing them to cut benefits, burdening their employees with higher costs, and in some cases, causing them to delay or forgo medical care and treatment. The acquisition also would eliminate important non-price competition between Reading Health System and SIR, potentially leading to a decrease in the quality of existing facilities and services.

The Commission votes approving both the administrative and federal district court complaints were 5-0. The administrative complaint was issued today, and a public version will be available on the agency's website shortly. The federal district court complaint will be filed next week in the U.S. District Court for the Eastern District of Pennsylvania. The evidentiary hearing is scheduled before an Administrative Law Judge at the FTC, beginning on April 16, 2013.

NOTE: The Commission issues or files a complaint when it has "reason to believe" that the law has been or is being violated, and it appears to the Commission that a proceeding is in the public interest. The complaint is not a finding or ruling that the named parties have violated the law. The administrative complaint marks the beginning of a proceeding in which the allegations will be ruled upon after a formal hearing by an administrative law judge.

The FTC's Bureau of Competition works with the Bureau of Economics to investigate alleged anticompetitive business practices and, when appropriate, recommends that the Commission take law enforcement action. To inform the Bureau about particular business practices, call 202-326-3300, send an e-mail to antitrust{at}ftc{dot}gov, or write to the Office of Policy and Coordination, Bureau of Competition, Federal Trade Commission, 601 New Jersey Ave., Room 7117, Washington, DC 20001. To learn more about the Bureau of Competition, read Competition Counts. Like the FTC on Facebook, follow us on Twitter, and subscribe to press releases for the latest FTC news and resources.

(FTC File No. 121-0155)

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Mr. JOHNSON. Lastly, I would like to submit for the record a study that shows physician-owned hospitals save Medicare almost $10 million over 10 years.

[The information follows: The Honorable Sam Johnson 4]

The Effects of Physician-Owned Hospitals on Medical Care Quality and Expenditures: A Review and Update

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ABSTRACT

Background: The purpose of this paper is to provide a summary and update of the evidence on the effect of physician-owned hospitals (POHs) on medical care quality and expenditures, focusing on two questions: (1) is the quality of care delivered in POH settings different from the quality of care delivered in non-POH (NPOH) settings?; and (2) is the level of medical expenditures in POHs higher than their NPOH counterparts?

Methods: For each of the two outcomes of interest—POH quality and expenditures—we conducted a two-part analysis consisting of a review of the literature and an analysis of available public data supporting direct comparisons of POHs and NPOHs for each measure.

Results: The literature shows that POHs provide a level of care equal to or greater than their NPOH counterparts. The performance of POH hospitals in the U.S. Medicare value-based purchasing program is consistent with the literature. POHs appear to achieve these quality rankings at a lower cost to the U.S. Medicare program, primarily because POHs are not paid the same subsidies as NPOHs.

Conclusions:
Much of the policy concerns over physician ownership, particularly those arguing that the "demand inducement" aspects of physician ownership drive up costs, are likely overstated. Conversely, taking the quality and expenditure savings estimates together, POHs would generate about $10 billion in savings over a 10-year period.

Keywords: physician ownership; physician owned hospitals; quality; outcomes; expenditures; costs; hospital value based purchasing; Medicare

Implications for Policy Makers

Physician-owned hospitals, or POHs, have been the subject of controversy globally. The main argument against POHs is "supplier-induced demand;" a notion that physician ownership implies high incentives for overuse of services. While at first glance this seems like a reasonable hypothesis, this line of thinking ignores the fact that all hospitals (especially those in the U.S.) are to some extent interested in increasing revenue. Thus, we have argued that the right question is, generally, how POHs differ, if at all, from their non-POH (or NPOH) hospital counterparts. Our research has been focused on that topic. The main implications to policy makers are that concerns over POHs are largely overstated. We find, through a combination of literature review and straightforward analysis of U.S. public data sources, that POHs have above-average quality and provide the same services for less reimbursement.

Implications for Public

One of the main tenets of "value-based purchasing," from the perspective of the public, is enabling health care consumers to determine what they are getting for their (or their employer's or insurer's) money. In some cases, consumers may be willing to pay more for services if they determine the quality to be better. In other cases, consumers may be interested in how much less they can pay without jeopardizing quality. In this case, we show that, in the U.S. and perhaps beyond, physician ownership results in better outcomes and, other things equal, lower overall expenditures.

1. Introduction

The debate over physician ownership of acute care hospitals has been active for the past decade. Most of the arguments distill down to a relatively simple debate. Critics argue that physician-owned hospitals (POHs) "over-utilize" medical care services because, they contend, physicians are more likely to utilize services in which they share an ownership interest.[1, 2] Defenders of POHs argue that the hospitals deliver a high quality of care, evident in their above-average performance in the Centers for Medicare and Medicaid Services' (CMS) new Hospital Value Based Purchasing Program (HVBP), and that the incentives to under-utilize or over-utilize medical care services are persistent issues throughout the health care system—just as evident in non-POHs (NPOHs), community hospitals, and doctors' offices as anywhere else.[3-7]

The purpose of this paper is to provide a summary and update of the evidence on the effect of POHs on medical care quality and expenditures, and to supplement the review with some recently published U.S. health system data. The objective is to address two relatively straightforward questions. First, is the quality of care delivered in POH settings different from the quality of care delivered in NPOH settings? Second, is the level of medical expenditures in POHs higher than their NPOH counterparts? In assessing the economic value of medical care interventions, we are generally interested in whether an intervention is more costly or less costly than the status quo. If an intervention is more costly, payers well generally look for evidence that the additional expenditures are resulting in better quality. The most desirable medical interventions, at least from a payer perspective, are those that generate better outcomes but do not cost more than the status quo; even better are interventions that result in better outcomes and cost less. In this paper we show that POHs have better outcomes and, overall, cost less per stay than their NPOH counterparts.

In this paper we employ two methods to address these questions. First, we review the literature pertaining to POH quality and expenditures. Rather than include this review as background, we present the review for each outcome as part of the results section. Second, we pair each review with an analysis of data from public U.S. sources. For quality, we present data from the HVBP program, comparing POHs and NPOHs. For expenditures, we conduct a simple analysis that calculates total 2013 Medicare outlays under two assumptions: status quo versus moving all current POH patients into NPOH settings. We then calculate the net difference between the two amounts.

2. Methods

For each of the two outcomes of interest—POH quality and expenditures—we conducted a two-part analysis consisting of a review of the literature and an analysis of available public data supporting direct comparisons of POHs and NPOHs for each measure. The literature reviews were conducted in PubMed, using combinations of the following key words paired with "physician ownership" or "physician owned hospital(s)": quality; outcomes; expenditures; costs; hospital value based purchasing; Medicare charges; and Medicare reimbursement. The objective of the review was to retrieve only empirical research on each topic; thus, articles focused on commentary and narrative analyses were not considered. In addition, our review was not

intended to be systematic; a systematic review on POHs was recently published,[8] and this helped guide our review.

To supplement the literature on POH quality, we conducted a comparison of POHs and NPOHs using public data from the CMS HVBP program. The HVBP program "attaches value-based purchasing to the payment system that accounts for the largest share of Medicare spending, affecting payment for inpatient stays in over 3,500 hospitals across the country."[1] Participating hospitals receive additional inpatient acute care service payments from CMS based on an overall quality score, the basis of which is the average of 14 scores across a variety of measures focused on process of care, mainly adherence to practice guidelines and best-practices.[9, 10]

To supplement the literature on POH expenditures, we conducted a comparison of average U.S. Medicare expenditures for the same outpatient and inpatient services across the two settings. Another important factor driving POH expenditures is that, due to the structure of the Medicare payment system, POHs generally receive less payment per hospitalization than an NPOH providing the same service. Total POH expenditures can be expressed as a simple identity: $TE_{POH} = Q_{POH} \cdot P_{POH}$, where TE_{POH} represents total medical care expenditures in POHs, Q_{POH} is the quantity of services provided in POHs, and P_{POH} is the average price per service provided in POHs. In the inpatient setting, P_{POH} is analogous to a Medicare Severity Diagnosis Related Group (MS-) payment in CMS's Medicare Inpatient Prospective Payment System (IPPS); in the outpatient setting, P_{POH} is analogous to CMS's Ambulatory Payment Classification (APC) groups paid under the Medicare Outpatient Prospective Payment System (OPPS).

Assuming the *quantity* of services provided in POHs (Q_{POH}) is essentially no different than the quantity of services provided in NPOHs (we address this in the expenditure literature review), all other things equal, in order for POHs to have higher *total expenditures* (as POH critics argue) it must be the case that $P_{POH} > P_{NPOH}$, where P_{NPOH} is the average price per service in NPOHs. To further explore this, we analyzed recently released Medicare Provider Charge Data (Inpatient & Outpatient) from CMS [11] to assess differences in Medicare payments to hospitals according to POH versus NPOH status. The basic hypothesis was that actual Medicare payment rates vary substantially by hospital, and that net payments per services in POHs is less than the same services provided in NPOHs; that is, $P_{POH} < P_{NPOH}$ for a given set of DRGs or APCs. We based this hypothesis on the fact that NPOHs are more likely to receive outlier payments, disproportionate share payments, indirect medical education, graduate medical education, capital expenses, and other pass-through expenses.[12]

The CMS inpatient data include hospital-specific charges for the more than 3,000 U.S. hospitals that receive Medicare IPPS payments for the top 100 most frequently billed discharges, paid under Medicare based on a rate per discharge using the MS-DRG for Fiscal Year (FY) 2013. These DRGs represent almost 7 million discharges or 60% of total Medicare IPPS discharges. For these DRGs, average charges and average Medicare payments are calculated at the individual hospital level. The CMS outpatient data include estimated hospital-specific charges for 30 APC groups paid under the OPPS for Calendar Year (CY) 2013. The 30 APCs

[1] See generally https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/index.html?redirect=/hospital-value-based-purchasing/

represent approximately 75% of all Medicare outpatient expenditures (based on communication with CMS). For these APCs, the estimated average charges and the average Medicare payments are provided at the individual hospital level.[2]

We compiled these downloaded CMS data using Stata® software to create inpatient and outpatient analytic databases. To each database we merged a crosswalk linking hospital provider identifiers with POH status (n = 209). We then calculated the average payment rate differentials (POH vs. NPOH) for the 100 DRGs and the 30 APCs. The last step was to extrapolate these findings to the national population, taking into account the fact that the DRG data represent about 60% of inpatient expenditures and the APC data represent about 75% of all outpatient expenditures. The goal was to calculate the added expense that would be incurred by government payers if all POH patients were no longer allowed to visit POHs (e.g., as a result of legislative restrictions). In this hypothetical construct, the associated calculation is to take the POH caseload and apply the NPOH average paid amounts.

3. Results and Discussion

3.1. Literature on Quality

The literature on POH quality began growing considerably in the mid-2000s. A study commissioned by the Centers for Medicare and Medicaid Services (CMS) observed cardiac and orthopedic surgical hospitals consistently performed better than expected given the mix of patients treated.[13] Moreover, the CMS study found that specialty cardiac hospitals performed better than their general hospital competitors on three of the four cardiac inpatient quality indicators based on ratios of observed versus expected rates. The three measures ("Patient Safety Indicators," or PSIs) were "selected infections due to medical care" (PSI = 7), "post-op pulmonary embolism or deep vein thrombosis" (DVT) (PSI = 12), and "post-op sepsis" (PSI = 13). For each of these measures, the "expected" rate of occurrence was significantly higher than the observed rate in the specialty hospital group, whereas in all but one measure general hospital competitors (NPOHs) had higher than expected rates.

Barro et al. (2006) analyzed Medicare claims data at the hospital referral region (HRR) level and found that specialty hospital entry leads to both a reduction in expenditures and a decrease in mortality.[14] A consistent theme in these and other studies is that specialty hospitals have higher procedural volumes on average, and are therefore well-positioned to exploit the positive outcome effects associated with higher volume. Like Barro et al., Cram et al. (2005) found no significant differences in mortality for cardiac patients treated at specialty hospitals and general hospitals after adjusting for lower severity and higher procedure volume at specialty hospitals.[15] Similar results were found by Nallamothu et al. (2006), who also studied cardiac specialized hospitals but used different methods.[16] Using a rich dataset from the National Registry of Myocardial Infarction, the authors found that greater hospital specialization in

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[2] See CMS-1589-FC-Claims Accounting narrative available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/CMS-1589-FC-Claims-Accounting-narrative.pdf

percutaneous coronary intervention ("PCI") was associated with lower risk of in-hospital mortality.

In addition to the learning effects of higher procedural volumes, another explanation for the better outcomes at specialized cardiac hospitals is better adherence to clinical practice guidelines and protocols. Popescu et al. (2008) used CMS data to compare the quality of care of specialty cardiac hospitals and competing general hospitals, and found that specialty hospital compliance with heart attack and heart failure guidelines was similar to that of competing general hospitals.[17]

In sum, the peer-reviewed literature on quality of care provided in POHs is remarkably consistent, finding that specialty hospitals and POHs provide at least the same quality of care as NPOHs, and according to most studies the levels of quality observed in POHs exceeds that of NPOHs. These findings are consistent with a recent review paper on POH "effectiveness," particularly among the more rigorous study designs.[8] Moreover, the published evidence on POH quality clearly supports the conceptual framework of the quality-related benefits of specialization, procedural volume, and learning-by-doing, which we have described previously.[7]

3.2. Value-Based Purchasing

POHs have performed exceptionally well in the HVBP program. In 2013 the largest reward went to a POH, and some of the biggest cuts went to NPOHs. Higher quality can result in cost savings in a number of different ways, but the most likely types of savings occur in the reduction of "excess" charges associated with (1) patient safety and preventable medical errors, and (2) avoidable deviations from established clinical practice guidelines (CPGs) and protocols. Prior to the HVBP, we would expect POHs to perform well in these dimensions. The CMS report found that POHs had substantially lower preventable medical errors, and the Popescu article (discussed above) found that POHs are better at following CPGs.

Whereas the 2006 CMS study focused on patient safety indicators,[13] the HVBP program focuses on related process of care measures.[10] Comparative data from the HVBP program for NPOHs versus POHs is shown in **Table 1**. POHs outperform NPOHs by a sizable margin in both of the HVBP composite measures. Consistent with the published studies to date, the HVBP process quality composite score is nearly 15.7% higher on average for POHs. The difference in patient-experience measures is substantially greater, where the POH score is nearly twice the NPOH score. Combined, the composite score for POHs is about 30% higher than the NPOH composite score.

Table 1.
POH Performance in the Hospital Value-Based Performance Program, 2013 (a)

Measure (b)	NPOH Mean (c)	POH Mean (d)	Diff. in Score	% Diff. in Score
HVBP Process Score	42.16	48.76	6.60	+15.7%
HVBP Patient Score	12.45	21.59	9.14	+73.4%
HVBP Total Score	54.61	70.35	15.74	+28.8%

Sources & Notes: (a) Based on data from CMS Hospital Compare and a list of current physician owned hospitals provided by Physician Hospitals of America; higher scores imply better performance; (b) HVBP = CMS Hospital Value-Based Payment program; (c) NPOH = non physician-owned hospital; (d) POH = physician-owned hospital

Higher HVBP process scores suggest better adherence to CPGs on the part of POHs, which is consistent with some of the literature on POHs.[17] Moreover, this differential is associated with a cost. One way to estimate the cost differential is to estimate the probability and costs associated with the medical problems most likely avoided due to improved CPG adherence. The 12 HVBP measures are generally designed to minimize the occurrence of certain avoidable adverse events, complications, and readmissions associated with common inpatient admissions, including acute myocardial infarction, heart failure, pneumonia, and a wide range of surgical procedures.

For the conditions associated with all 12 measures, rates of adverse events and complications average about 9%, taking into account differences in rates for the types of adverse events and complications associated with each measure.[18-22] For these events, the average added cost is about $15,000 in current dollars.[18, 23]. The mean expected added cost of adverse events and complications is the product of the two, or about $1,343 per admission. In addition, about 15% of the discharges associated with these admissions will result in re-admissions.[24, 25] Assuming an average cost per re-admission of $13,924 [24], the mean added expected costs for re-admissions is $2,064. Added to the adverse event and complication added cost, the total mean expected added cost per case associated with the 12 HVBP process measures is about $3,407. This can be viewed as an average for NPOHs, given that the vast majority of the cited data used in the calculations is based on acute care community hospitals. Given that POHs score 16% better in the HVBP process measures, we can assume that the average added cost for POHs would be 16% less, or $2,862.

If we assume that the 238 POHs generate approximately 4,500 discharges per year on average, totaling 1,071,000 admissions per year, then the total added costs of complications, adverse events and readmissions in POHs is about $3.07 billion per year. If we were to move all of those patients into NPOHs, where the average added cost is 16% higher, the total added costs of complications, adverse events and readmissions of the "re-assigned" POH patient grows to about $3.65 billion per year, for a total annual difference of $584 million. Assuming these

differentials persist, over a 10-year period with an annual average inflation rate of 3.5% the "quality savings" associated with POHs would generate $6.8 billion in savings.

3.3. Literature on Expenditures and Utilization

The majority of peer-reviewed published studies show that POHs are *not* associated with higher utilization. The studies commissioned by Congress were the first comprehensive studies of POHs. The first of these studies was conducted by Centers for Medicare and Medicaid Services (CMS) and Research Triangle International (RTI).[13, 26] The CMS study is especially noteworthy because they were able to measure actual physician ownership shares through site visits to 13 specialty hospitals, and link those ownership shares to Medicare claims data through the Medicare provider identifier; no other study has done this. The CMS study found that the incentive for physicians to refer to hospitals in which they have an ownership stake depended more on the size of the ownership stake rather than the fact that they were owners. Given that ownership shares on average were very low, the CMS study found that referral patterns were not significantly affected by the entry of specialty POHs into the market. The most important limitation of the CMS study is that it did not take into account endogenous POH entry and did not examine the role of baseline trends in utilization.

Using a different methodology, the CMS study essentially reached the same conclusions as a parallel study conducted by the Medicare Payment Advisory Commission (MedPAC) [27-31]—MedPAC's first of two reports. The MedPAC study used a "differences in differences" model to examine the effect of cardiac POHs on changes in Medicare cardiac treatment costs from 1996 to 2002. The study found no statistically significant findings in utilization rates between hospital referral regions (HRRs) with and without cardiac specialty hospitals. The main limitations of the MedPAC study are that it only focused on cardiac POHs and that the study did not take into account the likelihood that POHs are more likely to enter areas with higher than average pre-entry levels of utilization, thereby creating a potentially serious endogeneity problem. MedPAC later repeated their analyses using a larger sample of cardiac POHs and a more recent time period—1996 to 2004.[29] In the revised study, they found that cardiac surgeries per capita were 6% higher in markets with cardiac POHs. Again, the main limitations of the revised MedPAC study are that it only focused on cardiac POHs and that the study did not take into account endogeneity of POH market entry.

Nallamothu et al. (2007) focused exclusively on the effects cardiac POHs.[32] Using Medicare claims data from 1995 to 2003, they found that rates of change for total revascularization were higher in HRRs after cardiac POHs opened when compared with HRRs where new cardiac programs opened at NPOHs and HRRs with no new programs. Four years after their opening, the relative increase in adjusted rates was more than two-fold higher in HRRs where cardiac POHs opened when compared with HRRs where new cardiac programs opened at NPOHs and HRRs with no new programs. The relative increase in adjusted rates of coronary revascularization was 19.2% for HRRs with new cardiac POHs, compared to 6.5% for HRRs with new cardiac programs at NPOHs and 7.4% for HRRs with no new programs. Similar to the MedPAC studies, the main limitations of this study are that it only focused on cardiac POHs and it did not adequately take into account endogeneity of POH market entry. An additional

limitation of the study is that it is not clear how much variation in HRR utilization rates is explained by the models, and how well the models deal with unobservable time-variant HRR characteristics.

Two studies to date have examined the effect of POHs on Medicare expenditures, rather than focusing separately on the volume and price components of expenditures. The first of these studies-- Barro, Huckman, and Kessler (2006)-- analyzed Medicare claims data from 1993, 1996, and 1999, using a matched case control panel design with fixed HRR effects.[14] Their main findings were that hospital expenditures for patients treated in HRRs with cardiac specialty hospital entry ("entry HRRs") experienced roughly 3% slower growth in cardiac care expenditures compared to patients treated in HRRs without cardiac specialty hospitals ("control HRRs"). Under the reasonable assumption that HRRs with POH entry would have retained their 1993-1996 trend in expenditures and outcomes in the absence of POH entry, they found that specialty hospital entry leads to both a *reduction* in expenditures of at least 7% and a *reduction* in mortality of at least a 4%. The results were robust to several different specification tests. The main limitations of the Barro et al. study are the limited time frame (only three time points, with 1999 as the most recent year) and inadequate consideration of endogenous market entry.

Schneider et al. (2010) examined the effect of POHs on Medicare per-enrollee expenditures at the metropolitan area (MSA) level nationwide, spanning the 8-year time period from 1998 to 2005.[33] The study was the first POH study to use fixed effects panel data estimation with instrumental variables to account for the bias introduced by endogenous POH market entry (i.e., POHs may be more likely to open in high-growth/high-demand markets with high levels of Medicare per enrollee expenditures). After controlling for other variables that are likely to affect expenditures (especially the age and sex distribution of the MSA), Schneider et al. found no association between POH presence and Medicare expenditures per enrollee at the MSA level. The results were robust to changes in model specification, estimation technique, and definition of geographic market, leading the authors to conclude that "the 'demand inducement' aspects of physician ownership of acute care hospitals (if any) have no meaningful impact on market-level Medicare expenditures per enrollee." The results of Schneider et al. were somewhat similar to the results of two recent studies by Lu et al., both of which employed a sound methodological approach and found no POH effects on utilization.[34, 35]

Finally, two studies by Mitchell reach conclusions somewhat similar to those of Nallamothu et al. (2007), although the methods differ substantially. Mitchell (2005) used state-level data from Arizona, although the study is severely hampered by its assumption that physician owners can be identified simply as physicians with relatively high-volume admissions to POHs.[36] In addition, the study is largely descriptive, lacking necessary statistical controls for case mix differences, baseline trends, and the likely possibility that POH entry is endogenous (i.e., POHs will enter markets with high demand).

The other Mitchell study (2008) analyzed workers compensation claims in Oklahoma, finding that the entry of orthopedic specialty hospitals was followed by increases in market area utilization for complex fusion surgery.[37] The main problems with the Mitchell studies are the inability to determine whether utilization differences reflect appropriate or inappropriate care and the lack of a theoretical framework that specifies why financial incentives apply uniquely to

physician ownership and no other forms of organization—a finding that is contrary to the literature on the economics of organization.[38, 39]

In sum, based on these studies, the effect of POH on expenditures appears to be ambiguous. The studies with the most methodological rigor tend to reach the conclusion of "no effect," and one of those studies with particularly good methods finds that POHs *decrease* utilization and expenditures. There is clearly no trend toward showing that POHs lead to higher utilization, no study to date has been able to show whether any observed utilization differences represent appropriate or inappropriate medical care services. It is important to note that the CMS report on POHs found that physician owners do not change their referral patterns after taking an ownership interest in a hospital, [13] and that could explain why studies of POH utilization effects have failed to consistently find an effect.

3.4. Medicare Payment Differentials

Based on the preceding discussion of POH utilization and referring back to the discussion of our methodological approach, the *quantity* of services provided in POHs (Q_{POH}) is essentially no different than the quantity of services provided in NPOHs, all other things equal. Thus, in order for POHs to have higher *total expenditures* it must be the case that $P_{POH} > P_{NPOH}$, where P_{NPOH} is the average price per service in NPOHs. However, for all DRGs and APCs, we found that POHs had lower net payment rates than NPOHs. This differential was observed at the national level and within states.

Table 2 summarizes the results of this analysis. If all POH patients were re-assigned to NPOHs in 2013, an additional $267,568,504 in expenditures would be incurred by the Medicare program. Over a 10-year period, assuming a 3.5% annual inflation rate, the additional total expenditures incurred would be about $3.1 billion. Put differently, POHs result in $3.1 billion in savings attributable to lower reimbursement rates for the same procedures relative to their NPOH counterparts.

Table 2
Summary of Savings from POH-NPOH Payment Differentials, 2011-2013, and 10-Year Projected Savings

	2011	2012	2013	Percent Change (2011-2013)	10-Year Projected (c) (based on 2013)
Inpatient (a)	$228,876,105	$241,600,378	$255,959,743	10.6%	$2,559,597,430
Outpatient (b)	$8,392,096	$10,583,490	$11,608,761	27.7%	$116,087,610
TOTAL	$237,268,201	$252,183,868	$267,568,504	11.3%	$2,675,685,040
TOTAL (d)					$3,138,951,319

Notes & Sources: See text. (a) Savings based on 100 DRGs is adjusted to reflect all DRGs; (b) Savings based on 30 APCs is adjusted to reflect all APCs; (c) 10-year projected savings is equal to the 2013 amount multiplied by 10; (d) assumes 3.5% annual inflation during the 10-year projection period

4. Conclusions

In this paper we have reviewed the evidence on POH quality, utilization, and expenditures and reported the results of some straightforward additional analyses to supplement the published literature. The literature on quality unequivocally supports the hypothesis that POHs-- through a combination of specialization, higher procedural volume, and learning-by-doing—are able to consistently deliver quality as good and in most cases better than their NPOH counterparts. Our analysis of the HVBP data adds further support to this general finding. If all POH patients were re-assigned to NPOHs, an additional $6.8 billion in medical care costs associated with adverse events, complications, and readmissions would be incurred due to the HVBP process score differential, where POHs have consistently outperformed their NPOH counterparts.

The literature on POH expenditures and utilization fails to support the conjecture that POHs achieve their quality results at higher costs, either by increasing the intensity of services or "inducing" demand for unnecessary services. This is in part because there is no a priori reason why we would expect differences by ownership; both POHs and NPOHs face similar regulations, payment systems, and financial incentives. Thus, while we can to argue that demand inducement is a relevant issue in the U.S. health care system, it is not a factor that clearly differs by organizational model; we have evidence of many cases in which demand inducement is present in NPOH settings as well.

In addition to the absence of consistent findings on utilization, overall expenditures on POHs are significantly lower than expenditures on the same services in NPOH settings. The supplemental analysis reported in this paper shows that in 2013, if all of the care provided by

POHs were to migrate to NPOHs, the Medicare program would have to pay an additional $267 million, or $3.1 billion over a 10-year period.

Taking the quality and expenditure savings estimates together, POHs have the potential to generate $10 billion in savings over a 10-year period. In addition, the aforementioned CMS study of POHs found that POHs spend a substantially larger proportion of their revenue on community benefit in the form of charity care, federal and state income tax, sales tax, and real estate and property tax. The CMS report found that POHs spend between 4% and 7% of revenue on community benefit, compared to less than 1% for NPOHs. In sum, contrary to much of the popular press on POHs, these hospitals have largely figured out what all hospitals have been trying to do for some time: deliver a high-quality service at a reasonable cost. The evidence on quality, expenditures, and community benefit tell a story markedly different from the popular media, and show, to the contrary, that the innovative aspects of POHs have resulted in these hospitals rising through the ranks of CMS rankings while providing the same services for less money than their NPOH counterparts.

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Mr. JOHNSON. Finally, your testimony argues physician-owned hospitals should not be allowed to expand because they offer limited or no emergency service.

But isn't it true that Medicare does not require emergency departments, but actually only requires Medicare providers, including physician-owned hospitals, to comply with conditions of participation and the Emergency Medical Treatment and Active Labor Act? Yes or no. That is for you, Mr.——

Mr. UMBDENSTOCK. For me?

Mr. JOHNSON. Yes.

Mr. UMBDENSTOCK. Yes. When 60 percent of your patients come through the ER, the ER is a very important part of a, quote, "hospital." I would agree.

Mr. JOHNSON. Mr. Chairman, thank you for holding this hearing. And I am not here today to criticize one Medicare provider over another, but, instead, to discuss the important role physician-owned hospitals play in promoting competition in Medicare.

Instead of continuing the ObamaCare prohibition on these hospitals, which was included in the 2,000-plus-page law as a political favor to the American Hospital Association and others, we ought to allow patients access to the high-quality and lower cost care provided by physician-owned hospitals.

In America, we let competition pick winners and losers, not the government.

I will yield back the balance of my time.

Chairman BRADY. Thank you.

Mr. Thompson, you are recognized.

Mr. THOMPSON. Thank you, Mr. Chairman.

Thank you to all the witnesses for being here.

Mr. Chairman, I would like to ask unanimous consent to enter a letter into the record from the U.S. Chamber of Commerce, who wrote stating that defending America's free enterprise system—they are in opposition to the self-referral to physician-owned hospitals.

Chairman BRADY. Without objection.

[The information follows: The Honorable Mike Thompson Submission]

CHAMBER OF COMMERCE
OF THE
UNITED STATES OF AMERICA

R. BRUCE JOSTEN
EXECUTIVE VICE PRESIDENT
GOVERNMENT AFFAIRS

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November 21, 2014

The Honorable Harry Reid
Majority Leader
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The Honorable Mitch McConnell
Republican Leader
United States Senate
Washington, DC 20510

The Honorable John Boehner
Speaker
U.S. House of Representatives
Washington, DC 20515

The Honorable Nancy Pelosi
Democratic Leader
U.S. House of Representatives
Washington, DC 20515

Dear Majority Leader Reid, Speaker Boehner, Republican Leader McConnell, and Democratic Leader Pelosi:

The U.S. Chamber of Commerce, the world's largest business federation representing the interests of more than three million businesses of all sizes, sectors, and regions, as well as state and local chambers and industry associations, and dedicated to promoting, protecting, and defending America's free enterprise system, urges Congress to maintain current legal protections against certain self-referral to physician-owned hospitals. As you know, the House is currently circulating draft legislation that would repeal an important provision that currently protects employers and their employees. The Chamber has long been concerned about the significant problems stemming from physicians self-referring patients to hospitals in which they have an ownership interest. As articulated in letters dating back to 2007 and 2008, the Chamber continues to remain concerned about the increased utilization and costs associated with physician self-referral. For these reasons, the Chamber continues to oppose efforts to unwind current protections in the law.

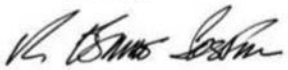
Unbridled, spiraling health care costs is one of the most important challenges facing our health care system today. One legal protection that currently helps combat unnecessary cost increases is a safeguard against certain self-referral practices. When the most profitable patient cases are referred to hospitals where physicians have a financial interest, "cherry-picking" occurs. While this referral practice increases profits for these physician-owned hospitals, such cherry-picking also has the negative impact of leaving the more complicated and poorly reimbursed cases to be treated by neighboring community hospitals. Studies by the Medicare Payment Advisory Commission (MedPAC), Government Accountability Office (GAO), and the HHS Office of Inspector General (OIG) have documented the dangers of self-referral. These data have driven Congress to take action to prevent these practices and limit the harm that results, under both Republican and Democratic leadership. If the most recent protection enacted

as part of the ACA is reversed, increased and unnecessary utilization of medical services will inflate premium costs to employers, raise the overall cost of health care for all Americans, and diminish access to quality medical care for communities.

Balancing entrepreneurial spirit and sound public policy is no easy feat, but Congress achieved the right balance when it prohibited self-referral prospectively while grandfathering arrangements in place prior to December 31, 2010. Congress also provided for a safety valve, allowing for growth if facilities can demonstrate a need in the community. This alternative affords proper exceptions when expansion is appropriate and necessary.

The Chamber urges Congress to not take a step backward on this policy which has historically enjoyed strong bipartisan support dating back over a decade. Although the Chamber and many lawmakers strongly opposed the Affordable Care Act (ACA) generally in 2010, the Chamber and many bipartisan lawmakers have for years supported the protections and safeguards codified in §6001 of the ACA. This provision is working by appropriately limiting the practice of self-referral to physician-owned hospitals, which increases utilization and costs to businesses and taxpayers, as well as distorting health care markets. The Chamber supports the current self-referral law and opposes any effort to unwind or weaken it.

Sincerely,



R. Bruce Josten

cc: Chairman Dave Camp
Ranking Member Sandy Levin
Chairman Paul Ryan
Ranking Member Chris Van Hollen
Chairman Fred Upton
Ranking Member Henry Waxman
Chairman Ron Wyden
Ranking Member Orrin Hatch

Mr. THOMPSON. Thank you.

Mr. Minissale, I would like to follow up on the questions that both the chairman and the ranking member had asked you and give you an opportunity to respond. They were referencing the type of services that your particular hospital does or doesn't provide.

And the CMS data that I am looking at tells us that about 70 percent of physician-owned hospitals—fewer than 5 percent of their admissions are Medicaid patients and a little over 20 percent admitted no Medicaid patients at all.

And your hospital—and, specifically, I think that is what they were asking you about—in 2013 had 24 percent Medicare discharges and 0 percent Medicaid discharges.

Can you kind of explain why these hospitals, in general, and yours, in specific—and they are often located in proximity to full-service hospitals—aren't treating Medicaid patients. And isn't there a need to do this in these underserved areas?

Mr. MINISSALE. I assume you are not—I am not sure about the State of your citing, but I assume you are not referring to the hospitals in North Houston, Odessa, San Antonio, that had physician ownership that I have managed in my career.

Mr. THOMPSON. No. I am talking about the hospital where you are now, Methodist McKinney. You had 24 percent Medicare discharges and 0 percent Medicaid discharges.

Mr. MINISSALE. Yes, sir. That is geography. In my experience, the Medicaid population tends to go to the closest facility due to transportation challenges, and we happen to have built the hospital in an area where there is not an indigent population.

Mr. THOMPSON. So it is all geography as it pertains to your hospital?

Mr. MINISSALE. I cannot say it is all. We are a Medicaid provider. There is now a McKinney bus service that could bring them there, and we are happy to take care of them.

So other than advertise, have our doors open, let the bus come over, I don't know how you make patients come to your facility.

Mr. THOMPSON. Thank you.

In my home State of California, we have hundreds of community hospitals and there is no shortage of competition, competition that is operating on a level playing field. I have got some concerns about the self-referral model.

And in my full-service hospitals at home, they compete on the quality of their service, the geography, and their reputation, not on whether or not physician owners will win, you know, financial gain as a result of this. And I worry about changing this law and what it would do to destabilize the continuity of care that we have in my area and others.

Mr. Umbdenstock, I don't have any of these hospitals in my community right now, and from the testimony that I have heard so far today, I don't think I want any.

But if the law were weakened and they could come in, what do you think the impact would be on my constituents and the other constituents in other areas that don't have this type of unfair competition?

Mr. UMBDENSTOCK. Well, I think it is the three things that I mentioned. One is that the patient mix and service mix that will

shift in your community could very well jeopardize the ability of full-service community hospitals to continue to provide a full array of services. There is certainly the question of increased utilization and, therefore, increased costs. And there is competition for employees who are already in short supply, as we all know. So I think that we have got serious concerns about that.

And there is an exception process. So if a hospital feels that it needs to grow and it is in a growing area and there is a high inpatient census on utilization and they do take high proportion Medicaid patients, CMS has already approved one. I only know of two applications. They have approved one and one is pending. So there is a mechanism to handle that.

Mr. THOMPSON. What about the current law that requires physician-owned hospitals to report annually to CMS about the ownership and all the particulars? It is my understanding that that hasn't been done. And aren't we putting the proverbial cart before the horse with trying to do this legislation without first having all the data necessary to be able to assess what is actually going on?

Mr. UMBDENSTOCK. I do know from what is up on the CMS Web site that they say that they have had a very low rate of response to their reporting requirements, so much so that they have yet again extended the submission deadline.

So, apparently, they are having trouble identifying those ownership and other indicators that they require. So one would think that that would be important information to have. Yes.

Mr. THOMPSON. Okay. Thank you.

Yield back.

Chairman BRADY. Thank you.

Mr. Smith, you are recognized.

Mr. SMITH. Thank you, Mr. Chairman.

And thank you to all our witnesses here today. I appreciate the insight that each and every one of you bring to the table here.

Certainly, as a representative of part of rural America, I can appreciate the challenges facing health care, facing the financing of health care. I have been here long enough to observe a lot of the arguments for and against various components of public policy as it relates to health care. And certainly, as a consumer from time to time of health care and as a patient, I think it is important that we observe what is going on.

Now, I get very concerned when there is an agenda of prohibitions and mandates. That could be inside ObamaCare or even beyond that, but I get very concerned. I know I have been working on an issue with critical-access hospitals in my district with a 96-hour precertification requirement that I think is burdensome, it is unnecessary, yet it is part of the long list of prohibitions and mandates that exist in health care.

And I would hope that we could have flexibility in our health care. I know that living in a community where we have, I think, a very vibrant community regional hospital, along with a Federally qualified health center and even some options for patients that would involve walk-in urgent care—I see the flexibilities that allow those to be used by patients. That is a good thing.

It is hard to say, perhaps—I mean, I don't know the exact financing mechanism of every patient, but I was just wondering if anyone

could speak to the fact of prohibitions and mandates leading to actual cost savings. If any of our witnesses would like to answer that.

Mr. UMBDENSTOCK. Yes, Congressman. I would be happy to.

Number one, this is an arrangement that has been arrived at over a discussion and a series of compromises over a dozen or more years. So this is an ongoing conversation in this industry.

Mr. SMITH. But it is the result of a compromise, the prohibition?

Mr. UMBDENSTOCK. Where we are today is the result of starting with new entries and limits on growth for the grandfather-in hospitals. Yes. This has been an ongoing conversation since at least 2003, that I am aware of, probably longer, number one.

Number two, the CBO has scored that this particular provision in the Affordable Care Act saved $500 million over 10 years. So, yes, it is a, quote, saver at the moment, and changing it would, obviously, in the CBO's opinion, unleash additional spending that would have to be paid for in some way under the Medicare program.

Mr. SMITH. You said at least at the moment. So long term do you think that we need the current prohibitions and mandates that are currently in place?

Mr. UMBDENSTOCK. Yes. And I think that we could ask CBO to score it again. But I don't see any reason why for the next 10-year segment they would come out with a substantially different answer.

Mr. SMITH. Okay. Anyone else wishing to respond?

Mr. MINISSALE. Yes, sir. You mentioned cost and the prohibition. One thing that we have seen is our competitors employing physicians. Five of our original physician investors' practices have been bought out since we opened and many, many more in the community.

In my understanding, there is data showing—I believe it is in California—from CMS that that actually increases cost. It doesn't decrease cost.

Our competitors are spending a lot of money on paid medical directorships to the high-paid procedurals. We don't pay medical directorships. We don't employ physicians.

I believe those things are part of the reason the data shows costs are going up. We would tend to focus on competition and quality that would lower costs and provide better care in the end.

Mr. SMITH. Okay. Thank you.

Anyone else wishing to comment?

Thank you, Mr. Chairman. I yield back.

Chairman BRADY. Thank you.

Mr. Davis, you are recognized for 5 minutes.

Mr. DAVIS. Thank you very much, Mr. Chairman.

You know, for many, many years we have had a great deal of conversation relative to how do we improve quality and contain cost at the same time. If we are still experiencing 60 percent hospital admissions through emergency rooms, does that say that our system needs to do anything in order to try and get to this real notion of cost savings?

Mr. UMBDENSTOCK. Yes, Congressman. Thanks for that question.

It does, indeed. And that is why the American Hospital Association and our 5,000 members are very much interested in new payment and new delivery system models.

It would indicate, as you say, that people are dropping into the healthcare system on an as-needed or ad hoc basis, not with any sort of long-term relationship to the system and certainly not a relationship that emphasizes early intervention, prevention, wellness, community-based services, and so on.

We believe that that is the right way to organize the system. We are trying to do that by coming together with other entities up and down the continuum of care.

As I mentioned in my oral statement and in our written testimony, there are significant legal barriers to doing that. But, ideally, that is what we would do. We would put the incentives for wellness and less utilization and align them between patients and providers.

Mr. DAVIS. Dr. Antos, can I ask you: Isn't it true that current law does not necessarily restrict or does not prevent increases in certain types of hospitals if they are needed in areas?

Mr. ANTOS. That is right, Congressman. There are exceptions that are limited. I assume we are talking about specialty hospitals now or physician-owned hospitals. There are some exceptions.

However, effectively, the provision under the Affordable Care Act effectively eliminates any chance that physician-owned hospitals can expand or that new ones can be created. The exceptions are very, very rare.

Mr. DAVIS. Is it not also true that, in many areas, many States, that locally determined decisions are made through health facilities, planning boards, and other entities that will allow or not allow a hospital to build or a new service to come in or a new service to start?

Mr. ANTOS. That is right. Certificate of need is the phrase. I live in Maryland, and Maryland has the certificate-of-need law.

I have to say my observation of the State of Maryland is that it is a difficult process and it is not at all clear that, in the end, you end up with decisions that would have been made in the market, decisions that would have been made by consumers as far as where they would choose to go for services.

Mr. DAVIS. Mr. Umbdenstock, let me ask you—current law requires physician-owned hospitals to report annually to CMS on their status and to provide a detailed description of the identity of each owner or investor in the hospital and the nature and extent of all ownership and investment interest.

But the CMS Web site still does not include this information and CMS says that they are concerned about the accuracy of the data they have received.

So the agency has once again extended the deadline for submission. Of course, this means that the public has no data on how many of these hospitals actually exist or who the ownership actually might be.

Do you think we ought to have that information before making further decisions about the issue?

Mr. UMBDENSTOCK. Yes, sir. Yes, Congressman. I do. Absolutely. Again, full-service hospitals are under very rigorous report-

ing and disclosure requirements to the government about such issues. And I think it is disappointing that a particular segment hasn't been able to come up with that information, at least, again, as I reference the cms.gov Web site.

So they are obviously concerned. And, yes, I would think that that is important information to have before any significant changes are proposed.

Mr. DAVIS. Thank you very much.

I see that my time is about to expire. Thank you, Mr. Chairman. I yield back.

Chairman BRADY. Thank you.

Mr. Marchant, you are recognized.

Mr. MARCHANT. Thank you, Mr. Chairman.

I represent a district around the DFW airport. We are very blessed in that we have several major hospitals that would be represented by your organization, but we also have an explosive growth in very highly technical, customer-oriented, private physician-owned hospitals.

And in my particular district, there is a great demand for that hospital. They are responsive. They seem to be a little more agile in filling market niches. They seem to be more responsive, in whole, to parts of my community.

Mr. Umbdenstock, where one of your hospitals is a partner with one of these physician-owned hospitals, what is the AHA's approach to that? How do those partners deal with this situation where they, in fact, are providing the capital and many times the loan and everything to start this other hospital, which is the case in my area?

Mr. UMBDENSTOCK. Yes, Congressman. Thank you.

First of all, I would point out that some of our member hospitals are in such partnerships, as is the case present here today. The Methodist Health System is an AHA member and a fine member and a fine organization. We are very pleased that they have maintained being an AHA member and participate in our broader discussions and debates.

When we formulated our position on this, it was through a very participative process of hospital members with specialty hospitals and those without. And, frankly, on this point, some of my members have agreed to disagree.

So the situation is the same, whether it is a freestanding or partnered entity, and our position is the same. It has not been an easy position for us to take. We respect all of our members, but it is one that the vast majority of our members support.

Mr. MARCHANT. But that would explain why the major hospitals in my district perhaps are not coming to me and saying that, "We are for this moratorium," where, in fact, many of them are telling me——

Mr. UMBDENSTOCK. I haven't looked at it by congressional district, but more broadly on SMSA basis and so on where they have very different views. Some, as we saw during the debate of this particular provision, are very much opposed to it. Others had made investments and were supportive of it.

But I can tell you, sir, that the vast majority of our members are supportive of current law and not in favor of relaxing it. Not an

easy position for us, but one that the members broadly support very strongly.

Mr. MARCHANT. Are you familiar with this group of hospitals across the Nation that, during the formulation of the Affordable Health Care Act, they started facilities, they had hospital wings or additions in various stages of construction and, when the Affordable Health Care Act was put in place, the Commissioner decided that, on a certain day, if those beds were not certified and accepted, that those beds would never be basically accepted for Medicare or Medicaid use?

Mr. UMBDENSTOCK. The act was enacted in March of 2010, and people had the ability through the end of December of 2010 to bring these online and get a Medicare provider number. So, in the law, there was a 9-month delay. In reality, there was a longer delay because this provision was always on the table and being debated.

I was having conversations with my own members, again, some of whom were making these investments in these organizations, who wanted to know what that date would be. So people were on notice because of the conversation for much longer than 9 months. That date was in the law. Yes.

Mr. MARCHANT. But the fact is that several hospitals were caught in this period of time and now have beds that they fully intended to use for Medicare and Medicaid patients, but because of the prohibition, because they were excluded, cannot use them for that purpose.

Is it the position of your organization that these hospitals never be recognized and never be allowed to use those beds for Medicare and Medicaid patients?

Mr. UMBDENSTOCK. That was the provision of the act. We are supportive of that provision. And, again, it was several years in the making. So there was a lot of lead time in that respect. We were counseling our own members that it was a very high-risk proposition.

Given the support for this measure, it would be a very high-risk proposition to keep going. Some members actually got their hospitals opened in that period of time. Others found themselves not able to do so before the well-publicized deadline.

Mr. MARCHANT. Thank you.

Mr. UMBDENSTOCK. Thank you, sir.

Chairman BRADY. Mrs. Black, you are recognized.

Mrs. BLACK. Thank you, Mr. Chairman.

I want to thank all of the panelists for being here today. Very interesting conversation on three very important issues.

Mr. Antos, I want to turn to you particularly about the Medicare Advantage plans. Many critics have suggested that the Medicare Advantage plans were overpaid and they don't provide a service that is more valuable than the fee-for-service. We have seen enrollment in Medicare Advantage plans all the way across the country, and I know in my district it more than tripled over the past decade.

And I know that what I hear from folks that are in the plan and the survey showed that seniors are more satisfied with their Medicare Advantage than they are with their fee-for-service program.

All this has occurred while the Medicare Advantage has been cut dramatically.

We see that continuing, and in some cases where they said they were going to cut it dramatically, we have seen a little bit of a reduction in that so they weren't cut quite as dramatically as what was talked about.

Do you agree that this competition—that Medicare Advantage is overpaid for their services it provides? Do you agree with what is being said, that they are overpaid?

Mr. ANTOS. No. I don't agree. I mean, the fact is that Medicare Advantage plans do provide good value not just for the people who enroll in them, but, also, for the taxpayer.

You know, one of the interesting facts about this is that people say that it is the younger Medicare beneficiaries, the ones who are turning 65, who are the new enrollees in Medicare Advantage. Actually, that is not true.

It turns out that most people, when they turn 65, sign on to traditional Medicare and, after a few years, they often find out that that isn't the plan they want to be in. It is not a health plan as they know it because they have spent 30 years in more organized healthcare delivery systems.

So in terms of value, I mean, there is very little question here. The fact that the bids—the amount that they bid is below the cost to fee-for-service across the country says that Medicare Advantage plans are able to provide full Medicare benefits at a lower cost than fee-for-service. The fact that they get paid more gets plowed back into additional benefits for beneficiaries.

Mrs. BLACK. And I am also interested—I heard you at another event talk about this very subject matter. And, in addition to that, one of the things that you did talk about is the research that you have done that suggests that the effects of the competition have actually seen the Medicare Advantage programs have that spillover effect on the fee-for-service in both lowering the costs and the increasing of the quality.

Can you talk just briefly about what you have done as far as the research there and how that has affected the fee-for-service in lowering those costs and increasing quality.

Mr. ANTOS. So, you know, an important point, too, for all of us to remember is that seniors are, in fact, the biggest customers of the healthcare system. And so, if the treatment for the senior population becomes more efficient and more effective, that is going to spill over on everything else that the health sector does.

In essence, what is happening is that Medicare Advantage plans are introducing better systems of coordinating care. They are especially focusing on the people with serious chronic diseases, the people who are the most expensive in the system. And when you have a sufficiently large volume of patients who are in those organized systems, well, it turns out the physicians also operate in the fee-for-service sector as well.

They don't change their practices just because the paycheck, which is going to go to some business office, comes from someplace else.

Mrs. BLACK. And, Mr. Antos, if I may—because I only have a couple of seconds left—I think this really makes the point of what

we have been talking about, that when we look at the Affordable Care Act, we talk about repealing and replacing with something that is more market-based and something that is more patient-centered.

And I think this is such a great model, when we look at the research that has been done, to say, when you do that, when something is more market-based and more patient-centered, we see a lowering of cost, at the same time an increasing of quality.

And so I am just really very interested to see more research done in this area that can show that, if you do that, the fee-for-service will actually follow because there is going to be competition on the other side to make sure the costs come down, but the quality is there.

Thank you so much, Mr. Chairman, for having this hearing today.

Chairman BRADY. Thank you, Mrs. Black.

Mr. Kind, you are recognized.

Mr. KIND. Thank you, Mr. Chairman. Thank you for having this hearing today.

I thank the panelists for your testimony.

Mr. Chairman, the reason I was late getting to the hearing this morning was I had a few interesting meetings on the current long-term care system and market that we have in the country.

And I think this is another area ripe for oversight and some additional hearings so that we come to grip before the Medicare program absolutely implodes due to where we are going with long-term care in this country.

But, Mr. Umbdenstock, let me start with you. And staying on the self-referral physician-owned hospital track, you cite in your testimony, both written and oral here today, that there are numerous studies from CBO, from MedPAC, from other independent researchers, citing that, with self-referrals at least, they are seeing data that is showing that they have an increase in utilization in both services and, therefore, costs in the Medicare system.

My question is: If there are ways for us to accelerate reform within the payment area so that we are getting the value of quality outcomes as opposed to fee-for-service, whether that would help address the over-utilization that you cited and that apparently exists based on these numerous studies out there?

Mr. UMBDENSTOCK. Thank you, Congressman.

Yes. Overall, the AHA is very supportive of the various payment demonstrations and experiments that are going on at the moment to try to figure out a better approach to financial incentives that will drive a better organized and more coordinated delivery system so that we can move toward that system.

Unfortunately, right now nobody has come up with an agreed-upon approach to do that. So we find ourselves with experiments and demonstrations and accountable care organizations and primary care medical homes and so on, all very important learning experiences. And, hopefully, based on that experience, we will come to more of a consensus on how to move off to the next payment system.

Mr. KIND. You know, I have enjoyed working with many of your members and those in Wisconsin, in particular, that have been

moving to a more integrated coordinated patient center and been real drivers in value in the healthcare system and that.

But they share frustrations I have had for some time. They say, "Well, how can we accelerate this? How can we move from fee-for-service to a more value of quality and align the financial incentives done the right way?"

You mentioned the Accountable Care Organizations. Secretary Burwell just announced an expansion of the pioneer ACL program, which I think is helpful, the medical home models, maybe some bundling in that.

But are we just still in this era of experimentation and trying to find out what works and what doesn't or are there some payment reforms that really do show some promise that maybe we ought to be stepping on the gas pedal a little bit harder on?

Mr. UMBDENSTOCK. Well, certainly, again, as you mentioned from your home State, very much one of an integrated delivery system, large groups connected to hospitals, connected to payment systems.

Just tomorrow I am going to meet with members from across the country who are in very similar models to that. We estimate that about 20 percent of our members at the moment—maybe high teens getting to 20—have a health plan or have some sort of relationship to a health plan where they are starting to integrate payment and delivery.

So the more we see of that, the more we see coordinated, integrated systems of care emerging. And so we are supportive of that. The only problem is that that is not right for every market yet. It is very difficult to do on small population bases, for example. Very difficult to do if the payment isn't right in socioeconomically disadvantaged urban areas.

And so it is a concept that we are all very interested in and moving toward, I believe, but it is all a matter of markets and timing.

Mr. KIND. What are you seeing in the area of uncompensated care numbers right now? Obviously, there is some improvement in some States. But I hail from a State that has rejected the Medicaid expansion funds and has left us with a huge shortfall in that regard. But, overall, what have you been seeing?

Mr. UMBDENSTOCK. It is much more favorable, as you might expect, in States that have chosen to expand Medicaid. Nationally, we believe that uncompensated care has dropped—or charity care has dropped about $7.5 billion with the additional coverage, and about two-thirds of that, maybe about five in round numbers, is from Medicaid.

So we definitely continue to urge all States to take advantage of that option. And it works for the States. It works for communities and employers who have a backstop if people should lose insurance. And it is working and helping providers as well.

Mr. KIND. Finally—I know I am running out of time—but I would like to follow up with you in regards to one of your recommendations for improvement, the standardizing the merger and review process between the two Fed antitrust agencies. I think that is a huge area that is going to require more scrutiny by all parties involved. So I would like to follow up with you in the future with that.

Mr. UMBDENSTOCK. We would be happy to. Big issue. Thank you, sir.

Mr. KIND. Thank you, Mr. Chairman.

Chairman BRADY. Thank you.

Ms. Jenkins, you are recognized.

Ms. JENKINS. Thank you, Mr. Chairman.

Like many Americans, I am concerned about the future of the Medicare program. The current trajectory of Medicare shows a trust shortfall in 2031, only 16 years from now. This impacts not just future beneficiaries, but many current beneficiaries as well.

Access to quality care is in jeopardy, and that is why this hearing really is so timely. Improvement of competition in Medicare has the potential to lead to lower prices, higher quality, and a more sustainable future for the program.

One area of Medicare that has already demonstrated these results is the Medicare Advantage program. And the latest numbers show that over 62,000 Kansans enrolled in a Medicare Advantage plan last year. These private plans compete against each other to offer beneficiaries increased coverage options.

Particularly in rural areas, a Rural Policy Research Institute study shows that 216,000 more rural beneficiaries chose a Medicare Advantage plan between 2013 and 2014. This is despite the cuts to Medicare Advantage in the President's healthcare law and despite the shrinking rural population in America.

So, Dr. Antos, Representative Black already touched on a few of my questions. So maybe I will just pick up there. How do you explain this apparent discrepancy between the President's cuts to Medicare Advantage and the increased popularity of the program?

Mr. ANTOS. Well, I think it is a tribute to the poor performance of the fee-for-service program in Medicare. As I mentioned, part of the issue is that, once you get to know Medicare, you realize that it isn't the program you thought it was going to be. And I think this explains to a very large extent why there has been such an expansion of enrollment among the younger Medicare beneficiaries.

Now, it is the case that Medicare Advantage plans are much better organized as businesses than the various unconnected fee-for-service providers. And so one of the criticisms that is sometimes made is that, well, they are over-billing. But they are not over-billing.

They are, in fact, properly coding the maladies and the conditions of their customers. And they are not only properly coding that, but they are also fully incentivized to find ways to provide kind of 360-degree care rather than narrow focuses on hospital services or physician services or what have you.

Ms. JENKINS. Okay. Great.

Given the increased popularity of the Medicare Advantage particularly in rural America, what would you suggest that Congress do to spur this trend along?

Mr. ANTOS. Well, certainly one of the things that really should be done is even the sort of situation when people enter the Medicare program. When you turn 65, the default is fee-for-service Medicare. That is one of the reasons why you have so many people who then change after a couple years, change the default.

Another big, big factor that I think really gets at the rural issue is to change the basis of the bidding. Right now fee-for-service Medicare is treated as if it was a national program. Of course, it is not really a national program. It is different in every region. It is different in every locality. And, yet, there is a national standard, there is a national benchmark, and so on.

What really ought to happen is that we have full, fair bidding and, in rural areas, where cost conditions are vastly different than in urban areas, that the bids from Medicare Advantage plans are measured against the actual cost of Medicare providing services in those areas.

Ms. JENKINS. Okay. Thank you.

I yield back.

Chairman BRADY. Thank you.

Dr. Price, you are recognized.

Mr. PRICE. Thank you, Mr. Chairman.

And I thank the panel. And I apologize for being late. And I am sorry if I repeat myself here.

I do want to focus in on the whole issue of competition in a particular area to start with, and that is the area of durable medical equipment.

You know, just because something says it is competitive doesn't necessarily mean it is competitive. And so it is important that you drill down and look at actually how programs run.

I would suggest, many of us would suggest, that the competitive bidding system for DME is neither competitive nor is it real bidding. And we have put forward a bipartisan solution to that that we call market purchase pricing that we think is superior.

But, Mr. Steedley, I want to have you reflect a little bit on the competitive bidding system in DME. What are your experiences? For those of us who were in health care—I was a physician for over 20 years taking care of patients—we oftentimes see a different example or different experience than what is relayed here in Washington.

So you and your peers who are trying to care for folks out there in the real world, what has competitive bidding meant to you all?

Mr. STEEDLEY. Thank you, Mr. Price.

You know, Barnes Healthcare Services had the opportunity in round 2 to bid in Atlanta. And, surprisingly, we actually won the bid; yet, we declined that bid because the bid came in lower than our bid. And that is an important piece to hear here. 50 percent of winning bidders in competitive bidding actually bid less than the median price that is accepted.

It is about a standard of care—there are certain costs that are built into taking care of patients at home. And, specifically, if we just talk—if I narrow into the wheelchair example I just used, there is measuring these patients at home, there is working with the physical therapists, there is working with those physicians. It is making sure that these patients are in chairs that are appropriate.

And it is important to differentiate, to your point. I am not talking about just a broken hip or a sore knee that is going to need 2 or 3 weeks, sometimes, or 6 weeks of healing. Some of these patients are terminally ill. Some of these have ALS, muscular dys-

trophy, quadriplegic, and these folks require specialization with their chairs.

And so, for us, when we are looking at our cost structure and the necessity to take care of these patients, the things that they are going to need, the current system for us doesn't bring in enough revenue, quite frankly, to take care of these patients in the way that they deserve.

Mr. PRICE. So what I hear you saying is that there are patients out there that need services, require services. And the system that is being touted here in this town by so many at CMS as being an improvement, it is, in fact, harming individuals' access to care. Is that an accurate statement?

Mr. STEEDLEY. And, specifically, I can tell you we take calls from patients, quite frankly, for winners in those areas where they have called because they can't get their wheelchairs repaired timely.

Some of these patients now, and I can supply a couple of these names for you later if you are interested, have decubitus sores, where they were put in inappropriate chairs with the wrong support structure for them.

What is going on is at this point, because the payment system is down so much, that providers are trying to find equipment that is under the cost. And that is not always appropriate for these patients.

Mr. PRICE. See, Mr. Chairman, this is the challenge that we have. It is that you have got folks who are winning supposed bids out here, but they don't have the expertise or the ability to carry out the care for those patients in that geographic area.

And I want to commend you, Mr. Steedley, for what you are doing. We are going to continue our work on the market pricing program. As I say, it was bipartisan last year. Last Congress, we had 180 cosponsors, 49 Democrats.

There is also a push to expand the payment rates for competitive bidding into noncompetitive bidding areas right now, and I know that that is a concern.

In fact, we had a letter that was signed by tens of individuals of the House that I ask unanimous consent to insert into the record to have OIG investigate exactly what the consequence of this would be.

[The information follows: The Honorable Tom Price Submission]

Congress of the United States
Washington, DC 20515

July 25, 2014

Daniel R. Levinson
Inspector General
U.S. Department of Health and Human Services
330 Independence Avenue, SW
Washington, DC 20201

Dear Inspector General Levinson:

We are writing to request that the Office of the Inspector General (OIG) conduct a study of the impact on senior health of the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) competitive bidding program and the National Mail Order Program for diabetic testing supplies, as implemented in the Round 1 Recompete, Round 2, and the Round 1 Rebid.

We make this request because the lack of transparency in the competitive bidding program from its inception and the limits of the studies and evaluations done to this point make it impossible to judge the impact of the program on the health and well-being of the particularly vulnerable group of Medicare beneficiaries for whom this Medicare benefit was specifically developed. They are beneficiaries with severe disabilities and/or multiple chronic illnesses who need DMEPOS products that enable them to care for themselves at home and avoid costly use of hospitals, emergency rooms, and nursing homes. Many are fragile and unable to have an effective voice in describing how the changed payment policy for DMEPOS has adversely impacted their health.

At this point there is abundant and concerning evidence of arbitrary manipulations of the price-setting system that directly limits seniors' access to care and technology, an inattention to growing contractor non-compliance that is significantly impacting the quality and choice of technologies and services, and inadequate efforts to measure health impacts on beneficiaries.

Members of Congress need a much better understanding of the impact this program has on our seniors. It would be a grave error if the bidding structure developed by the Centers for Medicare &Medicaid Services (CMS) severely reduces access to home support services just as Congress seeks to enhance care quality through greater coordination of care, especially for patients with complex and multiple chronic conditions. We believe competitive bidding can help Medicare to improve the quality and efficiency of care, but it has to be done in a way that assures both improved care outcomes and system efficiency. We ask your assistance in investigating and reporting on the following concerns:

I. The process by which CMS develops the composite price from which the median price is derived, as it directly impacts seniors' access to products and services.

- How was the capacity of the individual supplier established? How was the future capacity of each supplier determined? If a bidder's future capacity exceeded current capacity, precisely what criteria were relied on to evaluate a bidder's ability to support any expansion of their business? Were the criteria consistent with small business administration's criteria for business expansion and that of other government competitive bidding systems?

- Because supplier performance is key to senior access, and because significant concerns have been raised about winning bidders ability to perform in accord with their contract, we request the OIG to examine the winning bids of all companies to:

  1) Verify if they were licensed and certified in every competitive bidding area (CBA) for every product by the deadline in the Request for Bids;
  2) Document the financial resources relied upon by CMS to substantiate their ability to fulfill their expansion plans, in some cases more than 10,000% in a few months;
  3) Verify that each supplied all products in all categories in all CBAs each won on the first day of their first contract year and have continued to do so, as specifically required by Medicare; and
  4) Report your findings and any abnormalities noted, such as no record available that a supplier made a specific bid for a specific code in a product category and CBA.

- To better understand the accuracy of the price setting process, for the Round 1 Rebid, Round 2, and the Round 1 Recompete, please report the de-identified array of winning bids for the two lead products in each category (defined as the two Healthcare Common Procedure Coding System (HCPCS) codes with the largest dollar claims in a year), the actual units allowed for each winning bidder for that HCPCS code for the preceding year, the future annual capacity attributed to each of these bidders for each of the two HCPCS codes and whether the median price was calculated correctly for those products. Please also calculate what the median price ***would have been*** if it was based on the bids of the actual contracted suppliers 6 months after the date of program implementation.

II. Enforcement of Contracted Supplier Obligations

- CMS directs bidders be very clear that all suppliers must supply all products in every category in every CBA that supplier won. Moreover, failure to supply is a breach of contract. As a result, please report for each CBA and each product

category for the Round 1 Rebid, Round 2, and Round 1 Recompete the following information:

a) How many suppliers accepted and signed contracts;
b) How many of the contracted suppliers supplied all products in each category and in each CBA they won during the program's first 6 months;
c) How many supplied only a nominal amount (defined as 10% or less in the first six months of the annual capacity for which they bid);
d) The number of these total suppliers that were out of area (defined as more than 100 miles from the city center);
e) The number of out-of-area suppliers that either did not supply during the first 6 months following implementation or supplied a nominal amount as defined above;
f) The number of suppliers accepting contracts for categories of products for which they had no previous supplier experience in the category as a whole;
g) The number of suppliers of the total number of suppliers in the General Home Equipment and related supplies category and the External Infusion Pump and Supplies category in the Round 1 Recompete who had never supplied all the products in the category and whether claims data now shows them supplying all such products. This will help us understand how the grouping of disparate products has affected beneficiary access to included products; and
h) The number of suppliers withdrawing or excluded from the program, by product category and CBA, the reasons for withdrawal or exclusion, any actions taken to replace these suppliers, and the median price as recalculated at the time new suppliers were brought into the program.

- Please lay out in detail CMS' enforcement policy for supplier performance, its structure, and evidence of its systematic implementation and effectiveness. In addition, please address the following specific enforcement challenges:

  a) How CMS enforces the mandated 50% rule and whether CMS has authority to apply the rule on a contractual term basis, the anti-switching rule, and other regulatory requirements governing the provision of diabetic supplies, as successful self-care both deeply effects patient well-being and Medicare costs;
  b) Contractor compliance with nondiscrimination requirements under which a supplier is required to furnish beneficiaries with the same items that it would furnish to other customers;
  c) Differences between the brands of items listed on bids submitted by suppliers selected as contract suppliers and those provided over time to beneficiaries by such suppliers;
  d) Differences in functionalities or therapeutic advantage of the items furnished to Medicare beneficiaries in CBAs and those used by Medicare beneficiaries in non-CBAs;
  e) Differences between the average rental periods for various items in CBAs vs. non-CBAs;

f) Changes in the level and kind of services being offered to patients in conjunction with advanced technologies such as negative pressure wound therapy (NPWT), and the extent to which accreditation agencies use interpretive guideline standards established for NPWT to determine supplier compliance with quality standards; and
g) Changes in products and treatment patterns of enteral nutrition patients residing in skilled nursing facilities, nursing facilities, and intermediate care facilities, and whether the use of new enteral nutrition suppliers has increased costs to facilities and the Medicare program.

This information is crucial because if suppliers don't provide products and services as required by their contracts, then seniors' access to the products prescribed by their physicians is compromised, especially for products that are among the more expensive in any given HCPCS code.

Not making available to beneficiaries all products in a category is a **breach of contract** according to CMS' own explanations of the program. In fact, CMS argues that binding bids are not needed in the program because of this requirement. We note, however, that CMS is not enforcing the requirement. For example, upon hearing that beneficiaries were having problems with access to TENS from winning suppliers for the new General Home Equipment category used in the Round 1 Recompete, a manufacturer of the devices contacted each of the winning suppliers in this category and found that only 44 percent of the suppliers were offering TENS to beneficiaries. This is a form of market failure as argued by Professor Charles Plott and associates at the California Institute of Technology in their independent evaluation of the structure and bidding methodology used by CMS for the program. (http://www.caltech.edu/content/caltech-research-shows-medicare-auction-w

IN SUM, STRONG OVERSIGHT OF SUPPLIER PERFORMANCE IS KEY TO PRESERVING ACCESS TO DMEPOS THAT SUPPORT SENIORS' MAINTAINING HEALTH IN THE HOME.

III. Evaluating the Health Impact on Beneficiaries

- Given GAO's comments that CMS' methodology for evaluating the program's impact on beneficiary health was inadequate (12-693, page 41 and thereafter), and given that in its new report, GAO made no independent evaluation of the program's impact on beneficiary health, please include the following:

  - Evaluate the methodological differences between CMS and GAO in their approach to measuring the impact of the program on senior health;

  - Examine the health impact on seniors who lost access to their DME through the program by examining a statistically valid number of beneficiaries who were receiving DME in 2010 but not in 2011 in each product category and each CBA in Round 1 Recompete and in Round 2 to find out if the beneficiary

no longer needed their products, became self-pay and did not submit claims to Medicare, went without suppliers regardless of the health impact, moved to a nursing home, are frequently hospitalized as a consequence, visit emergency rooms regularly for supplies, are managing in some other way, or have died. CMS has testified that they track only beneficiaries with current claims (within the last 120 days) -- that is, the people that are getting their prescriptions filled. The health impact on all seniors is the right measure of the program.

- Conduct a detailed medical review or audit of a sample of patients, comparing total Medicare spending for those beneficiaries who have received DMEPOS through winning contractors with beneficiaries not residing in those areas and receiving DMEPOS paid for under fee schedules, as well as quantifying differences in rates of utilization of other covered Medicare services.

- Explore the potential for the OIG to establish an appeals office to evaluate stakeholder concerns while the process is underway.

In sum, while we believe competitive bidding can reduce costs while maintaining beneficiary access to quality care, this hybrid program appears to be compromising seniors' health by reducing beneficiaries' access to the supportive technologies and care that enables them to maintain their independence. Without the information requested above, Members of Congress cannot responsibly assure the well-being of the seniors they represent or the sustainability of this extremely important program designed to support the quality care of Medicare beneficiaries in their homes cost effectively.

Sincerely,

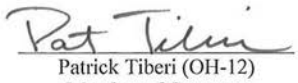
Tom Price, MD (GA-06)
Member of Congress

Bruce L. Braley (IA-01)
Member of Congress

Tom Reed (NY-23)
Member of Congress

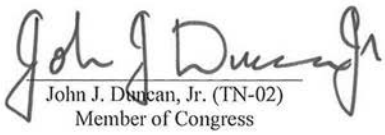
Tammy Duckworth (IL-08)
Member of Congress


Glenn 'GT' Thompson (PA-5)
Member of Congress


Patrick Tiberi (OH-12)
Member of Congress


Marsha Blackburn (TN 07)
Member of Congress

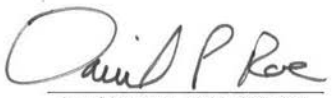

Richard Hanna (NY-22)
Member of Congress


John J. Duncan, Jr. (TN-02)
Member of Congress

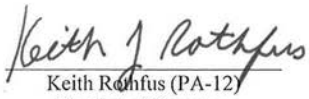

Diane Black (TN-06)
Member of Congress

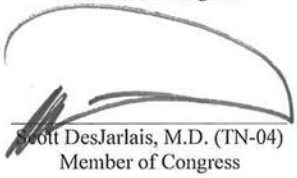

Tim Ryan (OH-13)
Member of Congress


Chris Collins (NY-27)
Member of Congress


David P. Roe, M.D. (TN-01)
Member of Congress


Todd Rokita (IN-4)
Member of Congress


Keith Rothfus (PA-12)
Member of Congress


Scott DesJarlais, M.D. (TN-04)
Member of Congress


Christopher Gibson (NY-19)
Member of Congress


Terri Sewell (AL-07)
Member of Congress

Dave Loebsack (IA-02)
Member of Congress

Mark Amodei (NV-2)
Member of Congress

Bill Johnson (OH-06)
Member of Congress

Alan Nunnelee (MS-01)
Member of Congress

Jackie Walorski (IN-02)
Member of Congress

J. Randy Forbes (VA-04)
Member of Congress

Peter King (NY-02)
Member of Congress

William L. Enyart (IL-12)
Member of Congress

Aaron Schock (IL-18)
Member of Congress

William R. Keating (MA-9)
Member of Congress

Yvette D. Clarke (NY-09)
Member of Congress

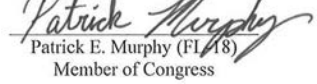
Carolyn McCarthy (NY-04)
Member of Congress

Brett Guthrie (KY-02)
Member of Congress

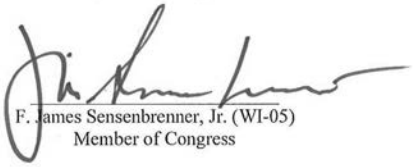
C.A. Dutch Ruppersberger (MD-02)
Member of Congress

Robert Pittenger (NC-09)
Member of Congress

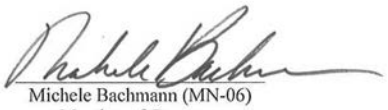
Tulsi Gabbard (HI-02)
Member of Congress



Patrick E. Murphy (FL-18)
Member of Congress

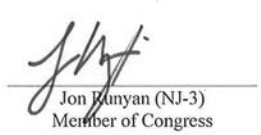


F. James Sensenbrenner, Jr. (WI-05)
Member of Congress

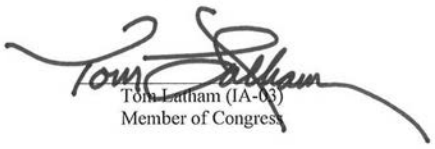


Michele Bachmann (MN-06)
Member of Congress

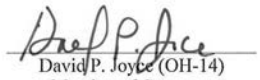
Collin C. Peterson (MN-07)
Member of Congress



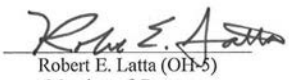
Jon Runyan (NJ-3)
Member of Congress



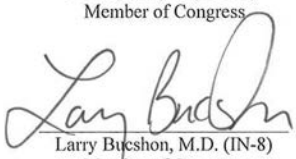
Tom Latham (IA-03)
Member of Congress



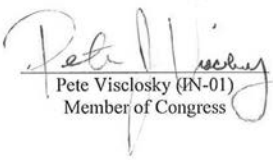
David P. Joyce (OH-14)
Member of Congress



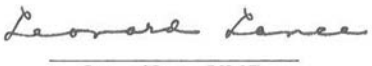
Robert E. Latta (OH-5)
Member of Congress



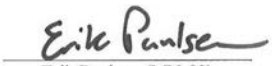
Larry Bucshon, M.D. (IN-8)
Member of Congress



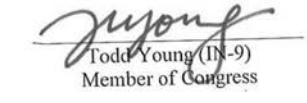
Pete Visclosky (IN-01)
Member of Congress



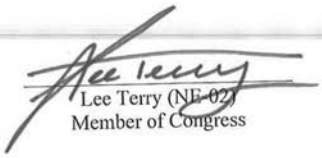
Leonard Lance (NJ-07)
Member of Congress



Erik Paulsen (MN-03)
Member of Congress

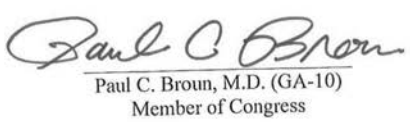


Todd Young (IN-9)
Member of Congress

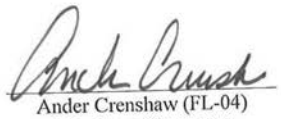


Lee Terry (NE-02)
Member of Congress

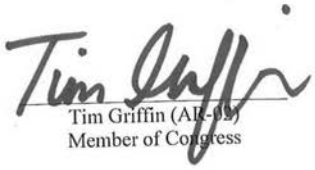
Jason Smith (MO-8)
Member of Congress



Paul C. Broun, M.D. (GA-10)
Member of Congress

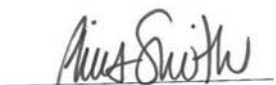


Ander Crenshaw (FL-04)
Member of Congress

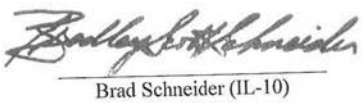


Tim Griffin (AR-02)
Member of Congress

Billy Long (MO-7)
Member of Congress



Chris Smith (NJ-04)
Member of Congress



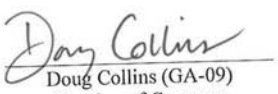
Brad Schneider (IL-10)
Member of Congress

Lou Barletta (PA-11)
Member of Congress

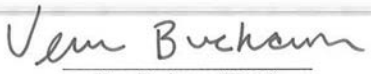
Ron DeSantis (FL-06)
Member of Congress

Bill Foster (IL-11)
Member of Congress

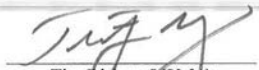
Austin Scott (GA-08)
Member of Congress



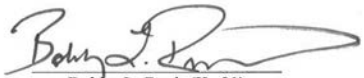
Doug Collins (GA-09)
Member of Congress



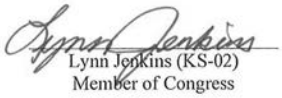
Vern Buchanan (FL-16)
Member of Congress



Tim Bishop (NY-01)
Member of Congress

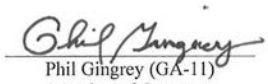


Bobby L. Rush (IL-01)
Member of Congress



Lynn Jenkins (KS-02)
Member of Congress

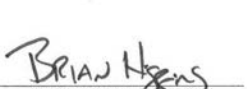
Michael R. Turner (OH-10)
Member of Congress



Phil Gingrey (GA-11)
Member of Congress

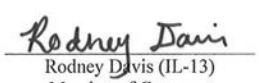
Shelley Moore Capito (WV-02)
Member of Congress

David B. McKinley (WV-01)
Member of Congress

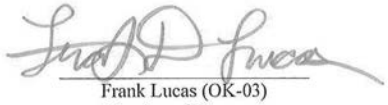


Brian Higgins (NY-26)
Member of Congress

Betty McCollum (MN-04)
Member of Congress



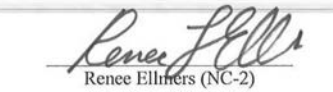
Rodney Davis (IL-13)
Member of Congress



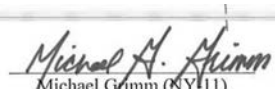
Frank Lucas (OK-03)
Member of Congress

Blaine Luetkemeyer (MO-03)
Member of Congress

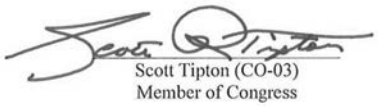
David Scott (GA-13)
Member of Congress



Renee Ellmers (NC-2)
Member of Congress

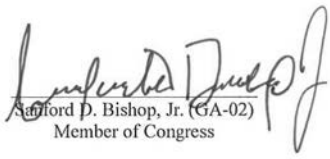


Michael Grimm (NY-11)
Member of Congress

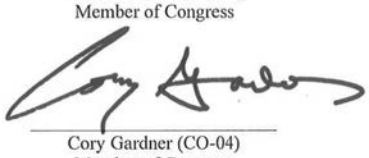


Scott Tipton (CO-03)
Member of Congress

Rick Crawford (AR-01)
Member of Congress

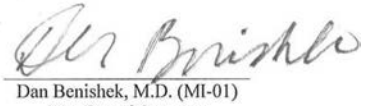


Sanford D. Bishop, Jr. (GA-02)
Member of Congress

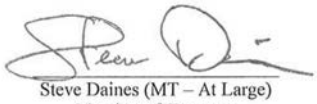


Cory Gardner (CO-04)
Member of Congress

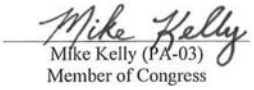
Ed Whitfield (KY-01)
Member of Congress



Dan Benishek, M.D. (MI-01)
Member of Congress

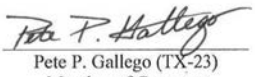


Steve Daines (MT – At Large)
Member of Congress



Mike Kelly (PA-03)
Member of Congress

Doug Lamborn (CO-05)
Member of Congress



Pete P. Gallego (TX-23)
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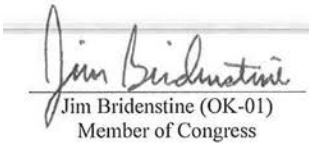
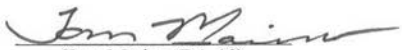
Mike Coffman (CO-06)
Member of Congress

Lynn Westmoreland (GA-03)
Member of Congress



Jim Bridenstine (OK-01)
Member of Congress

Mark Meadows (NC-11)
Member of Congress



Tom Marino (PA-10)
Member of Congress

Bob Gibbs (OH-7)
Member of Congress

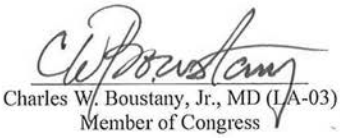
Michael T. McCaul (TX-10)
Member of Congress

Nick J. Rahall, II (WV-03)
Member of Congress

Steve King (IA-04)
Member of Congress

Hank Johnson (GA-4)
Member of Congress

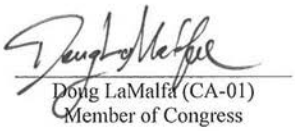
Rich Nugent (FL-11)
Member of Congress



Charles W. Boustany, Jr., MD (LA-03)
Member of Congress

Kerry Bentivolio (MI-11)
Member of Congress

Andy Barr (KY-06)
Member of Congress



Doug LaMalfa (CA-01)
Member of Congress

Steve Stivers (OH-15)
Member of Congress

Chuck Fleischmann (TN-03)
Member of Congress

Mike Michaud (ME-02)
Member of Congress

Vicky Hartzler (MO-04)
Member of Congress

Stephen F. Lynch (MA-08)
Member of Congress

Jim Matheson (UT-04)
Member of Congress

James R. Langevin (RI-02)
Member of Congress

Robert J. Wittman (VA-01)
Member of Congress

Peter DeFazio (OR-04)
Member of Congress

Bill Owens (NY-21)
Member of Congress

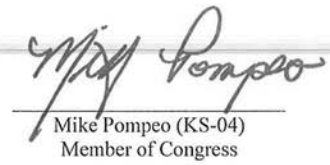
Corrine Brown (FL-05)
Member of Congress

Candice S. Miller (MI-10)
Member of Congress

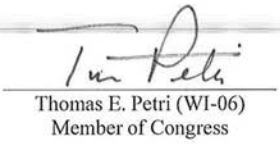
Charles W. Dent (PA-15)
Member of Congress

Albio Sires (NJ-8)
Member of Congress

James P. McGovern (MA-02)
Member of Congress



Mike Pompeo (KS-04)
Member of Congress



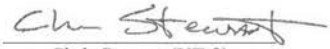
Thomas E. Petri (WI-06)
Member of Congress

Ed Perlmutter (CO-07)
Member of Congress

Luke Messer (IN-06)
Member of Congress

Gus Bilirakis (FL-12)
Member of Congress

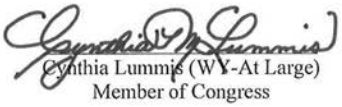
Lois Frankel (FL-22)
Member of Congress



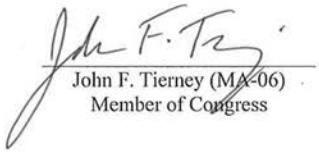
Chris Stewart (UT-2)
Member of Congress

Kevin Cramer (ND-At Large)
Member of Congress

Dennis A. Ross (FL-15)
Member of Congress

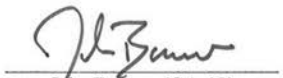


Cynthia Lummis (WY-At Large)
Member of Congress



John F. Tierney (MA-06)
Member of Congress

Sam Graves (MO-06)
Member of Congress



John Barrow (GA-12)
Member of Congress

Dan Maffei (NY-24)
Member of Congress

John B. Larson (CT-01)
Member of Congress

Rob Woodall (GA-07)
Member of Congress

David N. Cicilline (RI-01)
Member of Congress

Louise M. Slaughter (NY-25)
Member of Congress

Peter Welch (VT-At Large)
Member of Congress

Jim Jordan (OH-04)
Member of Congress

Ann Wagner (MO-02)
Member of Congress

James B. Renacci (OH-16)
Member of Congress

Gregg Harper (MS-03)
Member of Congress

Mr. PRICE. And the reason that that is important is that CMS uses claims data to determine whether or not folks get the kind of coverage or care that they need.

And, in fact, that is an inaccurate determiner of whether or not that patient is actually receiving the right care. So I am hopeful that the OIG will give us a report that actually reflects the sincere problems that are out there on the ground.

Thank you, Mr. Chairman. I yield back.

Chairman BRADY. Dr. Price, thank you for bringing this idea forward.

Mr. Renacci.

Mr. RENACCI. Thank you, Mr. Chairman.

I want to thank the witnesses. It is always interesting to come to these hearings and hear some of the concerns and issues. I, too, want to follow up with what Dr. Price talked about.

I am actually a member who had a DME company and went through competitive bidding before I came to Congress. I can tell you it was an interesting process because, as I thought I was doing a good job, I lost the competitive bid to another party.

I lost the bid to another party who then turned around and tried to sell me the bid back. And I know some of that cannot occur anymore with—hopefully—Mr. Tiberi's bill, which requires securing a security bond.

And with competitive bidding, again, the name sounds right, and I heard one of my colleagues talk about it being a Republican issue. Hey, Republicans and Democrats, it doesn't matter whether it is a Republican idea or a Democrat idea. It is a bad idea if it is not working.

And what I saw in competitive bidding, it was driving good companies out and, at the same time, it was not giving clients the adequate equipment that was needed.

And that is, Mr. Steedley, one of the things I know that you said. It is interesting. There was a company in Ohio that actually came to me. They had won a bid for a certain number of canes at a certain price.

And it was also ruining their reputation because, although they provided the certain number of canes at the certain price, it appeared that people, because there weren't enough other competitive companies out there, were continuing to come to them. And they didn't want to provide any more canes at the price because it was not in their best interest.

Are you seeing some of those same instances in the business model that you are currently running?

Mr. STEEDLEY. Yes, sir. And, to your point, the binding bid legislation is actually not going to go into effect for several more years. So that remains a little problematic.

To your point, there is a company in Orlando, Florida, that come to visit specifically—and I met with these folks. So I am talking from my personal experience here.

They won every single bid in round 2, all 90 MSAs in every product category in those bids. And to what you said a few minutes ago, their intention was to just resell those bids to desperate providers. It is still going on.

Mr. RENACCI. Well, see, I wasn't even aware of that. And that is an issue. I mean, I had to live with it, and it became a process where other companies were making money and actually driving the cost down, causing providers to have to sell their product at less than actually a price they could afford to pay.

Do you see that also in the current situation where pricing mechanisms are far below cost of actually providing the service?

Mr. STEEDLEY. Yes, sir. That continues. You know, if you look at even from the Association perspective, we are seeing a contraction now in the industry. Some of those folks are being bought by larger companies.

Just from a financial standpoint—and I think we are all businesspeople in the room—I can tell you those businesses are being bought sometimes for pennies on the dollar.

But, unfortunately, there are other providers that are going out of business because they did not win the bid. And, at some point, because they lost all that business in that area, they are gone and then the other providers that are left don't have enough left to sustain themselves anymore. So they are now going out of business.

What we are seeing, in essence—and competitive bidding is not the right word for this. What you are really seeing is a decimation of this industry. The lowest cost providers out there, the home care communities, are being taken apart slowly at this point.

And we talked a little about transparency. I said that in my opening statement earlier. We don't have good data from CMS that shows the correlation from the decrease in the Part B spin here and what that translates into on the Part A side.

I have spoken to patients that are telling me, because they can't get service, they are going to the emergency room or they are being admitted at some point for other problems subsequent to poor equipment or no equipment at all.

Mr. RENACCI. I know you touched on this a little bit. But this practice does have—for me, it has some concerns about patients and the actual care they are getting.

I know that, when I operated in multiple cities in rural and urban areas prior to coming to Congress—health care, nursing home facilities—and I can tell you that it is always more costly and many times in those rural settings.

Just briefly, what are you seeing with patients? You touched on that, but I want to make sure we hit home on that. What is happening to those patients that aren't getting the proper equipment?

Mr. STEEDLEY. You know, I can tell you—and I just saw this the week before last, I believe—what you are seeing is, people say, "Well, there is no problem with these patients, no access issues. At some point, what is going on is some of these folks that would ordinarily have got a different piece of equipment now are getting equipment that is no longer the best for them.

For instance, the case I am referring to, the lady was an elderly lady that was walking around very ambulatory, COPD or CHF, whatever her issues were, but was carrying one of those great big, heavy e-tanks around with her. And when I talked to her about that, she has a closet full of them because the provider that won would not give her a smaller, lighter weight portable tank because the cost of that system was more expensive.

Mr. RENACCI. Thank you very much.

Mr. Chairman, I yield back.

Chairman BRADY. Thank you.

I would like to thank today's witnesses for their testimony today.

We are going to continue this discussion about competition within hospitals and community hospitals and physician-owned hospitals, as well as looking at are there better ways to create savings from a durable medical equipment bidding as well as high-quality service to seniors.

And before I finish, I can see Mr. McDermott is anxious to submit a document for the record.

Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

For the record, I would like to submit a letter from Medicare Rights, which basically is in support of the competitive bidding process and ask unanimous consent.

Chairman BRADY. Without objection.

[The information follows: The Honorable Jim McDermott Submission 2]

MEDICARE RIGHTS CENTER
Getting Medicare right

May 19, 2015

The Honorable Kevin Brady
U.S. House of Representatives
Washington, DC 20515

The Honorable Jim McDermott
U.S. House of Representatives
Washington, DC 20515

Re: "Hearing on Improving Competition in Medicare: Removing Moratoria and Expanding Access"

Dear Chairman Brady and Ranking Member McDermott:

On behalf of the Medicare Rights Center (Medicare Rights), I am writing to submit a statement for the hearing record expressing support for the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) Competitive Bidding Program. Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. We provide services and resources to over 1.5 million beneficiaries, family caregivers, and professionals annually.

We believe the DMEPOS bidding program represents an important advancement in how Medicare pays for medical equipment and services. The program serves a triple aim, contributing to lower costs for older adults and people with disabilities, the right prices for Medicare, and a better deal for American taxpayers. According to the U.S. Department of Health and Human Services, "The program saved more than $580 million for beneficiaries and taxpayers in its first two years of operation, and it is projected to save the Medicare Part B Trust Fund $25.8 billion and beneficiaries $17.2 billion over ten years."[1]

Through the bidding program, medical equipment suppliers compete for Medicare's business on the basis of quality and price, submitting bids to serve beneficiaries in a specified region. Some claim the bidding program creates undue barriers to accessing needed medical equipment and supplies, but available evidence reflects the contrary. An initial report by the Government Accountability Office (GAO) determined beneficiary access and satisfaction were not affected by the bidding program in 2011, though careful monitoring was needed as the program expanded.[2] Similar findings were reported in 2012 through a subsequent GAO analysis.[3]

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[1] GAO, "Bidding Results from CMS's Durable Medical Equipment Competitive Bidding Program," (November 2014), available at: http://www.gao.gov/assets/670/666806.pdf
[2] GAO, "Review of the First Year of CMS's Durable Medical Equipment Competitive Bidding Program's Round 1 Rebid," (May 2012), available at: http://www.gao.gov/assets/600/590712.pdf
[3] GAO, "Second Year Update for CMS's Durable Medical Equipment Competitive Bidding Program Round 1 Rebid," (March 2014), available at: http://www.gao.gov/assets/670/661474.pdf

Trends heard on our national helpline are reflective of these findings. Our most common calls involve questions about coverage rules and concerns about denials of coverage. None of these inquiries are unique to the DMEPOS bidding program. We hear the same questions and concerns from those with Traditional Medicare in bidding areas, those in non-bidding areas, and among Medicare Advantage enrollees. We believe these trends reflect a general need for enhanced oversight of suppliers and education of beneficiaries across all Medicare coverage types.

While additional oversight may be warranted, according to GAO, the Centers for Medicare & Medicaid Services already utilize many tools to monitor beneficiary access through the DMEPOS bidding program. These tools include tracking 1-800-MEDICARE inquiries, analyzing national claims history, carrying out beneficiary satisfaction surveys, monitoring items furnished by suppliers, and conducting secret shopper calls. Another important beneficiary protection, unique to the DMEPOS bidding program, includes a dedicated ombudsman office, serving both Medicare beneficiaries and suppliers with bidding-related concerns.

In sum, we continue to support the DMEPOS bidding program, which is credited with creating sizable savings for the Medicare program, for beneficiaries, and for taxpayers—without compromising access to needed care. Rigorous oversight of the program, most notably of suppliers, should continue and be strengthened as necessary. Thank for the opportunity to submit a statement for the hearing record.

Sincerely,

Joe Baker
President
Medicare Rights Center

Chairman BRADY. Going forward, in continuing the discussions we had today, we will also be looking at issues of physician shortages, of disparities in rural health care within Medicare, as well as looking at improved programs on inpatient, outpatient and other hospital payment systems. So we will be encouraging input from both these witnesses as well as those in the audience today.

As a reminder, any member wishing to submit a question for the record will have 14 days to do so. If any members submit questions after the hearing, I would ask that the witnesses respond in writing in a timely manner.

With that, the committee is adjourned.

[Whereupon, at 11:51 a.m., the subcommittee was adjourned.]

[Submissions for the record follow:]

Dr. Anne S. Hast, Statement

Statement for the Record
House Ways and Means Health Subcommittee
Chairman Kevin Brady (R-TX) and Ranking Member Jim Dermott (D-WA)
"Improving Competition in Medicare: Removing Moratoria and Expanding Access"
May 19, 2015

INTRODUCTION:

I would like to thank Chairman Kevin Brady (R-Tx), Ranking Member Jim McDermott (D-WA), and the members of the House Ways and Means Health Subcommittee for the opportunity to submit comment in connection with the hearing "Improving Competition in Medicare: Removing Moratoria and Expanding Access."

I am Dr. Anne S. Hast, DNP, RN, CEO of Advanced Surgical Hospital, 100 Trich Drive, Washington, PA, 15301. I have dedicated my career, to the field of healthcare, serving in a variety of clinical, managerial, educational, and administrative positions. I have experienced many changes as healthcare reform has taken shape over this time. I enthusiastically support the goals of the Triple Aim and remain firm in my commitment, as an administrator, to lead healthcare change within my own organization in a manner that provides improved patient experience, improved health of our citizens, and reduced costs. I currently serve as the CEO of a physician owned orthopaedic specialty hospital, a hospital that embodies the spirit of the Triple Aim while embracing an entrepreneurial, creative, and innovative approach to the delivery of elective orthopaedic care. Advanced Surgical Hospital employs 143 community members, obtain goods and services from many local businesses, and provide exceptional orthopaedic care to our community. Advanced Surgical Hospital is precisely the healthcare delivery model our nation deserves. Yet, because of the successful lobbying efforts of organizations that want to reduce healthy competition, Advanced Surgical Hospital is not permitted, by law, to grow or expand services to the community. This mindset defies all logic and stands in the way of encouraging creative care models to grow and flourish in a manner that benefits patients, leads to innovation, and supports the economic growth of our communities.

OBJECTIVE:

Our objective is to end discrimination in federal law against hospitals with physician ownership by supporting legislation introduced on a bi-partisan basis, H.R. 976, to increase patient access to physician owned hospitals.

ADVANCED SURGICAL HOSPITAL:

Advanced Surgical Hospital was founded in April 2010 by eight orthopaedic surgeons that comprise Advanced Orthopaedics and Rehabilitation (AOR). The founding partners had a clear vision of the care experience they wanted for their patients. They were increasingly frustrated with the slow pace of change within many traditionally organized hospitals in the geographic area where they also served as the predominant orthopaedic care providers. They held the belief that a focused, agile, entrepreneurial care environment would better serve their patients. Patients would be better served as they had positive experiences with healthcare, had care provided in a "best in class" organization, and were provided care through clinical processes based on the latest research of best practice

delivered by a team of dedicated professionals uniquely focused on orthopaedic practices. The founding physician partners took a considerable risk in using personal funds to raise the capital necessary to build the facility and support start-up operating costs. Additionally, legislative changes in the Affordable Care Act placed a strict moratorium on physician owned start-ups, requiring that all of the funding, staffing, licensure, and CMS validation activities be completed within a four month period of time. Even with these seemingly insurmountable challenges, Advanced Surgical Hospital was licensed in the State of Pennsylvania in May 2010 and began serving patients in southern Allegheny County, Washington County, Greene County, and Fayette County with the vision of creating an elective surgical experience centered on quality, elegance and service.

Advanced Surgical Hospital has established strong integral business practices, recruited and retained exemplary employee and leadership teams, adopted an entrepreneurial mindset in approaching business opportunities, eagerly embraced change, and remained open to ideas gathered from "best in class" businesses. Advanced Surgical Hospital has achieved many awards and honors and national recognitions as a unique care setting achieving the highest quality ratings as based on publically reported metrics.

Advanced Surgical Hospital is led by a team of expert surgeons, clinical staff, therapists, and healthcare leaders that apply a Patient Family Centered Care design to meet the unique needs of patients and families. All too often, healthcare is perceived as a complicated maze of confusing, redundant processes that are stressful for patients and their families. The stresses imposed through the system of traditionally organized healthcare compound the stresses normally experienced when a healthcare condition is present. Advanced Surgical Hospital provides a different healthcare experience for the community. Advanced Surgical Hospital is an organization that places patients and families at the center of care and provides a high quality, low cost, exemplary patient experience. The patient centered care provided at Advanced Surgical Hospital has been recognized locally, regionally and nationally as evidenced by the accomplishments outlined below.

QUALITY OF CARE AND ACCOMPLISHMENTS:

Advanced Surgical Hospital is the regions highest performing hospital. This physician owned hospital and its team of dedicated physicians, staff, and leaders is committed to delivering each of the patients and family members it serves with care that is compassionate and exceptional in every aspect. Accomplishments include receiving the 5 Star Grading by CMS 2015. Advanced Surgical Hospital was the only hospital in the region that received this rating. The hospital has been in the 99th percentile for Patient Satisfaction since opening in April 2010. Advanced Surgical Hospital is required to survey every patient meeting criteria. Over 80% of patients surveyed complete and return the HCAHPS survey. Additionally, Advanced Surgical Hospital is the 2013 and 2014 Recipient of the Press Ganey Guardian of Excellence Award in Patient Satisfaction. This honor is awarded to fewer than 5% of all Press Ganey clients across the United States and Advanced Surgical Hospital is the only hospital in the region to receive this prestigious recognition for two consecutive years. Advanced Surgical Hospital was also recognized by Becker's Hospital Review 2014 as being one of the top physician owned hospitals to know in the United States and was recognized by Becker's Hospital Review 2014 as one of the 57 best overall patient rated hospitals in the United States. Advanced

Surgical Hospital was recognized by Becker Hospital Review 2014 as one of the best 67 hospitals in the United States for top nurse – patient communications.

Additionally, Advanced Surgical Hospital fully participated in 6 Hospital Engagement Network Collaborative in the State of Pennsylvania sharing knowledge and best practices with other acute care facilities, serving as a presenter at the best practice workshops on Fall Prevention and Wrong Site Surgery Prevention. In April 2015, the Hospital and Healthsystem Association of Pennsylvania awarded Advanced Surgical Hospital with several recognitions through the Pennsylvania Hospital Engagement Network. These award included: Overall Safety Across the Board Excellence Award, Wrong Site Surgery Prevention Project Excellence Award, Catheter Associated UTI Prevention Project Excellence Award, Venous Thromboembolism Prevention Project Excellence Award, and the Surgical Site Infection Prevention Project Excellence Award, Certificate of Appreciation Adverse Drug Events, Certificate of Appreciation Falls Reduction and Prevention Program.

Advanced Surgical Hospital had zero surgical site infections for 29 months. Advanced Surgical Hospital is fully accredited through the Joint Commission. The hospital received the Pittsburgh Business Times Best Places to Work Award in 2013 and 2014. Advanced Surgical Hospital also received a "perfect score" for the Highmark Hospital Pay for Value Program in FY2014 and maximum award points in FY2015 which encompasses the highest quality standards through our predominant payer. In 2014 and 2015, Advanced Surgical Hospital was named to the Women's Choice Award List: America's 100 Best Hospitals for Patient Experience.

Advanced Surgical Hospital has maintained a PHA Member in Good Standing since opening in April 2010. Advanced Surgical Hospital was named the 2014 Physician Hospital of the Year by Physician Hospitals of America (PHA). Advanced Surgical Hospital presented at the PHA 12th Annual Conference on "Creating an Exceptional Preoperative Experience" and at the 14th Annual Conference on "Enhancing the Transitions of Care Experience Through Patient Family Centered Care". Additionally, Advanced Surgical Hospital has published in the *Journal of Nursing Administration* and the *PHA Pulse.* These publications have showcased Advanced Surgical Hospital's achievements and outstanding awards while sharing best practices within the professional community.

Advanced Surgical Hospital has served as a site visit destinations for PHA Hospital colleagues from Texas, hospitals from New Jersey, and throughout the state of Pennsylvania, including the University of Pittsburgh Medical Center and Allegheny Health Network, to share our expertise and spread innovative practices to others. Advanced Surgical Hospital has participated in mentoring undergraduate student interns from Duquesne University, Saint Vincent College, Virginia Tech, Penn State University, Old Dominion University, and Christopher Newport University, Robert Morris University, Slippery Rock, as they explore and engage in academic study in healthcare related fields; Serve as clinical sites for medical students from LECOM and University of Pittsburgh; Serve as clinical site for physician assistant students from Chatham College, Seton Hill; PT / OT students from Duquesne, West Virginia University, West Liberty College, Saint Francis; PTA students from California University of Pennsylvania

Advanced Surgical Hospital is a setting in which a patient centered, quality focused environment demonstrates great success and generates a sense of pride in providing exemplary quality outcomes, innovation, and a passion to share best practices and advances within the professional community.

LOWER COSTS:

Advanced Surgical Hospital has steadily reduced Medicare Spending per Beneficiary (MSPB) from 1.09 to 1.03 over the five years since its founding. Ongoing measures are in place to further reduce costs. Detailed MSPB Spending Breakdowns by MDC as published in the Q4 2012 through Q3 2013 indicate that, for MDC 8 Musculoskeletal System and Connective Tissue Disorders, Advanced Surgical Hospital compares favorably at $22,986 average spending per episode verses $26,6534 and $26,432 at the state and national spending levels respectively. Although Advanced Surgical Hospital has no immediate plans for expansion, meeting future growth needs is impossible within the current restrictions of the moratorium.

EMERGENCY CARE PROCESSES:

Advanced Surgical Hospital provides emergency stabilization services to the community on a 24 / 7 basis. Patients presenting to the Emergency Stabilization unit are triaged and a disposition is established. Options for disposition include that the patient, if care needs fall within the scope of care at Advanced Surgical Hospital, may be admitted; those that require a higher level of care are transferred to a higher level of care based on patient choice or existing transfer agreement with a local community hospital; those that do not require inpatient admission are treated and released.

CONCLUSION:

Advanced Surgical Hospital offers elective orthopaedic care in the State of Pennsylvania serving patients in southern Allegheny County, Washington County, Greene County, and Fayette County. This physician owned hospital provides an exceptional level of patient centered care. Advanced Surgical Hospital demonstrates tremendous adaptive ability to apply Patient Family Centered Methodology and Practice to design care processes in a manner that combined best practices with exceptional, compassionate care. Since opening in 2010, Advanced Surgical Hospital has been successfully meeting the elective orthopaedic healthcare needs of Southwestern Pennsylvania residents in a manner that is consistent with their unwavering desire for quality care and exemplary surgical outcomes. Hospitals such as Advanced Surgical Hospital deserve a “level playing field” as they remain a viable component of the healthcare landscape within their communities. Our overall objective is to end discrimination in federal law against hospitals with physician ownership by supporting legislation introduced on a bi-partisan basis, H.R. 976, to increase patient access to physician owned hospitals.

Dr. Daryl List, Statement

Statement for the Record
House Ways and Means Health Subcommittee
Chairman Kevin Brady (R-TX) and Ranking Member Jim McDermott (D-WA)
"Improving Competition in Medicare: Removing Moratoria and Expanding Access"
May 19, 2015

I would like to thank Chairman Kevin Brady, Ranking Member Jim McDermott, and other members of the subcommittee for the opportunity to submit comments in connection with the above-mentioned hearing.

Edgewood Surgical Hospital, located in western Pennsylvania, made headlines as the first physician-owned hospital in the state. Headlines continue, not only for consistently ranking highest among the top hospitals in the state for patient satisfaction, but also among the leading hospitals in the U.S.A. for the lowest infection rate.

My name is Dr. Daryl List. I'm a minority owner of Edgewood Surgical Hospital. I've been affiliated with this hospital since its inception approximately twelve years ago and, for a majority of that time, have been a member of its board of directors.

Our surgical specialties include: general, orthopedic, ophthalmology, ENT, dental, podiatry, gastroenterology and acute and chronic pain management. We also provide imaging services with our state-of-the-art Open MRI.

Our original policy to accept all types of insurance remains intact.
And still, we are the lowest cost provider for surgical procedures in our area. Due to our combination of low-cost and quality-outcomes, some of our patients travel hundreds of miles because their insurer chooses Edgewood to provide total hip and knee replacements.

We've been able to flourish because of our commitment to quality low-cost care, despite other local health systems' lack of cooperation and less-than hospitable environment in our early years.

Our streamlined management style, cohesive staff, and hands-on physician-owner input allows us to respond to patient needs with changes to our health-care delivery much faster than many of the large health care systems. As a result, over the past twelve years, we have developed a loyal patient-base that appreciates our hospital's friendly staff, excellent care, cleanliness, and benchmark outcomes.

Our local government appreciates the increased tax base created by our for-profit entity. In summary, we have established ourselves as a leader in providing quality care and cost reductions in western Pennsylvania.

I appeal to the House Ways and Means Health Subcommittee to end the present federal discriminatory law of not allowing further expansion of physician-owned hospitals by supporting H.R. 976, thus increasing patient access to hospitals owned by physicians.

In conclusion, if the moratorium on expansion is not lifted our positive impact will proportionately decrease as surrounding hospitals continue to expand.

Respectfully submitted,
Daryl W. List, D.O.
Edgewood Surgical Hospital
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Michael Torn, Statement

Statement for the Record

House Ways and Means Health Subcommittee

Chairman Kevin Brady (R-TX) and Ranking Member Jim McDermott (D-WA)

"Improving Competition in Medicare: Removing Moratoria and Expanding Access"

May 19, 2015

Good Morning. My name is Michael Torn and I am currently the CEO of Edgewood Surgical Hospital (ESH) a physician-owned, surgical hospital in Transfer, PA. I have been in this role for seven years and have over 20 years of experience in various leadership roles of Hospital Administration; in both for-profit and non-profit entities. I would like to thank Chairman Kevin Brady, Ranking Member Jim McDermott and the other members of the subcommittee for this opportunity to provide input on the important issue of changing the Affordable Care Act (ACA), improving competition and expanding access to quality healthcare.

In my professional opinion, it is crucial that we take this opportunity to end the discrimination against physician-owned hospitals which is legislated in the ACA. We desperately need to improve competition and increase access to quality health care in all areas of the country, but especially here in Western Pennsylvania. I believe an effective starting point would be to abolish the ACA and allow physician ownership of specialty hospitals again.

A project funded by the Centers for Medicare and Medicaid Services (CMS) found the following:

- Although the policy debate tends to focus on specialty hospitals' possible "unfair" competitive advantage, we found that they actually stimulate a competitive environment in some markets, which could have positive effects on quality of care. Cardiac specialty hospitals in general, and orthopedic specialty hospitals in small markets in particular, heightened local competition for patients.
- Patient satisfaction among Medicare beneficiaries treated in specialty hospitals was very high. Contrary to allegations made by competing hospitals, we found very little evidence of poor quality of care in specialty hospitals relative to community hospitals; instead, we found many instances of high-quality care that should be encouraged. Physicians'

commitment to and pride in their specialty hospitals are powerful positive forces that critics have underappreciated. http://content.healthaffairs.org/content/25/1/106.full

Sadly, the lobbying influence for the largest health systems has attempted to cover the reality of what is happening in our communities. Once patients see a physician that is employed by a hospital system, they lose the ability to choose a physician that is not affiliated with that system. For example, if they see a UPMC physician and need a referral to a specialist, they will only be referred to a specialist within the UPMC system. This is unfortunate because many people do not have the time or the means to travel at least 60 miles to Pittsburgh to receive care.

We cannot utilize the same tactics that created the problem to start with. To decrease costs and deliver a higher quality of care, we must allow for competition in the arena of healthcare. If we continue with the status quo, these mega-hospital systems will eliminate choice all together.

At ESH, we have 50 physicians on staff; only 17 are owners. We have been open for 11 years. In 2014, ESH paid $95,000 in property and school taxes. Our Financial Classes are:

Medicare	36%
Medicaid	5%
Commercial	48%
Workers Comp	3%
Self-Pay	8%

We are the only hospital in the region that has partnered with Primary Health Network, a Federal Qualifying Health Center [FQHC] to help them improve access for low-income patients to receive high quality care at a lower cost. The large local non-profit hospital has not partnered with them or made concessions for those who are financially challenged.

It is unfathomable that the ACA would discriminate against physician-owned hospitals. When you or your loved ones must go to a hospital, terms such as "profit", "non-profit" or "physician owned" don't matter. What does matter is receiving the highest quality of care at the most affordable price. It's not the size, shape or ownership structure that makes a hospital – it's the care. Plain and simple, Edgewood is providing higher quality of care at a lesser cost.

Edgewood Surgical Hospital:

- ✓ ***Lowest infection rate in the Valley***
- ✓ ***Highest patient satisfaction rates in the Valley***
- ✓ ***Lowest patient-to-nurse ratio in the Valley***

Other sources, such as Medicare, **Patient Satisfaction Scores HCAHPS:** (Hospital Consumer Assessment of Healthcare Providers and Systems) indicate that Edgewood consistently has the highest patient satisfaction scores in our region.

Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)

- ***Edgewood Surgical Hospital*** **92%**
- Sharon Regional Health system **65%**
- UPMC Horizon **62%**
- Jameson Memorial Hospital **52%**

Payors, such as Highmark, have started publishing the reimbursement cost of various diagnostic and surgical procedures. ESH continues to demonstrate that we can provide higher quality at a lower cost as demonstrated below.

Knee Replacement Surgery

(COST TO INSURANCE COMPANY AND/OR PATIENT)

HIGHMARK.

EDGEWOOD SURGICAL HOSPITAL	SHARON REGIONAL HEALTH SYSTEM	UPMC HORIZON
$13,766 - $15,216	$17,911 - $19,797	$18,831 - $20,813

MRI of Lower Back without Contrast

EDGEWOOD SURGICAL HOSPITAL	SHARON REGIONAL HEALTH SYSTEM	UPMC HORIZON
$362 - $420	$615 - $679	$924 - $1,022

When I accepted the position of CEO in 2008, Edgewood was focused on growth and expansion and improving health care in this underserved community. Expansion plans for services and facilities were on the drawing board when the ACA came to pass. That brought everything to a halt and we were restricted from further growth. With the ACA in place, we have had to change our focus, and we cannot provide the range of services that we would like to for our community. However, if the ACA was lifted, we could change our direction and get back to growing our facilities and services.

Again, I would like to thank you for allowing me the opportunity to address this crucial issue that is interfering with the welfare of many of the members of our community. According to The Federal Trade Commission, "Competition in health care markets benefits consumers because it helps contain costs, improve quality, and encourage innovation." I couldn't agree more - if we want to do what is best for our patients, families, and community, we must change the laws oppressing physician-owned hospitals. It is time to get rid of the ACA, improve competition and expand access to healthcare.

David Lippert, Statement

Statement for the Record
House Ways and Means Health Subcommittee
Chairman Kevin Brady (R-TX) and Ranking Member Jim McDermott (D-WA)
"Improving Competition in Medicare: Removing Moratoria and Expanding Access"
May 19, 2015

Chairman Ryan and Subcommittee members, thank you for the opportunity to share testimony on the matter you weigh in this hearing. My name is David Lippert, and I am the Managing Member of Fresno Surgical Hospital (FSH) located in California. I am one of seven members which comprise the ownership of Physicians Surgery Centers, LLC, a minority owner and active management company for Fresno Surgical Hospital.

It is my desire to ensure that our facility, and those like it, is afforded the ability to continue to exist and grow as performance based markets would dictate.

Fresno Surgery Center was originally founded in 1984 as a physician owned ambulatory surgery center. Our center immediately rose in prominence based on the surgical outcomes, patient and physician satisfaction. In 1993 Fresno Surgical Hospital was licensed as an acute care hospital taking its quality of care to those surgical patients who needed care beyond the capability of an ambulatory surgery center. Over the years many market drivers have shaped and shifted the way that Fresno Surgical Hospital cared for our community, but none quite as drastically as the prohibitions laid out in the Affordable Care Act (ACA).

In the years leading up to the enactment of the ACA, FSH had achieved highest marks from many industry score keepers and demand by patients, insurers and physicians created the need to expand. This expansion would have allowed FSH to build an intensive care unit (ICU) along with additional inpatient beds and supporting facilities. Upon the enactment of the ACA the construction project had to be changed allowing only for the design improvements of operating rooms and patient beds currently in existence in 2010. FSH decided to enclose the structure that was slated to house the ICU and additional beds in hopes that it could at some point be filled. For many years now the second story shell of FSH has sat empty, in a region that CMS and the California Department of Health Services determined to have a looming hospital bed shortage.

While FSH continues to serve the broader community, it cannot do so to the extent that it, and the public it serves, would like. Currently 40% of the patients seen at FSH are Medicare or Medi-Cal (California Medicaid) participants. While the Hospital often loses money on these patients we consider it part of caring for the broader community, and do so with pride. With the current expansion prohibitions in place, patients have no choice but to go to other hospitals in the

region which have higher infection rates, worse outcome ratios, higher re-admission rates and cost patients, insurers and Medicare more money.

Approximately half of our admitting surgeons have no financial interest in FSH, but prefer to care for their patients at our facility based on outcomes, satisfaction and cost savings. All things equal, we simply do a better job at delivering better outcomes at lower prices than the large hospital systems. The increased transparency and data required under the ACA have borne this out.

Thank you for the opportunity to provide this testimony and for considering it in your evaluation of this proposed legislation.

Sincerely,

S. David Lippert
Managing Member, Fresno Surgical Hospital
6125 N. Fresno Street
Fresno, CA 93710
Cell (805) 701-3890 fax (559) 431-8242
david@psc-asc.com

Jason Leymeister, Statement

Improving Competition in the Medicare Program by Lowering Supervision Levels and Creating Independent CMS Billing Code for Radiologist Assistants

By: Jason Leymeister MS,RRA

A Radiologist Assistant (RA) is a midlevel healthcare provider, similar to a physician assistant or nurse practitioner, which provides services to patients in the Radiology sector of healthcare. An RA is a registered radiologist assistant (R.R.A.) that is nationally certified by the American Registry of Radiologic Technologists (ARRT). The RA is currently licensed in 29 states and growing. They work under the supervision of a Physician at all times and do not prescribe or offer diagnosis on their own accord. The RA saves time and money by performing exams and minor procedures for the Radiologist. This allows the Radiologist to offer a more focused and better quality interpretation of imaging studies therefore reducing the number of missed diagnosis.

The reduction of supervision levels and independent CMS billing number would instantly save millions a year in Medicare payouts. These savings will continuously accumulate into the billions in only a short amount of time.

The solutions for these problems are as follows:

Reducing levels of supervision by amending the current Medicare laws to include:

- *Defines the term "advanced level radiographer" to be RAs who perform radiologic procedures under the supervision of a radiologist.*
- *Provides that state law governs the Medicare physician supervision requirements for advanced level radiographers. It allows states to determine appropriate radiologist supervision levels and scope of practice for radiologist assistants. Medicare will only reimburse for procedures that the state determines is within the radiologist assistant's clinical competency.*

Create an independent billing code for RA's in CMS:

- *Have congress strongly recommend that CMS create a fast track or pilot program.*

Lafayette Surgical Specialty Hospital, Letter

LAFAYETTE SURGICAL
SPECIALTY HOSPITAL
— PHYSICIAN OWNED —

June 2, 2015

The Honorable Kevin Brady
Chairman
Ways and Means Subcommittee on Health
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

The Honorable James McDermott
Ranking Member
Ways and Means Subcommittee on Health
U.S. House of Representatives
II 02 Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Brady and Ranking Member McDermott,

Chairman Brady, Ranking Member McDermott, members of the subcommittee, allow me to introduce myself. l am Thomas V. Betiuccini, MD, FACS, MBA, a practicing neurosurgeon in practice over 30 years in my community, Lafayette, LA. l am a founding member of Lafayette Surgical Specialty Hospital (LSSH), a hospital owned by physicians and our corporate partner, National Surgical Healthcare. I also serve on the Board of Directors of Physician Hospitals of America and am a former Chairman of the LSSH Board of Directors. I recognized and experienced the exemplary patient care this hospital model offers through professional and legislative activities during conceptualization and development of physician owned hospitals in Louisiana and across the country.

Physician ownership and focused patient care are not new health care models and have been successful since the mid twentieth century. The concept reemerged a dozen years ago or so as physicians grew increasingly frustrated and discouraged by the ineptitude, indifference and sclerotic bureaucracy of large community hospitals which failed to improve conditions, environment and care for patients for decades. Physicians were never allowed to have a substantive voice or influence in decisions affecting care despite endless serious attempts to do so.

The overwhelming success of physician owned hospitals (POHs) relative to care, outcomes and cost alone justifies legislative support of this model, without restriction, and at least passage of HR 976 and HR 2513 currently under consideration. Numerous independent CMS and other government agencies repeatedly show the superiority of this approach to patient care. Criticisms by our competitors are simply without merit when the facts are examined in an unbiased manner. As our second U.S. President reminded us: "Facts are stubborn things…"

There is a bipmiisan suppmi for HR 976 as legislators recognize the benefits to patient care and communities in states where physician owned hospitals exist. Their careful analyses of the issues and statistics, discussions with physicians and administrative staff and hospital visits have surprised many; but all understand the value created by this innovative, competitive indushy and the importance the involvement of the men and women who know medicine and patient care best --- physicians.

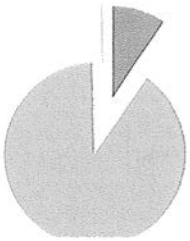
1101 Kaliste Saloom Road Lafayette, LA 70508 PH (337) 769-4100 FX (337) 769-4-209 www.LafayetteSurgical.com

Our Story

Lafayette Surgical Specialty Hospital (LSSH) is a 20-bed, 74,000 square foot physician-owned hospital located in Lafayette, LA. LSSH is a pmtnership of National Surgical Healthcare (NSH) and 34 individual physician investors. The Joint Commission accredited hospital consists of eight operating rooms and three procedure rooms where approximately 8,000 cases are performed annually. Since its inception in 2004, LSSH has been recognized as a state-of-the-art patient-focused facility that embraces specialized technology and equipment. The facility provides a wide scope of services including Neurosurgery, Orthopedics, ENT, General Surgery, Urology, Gynecology, Cosmetic Surgery, Bariatric Surgery, Pain Management, and Imaging and Diagnostic services.

LSSH is proud to maintain Joint Commission Accreditation year after year. This means that they continuously demonstrate safe, high-quality care, as determined by compliance with Joint Commission standards and National Patient Safety Goals. This deemed status accreditation ensures that LSSH meets the Centers for Medicare and Medicaid Services Conditions of Patticipation to care for Medicare and Medicaid patients.

LSSH contributes over $1.5 million annually to the Lafayette tax base through sales, propetty and payroll taxes and employs 215 people with annual salaries of approximately $10,000,000. LSSH is a good corporate citizen, active in the community and involved in charity work. They are a partner with the Lafayette Community Healthcare Clinic (LCHC) an organization that provides quality outpatient health care for the eligible working uninsured. Along with supplying manpower and sponsoring clinic sessions throughout the year, they also provide free services to LCHC clients in need. LSSH is a long time sponsor of their annual fundraiser "Silver Bell Soiree". LSSH also participates in and contributes to the following organizations: Affiliated Blind of Louisiana, Healing House, Family Tree, Festival International de Louisiane, Junior League of Lafayette, Lafayette Parish Medical Society, National Medical Association, UL Nursing Honor Society, and United Way of Acadiana.



"'Unpaid Cost of Medicaid Services($ 814,946)

↑Unpaid Cost of Medicare Services($ 7,682,730)

Charity Care & Donations ($47,716)

Payor Mix

	2013	2014	YTD April 2015
BCBS	37%	40%	41%
Medicare	28%	26%	28%
Comm/Out of Net	16%	15%	**11%**
WorkComp	10%	11%	12%
Medicaid	3%	2%	2%
In Network	2%	**1%**	2%
Legal	2%	3%	2%
SelfFay	1%	1%	**1%**
Govt	1%	1%	**1%**

Quality of Care

LSSH focuses on high quality and safety through patient-centered care delivered by highly skilled, dedicated and compassionate caregivers. Our measures of success include:

- Surgical Site Infection Rate of 0.40%, below the national benchmark of 0.90% (2013-2014)
- Hospital Wide Readmission Rate
  - Ranked 13'• in Louisiana (2012-2013)
  - Rate of 15.0%, below the national benchmark of 15.2% (2013-2014)
- Hand Hygiene Compliance Average of92% (2013-2014)
- Complication Rate after Total Joint Surgery 2.6%, below the national benchmark of 3.1% (2011-2014)

LSSH employs 215 people, 90 of which are registered nurses. All of our registered nurses maintain ACLS and PALS ce1tification as well as continuing education. The nurse to patient ratio is 1:4 or 1:5 based on acuity which allows for personal attention to the needs of each patient. These factors attribute to the low average length of stay of two days and patient satisfaction rates that are consistently 98% or higher.

Patients frequently comment on patient satisfaction surveys about the care they received at LSSH.

"Eve1yone was pleasant and caring. They explained in terms that I can understand. I really like the hospital and staff. I am glad my doctor is a part of such an excellent hospital!"

"The compassionate care, friendliness and attentiveness to my needs at your hospital were the best I've ever encountered at any hospital. Thank you for making my stay with you such a pleasant one. EveiJ>one made me feel right at home- true Southem hospitality."

"Every one of the medical staff was very ji-iendly and nice. I was treated with courtesy and respect. I will tell eve1yone that LSSH is the place to go and I will return if needed. I was ve1y pleased."

"Everyone is always so pleasant! I love the personal treatment we always receive. We are always so happy to return to LSSH due to that personal touch! Thank you for all that you do."

LSSH continues to work on performance improvement initiatives such as Wrong Site Surgery Prevention through the Joint Commission's Targeted Solutions project. In effmt to reduce surgical booking defects, the workgroup implemented the review of critical information (intake sheets, preference cards, consents and history and physicals) at different intervals for defects to ensure the accuracy of information. This allows for immediate resolution of issues and as a result, there was a decline in overall defects, a reduction in cancellations, and most importantly, no wrong site operations.

LSSH also implemented strategies from Project Joints, an Institute for Healthcare Improvement initiative focused on surgical site infection prevention. The project results prompted three evidenced based interventions, all of which were implemented for all adult surgical patients.

LSSH established a strong reputation and presence in the Acadiana community by exceeding patients' expectations for treatment, comfort, safety, and cost. CMS recently initiated a Star Rating for patient experience. Locally, LSSH is one of three hospitals in Lafayette which earned 5 Stars. Statewide, there were 17 hospitals that earned a 5-Star rating; eight of them are physician owned hospitals. LSSH is one of 251 hospitals nationwide to earn this ranking.

Value Based Purchasing incentives exceeded expectations for FY 2015. LSSH was eligible for pmticipation in the four domains of care; clinical process, patient experience, outcomes, and efficiency. Scores in these domains earned LSSH back the 1.5% payment reduction, plus an additional 0.858% (compared to only 0.19% in 2013) to yield a Value -Based Incentives Payment Percentage of 2.3589%.

LSSH continuously receives awards from various organizations for their quality and patient satisfaction. In 2011, the hospital received the Louisiana Hospital Capstone Quality Award, presented by eQHealth Solutions, the Medicare Quality Improvement Organization for Louisiana. LSSH was presented the award for improving the quality of health care for patients in the clinical area of surgical care. The one year project was aimed at achieving a 99% compliance rate with antibiotic cases for mthopedic and neurosurgery cases. It only took the hospital five months to reach their goal. LSSH received the 2013 National Surgical Healthcare (NSH) Quality Award for achieving and exceeding benchmark goals in patient satisfaction, infection prevention, medication administration and patient safety in addition to having no sentinel events. This is the highest award given to one of the 14 NSH acute care hospitals for overall improvement in their CMS quality scores.

Other LSSH awards for high quality and patient satisfaction include:

- America's Best Hospitals for 01thopedics-WomenCe1tified (2015)
- Outstanding Patient Experience Award – Healthgrades (2014, 2015)
- America's 100 Best Hospitals for Patient Experience-WomenCertified (2011, 2012,2014, 2015)
- Specialty Hospital of the Year-Louisiana State Nurses Foundation (2014)
- Best Specialty Hospital in Acadiana-The Times of Acadiana Readers' Poll (2013, 2014)
- Integrity Award-Better Business Bureau of Acadiana (2014)
- National Surgical Healthcare Satisfaction Award (2014)
- Hospital of the Year-Louisiana State Nurses Foundation (2007-2010)

It has been proven that happy employees make happy patients and LSSH is a shining example of employee satisfaction. They received the 100 Great Places to Work 2013- Becker's Hospital Review and Best Places to Work in Healthcare 2010, 2011, & 2014 – Modern Healthcare Magazine. LSSH employees have a voice, have autonomy to do their jobs, and are engaged in the family atmosphere encouraged by management.

Lower Cost

LSSH continuously looks for opportunities to lower cost to patients. Currently we participate in cost reduction initiatives such as reprocessing of select supplies, pricing formularies with vendors, and working with a Group Purchasing Organization (GPO) to ensure lowest cost for supplies.

Need to Expand and Hospital Preference

Excellent patient care and outcomes have resulted in an outstanding reputation for LSSH and increasing demand for services such that we can no longer accommodate patients and their surgeons unless we expand the number of operating rooms at our facility. Patients and surgeons either lose choice of hospital or delay their care, neither of which is satisfactory. None of us would prefer or easily accept that circumstance.

The eight physicians, myself included, who conceived of and built LSSH had three objectives: optimum patient care, highly qualified and satisfied employees and a better working environment for physicians. We achieved this by establishing high standards and committing to staying involved in major decisions relative to those goals. Despite the significant financial risk we simply wanted a better hospital to care for our patients. Any surgical care I can safely provide for my patients is done at LSSH as I trust the reliability and excellence of care provided there and can influence decisions affecting such care. That is not possible elsewhere in Lafayette.

Emergency Care

Emergency care at our hospital is provided by physician specialists who are available within minutes and by a highly competent nursing staff trained in emergency procedures and available constantly due to a low patient to nurse ratio. When necessary, transfer to a tertiary facility can be done rapidly. Due to rigorous patient screening standards developed by our anesthesia physicians this is rarely necessary. We do not have an Emergency Depattment (ED) by design. The criticism that many POH's lack emergency departments is a specious one. Designated EO/trauma centers serve the public best as concentrated high volume care by specialists creates excellence. The American College of Surgeons endorses this model and all metropolitan centers have adopted it. Requiring all hospitals to have an ED would not only waste resources but would be excessively costly and dilute focused care.

Conclusion

It is abundantly clear that physician owned hospitals provide outstanding health care to our citizens all of whom we want to have access to the best care. There was a valid reason this health care model developed and there are valid reasons it should be allowed to grow. This cannot be gainsaid.

Imitation is the sincerest form of flattery. Thus, large community hospitals across the country have emulated our model as they know and have said that focused care and physician involvement in health care decisions improves patient care. Indeed, LSSH has raised health care standards in our community, compelling the large community hospitals to improve their standards in order to remain competitive, as is the case with other cities in which physician owned hospitals exist. Criticism of the AHA and hospitals they represent, therefore, are disingenuous, at best, when claiming financial gain tlu·ough self referral is the primary goal of our hospitals and physicians. If that were the case, practice patterns (greater volume of surgical cases, for example) would have changed for individual surgeons. This argument has not been made as there is no data that could suppmt such a claim.

Competition has always been the lifeblood of progress and excellence in our country, both personally and in business. To limit it when there is no valid reason, especially in health care, is a disservice to those we provide service to for their well being and worse when one's life is on the line. I urge your serious, unbiased consideration and suppmt of HR 976 and HR 2513 and rescission of moratoria restricting greater access to care through expansion of physician owned hospitals.

Sincerely,

Thomas V. Be1tuccini, MD, FACS, MBA

Medicare Rights, Letter

MEDICARE RIGHTS CENTER
Getting Medicare right

May 19, 2015

The Honorable Kevin Brady
U.S. House of Representatives
Washington, DC 20515

The Honorable Jim McDermott
U.S. House of Representatives
Washington, DC 20515

Re: "Hearing on Improving Competition in Medicare: Removing Moratoria and Expanding Access"

Dear Chairman Brady and Ranking Member McDermott:

On behalf of the Medicare Rights Center (Medicare Rights), I am writing to submit a statement for the hearing record expressing support for the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) Competitive Bidding Program. Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. We provide services and resources to over 1.5 million beneficiaries, family caregivers, and professionals annually.

We believe the DMEPOS bidding program represents an important advancement in how Medicare pays for medical equipment and services. The program serves a triple aim, contributing to lower costs for older adults and people with disabilities, the right prices for Medicare, and a better deal for American taxpayers. According to the U.S. Department of Health and Human Services, "The program saved more than $580 million for beneficiaries and taxpayers in its first two years of operation, and it is projected to save the Medicare Part B Trust Fund $25.8 billion and beneficiaries $17.2 billion over ten years."[1]

Through the bidding program, medical equipment suppliers compete for Medicare's business on the basis of quality and price, submitting bids to serve beneficiaries in a specified region. Some claim the bidding program creates undue barriers to accessing needed medical equipment and supplies, but available evidence reflects the contrary. An initial report by the Government Accountability Office (GAO) determined beneficiary access and satisfaction were not affected by the bidding program in 2011, though careful monitoring was needed as the program expanded.[2] Similar findings were reported in 2012 through a subsequent GAO analysis.[3]

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[1] GAO, "Bidding Results from CMS's Durable Medical Equipment Competitive Bidding Program," (November 2014), available at: http://www.gao.gov/assets/670/666806.pdf
[2] GAO, "Review of the First Year of CMS's Durable Medical Equipment Competitive Bidding Program's Round 1 Rebid," (May 2012), available at: http://www.gao.gov/assets/600/590712.pdf
[3] GAO, "Second Year Update for CMS's Durable Medical Equipment Competitive Bidding Program Round 1 Rebid," (March 2014), available at: http://www.gao.gov/assets/670/661474.pdf

Trends heard on our national helpline are reflective of these findings. Our most common calls involve questions about coverage rules and concerns about denials of coverage. None of these inquiries are unique to the DMEPOS bidding program. We hear the same questions and concerns from those with Traditional Medicare in bidding areas, those in non-bidding areas, and among Medicare Advantage enrollees. We believe these trends reflect a general need for enhanced oversight of suppliers and education of beneficiaries across all Medicare coverage types.

While additional oversight may be warranted, according to GAO, the Centers for Medicare & Medicaid Services already utilize many tools to monitor beneficiary access through the DMEPOS bidding program. These tools include tracking 1-800-MEDICARE inquiries, analyzing national claims history, carrying out beneficiary satisfaction surveys, monitoring items furnished by suppliers, and conducting secret shopper calls. Another important beneficiary protection, unique to the DMEPOS bidding program, includes a dedicated ombudsman office, serving both Medicare beneficiaries and suppliers with bidding-related concerns.

In sum, we continue to support the DMEPOS bidding program, which is credited with creating sizable savings for the Medicare program, for beneficiaries, and for taxpayers—without compromising access to needed care. Rigorous oversight of the program, most notably of suppliers, should continue and be strengthened as necessary. Thank for the opportunity to submit a statement for the hearing record.

Sincerely,

Joe Baker
President
Medicare Rights Center

Dr. David L. Sappenfield, Statement

Statement for the Record
House Ways and Means Health Subcommittee
Chairman Kevin Brady (R-TX) and Ranking Member Jim McDermott (D-WA)
Improving Competition in Medicare: Removing Moratoria and Expanding Access
May 19, 2015

My name is David L. Sappenfield, MD and I am an ophthalmologist practicing for the last 26 years in Durham, North Carolina. I am currently an investor and approximately 1.5% owner in North Carolina Specialty Hospital (NCSH), a part physician-owned acute care surgical hospital also in Durham. Most importantly, however, I am a staff physician proudly and actively treating patients at NCSH. I started practice at McPherson Hospital and clinics, a private practice specializing in eye, ear, nose and throat care. Our practice was originally founded in the early 1900's here at a time when patient bills were sometimes satisfied by bartering for goods rather than cash payments. Our specialty hospital facility predated by many years all others in our region (including the now well-known Duke Hospital). Our doctors have taken great pride in treating all who need to be seen in a way each of us would want to be treated. Medical care has markedly changed over the last century and our hospital, in order to survive, has begun offering new services including orthopedic care. In 1998, our affiliation with Triangle Orthopedic Associates led to the founding of NCSH with the bed licenses formerly utilized by McPherson Hospital. Although our hospital name and scope of practice changed, our goal of always providing state-of-the-art care in a patient-centered environment never wavered.

As detailed in other testimony provided by Dr. Richard Bruch, a retired orthopedist who serves as Board Chair of NCSH, our hospital provides superb care as documented by the ratings of CMS and other entities. Currently NCSH ranks 10th in the nation under the CMS combined ratings for Value-Based Purchasing Program and the Hospital-Acquired Conditions Program. The CMS 30 day Readmission rating is released quarterly and NCSH always ranks #1 - #4 in the state. NCSH is one of only 251 hospitals in the nation to hold a 5 star CMS Patient Satisfaction rating. Consumer Reports Health assigned NCSH its highest rating for safest hospitals to have surgery, one of only two North Carolina hospitals to earn this designation.

How is this quality achieved? NCSH has a patient to nurse ratio of 4:1. All nurses must achieve ACLS and PALS certification within 6 months of employment. NCSH has an employee turnover rate of 7% annually; this rate is 1/3 the rate in the Triangle North Carolina region. Hospitalist physicians, who are Internists, are on site 24 hours per day, 7 days per week and they see every inpatient twice daily and record chart entries for these visits. A physician Anesthesiologist is present for every surgery performed. Medication reconciliation is performed on every inpatient by a licensed pharmacist. This is unique in the hospital industry and helps to make certain that every patient receives their medications correctly. As a result of this quality care, patient transfers to another hospital are low. During the past year, the patient transfer rate was 0.14%, 14 patient transfers with 10,056 patients treated.

NCSH provides lower cost care than other hospitals in the Raleigh-Durham-Cary-Chapel Hill area. For the same procedure, inpatient CMS reimbursement is more than 18% less than at the "non-profit" hospitals. For example, DRG Code 470 includes total knee replacement surgery. The Raleigh-Durham-Cary-Chapel Hill region has 8 hospitals performing these surgeries. NCSH Medicare payment for these surgeries is $10,102. The average Medicare payment for the remaining 7 hospitals in the region is $12,448. NCSH performs the same surgery at a lower cost and provides higher patient satisfaction and outcomes than our competition.

As a private, "for-profit" hospital, NCSH's potential growth has been restrained by the near strangle-hold "non-profit" Duke University Health System now holds on our local marketplace. NCSH has also been severely affected by Section 6001 of the Affordable Care Act. While Duke has been allowed to grow nearly unfettered, thereby allowing them to impose their own restrictions on access to care, greatly needed expansion NCSH might have considered has been stymied. We are therefore unable to offer any greater completion to Duke which could then drive down patient/payor costs and improve access/quality.

I therefore implore you to repeal or amend the Affordable Care Act Section 6001 so that existing hospitals with physician ownership may provide needed quality care to Medicare, Medicaid and Tricare patients. H.R. 976 begins the process of allowing hospitals with physician ownership to provide additional outstanding care at substantial savings to our patients and to government/private payors. Why should we continue to deny our great nation better care at lower cost while monopolistic "health systems" limit access/quality and drive up prices?

Thank you for your interest and support!

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Michael Russell, Statement

Statement for the Record
House Ways and Means Health Subcommittee
Chairman Kevin Brady (R-TX) and Ranking Member Jim McDermott (D-WA)
"Improving Competition in Medicare: Removing Moratoria and Expanding Access"
May 19, 2015

My name is Michael E. Russell II, M.D., orthopedic spine surgeon and one of the physician owners of Texas Spine & Joint Hospital (TSJH). Thank you Chairman Brady, Ranking Member McDermott and the subcommittee members for considering testimony in this important hearing. Texas Spine & Joint Hospital seeks an end to federal discrimination of physician-owned hospitals and encourages you to support H.R. 976 as a means to increase patient access to physician-owned hospitals.

Founded in 2002 in Tyler, TX, Texas Spine & Joint Hospital is a physician-owned hospital specializing in orthopedic and spine surgery, procedures, and tests. Serving the largest rural community in the state of Texas, TSJH includes a licensed acute care hospital, an outpatient surgery center, two walk-in clinics, and an ancillary imaging center. With 40 physician owners and a total medical staff of over 196, TSJH employs 300 full and part-time employees.

Much of the east Texas area is designated as rural, poor and medically underserved according to the United States Department of Health and Human Services. This includes multiple counties in the immediate service area of Texas Spine & Joint Hospital. Despite serving patients in such a rural and economically disadvantaged area, Texas Spine & Joint Hospital continues to receive distinguished rankings from both government agencies and private benchmarking firms. Recent honors include:

- 5-Star ranking from www.medicare.gov Hospital Compare for HCAHPS patient surveys
- Texas Medical Foundation Health Quality Institute's Gold Award for Texas Hospital Quality Improvement 2014
- Ranked in the 99th percentile nationally for patient satisfaction according to Press Ganey
- Top 100 in Nation and #1 in Market for Medical Excellence in Spinal Fusion and Spinal Surgery according to CareChex 2015
- #1 in Market for Patient Safety in Major Orthopedic Surgery according to CareChex 2015
- Top 100 in Nation and #1 in Market for Patient Satisfaction in Overall Hospital Care, Overall Medical Care and Overall Surgical Care according to CareChex 2015
- Becker's Hospital Review "125 Hospitals with Great Orthopedic Programs" in 2014
- Becker's Hospital Review "100 Hospitals with Great Neurosurgery and Spine Programs" in 2014
- Becker's Hospital Review "82 Physician-Owned Hospitals to Know" in 2014

These rankings and recognition, based on actual patient data, were earned while serving a patient base that is over 60% Medicare and Medicaid. Annually, TSJH performs over 2400 inpatient surgeries and over 15,000 spinal interventions. Additionally, TSJH ranks in the top 7% nationally in value-based purchasing, according to the American Hospital Association.

With a limited number of licensed beds, the hospital routinely operates at maximum capacity. At times, patients are unable to access much needed services because, simply put, the hospital is full. Unfortunately, under section 6001 of the healthcare bill, Texas Spine & Joint Hospital is unable to expand despite overwhelming support and need from the local community. By enabling expansion, more patients will be able to access the high-quality, lower-cost healthcare provided by TSJH.

As a physician-owned hospital, Texas Spine & Joint Hospital pays millions of dollars in local, state and national taxes. This is unlike major medical centers and large hospital systems that enjoy non-profit status while receiving additional state and national funding for serving medically underserved areas. TSJH operates in the same medically underserved areas, cares for a similar percentage of Medicare and Medicaid patients, and provides free services to Bethesda Health Clinic, a local clinic for the working poor, yet receives no governmental assistance.

The physicians and staff of Texas Spine & Joint Hospital implore the subcommittee members to acknowledge the vital role this hospital plays in the care of east Texans by lifting the ban on physician-owned hospitals. Again, I thank you for your time and consideration of this important topic.

Respectfully,

Michael E. Russell, II, M.D.
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MER:jm

Sharon P. Pearce, Letter and Addendum

June 1, 2015

Rep. Kevin Brady
Chairman
House Ways and Means Health Subcommittee
301 Cannon Senate Office Building
United States House of Representatives
Washington, DC 20515

Rep. Jim McDermott
Ranking Member
House Ways and Means Health Subcommittee
1035 Longworth House Office Building
United States House of Representatives
Washington, DC 20515

Dear Chairman Brady and Ranking Member McDermott:

On behalf of over 48,000 members of the American Association of Nurse Anesthetists (AANA), I am writing to thank you for holding the first of several hearings on improving Medicare access through increased competition. Advanced practice registered nurses (APRNs), including Certified Registered Nurse Anesthetists (CRNAs), practicing to the full scope of their training and expertise ensures patient safety and access to safe, high-quality care, and promotes healthcare cost savings as well as increased competition in the healthcare marketplace and the Medicare program. For your consideration, we are enclosing a synopsis of two letters the AANA submitted to the Federal Trade Commission regarding their workshops on ''Examining Health Care Competition'' for further information.

Current reimbursement structures in Medicare impede full practice by CRNAs and add to waste in the program. Medicare reimburses CRNAs and anesthesiologists at the same rate for the same high quality service -- 100 percent of a fee for providing non-medically directed (CRNA) or personally performed (anesthesiologist) services. Medicare also operates a payment system for "anesthesiologist medical direction"[1] that provides a financial incentive for anesthesiologists to "medically direct" CRNAs who are already directly providing patient access to high quality anesthesia care themselves as part of the surgical team caring for the patient. The Centers for Medicare & Medicaid Services (CMS) has stated that medical direction is a condition of payment of anesthesiologist services and not a quality standard.[2] An anesthesiologist claiming medical direction services may be reimbursed 50 percent of a fee in each of up to four concurrent cases that the physician "medically directs", totaling 200 percent over a given period of time, twice what the anesthesiologist may claim when personally performing anesthesia services in one case. Under medical direction, the CRNA may claim the remaining 50 percent of a fee for his or her case. Peer-reviewed evidence demonstrates anesthesiologist medical direction increases healthcare costs without improving value.[3]

Furthermore, current Medicare regulations[4] contain a costly and unnecessary requirement for physician supervision of CRNA anesthesia services that do not support delivery of health care in a manner that

[1] 42 CFR §415.110. http://www.ecfr.gov/cgi-bin/text-idx?SID=5ce8cb6375c7d5c22c454c7ec1fe07de&node=42:3.0.1.1.2&rgn=div5#42:3.0.1.1.2.3.1.4
[2] 63 FR 58813, November 2, 1998, http://www.gpo.gov/fdsys/pkg/FR-1998-11-02/pdf/98-29181.pdf .
[3] P. Hogan et. al, "Cost Effectiveness Analysis of Anesthesia Providers." Nursing Economic$. 2010; 28:159-169. http://www.aana.com/resources2/research/Documents/nec_mj_10_hogan.pdf
[4] 42 CFR 482.52(a)(4) for hospitals (see http://www.ecfr.gov/cgi-bin/text-idx?SID=04387f6850fa030cb817311427be6f5f&mc=true&node=se42.5.482_152&rgn=div8), 42 CFR 485.639 (c) for CAHs (see http://www.ecfr.gov/cgi-bin/text-idx?SID=04387f6850fa030cb817311427be6f5f&mc=true&node=se42.5.485_1639&rgn=div8),

allows states and healthcare facilities nationwide to make their own decisions based on state laws and patient needs. These requirements are more restrictive than the majority of state laws and impede local communities from implementing the most innovative and competitive model of providing quality care. Given the growing population of persons in the United States requiring healthcare, particularly among Medicare eligible populations, physician supervision requirements stand in the way of deploying the vast workforce contained with the supply of APRNs. Unnecessary requirements for physician supervision of APRNs contribute to duplication and waste in the healthcare delivery system. Scientific peer-reviewed research underscores that such supervision does not affect quality or outcomes and increases healthcare costs and also illustrates how CRNAs consistently deliver safe, high-quality, cost-effective anesthesia care.[5]

CRNAs play a vital role in ensuring access to safe, high quality and cost effective anesthesia care. Congress and Medicare may advance patient access to care, reduce healthcare costs and waste in the Medicare program, while promoting competition, by eliminating policy barriers to the full use of CRNAs. We look forward to working with you on this important issue and should the Committee have any questions, please contact the AANA Senior Director of Federal Government Affairs, Frank Purcell, at 202.484.8400, fpurcell@aanadc.com.

Sincerely,

Sharon Pearce

Sharon P. Pearce, CRNA, MSN
President

Attached: Addendum I: AANA Comments to Federal Trade Commission Health Care Workshop Request for Comment

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and 42 CFR 416.42 (b)(2)for ASCs (see http://www.ecfr.gov/cgi-bin/text-idx?SID=8198c35c58c98715100eb32ff0046536&mc=true&node=se42.3.416_142&rgn=div8).

[5] See American Association of Nurse Anesthetists, CRNAs: The Future of Anesthesia Care Today, http://www.future-of-anesthesia-care-today.com/research.php, and Christopher J. Conover and Robert Richards, "Economic Benefits of Less Restrictive Regulation of Advanced Practice Registered Nurses in North Carolina: An Analysis of Local and Statewide Effects on Business Activity, Duke University, February 2015, available at: http://chpir.org/wp-content/uploads/2015/02/Report-Final-Version.pdf.

Addendum I

The following comments were submitted in response to FTC Health Care Workshop, Project No. P131207 on March 10, 2014 and FTC Health Care Workshop, Project No. P13-1207 on February 16, 2015.

The AANA provided the FTC Health Care Workshop content covering the following areas:

I. Background of the AANA and Certified Registered Nurse Anesthetists (CRNAs)
II. Alternatives to Traditional Fee-for-Service Payment Models
III. Provider Network and Benefit Design
IV. Professional regulation of healthcare providers
V. Measuring and assessing quality of care
VI. Price transparency of healthcare services.

The content was composed so that each section could be read and considered independently by each workshop panel, therefore some material was repeated throughout the subject areas.

I. BACKGROUND OF THE AANA AND CRNAs

The AANA is the professional association for CRNAs and student nurse anesthetists. AANA membership includes more than 48,000 CRNAs and student registered nurse anesthetists representing over 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) and anesthesia professionals who safely administer more than 38 million anesthetics to patients each year in the United States, according to the 2012 AANA Practice Profile Survey. Nurse anesthetists have provided anesthesia care to patients in the U.S. for over 150 years, and high quality, cost effective and safe CRNA services continue to be in high demand. CRNAs are Medicare Part B providers and since 1989, have billed Medicare directly for 100 percent of the physician fee schedule amount for services.

CRNAs practice in every setting in which anesthesia is delivered: traditional hospital surgical suites and obstetrical delivery rooms; critical access hospitals; ambulatory surgical centers; the offices of dentists, podiatrists, ophthalmologists, plastic surgeons, and pain management specialists; and U.S. military, Public Health Services, and Department of Veterans Affairs healthcare facilities. CRNA services include providing a pre-anesthetic assessment, obtaining informed consent for anesthesia administration, developing a plan for anesthesia administration, administering the anesthetic, monitoring and interpreting the patient's vital signs, and managing the patient throughout the surgery. CRNAs also provide acute and chronic pain management services. CRNAs provide anesthesia for a wide variety of surgical cases and are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities.

Peer-reviewed scientific literature shows CRNA services ensure patient safety and access to high-quality care, and promote healthcare cost savings. According to a May/June 2010 study published in the journal of *Nursing Economic$*, CRNAs acting as the sole anesthesia provider are the most cost-effective model for anesthesia delivery, and there is no measurable difference in the quality of care between CRNAs and other anesthesia providers or by anesthesia delivery model.[i] Furthermore, an August 2010 study published in *Health Affairs* shows no differences in patient outcomes when anesthesia services are provided by CRNAs, physicians, or CRNAs supervised by physicians.[ii] Researchers studying anesthesia safety found no differences in care between nurse anesthetists and physician anesthesiologists based on an exhaustive analysis of research literature published in the United States and around the world, according to a scientific literature review prepared by the Cochrane Collaboration.[iii]

According to a 2007 Government Accountability Office (GAO) study, CRNAs are the predominant anesthesia provider where there are more Medicare beneficiaries and where the gap between Medicare and private pay is less.[iv] Nurse anesthesia predominates in Veterans Hospitals, the U.S. Armed Forces and Public Health Service. CRNAs work in every setting in which anesthesia is delivered including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers (ASCs), pain management facilities and the offices of dentists, podiatrists, and all types of specialty surgeons. As colleagues and competitors in the provision of anesthesia and pain management services, CRNAs and anesthesiologists have long been considered substitutes in the delivery of surgeries.[v]

In its landmark publication *The Future of Nursing: Leading Change, Advancing Health*, the Institute of Medicine made its first recommendation that advanced practice registered nurses (APRNs) such as CRNAs be authorized to practice to their full scope, in the interest of patient access to quality care, and in the interest of competition to help promote innovation and control healthcare price growth.[vi]

II. ALTERNATIVES TO TRADITIONAL FEE-FOR-SERVICE PAYMENT MODEL

The AANA supports the FTC's efforts to better understand the potential benefits of alternative payment models and whether they can offer significant cost savings while maintaining, or helping to improve, quality of care. Under the current fee-for-service model, there are instances where the current model contributes to high costs without improving quality. Similar to general physician payment, Medicare reimburses CRNAs and anesthesiologists the same rate for the same high quality service -- 100 percent of a fee for providing non-medically directed (CRNA) or personally performed (anesthesiologist) services. It also includes a system for "anesthesiologist medical direction"[vii] that provides a financial incentive for anesthesiologists to "medically direct" CRNAs who are capable of and are often providing patient access to high quality anesthesia care unassisted. An anesthesiologist claiming medical direction services may be reimbursed 50 percent of a fee in each of up to four concurrent cases, a total of 200 percent over a given period of time, twice what the anesthesiologist may claim when personally performing anesthesia services in one case. Under medical direction, the CRNA may claim the remaining 50 percent of a fee for his or her case. Peer-reviewed evidence demonstrates anesthesiologist medical direction increases healthcare costs without improving value.[viii] Furthermore, the Centers for Medicare & Medicaid Services (CMS) has stated that medical direction is a condition of payment of anesthesiologist services and not a quality standard.[ix]

In demonstrating the increased costs, suppose that there are four identical cases: (a) has anesthesia delivered by a non-medically directed CRNA; (b) has anesthesia delivered by a CRNA medically directed at a 4:1 ratio by a physician overseeing four simultaneous cases and attesting fulfillment of the seven conditions of medical direction in each; (c) has anesthesia delivered by a CRNA medically directed at a 2:1 ratio; and (d) has anesthesia delivered by a physician personally performing the anesthesia service. (There are instances where more than one anesthesia professional is warranted; however, neither patient acuity nor case complexity is a part of the regulatory determination for medically directed services. The literature demonstrates that the quality of medically directed vs. non-medically directed CRNA services is indistinguishable in terms of patient outcomes, quality and safety.) Further suppose that the annual pay of the anesthesia professionals approximate national market conditions, $170,000 for the CRNA[x] and $540,314 for the anesthesiologist.[xi] Under the Medicare program and most private payment systems, practice modalities (a), (b), (c) and (d) are reimbursed the same. Moreover, the literature indicates the quality of medically directed vs. non-medically directed CRNA services is indistinguishable. However, the annualized labor costs (excluding benefits) for each modality vary widely. The annualized cost of practice modality (a) equals $170,000 per year. For case (b), it is ($170,000 + (0.25 x $540,314) or $305,079 per year. For case (c) it is ($170,000 + (0.50 x $540,314) or $440,157 per year. Finally, for case (d), the annualized cost equals $540,314 per year.

Anesthesia Payment Model	FTEs / Case	Clinician costs per year / FTE
(a) CRNA Nonmedically Directed	1.00	$170,000
(b) Medical Direction 1:4	1.25	$305,079
(c) Medical Direction 1:2	1.50	$440,157
(d) Anesthesiologist Only	1.00	$540,314
Anesthesiologist mean annual pay	*$540,314*	*MGMA, 2014*
CRNA mean annual pay	*$170,000*	*AANA, 2014*

If Medicare and private plans pay the same rate whether the care is delivered according to modalities (a), (b), (c) or (d), someone in the health system is bearing the additional cost of the medical direction service authorized under the Medicare regulations at 42 CFR §415.110. This additional cost is shifted onto hospitals and other healthcare facilities, and ultimately to patients, premium payers and taxpayers. With CRNAs providing over 38 million anesthetics in the U.S., and a considerable fraction of them being "medically directed," the additional costs of this medical direction service are substantial. In addition, the most recent peer-reviewed literature makes clear that the requirements of anesthesiologist medical direction are often not met in practice– and if anesthesiologists submit claims to Medicare for medical direction but did not perform all of the required services in each instance, then the likelihood of widespread Medicare fraud in this area is high. Lapses in anesthesiologist supervision of CRNAs are common even when an anesthesiologist is medically directing as few as two CRNAs, according to an important new study published in the journal *Anesthesiology*.[xii]

Another factor driving up the cost of healthcare under the current fee-for-service model is the practice of hospital subsidization of anesthesiology groups, in which hospitals pay high compensation to anesthesiology groups to offset the shortfall from decreasing reimbursement to these anesthesiology groups. According a nationwide survey of anesthesiology group subsidies,[xiii] hospitals pay an average of $160,096 per anesthetizing location to anesthesiology groups, an increase of 13 percent since the previous survey in 2008. An astounding 98.8 percent of responding hospitals in this national survey reported that they paid an anesthesiology group subsidy. Translated into concrete terms, a hospital with 20 operating rooms pays an average of $3.2 million in anesthesiology subsidy. Such payments from hospitals to anesthesiology groups do not appear on hospitals' Medicare cost reports or their billings to health plans, making information about them hard to come by except from survey information. Anesthesiology groups receive this payment from hospitals in addition to their direct professional billing. Without question, such subsidy payments to anesthesiology groups represent cost-shifting away from other critical services within the healthcare delivery system.

As the FTC examines the merits of alternative payment systems, we recommend ensuring that these alternatives are in the best interests of the patients receiving care, that they encourage improvements in patient care quality and efficiency, and that the alternative payment systems have been developed and deployed in a manner that healthcare professionals deem as valid.

Alternative payment systems should recognize and reward all qualified healthcare providers, not just physicians, for ensuring patient access to safe, cost-effective healthcare services. Bundled payment systems can reward care coordination and cost-efficiency, but without an equal and crucial focus on quality such systems can lead to a harmful "race to the bottom" when incentives to cut costs are not balanced with quality standards – an outcome that must be avoided. Bundled payment systems should recognize the full range of qualified healthcare providers delivering care, including CRNAs and other APRNs, and avoid physician-centricity that increases costs without improving quality or access.

Alternative payment models, such as bundled payment, have the potential to drive value-based healthcare delivery, particularly in anesthesia care and related services, and meet the triple health care aims of improving patient experience of care, improving population health and reducing health care costs. But certain alternative payment models do not follow these goals and instead lead to higher healthcare costs and decreased access to safe, high quality anesthesia providers such as CRNAs. One type of payment model that does not drive value-based healthcare delivery can be found in large group practices composed solely of anesthesiologists. Holding substantial market power, these large anesthesiologist-only group practices enter into exclusive single source contract service agreements with health systems, facilities and surgeons where the group practice's market power increases costs, limits choice of anesthesia provider, and imposes opportunity costs that deprive resources from delivery of other critical healthcare services. Such enterprises may use their market power to maximize their income without relation to the actual costs of performing the procedure.[xiv] For example, according to the New York Times, a patient was billed $8,675 for anesthesia during cardiac surgery. The anesthesia group accepted $6,970 from United Healthcare, $5,208.01 from Blue Cross and Blue Shield, $1,605.29 from Medicare and $797.50 from Medicaid.[xv] This type of model drives up healthcare costs and puts additional economic strain on consumers and the country.

III. PROVIDER NETWORK AND BENEFIT DESIGN

We have found that in some states, health plan networks operating in exchanges and in the private market conduct discriminatory behaviors based on provider licensure which violates the provider nondiscrimination provision in the Affordable Care Act and inhibits CRNAs' ability to practice to full extent of their scope of practice. The end result of these practices is increased healthcare costs, diminished competition and reduced patient choice for safe, high quality and cost-effective anesthesia and related services.

The federal provider nondiscrimination provision in the Patient Protection and Affordable Care Act (Sec. 1201, Subpart 1, creating a new Public Health Service Act Sec. 2706(a), "Non-Discrimination in Health Care, 42 USC §300gg-5),[xvi] which took effect January 1, 2014, states that "a group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any healthcare provider who is acting within the scope of that provider's license or certification under applicable State law." It also states that, "nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures."

Section 2706 is an important law because it promotes competition, consumer choice and high quality healthcare by prohibiting discrimination based on provider licensure that keeps patients from getting the care they need. To promote patient access to high quality healthcare, market competition and cost efficiency, health insurance exchanges, health insurers and health plans must avoid discrimination against qualified, licensed healthcare professionals, such as CRNAs, solely on the basis of licensure. Proper implementation of the provider nondiscrimination provision is crucial because health plans have wide latitude to determine the quantity, type, and geographic location of healthcare professionals they include in their networks, based on the needs their enrollees. However, when health plans organize their healthcare delivery in such a way that they discriminate against whole classes of qualified licensed healthcare professionals by licensure -- by prohibiting reimbursement for anesthesia and pain management services provided by CRNAs, for example -- patient access to care is impaired, consumer choice suffers, and healthcare costs climb for lack of competition.

The provider nondiscrimination provision also respects local control and autonomy in the organization of healthcare delivery systems, health plans and benefits. It does not impose "any willing provider" requirements on health plans, and it does not prevent group health plans or health insurance issuers from establishing varying reimbursement rates based on quality or performance measures.

Types and Examples of Provider Discrimination

The AANA believes it is discrimination if health plans or health insurers have a policy that reimburses differently for the same services provided by different provider types solely on account of their licensure. Medicare reimburses CRNAs directly for their services and does so at 100 percent of the physician fee schedule amount for services, the same rate as physicians for the same services. The Omnibus Budget Reconciliation Act (OBRA) of 1986 authorized direct reimbursement of CRNA services under Medicare Part B beginning in 1989.[xvii] The Medicare regulation implementing the OBRA law, updated as part of a November 2012 final rule further clarifying the authorization of direct reimbursement of nurse anesthesia services within the provider's state scope of practice,[xviii] states, "Medicare Part B pays for anesthesia services and related care furnished by a certified registered nurse anesthetist who is legally authorized to perform the services by the State in which the services are furnished."[xix] The final rule also states, "Anesthesia and related care means those services that a certified registered nurse anesthetist is legally authorized to perform in the state in which the services are furnished." The agency also said in the rule's preamble, "In addition, we agree with commenters that the primary responsibility for establishing the scope of services CRNAs are sufficiently trained and, thus, should be authorized to furnish, resides with the states."[xx] Therefore, the Medicare agency stands on solid ground in clarifying that the nondiscrimination provision should apply to private plans in a way that is consistent with Medicare direct reimbursement of CRNA services where they are allowed to furnish those services under state law.

Unfortunately, we have heard from our members who state that certain health plans and insurers across the United States have policies that discriminate against CRNAs. In many of these cases, health plans or insurers either do not reimburse CRNAs at all for anesthesia services that are fully reimbursed when performed by anesthesiologists, or they reimburse CRNAs at a lower rate than anesthesiologists for performing the same services. For example, effective November 1, 2013, Regence Blue Shield of Idaho lowered CRNA reimbursement by 15 percent for anesthesia services. Its new policy states, "Physician conversion factor is $55.10. Certified Registered Nurse Anesthetist conversion factor is $46.84."[xxi] When justifying its rationale for setting the reimbursement rates for all non-physician healthcare providers, including CRNAs, at 85 percent of the physician rate, Regence stated in a letter to a CRNA that the decision was in part "based on the difference in education, training and scope of practice" between physician and non-physician providers. Regence did not identify any differences in "quality or performance measures" to explain the reimbursement differential. As we have shown above, the literature is clear in showing that no quality outcomes difference can be found between the models of CRNA anesthesia care, anesthesiologist services, or both professionals providing anesthesia care together.

If a health plan or health insurer network offers a specific covered service, Section 2706 requires that the health insurer or health plan network include all types of qualified licensed providers who can offer that service. If a health plan offers coverage for anesthesia services, it should allow all anesthesia provider types to participate in their networks and should not refuse to contract with CRNAs just based on their licensure alone. For example, as of April 2012, Blue Cross Blue Shield of South Carolina states in its anesthesia guidelines policy manual that it will not reimburse CRNAs for monitored anesthesia care (MAC), but it will pay anesthesiologists for these same services.[xxii] Specifically the policy states, "BlueCross may reimburse for modifiers QS, G8 and G9 if a physician personally performs the procedure (modifier AA) and if the procedure meets medical necessity criteria. BlueCross will not reimburse CRNAs for MAC."[xxiii]

The AANA views all of these policies outlined above as examples of discrimination against CRNAs based on their licensure and not based on CRNA quality and performance, and such discrimination clearly is prohibited by Section 2706. These policies impair patient access to care provided by CRNAs, and they expressly impair competition and choice, and contribute to unjustifiably higher healthcare costs without improving quality or access to care. The negative impacts of provider discrimination can hit rural communities hardest, where CRNAs are the primary anesthesia professionals and often the sole anesthesia providers. The availability of CRNAs in rural America enables hospitals and other healthcare facilities to offer obstetrical, surgical, and trauma stabilization services to patients who otherwise might be forced to travel long distances for these essential care. As stated above, CRNAs have been providing safe and high-quality anesthesia care in the United States for 150 years and the AANA is a determined advocate for patients and CRNAs concerning issues such as access to quality healthcare services and patient safety.

We believe proper implementation of the provider nondiscrimination provision by preventing health plans and health insurers from discriminating against specific types of health providers, such as CRNAs, will ensure full access to anesthesia services and to the procedures and services that they make possible, efficient delivery and local management and optimization of these services, and equitable reimbursement for CRNA services based on quality and performance, rather than licensure. This is consistent with the FTC's and the public's interests in quality, access and cost-effectiveness. Ensuring that health plans and health insurers adhere to the provider nondiscrimination law will protect competition and patient choice and promote patient access to a range of beneficial, safe, and cost-efficient healthcare services, such as those provided by CRNAs.

IV. PROFESSIONAL REGULATION OF HEALTHCARE PROVIDERS

Several constraints in the legislative, regulatory, and practice arenas inhibit CRNAs' ability to practice to full extent of their scope, reducing competition and choice and increasing healthcare costs. CRNAs' ability to practice to their full scope is also affected by Medicare regulations associated with Medicare Part A Conditions of Participation and Conditions for Coverage (CoPs and CfCs). The Medicare CoPs and CfCs are federal regulations with which particular healthcare facilities must comply in order to participate in the Medicare program. While these regulations directly apply to facilities, they affect CRNA practice and impair competition and choice. In particular, the requirement for physician supervision of CRNA services is costly and unnecessary.[xxiv] This requirement is more restrictive than the majority of state laws and impedes local communities from implementing the most innovative and competitive model of providing quality care. Reforming the CfCs and the CoPs to eliminate the costly and unnecessary requirement for physician supervision of CRNA anesthesia services supports delivery of health care in a manner allowing states and healthcare facilities nationwide to make their own decisions based on state laws and patient needs, thus controlling cost, providing access and delivering quality care.

Though one common argument for additional regulation is to protect public safety, there is no evidence that physician supervision of CRNAs improves patient safety or quality of care. In fact, there is strong and compelling data showing that physician supervision does not have any impact on quality, and may restrict access and increase cost. Studies have repeatedly demonstrated the high quality of nurse anesthesia care, and a 2010 study published in *Health Affairs*[xxv] led researchers to recommend that costly and duplicative supervision requirements for CRNAs be eliminated. Examining Medicare records from 1999-2005, the study compared anesthesia outcomes in 14 states that opted-out of the Medicare physician supervision requirement for CRNAs with those that did not opt out. (To date, 17 states have opted-out.) The researchers found that anesthesia has continued to become safer in opt-out and non-opt-out states alike. In reviewing the study, the *New York Times* stated, "In the long run, there could also be savings to the health care system if nurses delivered more of the care."[xxvi]

Another restriction in the Part A CfC regulations impairs CRNAs' ability to evaluate the risk of anesthesia in ambulatory surgical centers (ASCs), which again constrains competition and choice and increases healthcare costs without improving quality. Performing the comprehensive preanesthetic assessment and evaluation of the risk of anesthesia is within the scope of practice of a CRNA.[xxvii] We have asked that CMS recognize CRNAs as authorized to evaluate the risk of anesthesia immediately before a surgical procedure performed in an ASC in the same manner that the agency recognizes both CRNAs and physicians conducting the final pre-anesthetic assessment of risk for a patient in the hospital. In actual practice, CRNAs evaluate patients preoperatively for anesthesia risk in the ASC environment. The CRNA has a duty to do so, consistent with Standard 1 of the Standards for Nurse Anesthesia Practice.[xxviii] The current ASC rule on preanesthesia examination is inconsistent with ASC rules regarding patient discharge, and with Medicare hospital CoPs in this same area. Under the hospital CoPs for anesthesia services (42 CFR§ 482.52 (b) (1)), CRNAs are recognized to perform the

pre-anesthesia evaluation for hospital patients presenting with a greater range of complexity and multiple chronic conditions than ASC patients.

Yet another restrictive regulation in the CoPs is the requirement that a physician serve as the director of anesthesia services. This requirement places regulatory burdens on hospitals where they need to pay a stipend for a physician "in name only" to serve as director of the anesthesia department instead of allowing the hospital to have the flexibility to retain those services if they so desired. In some cases, the existing regulation leads to confusion by placing into the hands of persons inexpert in anesthesia care a federal regulatory responsibility for directing the unified anesthesia service of a hospital solely because he or she is a doctor of medicine or of osteopathy. In other cases, the hospital may contract with and pay a stipend to an anesthesiologist for department administration only, solely because there is a federal regulation. There is no evidence supporting the requirement for a physician or osteopathic doctor to direct anesthesia services. Again, such a regulation impairs choice and competition, and increases healthcare costs without improving quality.

Constraints in the legislative, regulatory, and practice arena can ultimately result in anticompetitive practices and collusion, increasing healthcare costs and diminishing quality of care and patient choice. In the early 2000s, the FTC and DOJ conducted two years of hearings on healthcare and antitrust, yielding a landmark joint report entitled *Improving Health Care: A Dose of Competition.*[xxix] More recently, the IOM report entitled *The Future of Nursing: Leading Change, Advancing Health*[xxx] specifically recommended that the FTC examine how anticompetitive acts, such as limiting APRNs like CRNAs from providing care to the fullest extent of their education and skill, reduce patient choice and increase healthcare costs without improving quality.

On the state level, the staff of the FTC's Office of Policy Planning, Bureau of Economics, and Bureau of Competition has submitted comment letters in response to proposed bills and a proposed rule that, if adopted, would impact the scope of practice of CRNAs and advanced practice nurses. In these letters, the FTC discouraged unnecessary restrictions on CRNA practice[xxxi] and supported eliminating requirements that advanced practice nurses collaborate with, or be supervised by, physicians.[xxxii]

The FTC has warned that unnecessary legislative or regulatory restrictions on CRNA pain management practice, if adopted, could reduce competition, raise the prices of pain management services, reduce the availability of these services, especially for the most vulnerable patients, and discourage healthcare innovation in this area. [xxxiii] Allowing CRNAs to practice to the full scope of their training and expertise in all areas of their practice will increase competition in the healthcare marketplace, as reflected by the FTC's own assessment of the competitive impact of various bills and proposed rules relating to regulatory restrictions on advanced practice nurses.

The FTC submitted letters commenting on restrictive pain management bills in Tennessee (2011), Missouri (2012) and Illinois (2013) respectively, expressing significant concern about overbroad state proposals that would prohibit or unduly restrict CRNA pain management practice, thereby raising prices and reducing availability of CRNA services.[xxxiv] In Tennessee and Missouri, the bills ultimately passed; however, the FTC comment letters generated discussion amongst the legislators and were cited during hearings. CRNAs utilized these letters as educational tools with legislators and as references during negotiations for more acceptable and less restrictive bill language. In Illinois, a restrictive pain management bill stalled at the committee level in 2013; a similar, revised restrictive pain management bill was introduced in Illinois in 2014 and is currently pending.[xxxv] The CRNAs are using the FTC's 2013 comment letter on the previous Illinois pain management bill in their efforts to educate legislators on the anti-competitive impacts of the bill.

In addition, the FTC commented favorably on bills in Connecticut (2013) and Massachusetts (2014) that proposed eliminating unnecessary restrictions on advanced practice registered nurses (APRNs).[xxxvi] The FTC stated that eliminating the requirement that APRNs have collaborative agreements with physicians in order to practice independently could benefit Connecticut health care consumers by expanding choices for patients, containing costs, and improving access to primary health care services (note that this collaborative agreement requirement does not apply to CRNAs).

V. PRICE TRANSPARENCY OF HEALTHCARE SERVICES

Anesthesia pricing is among the most opaque in all of healthcare, impairing competition and innovation. The medical direction payment model, in which an anesthesiologist performs seven specific tasks in each of up to four concurrent cases in exchange for 50 percent of a Medicare anesthesia fee, the CRNA providing the anesthesia service claiming the other 50 percent[xxxvii], is unique in healthcare, fails to fairly or accurately reflect the services provided to patients by each professional, and contributes significantly to healthcare cost growth. When a hospital employs CRNAs, and contracts with

an anesthesiology group to provide anesthesiologist services, it is not uncommon for patients and plans to receive two bills for anesthesia services – or to learn, unpleasantly, that the anesthesiologist group is outside of the plan's network and demands full payment directly. The medical direction payment model introduces high costs of additional personnel that are not required to deliver an anesthesia service safely and effectively.

On account of the medical direction payment model, it is increasingly common that billings for anesthesia services do not represent all anesthesia costs in the system. One factor driving up the cost of healthcare is the practice of hospital subsidization of anesthesiology groups, in which hospitals pay high compensation to anesthesiology groups to offset the shortfall from decreasing reimbursement to these anesthesiology groups. According a nationwide survey of anesthesiology group subsidies,[xxxviii] hospitals pay an average of $160,096 per anesthetizing location to anesthesiology groups, an increase of 13 percent since the previous survey in 2008. An astounding 98.8 percent of responding hospitals in this national survey reported that they paid an anesthesiology group subsidy. Translated into concrete terms, a hospital with 20 operating rooms hospital pays an average of $3.2 million in anesthesiology subsidy. Anesthesiology groups receive this payment from hospitals in addition to their direct professional billing.

The agency also asked for examples where price transparency might facilitate price coordination among healthcare providers thereby damaging competition. Some anesthesia groups establish single source contracts with hospitals and healthcare facilities and the anesthesiology group does not negotiate with health plans. The group bills the patient directly for specific procedures, resulting in high out of pocket costs for the patient and curbing competition that could give patients more choices that may be less expensive.[xxxix] This type of model uses economic incentives and to drive up healthcare costs, while putting economic strains on consumers.

XI. MEASURING AND ASSESSING QUALITY OF HEALTH CARE

As we have stated previously, peer-reviewed scientific literature shows CRNA services ensure patient safety and access to high-quality care, and promote healthcare cost savings. According to a May/June 2010 study published in the journal of *Nursing Economic$*, CRNAs acting as the sole anesthesia provider are the most cost-effective model for anesthesia delivery, and there is no measurable difference in the quality of care between CRNAs and other anesthesia providers or by anesthesia delivery model.[xl] Furthermore, an August 2010 study published in *Health Affairs* shows no differences in patient outcomes when anesthesia services are provided by CRNAs, physicians, or CRNAs supervised by physicians.[xli]

In three significant aspects, Medicare billing modalities tend to significantly underrepresent the contributions that CRNAs and other APRNs make to healthcare delivery. In the field of anesthesia, billing services as "medically directed" suggests that in such cases anesthesiologists have performed each of the seven medical direction steps for which medical direction reimbursement is claimed. According to AANA member surveys and more importantly the American Society of Anesthesiologists journal *Anesthesiology*, medical direction frequently lapses[xlii] and one or more of the "medical direction" services are actually performed by the CRNA, just as they are performed when a service is billed nonmedically directed. Second, in many fields, the services of CRNAs, APRNs and other healthcare providers are frequently billed "incident-to" the services of a physician. Under "incident-to," the claim is paid at 100 percent, and the claim indicates that the service was provided by the physician not the CRNA or other APRN, without providing any modifier indicating who actually performed the service. "Incident-to" drives substantial underrepresentation of APRN services when claims data undergo examination. Last, not all Medicare Part B services provided by CRNAs are billed through Medicare Part B. In qualifying rural hospitals, Medicare Part A reimburses for the "reasonable cost" of CRNA services through a pass-through payment to the hospital. The CRNA may not bill Part B for services that the hospital bills Medicare through Part A. With CRNA services predominating in rural America, and many CRNA services noted not in Part B claims but embedded in Part A cost reports, ordinary Part B claims data underrepresents the anesthesia and pain management services CRNAs provide, particularly in rural and frontier parts of the United States.

With respect to registries, we strongly recommend that the infrastructure for quality reporting be accessible and transparent, particularly when it drives incentive payments from public benefit programs. Current registry procedures raise serious concerns about their accuracy and reliability with respect to reporting CRNA service provision. Under many registry practice rules the services that CRNAs and APRNs provide are often kept from being reported to registries organized and managed by medical specialty societies. When APRN services and data are reportable, the terms for participation and data submission are different from those that medical specialty society registries extend to physicians. In some cases physician organizations charge exorbitant fees for non-guild members to enroll in a registry, which is prohibitive to advanced practice nursing groups' participation. In this way, registries developed in response to public

policy promoting healthcare quality may instead be used to justify illegitimate protection of guilds, higher healthcare costs, less competition and reduced access to care.

The FTC asked for a description of any challenges that are encountered when measuring quality. The AANA remains concerned over the use of EHR reporting, especially when CRNAs and other APRNs are ineligible for EHR incentives, and note that this is a barrier to reporting of quality measures. We understand that the HITECH Act[xiii] did not include CRNAs as an "Eligible Professional," thus making them ineligible for incentive payments. However, CRNAs are "eligible professionals" under the Physician Quality Reporting System (PQRS) who regularly report quality measures and are eligible for incentive payments under that program. The AANA remains concerned that CRNAs must not be penalized in Medicare payment or in eligibility for PQRS incentives simply because they are currently ineligible for the EHR incentive program. We note that CMS seems to assume that CRNAs and other healthcare professionals will rely on the facilities where they work in order to adopt this technology. However, whole categories of healthcare facilities, such as ambulatory surgical centers (ASCs), are also ineligible for EHR incentive programs. Multiple levels of ineligibility cause an additional obstacle for providers, such as CRNAs, to have access to this technology in order to report quality measures electronically. Furthermore, the AANA is concerned that as CMS moves from claims based reporting to solely reporting through EHR-based reporting systems and through clinical registries, information on CRNAs will be underreported. As CMS expands the quality measures that can be reported through an EHR and ultimately ends the way that CRNAs predominately report measures, healthcare professionals such as CRNAs are at risk for being penalized and being placed at a disadvantage if they do not have access to report through a qualified EHR.

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[xvi] Patient Protection and Affordable Care Act, Sec. 1201, Subpart 1, creating a new Public Health Service Act Sec. 2706(a), Non-Discrimination in Healthcare (42 U.S.C. §.300gg-5). The statutory provision reads as follows: "(a) Providers.--A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any healthcare provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any healthcare provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures."

[xvii] Pub.L. 99-509 (42 U.S.C. § 1395 ll(a)(1)(H), 42 U.S.C. § 1395 s(s)(11)).

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[xxi] Regence Blue Shield of Idaho Professional Fee Schedule 2013 Supplemental Information: http://www.assets.regence.com/idreg/library/docs/2013-11-01/supplemental-information.pdf

[xxii] Blue Cross Blue Shield of South Carolina Anesthesia Guidelines: http://web.southcarolinablues.com/UserFiles/schlues/Documents/Providers/Anesthesia%20Guidelines_2012.pdf

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[xxxi] *See* FTC November 3, 2010 letter to the Alabama State Board of Medical Examiners at http://www.ftc.gov/opa/2010/11/alabamarule.shtm .

[xxxii] *See* FTC March 19, 2013 letter to Connecticut State Representative Theresa W. Conroy at http://www.ftc.gov/news-events/press-releases/2013/03/ftc-staff-connecticut-should-consider-expanding-advance-practice and FTC January 23, 2014 letter to Massachusetts State Representative Kay Khan at http://www.ftc.gov/news-events/press-releases/2014/01/ftc-staff-massachusetts-should-consider-removing-physician.

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[xxxix] Hogan, *op cit.*

[xl] Dalisse, *op cit*

[xli] Epstein, *op cit*

[xlii] American Recovery and Reinvestment Act of 2009. Pub. L. No. 110-275. http://www.gpo.gov/fdsys/pkg/PLAW-111publ309/html/PLAW-111publ309.htm

American Medical, Statement

Statement

of the

American Medical Association

to the

Committee on Ways and Means
Subcommittee on Health
United States House of Representatives

Re: Improving Competition in Medicare

May 19, 2015

The American Medical Association (AMA) appreciates the Ways and Means Committee, Subcommittee on Health for conducting this hearing on improving competition in Medicare.

The AMA strongly supports and encourages competition between and among health care providers and facilities as a means of promoting the delivery of high quality, cost-effective health care. Providing patients with more choices for health care services stimulates innovation and incentivizes improved care, lower costs, and expanded access.

Potential of Alternative Payment Models to Foster Competition

The Medicare Access and CHIP Reauthorization Act, or MACRA, which was signed into law on April 16, 2015, provides incentives and a pathway for physicians to develop and participate in new models of health care delivery and payment. Physicians with sufficient revenue or patients related to qualifying alternative payment models (APMs) will receive a five-percent bonus in 2019 through 2024, and slightly higher payment updates beginning in 2026. Qualifying APMs will include Center for Medicare and Medicaid Innovation models (other than health care innovation awards), accountable care organizations (ACOs) under the Medicare Shared Savings Program, Health Care Quality Demonstration Programs, and

demonstrations required by federal law. A new Physician-Focused Payment Model Technical Advisory Committee will make recommendations on physician-focused payment models.

Properly-structured APMs can foster competition in several ways. When payments are made for larger "bundles" of services, they give physicians greater flexibility to design their care in the most effective and efficient way, rather than being constrained to deliver only the specific services which are eligible for payment. This enables development of more innovative approaches to care delivery, which in turn will result in more and better choices for patients.

By using Procedural Episode Payments and Condition-Based Payments, a single price and relevant quality/outcome measures are defined for all of the services associated with delivery of a specific procedure or for treatment of a specific condition. This enables patients and purchasers to easily make understandable, apples-to-apples comparisons among providers, rather than being forced to estimate total costs based on the prices of individual services, rates of complications, etc.

Procedural Episode Payments and Condition-Based Payments allow independent physicians in single-specialty and smaller multi-specialty groups to take accountability for the costs and quality of care they deliver without the need to consolidate with hospitals or other physician groups as is required in ACO and global payment models. Episode and Condition-Based Payment models can also be managed with far fewer patients than are needed for an ACO or global payment structure, which enables smaller practices to participate. In addition, these payment models can empower small physician groups to manage total spending for patients if they wish to, by allowing them to purchase care for specific conditions from other providers when needed at a predictable price.

Finally, condition-based payment models focus competition on what patients most need and want—high-quality, affordable care for the specific health problems they are facing—rather than on the prices of specific procedures which they may not need.

Restoring Competition in Hospital Markets

Another way of unleashing the potential of competition in Medicare is to lift restrictions on physician-owned hospitals so that they can meet the growing patient demand for high quality care. Section 6001 of the Affordable Care Act, or ACA (42 USC 1395nn), eliminated the Stark law's "whole hospital exception" for physicians who have an ownership interest in an entire hospital and are authorized to perform services there, and prevents physician-owned hospitals from expanding their treatment capacity unless certain restrictive exceptions can be met. Thus, as health law Professor Thomas Greaney observes, "the ACA all but put an end to one source of new competition in hospital markets by banning new physician-owned hospitals that depend on Medicare reimbursement."[1]

This lost source of competition is especially missed because the physician-owned hospital has developed an enviable track record for high quality and low cost care. A Centers for Medicare & Medicaid Services (CMS) study in 2005 found that measures of quality at physician-owned cardiac hospitals are generally at least as good, and in some cases better, than at local community hospitals.[2] According to CMS, specialty hospitals offer very high patient satisfaction and high quality of care. More recently, the comparative efficiencies of physician-owned hospitals have been shown in the results of CMS' Hospital Value-Based

[1] Thomas L. Greaney, *The Affordable Care Act and Competition Policy: Antidote or Placebo?*, 89 OR. L. REV. 811, 841 (2011).
[2] Study of Physician-Owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization act of 2003 (CMS Report) at 36-55, *available at:* http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/RTC-StudyofPhysOwnedSpecHosp.pdf.

Purchasing Program. Nine of the top 10 performing U.S. hospitals listed in late 2012 by CMS were physician-owned. Of the 238 physician-owned hospitals in the U.S., 48 were ranked in the top 100.[3]

Additional studies show that many of the physician-owned hospital facilities achieve greater patient satisfaction, reduce costs, and improve infection rates. Research by economics Professor Ashley Swanson finds that treatment at a physician-owned hospital "can lead to substantial improvements in mortality risks for cardiac patients."[4] She concludes that "the results suggest that banning of further physician ownership as part of the ACA may have detrimental effects on patient health."

Accounting for the high performance of physician-owned hospitals is a number of efficiencies that CMS identified in its 2005 report. They include: specialization, improved nursing staff ratios and expertise, patient amenities, patient communication and education, emphasis on quality monitoring, and clinical staff perspectives on physician ownership. For example, physician-owned hospital staff has the ability to focus on a limited number of procedures and diseases. Nurses do not have to be pulled to different types of inpatient wards to care for patients with a broad range of clinical problems. Clayton M. Christensen, a noted Harvard scholar on disruption in industry, projects that specialty hospitals could reduce costs for hospitalizations by 15 to 20 percent and is the disruptive solution for health care.[5]

However, limiting the viability of physician-owned hospitals puts them at a significant competitive disadvantage, ultimately redounding to the detriment of patient choice, community health needs, and the costs borne by the Medicare program itself. Ensuring seniors' access to care by allowing these high-performing hospitals to meet consumer demands would empower patients and tap the benefits of competition within Medicare.

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[3] *See* American Medical News (April 29, 2013).
[4] Ashley Swanson, PhD, *Physician Investment in Hospitals: Specialization, Incentives, and the Quality of Cardiac Care* (December 18, 2013), *available at*: http://econ.berkeley.edu/sites/default/files/swanson_poh_curr%20(1).pdf.
[5] *See* Clayton M. Christensen, Jerome Grossman, and Jason Hwang, THE INNOVATOR'S PRESCRIPTION: A DISRUPTIVE SOLUTION FOR HEALTH CARE (New York: McGraw-Hill, 2009).

Lifting the ban on physician-owned hospitals could also allow physicians who run other new care models to acquire hospitals, better control hospital costs, and supervise the overall health care product sold. Physician-owned hospitals represent a potential alternative to the existing hospital-dominated integration, but only so long as they are permitted to expand and remain competitive. This opportunity is particularly timely because of the avenues afforded by MACRA to leverage APMs to increase competition and improve health care quality.

Conclusion

The AMA applauds the Subcommittee's efforts to enhance Medicare access, choice, and quality through improved competition. The recently enacted MACRA legislation provides a unique opportunity to foster competition through properly-structured APMs. Lifting restrictions on physician-owned hospitals offers another opportunity to increase quality and lower costs through improved competition. We appreciate the opportunity to provide our comments on this important topic, and we look forward to working with the Subcommittee and Congress on achieving high quality, cost-effective care for seniors and all Americans.

Dr. Frederick E. Liss, Statement

House Ways and Means Subcommittee
Chairman Kevin Brady (R-TX and Ranking Member Jim McDermott (D-WA)
"Improving Competition in Medicare: Removing Moratoria and Expanding Access"
May 19, 2015
Statement for the Record
Frederic E. Liss, M.D.
Founder, Chairman and Chief Medical Officer
Physicians Care Surgical Hospital

17 May 2015

Dear Chairman Brady, Ranking Member McDermott and members of the Ways and Means Subcommittee on Health,

Thank you for convening this hearing to examine the critically important issue of improving competition in Medicare, and for the opportunity to submit this statement for the record of this proceeding. My name is Frederic Liss and I am the founder, Chairman of the Board and Chief Medical Officer of Physicians Care Surgical Hospital, in Royersford, PA, in the western suburbs of Philadelphia. I am an actively practicing, full time orthopaedic hand and upper extremity surgeon with the Rothman Institute, a 120-physician group, providing comprehensive musculoskeletal care throughout all of southeastern Pennsylvania and New Jersey.

OBJECTIVES:
(A) To provide the Subcommittee with factual information and to present the committee's members with compelling reasons to reassess and change federal law that is currently reducing competition in Medicare through discrimination against hospitals with physician ownership.
(B) To urge the committee's members to take action to increase Medicare and Medicaid patient access to care and choice, reduce the cost and raise the quality of healthcare by ending the moratorium on physician owned hospitals, all of which can be accomplished with the bipartisan HR 976, already introduced in the House.

ABOUT PHYSICIANS CARE SURGICAL HOSPITAL:

- "PCSH" is a physician owned hospital whose ownership structure is 85% physicians and 15% Nueterra Healthcare. We have a management contract with Nueterra.
- PCSH was founded in 2010, after development over 2-3 years before that.
- Our mission was to create a patient centered hospital and to provide *all* of our patients with the choice of the lowest cost, highest quality surgical care possible.
- 24 physicians set out on this mission because we were disillusioned with the quality of care that was being provided by the publically held "for profit" hospital system (Community Health Systems) that purchased the two main hospitals and several other hospitals where I have practiced for the last 20 years, here in southeast Pennsylvania. After these acquisitions we witnessed a steep decline in hospital employee satisfaction that led to poor efficiency of surgical operations an unpleasant work environment and ultimately a very significant decline in patient satisfaction.
- We opened in October of 2010 and received our Medicare licensure before the grandfathering deadline imposed by the Affordable Care Act (ACA), marking the elimination of the hospital exception for physician ownership of hospitals that was in place in the Social Security Act.

- PCSH has 5 operating rooms, 12 inpatient beds, a 1 bed emergency area, laboratory, x-ray department, pharmacy, pathology and physical therapy
- We are a multispecialty hospital that includes ENT, Orthopedics, Ophthalmology, Gynecology, Pain Management, and General Surgery
- We have in-house physician hospitalist coverage for inpatient and walk in emergencies 24 hours a day, 7 days a week, 365 days a year.
- We have 104 employees
- We have approximately 50 physicians on staff, only about ½ of whom are owners
- We accept Medicare, Medicaid, Tricare, workman's compensation, and most commercial insurances. In Pennsylvania, we ***pay*** a surcharge per year for the right to treat Medicaid patients and we treat the uninsured with greater flexibility to absorb than the local community hospitals. Local hospitals require vetting processes that often unacceptably delay surgeries on the uninsured.
- PCSH employees, administration and staff are actively engaged in charity projects that serve the greater good of the community in which we live and operate. This is part of the mission statement and fiber of PCSH.
- Our commitment to every employee at PCSH is that whenever we distribute profits to the owners, part of that goes to them, and we base it on performance. This leads to very engaged and motivated staff, so that they too, have "ownership" of our success
- Employee satisfaction is far above national averages at our facility

QUALITY AND COST/THE VALUE PROPOSITION:

- We have learned from data released by CMS, that we perform total joint replacements and spinal surgeries at ½ the cost to Medicare of other hospitals in our community and at less than ¼ the cost to Medicare compared to the University hospitals in our market area in Greater Philadelphia.
- We have also learned that as much as 50% of the cost of an episode of total joint replacement or spinal surgery may come after the surgical admission, when a patient goes to rehabilitation. We have instituted pre-operative education for the patients and have learned that very few patients need to have in-patient or even in home rehabilitation.
- PCSH was ranked 3rd *in the entire United States* for 2013, on the top box score for HCAHPS ("I would definitely recommend this hospital").
- PCSH received the highest score (a 5 star rating) by CMS in its new rating system for hospitals, used to evaluate patient experiences. Our hospital was only one of 2 hospitals in southeastern Pennsylvania to receive 5 stars and one of 251 in the entire United States.
- We are not alone in our accomplishments. Although POHs represent only 6% of US hospitals, in 2015 physician owned hospitals account for 43 of the top 100 performers across the nation on the Value Based Purchasing Program legislated in the ACA, 22 of the top 25 hospitals on HCAHPS, and account for over $3 billion in savings for the Medicare program over 10 years according to CMS reimbursement data per DRG, now under review by the CBO.

PROBLEM WITH RESTRICTION ON EXPANSION:

- Physicians Care is in high demand by patients who live in our community
- Medicare patients love PCSH because we represent the values and quality in healthcare with which our elderly were raised and accustomed. We are convinced that this is why our HCAHPS and Star ratings are so high.
- Unfortunately, we have had to turn patients away because we do not have enough inpatient beds to meet the demand in our community. In order to meet demand capacity for our facility, we need to add 10 inpatient beds.
- Our staff physicians prefer to operate at PCSH because their patients receive the best care in the country AND because they have the best experience operating there over any other facility
    - 97% on time Operating Room starts
    - Top notch anesthesia department with excellent post operative pain management for their patients
    - Almost a zero infection rate
    - 24/7 inpatient hospitalist coverage for their patients
    - Nurse to patient ratio usually 1:2, maximum 1:4
    - A very happy and engaged staff
- The problems we are experiencing as a direct result of section 6001 of the ACA:
    - We can not fully accommodate the demand of patients in our community
    - When we have a bed shortage (occurs every month), then we must tell surgeons to limit the number of cases they can do on given days. This sometimes results in surgeons taking an entire day of surgery to another facility in order that they meet the needs of all of their patients. It is not feasible for surgeons to run between facilities on surgical days. This adds stress and inefficiency to the system and to our patient's and our lives.
    - The bed shortage also limits our ability to accommodate emergency admissions
    - These are unfair effects of section 6001 of the ACA.

CONCLUSIONS:

- PCSH and physician owned hospitals as a group have consistently demonstrated unprecedented quality, patient satisfaction, employee satisfaction and substantial savings for Medicare and healthcare in general.
- Competition in the marketplace is what stimulates improvement of quality and lowering of cost. Patients deserve access to this type of quality of care, and Americans have the choice to drive the healthcare marketplace.
- Physician owned hospitals have embraced the tenants of the ACA, and for all of these reasons we deserve the right to expand, compete in the marketplace and to drive value into what Americans get in return for their healthcare dollars.
- We urge the committee's members to end the moratorium on physician owned hospitals by eliminating section 6001 from the ACA.

Thank you again for the opportunity to present this information. I remain at the Subcommittee's disposal as a resource, should any further information be needed.

Respectfully Submitted,

Frederic E. Liss, M.D.

CHAIRMAN AND MEDICAL DIRECTOR

PHYSICIANS CARE SURGICAL HOSPITAL

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ROTHMAN FIRST

Mark McDonald, Statement

Statement for the Record
House Ways and Means Health Subcommittee
Chairman Kevin Brady (R-TX) and Ranking Member Jim McDermott (D-WA)
"Improving Competition in Medicare: Removing Moratoria and Expanding Access"
May 19, 2015

My name is Mark McDonald, MD, CEO and Medical Staff President for the Institute for Orthopaedic Surgery (IOS), and I am writing this letter to request support for H.R. 976 which calls for removal of the moratoria on physician-owned hospitals. I would like to thank Chairman Kevin Brady (R-TX), Ranking Member Jim McDermott (D-WA) and other members of the House Ways and Means Health Subcommittee for their consideration of this request.

The members of the Physician Hospital Association (PHA), and the patients we serve, would greatly appreciate the House Ways and Means Health Subcommittee's support on H.R. 976, that would eliminate Section 6001 from the Affordable Care Act. H.R. 976 would allow physicians to treat Medicare and Medicaid patients at new and expanded hospitals in which they have an ownership interest.

The Institute for Orthopaedic Surgery (IOS) is one of 9 physician-owned hospitals throughout Ohio and approximately 250 physician-owned hospitals across the United States providing high-quality, low-cost care to patients. As a member of the Ways & Means Committee with jurisdiction over Medicare, it is of the utmost importance that House Ways and Means Health Subcommittee recognizes these hospitals as centers of excellence and allows them to expand.

IOS was one of the first orthopedic surgical specialty hospitals in the state and nation. IOS is an accredited specialty hospital designed specifically to meet the orthopaedic and musculoskeletal needs of patients and their families. As a facility that focuses exclusively on orthopaedics, we distinguish ourselves as a specialty hospital, accredited by the *Joint Commission*. Created in 1998 as an ambulatory surgery center, IOS converted to an acute care hospital in 2002. IOS provides comprehensive orthopedic services in one location from diagnosis to treatment to surgery and post-surgery rehabilitation. Following the transition from an ambulatory surgery center to and acute care hospital, IOS entered into a joint venture ownership agreement with a non-physician owned community hospital to expand the caliber of services provided to the patients in our community. IOS now serves a diverse population of residents within a 10 county region in Northwest Ohio.

As a specialty hospital, we believe we deliver incredibly *special care to our patients* and our patients support this. Our patient satisfaction survey scores show our patients rank our hospital in the 99 percentile of all hospitals and 99% of our patients would recommend us to others. Safe, quality, state-of-the-art patient care is our focus**.** From surgery to rehab, the physicians, nurses and clinical team at IOS concentrate on providing the best cutting edge orthopedic care. It is what we're committed to doing, day-in and day-out, each and everyday.

Earlier this month the Centers of Medicare and Medicaid Services released star ratings based on Patient satisfaction and experience. IOS was ranked among the top seven percent of the 3,553 hospitals rated. IOS was one of the 251 hospitals that received a five-star rating. The ratings are the result of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) a comprehensive survey administered to a random sample of patients continuously throughout the year. Medicare's new summary star rating is based on 11 facets of patient experience, including how well doctors and nurses communicated, how well patients believed their pain was addressed, and whether they would recommend the hospital to others.

Although there have been accusations by the opponents of physician-owned hospitals that we only accept high paying cases and defer low paying cases to other hospitals, this is not true. If this were an accurate assessment, there would be a discrepancy between the payor mix in our physician office and IOS. The payor mix in both facilities includes approx 36% of patients covered by Medicare and Medicaid. The following is the payor mix for IOS as of April 2015,

- **Medicare 30%**
- **Medicaid 7%**
- Blue Cross 25%
- Commercial 35%
- Other 3%

Physician-owned hospitals, such as IOS, have proven greater efficiency in their ability to identify and implement improvements in patient care. Multiple patient safety initiatives have been implemented at IOS and then copied by community hospitals. Some examples of these patient safety initiatives include the following,

- MRSA screening protocols to avoid post-op surgical site infections
- Use of Tranexamic Acid to decrease blood transfusions
- Screening for sleep apnea which has improved patient safety
- Decreased length of stay following total joint replacement surgery and spine surgery

The payor mix for patients receiving care at IOS indicates our desire and willingness to serve patients who are covered by Medicare and Medicaid. IOS would like to provide care to Medicare and Medicaid patients even though our ability to do so is being restricted by the moratorium placed on physician owned hospitals in 2005.

Studies have shown the positive learning effect associated with higher procedural volumes for specific types of cases performed in physician-owned hospitals. Patients who receive care in physician-owned hospitals have been able to recognize the beneficial impact on the quality of care provided. By focusing on specific areas of medicine, physician-owned specialty hospitals are able to identify opportunities to improve quality and lower costs. In September of 2013, IOS was recognized by Consumer reports as one

of the top 11 hospitals in the state of Ohio. A variety of factors were considered in the study, including patient outcomes, complication rates, patient safety and patient satisfaction.

Patient safety is the highest priority in every hospital, including physician-owned hospitals. Although many physician-owned hospitals don't offer the services of a dedicated emergency department, there are policies in place to appropriately manage emergency situations for every patient treated in physician-owned hospitals. A key component of being able to manage emergency situations, is to have the appropriate medical staff available. IOS has dedicated Medical staff, including physicians on-call 24 hr/day to provide medical care in the event of an emergency situation. The medical staff at IOS is comprised of a diverse array of specialists, including Internal Medicine specialists, Cardiologists, Infectious Disease specialists, Anesthesiologists and Orthopaedic Surgeons. In addition to the highly qualified medical staff, IOS has contractual agreements with two other hospitals for situations in which a patient requires services that are not provided at IOS.

As demonstrated by the HCAHPS program, IOS ranks in the 99 percentile for patients who would recommend our facility. Our patients have clearly stated that they prefer to receive their care at IOS, even though the Federal government has placed restrictions on physician-owned hospitals to prevent further growth. In the current climate of value based purchasing and pay-for-performance, it makes complete sense to promote the growth of physician owned hospitals, as they continue to lead the way in performance measures. The patient is the ultimate benefactor when physician-owned hospitals are allowed to expand. There will be greater access to high quality care, and more patients will be able to receive their care in physician-owned hospitals. In addition, there would be increased pressure on the under-performing hospitals to improve their quality or accept a cut in payments through the value-based-purchasing program. The most appropriate decision is to remove the restrictions on physician-owned hospitals and allow the highest performing hospitals to expand. We greatly appreciate your consideration of this request and the assistance you can provide to expand access to high quality care for patients.

K&S Consulting, Statement

k+s consulting

Statement for the Record
House Ways and Means Health Subcommittee
Chairman Kevin Brady (R-TX) and Ranking Member Jim McDermott (D-WA)
"Improving Competition in Medicare: Removing Moratoria and Expanding Access"

May 27, 2015

My name is Jakob Kohl and I am the COO of K+S Consulting, a patient focused and physician driven, management and investment company that in conjunction with physician investors owns, operates and oversees hospitals, surgical centers and other healthcare providers in and around the Houston area. I would like to thank Chairman Brady, Ranking Member McDermott and other members of the subcommittee for the opportunity to submit comments in connection with improving competition in Medicare, with specific focus on removing moratoria and expanding access.

My purpose in presenting this statement is to support the effort to end discrimination in federal law against hospitals with physician ownership. We believe that all hospitals should compete on a level playing field where outcomes and quality measures drive decision making, regardless of the ownership type of the hospital. We believe that full transparency and fair competition within the hospital industry will drive excellence across the board, and the current restrictions within Medicare and Medicaid severely restrict this competition. The restrictions are denying Medicare beneficiaries access to the best facilities at a time when even more patients are entering the healthcare marketplace.

K+S Consulting partners with physicians in our communities to build and operate excellent hospitals and surgical centers. We employee nearly 450 individuals throughout greater Houston and have performed 7,417 cases in 2014 alone. Our facilities report outstanding patient safety data – with extremely low infection rates of less than .04 percent and patient satisfaction ranking consistently above 95 percent.

One of our facilities was in operation before the restrictions were put in place and two other facilities opened after the law was enacted. This means that our older facility can continue to see Medicare and Medicaid patients, but cannot grow with the community because any expansion would trigger additional restrictions according to existing law; and our two newer facilities simply cannot see these patients and be reimbursed for care provided. Our strategy focuses entirely on working with physicians in our community, and we believe that is a primary key to advancing quality health care services across the board.

When physicians are partners in hospitals, the entire team can focus on excellent patient services and quality outcomes. Medicare and Medicaid patients deserve the right to see the best providers willing to accept a contract. By denying the ability of our new facilities to participate in Medicare with our physician partners, our patients are having their rights severely limited.

Correcting this problem can be accomplished through a bi-partisan basis in H.R. 976, which we are requesting that you support. This bill will *fully restore* patient access to physician owned hospitals and allow all of us to compete on a level playing field.

Thank you for your attention to this issue, I am happy to respond to questions.

About K+S Consulting:

K+S Consulting is a management and investment company that owns, operates and oversees the operations of outpatient surgical centers, hospitals and other health care providers. Founded in 2003 and built around a culture of innovation, we develop and manage physician-driven operations with commitment to excellent care and service. Our physicians, staff and partners are an inspiration and share our investment in the innovative delivery of healthcare in greater Houston and beyond.

The partnerships fostered by K+S with local physicians leads to patient care that raises the bar in all key-performance indicators. By focusing on high patient satisfaction from our outstanding services and compassionate care, our team welcomes transparency of our operations. We believe that patients should have the choice to utilize quality services and facilities based on their own preferences and needs without artificial barriers imposed by government regulations. We look forward to working with our elected officials to find reasonable policies to facilitate fair and open competition.

K+S Consulting Entities:

- Humble Surgical Hospital
- Outreach Diagnostic Clinic and Eye Care
- Lake Woodlands Surgical
- Westside Surgical Hospital and Breast Center
- Spring Central Hospital

Edward Kerens Jr., Statement

Statement for the Record
House Ways and Means Health Subcommittee
Chairman Kevin Brady (R-TX) and Ranking Member Jim McDermott (D-WA)
"Improving Competition in Medicare: Removing Moratoria and Expanding Access"
May 19, 2015

My name is Edward "Paul" Kerens Jr. I have been the Senior Executive Officer for Kansas City Orthopaedic Institute LLC, a physician own hospital since its inception. I was hired for the hospital project which was a joint venture between 14 orthopeadic surgeons and Saint Luke's Hospital. Kansas City Orthopaedic Institute, LLC (KCOI) is an acute care hospital licensed in the State of Kansas that focuses on orthopaedic care. I have worked in healthcare for 35 years, my entire career. My management experience has ranged from physician group practice management to large academic hospital health systems. The past 16 years at KCOI have been the most rewarding of my career. I attribute that to the high level of physician participation in the governance that controls all operations of the hospital but most importantly the focus on the patient first.

I would like to thank Chairman Brady, Ranking Member McDermott, and all the members of the subcommittee for this opportunity to submit my testimony in connection with the above-mentioned hearing.

My objective in submitting testimony is to educate the committee on the exceptional care provided in a physician owned hospital in hopes that an end can be brought to the unjust regulations put on physician owned hospitals. Physician owned hospitals as part of the Affordable Care Act are limited in growth, a stipulation that does not exist on other hospitals in this country. I ask this subcommittee and all members of the house to support H.R. 976 so that patients can continue to have access to some of the best health care delivered in this country today.

Kansas City Orthopaedic Institute was created in the late nineties when three groups of orthopeadic surgeons came together to build a hospital. The reason they felt the need to build a hospital was because these physician were frustrated by the inefficient care that was delivered at the other hospitals where they practiced. Much of their surgical day was spent standing around waiting. They also had to listen to patients complain about their wait times and how long it took for nurses to respond to their needs while in the hospital. So when they built their hospital the primary focus was to improve efficiency. They knew very little about running a hospital but they did know how to care for patients and that is where they placed their focus. They made sure that the nurse to patient ratio was better than in other hospitals where they practiced. At KCOI the nurse to patient ratio on the inpatient unit is one nurse for every two patients. At the other hospitals in town you will find as many as one nurse serving 10 to 12 patients. The result has been that KCOI is now the only five star rated hospital in the Kansas City market according to the new rating system released earlier this month by CMS. KCOI also scores very well under the CMS value base purchasing program. KCOI received the 15th highest score earlier this year out of over 3500 hospitals nationally. The patient satisfaction scores at KCOI are some of the highest as well. The post-surgical infection rate at KCOI is 15 times lower than the national average. This story, according to my colleagues, is similar at other physician owned hospitals around the country. It makes no sense that the government has passed legislation that restricts the growth of some the highest quality hospitals in this country. It does make sense that physicians, who ultimately are the

people responsible for the care of the patient, have the ability to own and govern the facilities where they proved the care to their patients.

Kansas City Orthopaedic Institute LLC has always been community minded and welcomes all patients. In addition to commercial insurance plans, KCOI participates with Medicare, Medicaid, and Tricare. KCOI has a charity policy that provides discounted or even free care to patients based on their ability to pay. In our community KCOI has signed an agreement that provide free care to patients living in Wyandotte and Johnson County who could not otherwise pay for their orthopaedic care.

The one thing that the physicians did not do properly when they opened their own hospital was build it big enough. They did not realize that patients would recognize such a difference and demand care at KCOI over other hospitals. KCOI is in need of additional inpatient beds and operating rooms to take care of the patients in the market. KCOI's growth should not be limited by the government. The only limit to the growth of KCOI should be by the demand of the patient like any other business. If KCOI continues to deliver a superior product they should be allowed to grow to accommodate the demand. This is why I am asking you to support and pass H.R. 976 which will increase patient access to physician owned hospitals.

Mark Kennedy, Statement

Statement for the Record

House Ways and Means Health Subcommittee

Chairman Kevin Brady (R-TX) and Ranking Member Jim McDermott (D-WA)

"Improving Competition in Medicare: Removing Moratoria and Expanding Access"

May 19, 2015

My name is Mark W. Kennedy, Chief Executive Officer of Star Medical Center, located in the Dallas, Texas suburb of Plano, Texas. I have worked over the past 20+ years in healthcare as both an entrepreneur and as a senior manager involved in hospital management. Prior to my current employment, I successfully organized two Texas based physician owned acute care hospitals, served on numerous for profit and not for profit hospital boards, and developed over 10 contract managed not for profit acute care hospitals. My sincere thanks to Chairman Kevin Brady and the Ranking Member Jim McDermott and other esteemed members of the subcommittee, for this opportunity to submit my comments regarding the removal of the unfair barriers to physician and patient access to quality healthcare imposed through existing Moratoria on physician ownership of acute care hospitals.

The great motivator for me in writing this letter to the House Ways and Means Health Subcommittee is the hope that reason and the embrace of the truth, will prevail in its consideration of ending the discrimination in our federal laws against physician ownership of acute care hospitals. I believe that the current legislation, found in Section 6001 of the Affordable Care Act, unfairly singles out physicians and denies them the right to participate in the Free Enterprise System by prohibiting them from ownership in acute care hospitals. By denying this right to physicians, there now exists an extreme prejudice of the very body of professionals sworn to, "first, do no harm". There are those interests that apparently advance myths and distortions to argue against physicians being allowed to enjoy hospital ownership. Bottom line, there is no credible evidence that supports the notion that physicians, as a whole, cannot maintain their objectivity, ethics, and integrity in patient care, while owning a hospital in which they practice medicine. Of course, as in any profession, there are those exceptions that fail in their public trust. Examples of this are prevalent throughout the professional world, i.e. lawyers, accountants, business leaders, etc., in which egregious acts of malfeasance have been committed. And, the actions of such bad actors, has not resulted in federal legislation banning any of these professional groups from ownership in their respective places of business. The standard is not the same for physicians. Patients deserve the options of choice to where they may seek their healthcare needs. Likewise, physicians deserve the same rights of all Americans to,..."Life, Liberty, and the Pursuit of Happiness". Consequently, it is the objective of this letter to respectfully encourage the leadership of the House Ways and Means Health Committee to support legislation introduced on a bi-partisan basis, H.R. 976, to increase patient access to physician owned hospitals.

Our hospital is a relatively small facility (23,500 SF) that is jointly owned by approximately 40 physicians, comprised in an array of specialties including Spine, Orthopaedic, General Surgery, Gastroenterology, Pain Management, Gynecology, Urology, Ear, Nose, and Throat, Breast Reconstruction, Podiatry, Hand, and Family Practice. Our hospital opened in November 2013 with the expressed commitment by our physician owners to provide the safest, cost effective and highest quality of care to the patients we serve on a daily basis. The hospital employs approximately 80 skilled workers with an approximate $$ Million annual payroll The physician founder and physician investors of Star Medical Center identified the need for specialized healthcare care in the 1,000,000+ population, comprising its North Dallas/Plano/Richardson/Garland service area. Since opening in November 2013, our physician joint ventured for profit acute hospital has provided effective health care to over 3,000 patients. However, due to the provisions in Section 6001 of the Affordable Care Act, our physician owners of Star Medical Center are prohibited from participating in the any of the Federal Reimbursement patient care programs (i.e. Medicare, TriCare, Medicaid, etc.). Consequently, patients covered by these government programs are not allowed access to our hospital. Should the ban on physician owned hospitals be lifted, it is very likely our healthcare institution would apply for a Medicare Provider Number and extend care to this significant patient population. During January 2015, as a licensed acute care hospital we successfully achieved a full 3-year accreditation through one of the world's leading certification bodies, Det Norske Veritas – Germanischer Lloyd (DNV-GL). Of particular note, when our patients require admission for overnight stays, they experience unique 1:1 Nurse to Patient care, which results in high patient satisfaction and high physician satisfaction surveys. Additionally, our physician owned hospital promotes access to the public of our emergency services and is constantly marketing these ER services to the service area population through mailers, Open House events, and our prominent LED signage located on the heavily traveled Turnpike immediately adjacent to our hospital. Our efficiently sized facility, designed for today's patient environment, enables our physicians to provide the best care possible and an opportunity to often deliver at a price below nearby medical centers.

In conclusion by removing this barrier to patient access and physician access of a physician owned hospital, as found in Section 6001 of the Affordable Care Act, we will be able to better serve our patients by offering our medical services to all segments (Medicare, Medicade, Managed Care, Private Pay) of the medical service area. By leveling the playing field for acute care services providers, our hospital can effectively compete and provide a viable differentiator in the marketplace. We believe our patients will ultimately benefit by having another desirable option in which to seek needed healthcare. We believe that through competition, the water level of quality and good patient economics will improve in our healthcare landscape. Further, we believe that as a result of our very effective model of physician ownership, that costs will be driven down for taxpayers, physicians will have an excellent environment by which to provide patient-centric medicine, and better outcomes will be increasingly realized by all stakeholders. Again, I respectfully request your full agreement and commitment to support the passing of H.R. 976.

Robert Behar, Statement

Statement for the Record
House Ways and Means Health Subcommittee
Chairman Kevin Brady (R-TX) and Ranking Member Jim McDermott (D-WA)
"Improving Competition in Medicare: Removing Moratoria and Expanding Access"

My name is Robert Behar, MD, MBA and I am the CEO of North Cypress Medical Center in Cypress, Texas, a Northwest suburb of Houston, Texas. North Cypress Medical Center is a 139 bed licensed acute care hospital that is 100% physician owned and operated. I want to thank the Chairman, Ranking Member and other members of the subcommittee for the opportunity to submit comments in connection with the above-mentioned hearing.

The purpose of this testimony is to provide you with hard data and testimonials as to why we believe there should be an end to the law discriminating against physicians owning hospitals. We are also in support of the H.R. 976, bipartisan legislation that would end this discrimination and increase patient's access to some of the highest quality hospitals in the country.

North Cypress Medical Center opened its door to our community in January 2007.We started out as a 64 bed acute care facility. Within 36 months of opening, to meet the demand of Northwest Houston and Cypress we expanded to the present 139 beds, a 20 bed emergency room, and a 20 bed intensive care unit. Currently, North Cypress Medical Center has 361 physicians on staff; only 140 are investors.

From the onset, North Cypress Medical Center's mission was to care for the sickest patients regardless of age, or ability to pay. We felt the foundation of our success started with a goal and vision to provide the most advanced technologies to our community with superior and very personal customer service. We work tirelessly to deliver this to our community and our medical staff in everything we do.

Cypress, a suburb of Houston, for the two decades leading up to North Cypress Medical Center's opening, was completely devoid of an acute care facility. In fact to this day, North Cypress Medical Center stands alone as the only facility on Highway 290, the major thoroughfare of the Northwest Houston Corridor. By 2020, the population of Cypress is projected to reach over 1,000,000 people.

With the commitment to care for the sickest patients, our emergency rooms have been the nexus of our acute care delivery system.

- Our emergency rooms treated over 53, 000 patients in 2014.
- We are a fully Accredited Chest Pain and Stroke Center
- OVER 80 % of North Cypress Medical Center Hospital admissions originate from the Emergency Rooms
- We are the receiving hospital for six 911 EMS services in Northwest Houston with over 6000 ambulance patients transported to our facilities in 2014.

- We had less than 48 hours of 'EMS divert' status in 2014, with a full commitment to ensure ER services available through high census periods.
- Four Straight Years of Emergency Room Patient Satisfaction Scores in the Top National Quartile
- Active involvement in Regional Disaster/Trauma Response System
- Diverse array of Specialists who voluntarily take call for our emergency room, including Cardio-Thoracic Surgery, Cardiology ,Critical Care, Otolaryngology, Gastroenterology, General Surgery, Gynecology, Oncology, Infectious Disease, Internal Medicine, Nephrology, Neurology, Neurosurgery, Ophthalmology, Oral Surgery, Orthopedic Surgery, Pediatrics, Neuro-Vascular Interventional Radiology, Urology

As an institution we admitted over 14,700 patients in 2014. 57% of those patients represented Medicare/Medicaid/Tricare/Charity care. Additionally, our institution delivered $93,000,000 in uncompensated charity care in 2014.

Some of the services include:

- Active Cardiac Surgery and Neurosurgical Programs
- 1790 ICU admissions in 2014; 566 of those patient required ventilator support
- Comprehensive Oncology program with the most advanced instrumentation
- Robotic Assisted Surgical Program
- Robotic Assisted Cardiac Electrophysiology Program
- Extracorporeal Membrane Oxygenation for Severe Respiratory failure
- Epilepsy Monitoring Unit
- Comprehensive Orthopedic Joint Center
- Cardiac Interventional Program
- Neurovascular Interventional Program
- Pediatric Unit

The challenge to deliver these cutting-edge and very technical services requires the dedication of over 1,800 local employees who embody the facilities' commitment to excellence. This commitment is evidenced by the fact that other community hospitals are transferring patients to North Cypress Medical Center to receive these critical procedures and services. These transfers are made both for higher level of care and by patient request to be cared for at our facility.

North Cypress Medical Center prides itself on delivering high quality evidence-based care. Some of our awards include:

- *Rated one of the Top 100 hospitals in the nation for Coronary Interventions in 2015*
- *Healthgrade's Five-Star Recipient for Total Knee Replacement in 2015*

- *Healthgrade's Five-Star Recipient for Coronary Intervention Procedures in 2015*
- *Healthgrade's Five-Star Recipient for The Treatment of Respiratory failure in 2015*

The problem at hand is as follows. Since the 2010 restriction to build, North Cypress Medical Center is constantly at capacity. When the restriction took hold, NCMC was in the process of completing 4 state of the art cardio-thoracic operating rooms and 24 intensive care capable rooms. To this day, and to the disservice of this community, they sit empty, unused, while our aged Medicare patients wait to be treated in the precious few remaining licensed beds. With the facility virtually at constant capacity, an unnecessary burden is created, which would be relieved by our proposed expansion of medical beds and the licensing of those already built. As an institution we have made a commitment to serve our community at all cost, provided we can achieve this goal safely. In the effort to do so, we very rarely employ 'EMS divert', which represents less than a total of 48 hours in 2014. We believe that placing this institution on divert would be an enormous detriment to the community. The growing community deserves this expansion. As we have presented, we do not avoid caring for the sickest patients, regardless of their ability to pay. We want to continue to efficiently and safely do this as our community grows and ages over the coming years.

In our expansion plans we were also about to begin construction of obstetrical and neonatal care units, and additional cardiac catheterization suites when the 2010 legislation created the moratorium effecting physician owned facilities. This expansion is critical for North Cypress Medical Center to respond to the needs of our community. Both For-Profit and Not-For-Profit hospitals in Houston have taken the 'last to market' approach, choosing to provide well compensated services to ensure preservation of their bottom lines. It is well known that obstetrical services do not represent significant profit centers for hospitals, yet at the same time the Cypress community remains without an acute care facility to provide obstetrical services. This requires the transfer of all obstetrical patients to other facilities, which is inconvenient and can jeopardize the mother and her unborn child's safety. We managed over 1,000 pregnant patients in our emergency rooms in 2014. We find it unacceptable that North Cypress Medical Center serves over 200 square miles in Northwest Houston and the adjacent counties, yet is prohibited from offering obstetrical and neonatal services. This requires the transfer of laboring patients to other facilities to receive what is generally regarded as basic medical services. Given the opportunity to expand we will fill that void.

One solution suggested for our bed capacity issue was for NCMC to build a non-Medicare certified facility and thus serve only the needs of non-Medicare and Medicaid patients. This is contrary to the mission of NCMC, which has always been to serve the medical needs of all patients, of all ages, regardless of the economics of providing that care.

NCMC is a tax paying institution that has paid $62,000,000 in state and federal taxes since 2007. We are the second largest employer in Cypress, with over 1800 local employees.

We are asking for the passage of H.R. 976 to allow great facilities like ours to continue to meet the needs of our patients.

Thank you for your consideration.

Robert A. Behar, M.D., M.B.A.
CHAIRMAN OF THE BOARD
AND CHIEF EXECUTIVE OFFICER
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John R. Graham, Statement

NCPA
NATIONAL CENTER FOR POLICY ANALYSIS

IDEAS CHANGING THE WORLD

Medicare Fraud: Moratoria Miss the Mark

Statement for the Record

John R. Graham

Senior Fellow
National Center for Policy Analysis

"Improving Competition in Medicare:
Removing Moratoria and Expanding Access"

Ways and Means Subcommittee on Health

May 19, 2015

Chairman Brady and members of the committee, thank you for the opportunity to submit written comments about ways to improve competition in the Medicare program. I am John R. Graham, a senior fellow at the National Center for Policy Analysis. We are a nonprofit, nonpartisan public policy research organization dedicated to developing and promoting private alternatives to government regulation and control, solving problems by relying on the strength of the competitive, entrepreneurial private sector.

Summary

Medicare fraud is a serious problem. The Medicare bureaucracy has the power to impose moratoria on new providers in geographic or program areas it deems susceptible to fraud. However, preventing new competitors from providing Medicare benefits reduces competition and cannot reduce fraud by incumbent providers. A better way would be to give Medicare beneficiaries a financial interest in combatting fraud.

Background

Last February, the Government Accountability Office issued its annual report on federal programs that it identifies as high risk due to their greater vulnerabilities to fraud, waste, abuse, and mismanagement. Medicare is a longstanding member of the list: "We designated Medicare as a high-risk program in 1990 due to its size, complexity, and susceptibility to mismanagement and improper payments". A quarter of a century has gone by and Medicare is still on the list.

In 2013, Medicare spent $586 billion taxpayer dollars. The FBI has estimated that three percent to 10 percent of all health spending is fraudulent. For Medicare, that would amount to at least $17 billion and up to almost $60 billion.

The Obama Administration has ramped up antifraud efforts, with notable success. Last year, the Government Accountability Office reported that Medicare had strengthened its antifraud activities considerably, but noted further progress was needed.

The U.S. Department of Health & Human Services and the U.S. Department of Justice collaborate on the Health Care Fraud and Abuse Control (HFAC) Program, which was established in 1997 and received a cash infusion from the Affordable Care Act (ACA) of 2010. In its 2014 annual report, the HFAC Program reported a return of $7.70 on every dollar spend on antifraud efforts, recovering $3.3 billion in 2014 and over $27.8 billion since 1997.

This success is largely due to good investigative work by the Department of Health & Human Services, Federal Bureau of Investigation, and other agencies. Despite their efforts, they are only catching no more than one fifth of the dollars lost to Medicare fraud.

The (ACA) gave the Secretary of Health & Human Services a new power to combat fraud: The authority to impose temporary moratoria on new providers if the geographic area or applicant type indicates a significant risk of fraud, waste, or abuse. Some in Congress have been frustrated that the Secretary has not used this power enough. In 2011, Senators Hatch and Grassley wrote a letter to former Secretary Sebelius insisting that she start imposing them. They followed up with

a letter on March 28, 2013, which noted that despite the moratoria rule having been in force for over two years, none had yet been imposed.

In July 2013, the CMS issued its first set of moratoria. Further announcements were made in January 2014, July 2014 and January 2015.

More and Different Provider Regulation Unlikely To Stop Fraud

Moratoria are unlikely to prevent fraud and likely to have unintended consequences by reducing competition. It is a little like solving bank robberies by preventing people from entering banks. Indeed, effective fraud protection and prevention should encourage, not prevent, new providers from entering Medicare and shaking up the *status quo*. If the only way to reduce fraud is to prevent new providers from entering a market, it suggests that the market itself is perversely structured to invite fraud.

Imposing moratoria is the extreme case of focusing antifraud efforts on regulating providers. While this focus has improved recovery, the burden of compliance has become so great that it is interfering with honest providers' ability to do business with Medicare. Enrollment by providers is already highly bureaucratized. The ACA actually made honest providers pay explicitly for auditing fraud by imposing a new application fee of $505 for enrolling each new practice location.

Many trade and professional associations have complained that the burden of antifraud compliance is increasing their members' costs and frustrating their businesses. Many complaints address Recovery Audit Contractors (RACS), to whom Medicare pays a share of the spoils from claims they challenge. This has resulted backlog of 500,000 denied claims being appealed. Although honest providers are susceptible to the temptation to "upcode" claims, it is unlikely that this backlog comprises many claims from actual fraudsters, who are unlikely to appeal a denied claim.

Indeed, the bureaucratic burden might have become counterproductive. The largest Medicare fraud in history was uncovered in 2012 and executed by a Texas doctor who billed Medicare $375 million for care that was not provided. He recruited homeless people and paid them $50 to sign forms evincing that they had received treatment from him. "Jack Fernandez, a Florida lawyer who formerly prosecuted healthcare fraud for the federal government, whistled out loud when he heard the dollar amount in the Roy case. But he said the red tape and complex laws and regulations that come with filing Medicare claims made it easy to slip false claims through the system," according to the *Los Angeles Times*.

Dialing up the pressure on providers even more, to the extreme of imposing moratoria on new entrants, is unlikely to improve fraud recovery and prevention for two reasons: Fraud is a common feature of insurance markets; and government does not have the right incentives to prevent fraud. Combining these results in a toxic brew in which fraudsters can breed happily.

In proper markets, insurance only comes into play for unforeseen and catastrophic events. This is because third-party payments are unavoidably susceptible to attempted fraud. Consider the classic case of a businessman who has unsold inventory, hires someone to torch his warehouse,

and submits a claim to his property insurer. The desperate and unethical businessman has to take extreme measures to defraud the insurer. In Medicare, and U.S. health care in general, so many low-cost and routine items and services are run through insurance claims that fraudsters can easily pick holes in the system.

Because Medicare is spending taxpayers' money, not its own, it cannot have the right incentives to effectively prevent and recover from fraud. Private insurers invest in effective measures, because their investors require it. When people spend their own money directly, they are also vigilant against fraudsters.

A Better Way: Reward Beneficiaries for Preventing Fraud

Medicare makes a faint-hearted attempt to enlist seniors' support in preventing fraud. Between 1997 and 2012, Senior Medicare Patrols have resulted in saving Medicare more than $106 million. That is good work for volunteers, but it is only $7 million annually – a drop in the bucket.

A better way to prevent fraud from the demand side would be to give beneficiaries direct control of more of the money Medicare spends on their behalf. Consider an obvious example: Certain categories of medical equipment are notoriously susceptible to Medicare fraud. Durable Medical Equipment (DME) incudes power wheelchairs, electrical hospital beds and diabetic test strips. In 2011, Medicare began a competitive bidding program for these items. Since then, DME bidding has saved $2 billion for Medicare.

Note that all these savings accrue to the government: They are invisible to Medicare beneficiaries. Much more could be saved if Secretary Burwell were able to tell America's seniors something like this:

> "Medicare has been paying over $4,000 for your power wheelchairs. We know that they can be purchased for around $3,000, or even less in some parts of the country. So, go find a power wheelchair for less than $4,000, send Medicare the invoice, and we'll add a share of the savings to your Social Security deposit, Medical Savings Account, or Health Savings Account as soon as we've verified the transaction."

Of course, this means that Medicare beneficiaries have to control more Medicare spending directly, as recommended by NCPA Senior Fellow and former Medicare trustee Tom Saving. Currently, Medicare beneficiaries can enroll in Medicare plans with Medical Savings Accounts, but these have limited availability. Further, current Medicare beneficiaries do not have access to savings in fast-growing Health Savings Accounts, because they are only a decade old.

Optimizing Medicare beneficiaries' ability to combat Medicare fraud through prudent purchasing power will require reforms that include shifting a significant proportion of current Medicare spending away from providers who submit claims to federal Medicare contractors and into seniors' Health Savings Accounts and Medical Savings Accounts.

Continuing to focus antifraud efforts solely on playing whack-a-mole with fraudsters, to the extreme of preventing new competitors by imposing moratoria, is unlikely to reduce fraud much further.

Thank you for the opportunity to submit these written comments.

Blake Curd, Statement

Statement for the Record
House Ways and Means Health Subcommittee
Chairman Kevin Brady (R-TX) and Ranking Member Jim McDermott (D-WA)
"Improving Competition in Medicare: Removing Moratoria and Expanding Access"
May 19, 2015
Submitted by Blake Curd, MD
CEO, Sioux Falls Specialty Hospital
President, Physician Hospitals of America

Physician Owned Hospitals: Beacons in Healthcare

Dear Chairman Brady, Ranking Member McDermott and distinguished members of the Subcommittee, I want to thank you for holding this hearing focused on improving competition within Medicare. Physician Hospitals of America believes that if physician-owned hospitals (POH) are able to fairly compete in the delivery of healthcare services, patients will benefit from greater access to high quality, lower cost healthcare. As the Federal Trade Commission (FTC) recently reiterated during a February 24, 2015 workshop on healthcare competition, "The FTC has long argued that consumers benefit from health care competition….Numerous studies confirm that vigorous competition in healthcare markets helps to reduce costs, improve quality, and expand access for consumers."

The POH industry is an important component and competitive force within our healthcare system that ensures patients receive the highest quality of care. Recent government data supports the fact the POHs are centers of excellence that have lower costs. Yet current law both prohibits newly constructed physician owned hospitals from being able to treat Medicare and Medicaid patients and restricts the Medicare-licensed physician owned hospitals that were grandfathered under the law from growing to meet community need. This anti-competitive policy is bad for our health care system, bad for Medicare and most important, bad for patients. We strongly urge Congress to allow hospitals with physician ownership to compete on a level playing field with every other hospital in the country, particularly when it comes to growth. While current law provides a process for expansion, it is so restrictive that only one hospital has received CMS approval to add to its current capacity.

History of Physician Ownership

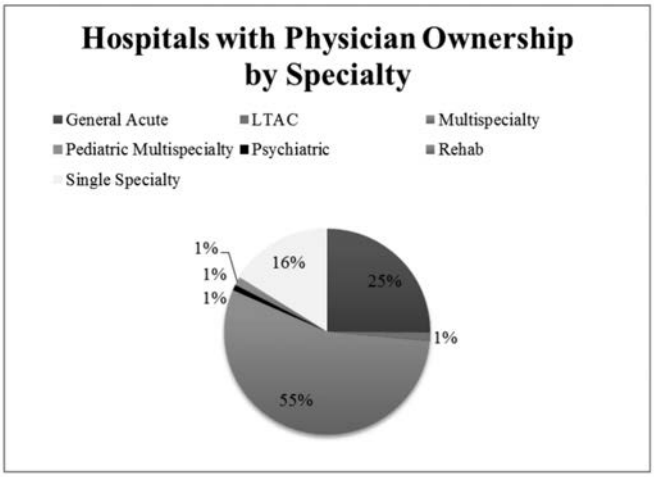
Throughout the first half of the twentieth century, it was common for physicians to own and manage hospitals, stemming from the practice of physicians caring for patients in their own homes. In-home care eventually evolved towards community hospitals. Then continuing into the 1940s-1980s, other hospital models began to emerge including large religious and secular non-profits as well as the corporate for-profit model. The physician-ownership model later emerged in the 1990s as a natural consequence of healthcare specialization and the need for more efficient care. Doctors who were specialists found it very difficult to be productive and efficient in large, general hospitals.

Surgical specialists soon led the way for physician-owned surgical specialty hospitals and other specialties soon followed. Today the single specialty model is the exception within the industry as they make up only about 16% of hospitals with physician ownership. The model is attractive for many

reasons, chief among them is that with doctors being in charge with a financial stake in the success of the hospital, there are lower complications, better outcomes and lower costs.

What does the current POH Industry look like?

Today there are approximately 250 hospitals with some form of physician ownership and the services they offer are varied according to community needs. The following chart shows the current make-up of the POH industry:



Ownership Model Varies

There are also varying models of ownership by physicians in hospitals. Some hospitals are owned in full by physicians, some are joint ventures with tax-exempt hospitals where physicians own just a percentage of the hospital, and some are joint ventures with for-profit companies. What all of these models have in common is a belief that patients benefit from higher quality of care when physicians have a financial stake in a hospital, thereby having more control in how care is delivered.

CMS Data Confirms POHs as Centers of Excellence

The new Medicare Hospital Value-Based Purchasing program (VBP) was enacted to either reward or penalize hospitals based on the quality of care they provide to patients based on a number of quality indicators. In 2013, the first year of this program, 9 of the top 10 and 53 of the top 100 bonus recipients were POHs. 27% of the POHs participating were in the top 100 performers compared to only about 1% of the participating non physician-owned hospitals (NPOHs). 60% of POHs received bonus payments while only 22% of NPOHs did. Moreover, only 20% of POHs were penalized compared to 64% for

NPOHs. These numbers are striking if one considers POHs only made up about 5% of the hospitals that were eligible to participate.

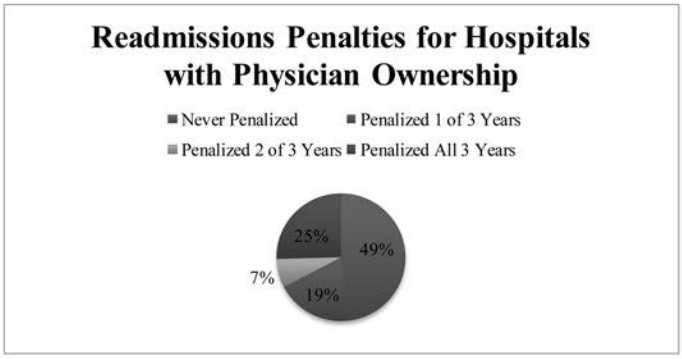
In 2014, CMS added mortality rates to the program as a quality indicator and most POHs could not qualify to participate as their hospitals lacked the minimum number of patient deaths.

For Fiscal Year 2015, additional data was added to VBP that could be utilized for scoring instead of the mortality rates, including readmissions and hospital-acquired conditions (HACs). Most POHs were again able to participate. POHs remained the standout performers. Seven of the top 10 hospitals awarded bonus payments were physician-owned, as were 43 of the top 100. 67% have never been penalized in their VBP adjustment compared with 36% of NPOHs. Only 8% of POHs have been penalized all three years of the program compared to 19% of NPOHs. In the three years for which CMS provides data (FY 2013, 2014, and 2015), 49% of POHs have never been penalized for readmissions, while an additional 19% have only been penalized 1 out of the 3 years. On the other hand, only 17% of NPOHs have never been penalized for readmissions during this same period.

The HAC program identifies a group of reasonably preventable conditions, including infections, that patients did not have upon admission to a hospital, but which developed during the hospital stay. Only 10% of POHs received a penalty in FY 2015 (the only year for which CMS published HAC data). Conversely, 21% of NPOHs received a penalty for HACs.

In 2015, CMS also released Summary Star Ratings for hospitals based on their Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS), which measures patient satisfaction with their care and overall experience. Once again, POHs stood above the competition. 42% of POHs received a 5-star rating compared to 5% of NPOHs. 84 of the 251 (or 33%) hospitals receiving a 5-star rating were POHs, despite comprising approximately 5% of the total number of participating hospitals.

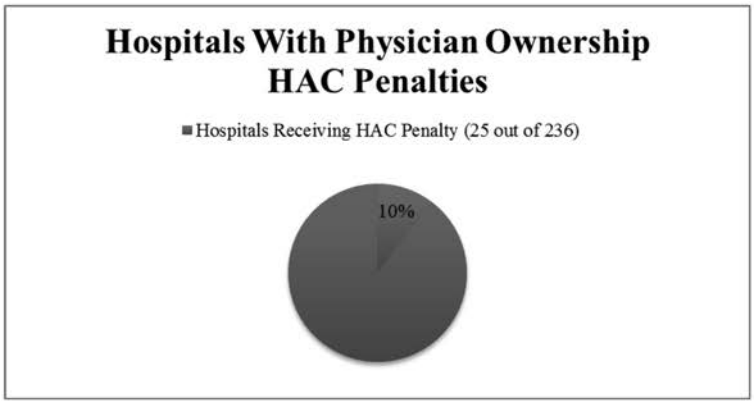
The CMS data is irrefutable in quantifying the quality POHs provide.[i] Patients don't just do better when treated at a POH, they do significantly better.

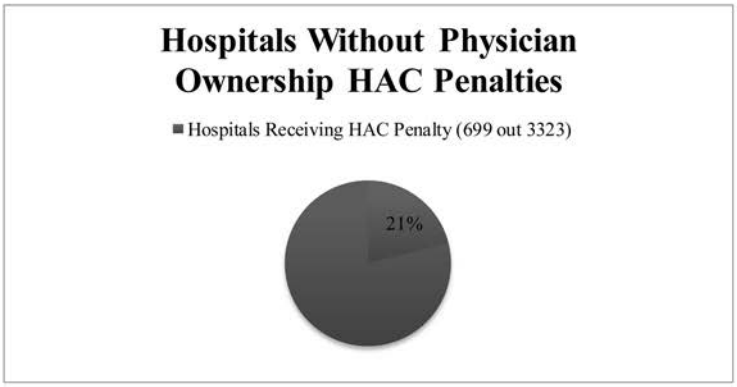


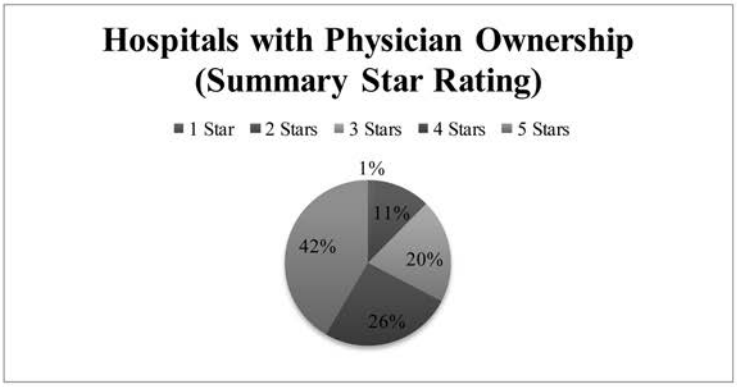

Readmissions Penalties for All Other Participating Hospitals
Never Penalized
Penalized 1 of 3 Years
Penalized 2 of 3 Years
Penalized All 3 Years
17%
15%
53%
15%


Value-Based Purchasing for Hospitals with Physician Ownership
Never Penalized
Penalized 1 of 3 Years
Penalized 2 of 3 Years
Penalized All 3 Years
8%
9%
16%
67%


Value-Based Purchasing for All Other Participating Hospitals
Never Penalized
Penalized 1 of 3 Years
Penalized 2 of 3 Years
Penalized All 3 Years
19%
36%
23%
22%


Hospitals With Physician Ownership HAC Penalties
Hospitals Receiving HAC Penalty (25 out of 236)
10%


Hospitals Without Physician Ownership HAC Penalties
Hospitals Receiving HAC Penalty (699 out 3323)
21%


Hospitals with Physician Ownership (Summary Star Rating)
1 Star
2 Stars
3 Stars
4 Stars
5 Stars
1%
11%
20%
26%
42%

Physician Ownership Model

The governance model of POHs revolves around patients. It is the patients that have been forgotten by the opponents of POHs in this political debate. Many POHs were developed by physicians who were frustrated that they could not utilize the equipment they believed would lead to better outcomes or were forced to work with staff whose competence they questioned. In many cases, the frustration led them to invest in their own facilities where they have direct control over how the hospital runs. These physicians have the ability and motivation to design a hospital's layout and operations in a way that maximizes quality and efficiency. This leads to better outcomes at lower cost as they make needed investments at the bedside, without spending extravagantly if there isn't a correlation to patient outcomes.

A GAO report found the majority of physician owners have shares of only 2-4% of their hospital.[ii] The GAO also concluded the majority of physicians who refer patients to POHs have no ownership interest in the facilities, and thus, have no financial incentive to make such referrals. Approximately 74% of physicians with admitting privileges at POHs are not investors, suggesting the attractiveness of the model goes well beyond financial gain[iii]. Physicians' control every facet of how a POH is run – bureaucratic and administrative inefficiencies are greatly reduced compared to NPOHs. Operating rooms (ORs) run as a well-oiled machine – both the surgical/medical team and support staff. After a surgery the ORs are turned over in 15 minutes or less, while at NPOHs this often approaches an hour.[iv] This makes for unhappy patients and physicians.

The governance model also allows for rapid change. If there is a need identified that will improve patient care it does not have to run through committee after committee, it can be implemented immediately. All of this greatly contributes to high quality patient outcomes and satisfaction.

Community Support versus Profiteering

All hospitals, whether tax-exempt, for-profit, and physician-owned hospitals, need to be profitable to stay open. There are numerous examples of physicians purchasing tax-exempt and for-profit hospitals

that were closing due to bankruptcy. St. Joseph's in Houston, TX and Doctor's Hospital of Michigan in Pontiac, MI are just two examples of physicians purchasing hospitals that were closing so that care would be preserved for underserved populations. The opponents of POHs abandoned these communities and it was physicians who maintained access to care. Physicians could not do this today under current law.

Tax-exempt models perpetuate an inefficient model. By needing to "reinvest" or spend down their profits, often by expanding their physical plant or increasing administrative overhead, they add significant additional costs to the system, as Medicare bases a portion of reimbursements on facility cost reports. This creates inefficiencies that have little return for patients.

The for-profit model naturally creates investor pressures for high returns on investment. Almost 3 million shares of Hospital Corporation of America's (HCA) stock trade every day. These shareholders rarely have any tie to the community where there is an HCA hospital. Investors are seeking a profit through dividends and a higher stock price.

The POH model is based upon investments by individual physicians. These physicians are treating patients – often their neighbors – and devote their career to the community in which they live and practice. The majority of income is derived from providing physician services, not the hospital investment; however, the investment assures they can provide services on their own terms, not an administrator's.

The diversity of these models creates a competitive environment which is good. PHA believes patients benefit when they have more choice in who provides their healthcare. Public policy should encourage physicians who believe in their services enough to financially invest in where they treat patients. All the data demonstrates the real beneficiary is patients.

According to HRSA, nearly 30% of all POHs serve Medically Underserved Areas and/or Medically Underserved Populations.

Most importantly, in terms of community benefit, a CMS study found that POHs spend an average of 5.5% of their total revenue on community benefit, compared to only .87% for NPOHs. Community benefit includes taxes paid and charitable care.[v] As an example, in the case of the Indiana Orthopaedic Hospital, a portion of hospital ownership was placed in security trust for charitable purposes and over $2.1 million has been donated to the Central Indiana Community Foundation. Clearly POHs are not the greedy, profiteering enterprises for which they are accused of being by their opponents.

CBO Estimates

Over the past 10 years the CBO has scored anti-POH legislation as saving anywhere from$2.8 billion to most recently $300 million. Countering CBO's $500 million score during the ACA debate was CMS's Office of the Actuary that concluded there would be no budget impact. In fact, in 2014 CMS published Medicare payments to hospitals for the top 100 DRGs and top 30 APCs for the first time. CBO did not have access to this data prior to this time. The data also included the number of cases each hospital

performed. Using simple arithmetic, if all the cases that were performed at POHs were transferred to their competitors within the same hospital referral region, it would cost an additional $3.2 billion over 10 years to treat those patients.[vi] Simply put, POHs provide less costly care for patients than their competition.

Utilization

After a decade of debate, critics of POHs have not been able to construct a coherent, evidence-based case that POHs have higher utilization (i.e. "inappropriate" utilization) than their NPOHs. There has never been any evidence provided in any recognized study, government-produced or otherwise, that POHs result in inappropriate utilization.[vii]

POHs that provide focused services yield utilization of a very narrow procedure group. In doing so, they excel at providing the highest levels of quality and efficient care. The model creates what would be considered "centers of excellence" in any other industry. Providing efficient care means a hospital is able to perform more surgeries or procedures in the same time frame than NPOHs. In fact, many physicians will not treat Medicaid patients unless it is at a POH as they can do several Medicaid cases in the same amount of time it takes them to do one case at a NPOH. This efficiency of care allows the physician to continue to serve Medicaid patients. Without it, they would lose money and ultimately would have to greatly reduce such services.

One of the goals of the ACA is to improve access to healthcare services and POHs are able to better serve more patients than their counterparts.

Demand Matching is not Cherry Picking

The national associations that represent NPOHs continue to falsely accuse doctors at physician-owned facilities of "cherry-picking" patients. If one steps back and thinks about the issue, POHs not only do not cherry pick patients, but they are fighting for the ability to serve more Medicare and Medicaid patients. Section 6001 did not outlaw new POHs; it mandated that CMS would not provide reimbursement for treating those patients at new POHs and grandfathered POHs could not expand and continue to serve Medicare and Medicaid beneficiaries. POHS are fighting the current political battle so they can serve all patients.

In a working paper titled "Physician Investment in Hospitals: Specialization, Incentives, and the Quality of Cardiac Care," Dr. Ashley Swanson – a professor at the University of Pennsylvania's Wharton School of Business and a former associate of Jonathan Gruber, the principal architect of the ACA – asserts that "there is little evidence of physician-owner cherry picking" and that "the banning of further physician ownership as part of the ACA may have detrimental effects on patient health." She continues, "Treatment at a physician-owned facility can lead to substantial improvements in mortality risk for cardiac patients." She finds that not only do physician owners not cherry pick, they provide a higher quality of care for their patients compared to their competition.

Rather than cherry pick, physician owners of hospitals ensure their patients are treated at the facility that will best meet the patient's needs. An efficient healthcare system provides choice and different levels of care. As previously stated, not all patients need the same level of care and physician-owned

hospitals provide a valuable option for many patients, just as an ambulatory surgical center or a large general acute care facility does for others. The key is that physicians provide informed consent with patients and the patient decides where the healthcare services will take place. Most physician owners of hospitals are have privileges to practice at multiple NPOHs simultaneously, just as physicians without an ownership stake in a hospital are affiliated with multiple facilities, including POHs. Cherry picking does not occur at POHs; matching the patient to the facility that will provide the optimum outcome is the driver of referrals.

Ironically, in 2007, CMS eliminated any incentive that might lead to the so-called "cherry picking" of Medicare patients. CMS changed the inpatient hospital payment policy to base payments on actual costs rather than charges, better reflecting the severity of a patient's condition. The agency believed these changes would more accurately reflect the costs of caring for a patient and reduce incentives that might exist for any hospital to treat the healthier and more profitable patients. Physician Hospitals of America welcomed the transition to a severity-adjusted DRG system, whereas the new policy was opposed by the associations representing NPOHs.

Services Vary at Hospitals

Over 60% of POHs have emergency departments. It is true there are POHs that do not have an emergency department. This is also true for some non-physician-owned hospitals. Hospitals are licensed at the state level and some state laws require a hospital to offer certain services while others do not. This includes emergency services. As part of the Medicare Conditions of Participation, POHs, as well as any other hospital, are required to detail a plan for how emergencies and transfers are handled. POHs fully comply with this mandate.

Community needs are the key drivers to any service offered by hospitals. Government regulation also dictates how those services are to be delivered. Hospital emergency department services vary significantly in terms of the level of treatment provided. For instance, of the nearly 6,000 hospitals across the country, only 1,675 of them have a trauma center[viii]. It is not uncommon for patients with severe injuries or medical conditions to be transported from one hospital to one that is better equipped to provide a higher level of care. This is also true for burn victims. As of 2012, there are 123 self-designated burn care facilities in U.S. hospitals. When a severely burned patient is transported to a general community hospital, it is usually necessary for that patient to be transported to one that is equipped to treat these more complex cases. Another example of varied services within the hospital industry is Neonatal Intensive Care Units (NICU). There are varying degrees of care that NICU's offer and many hospitals do not have any level of this specialized care so newborn babies in need of neonatal care are routinely transferred to another hospital with a NICU because they have the experience, equipment, research and processes to assure the best care possible. All hospitals, no matter what type, transfer patients from time to time ensuring they receive treatment in the best possible environment.

Conclusion

Opposition to physician-owned hospitals did not come from patients, who flock to these facilities because of their positive outcomes and overall experience. The ban on physician-owned hospitals is not

and never has been organic. It has come from the Big Hospital lobby which views any disruptive innovator as a threat to their bottom line. It is this group that has requested that Congress ban POH expansion. Patients are certainly not a focus in the pursuit of this policy.

It is time to put sound policy before politics. Patients should always be the driving force behind providing hospital services. They should be able to seek treatment at hospitals that provide high quality outcomes and patient satisfaction at a low cost. Physicians want to ensure their patients receive the best care possible. The POH results speak for themselves.

Section 6001 has had a negative effect on patients as access to lower cost, high quality centers of excellence has been limited. We believe public policy should be implemented that align with high quality patient care and not the politics of David versus Goliath. We appreciate the Chairman for holding this hearing as the current policy simply stifles patient access to some of the best hospitals in the country. PHA asks Congress to repeal Section 6001 of the Affordable Care Act.

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[i] 2012 CMS Hospital Value Based Purchasing Data

[ii] Specialty Hospitals: Information on National Market Share, Physician Ownership and Patients Served. Washington, DC: Government Accountability Office; 2003

[iii] Specialty Hospitals: Geographic Location, Services Provided and Financial Performance. Washington, DC: Government Accountability Office; 2003

[iv] PHA Benchmarking Report

[v] CMS. Study of Physician-owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003: Centers for Medicare and Medicaid Services, Department of Health and Human Services;2005.

[vi] "Physician-Owned Hospitals Result in Lower Expenditures," Issue Brief, Avalon Heath Economics. 2013

[vii] "Do Physician-Owned Hospitals lead to Higher Utilization?" Issue Brief, Oxford Outcomes. 2012

[viii] TIEP: Public Reports – Trauma center Designation and verification by Level of Trauma Care

Salina Surgical, Statement

Statement for the Record
House Ways and Means Health Subcommittee
Chairman Kevin Brady (R-TX) and Ranking Member Jim McDermott (D-WA)
"Improving Competition in Medicare: Removing Moratoria and Expanding Access"
May 19, 2015

Dear Sirs:

I am the CEO of Salina Surgical Hospital in Salina, Kansas. I would like to thank you, Chairman Brady, Ranking Member McDermott, and other members of the subcommittee for the opportunity to submit comments in connection with the above-mentioned hearing.

My objective today is to help the House Ways and Means Health Subcommittee understand why ending discrimination in Federal Law against hospitals with physician ownership is necessary if we ever hope to make positive change that will positively affect both Medicare and Medicaid patients across the country. Patients should be the driving force behind providing hospital services. Patients should be able to seek treatment at hospitals that provide high quality outcomes and patient satisfaction at a lower cost. Section 6001 of the ACA both prohibits newly constructed physician owned hospitals (POH) from being able to treat Medicare and Medicaid patients and restricts the Medicare-licensed physician owned hospitals that were grandfathered under the law from growing to meet community needs. This anti-competitive policy is bad for our health care system, bad for Medicare and most important, bad for patients. I am strongly urging Congress to allow hospitals with physician ownership to compete on a level playing field with every other hospital in the country, particularly when it comes to growth. This can be accomplished by supporting the bi-partisan legislation, H.R. 976, to increase patient access to physician owned hospitals.

Salina Surgical Hospital (SSH)

About Us

Opening our doors in 1999, Salina Surgical Hospital was the concept of a group of local community involved physicians and investors with a commitment to patient satisfaction and care. Salina Surgical Hospital and Salina Regional Health Center (SRHC), our community hospital, formed a joint venture to develop a state of the art entity with the mission to provide the highest quality healthcare services at a reasonable cost using modern, state-of-the-art technology in a friendly and caring environment by highly-skilled, compassionate staff in an effort to serve the people of Salina and its surrounding communities. SSH is a multi-specialty hospital that provides both inpatient and outpatient services.

Salina Surgical Hospital is located in Salina, Kansas. We serve the city of Salina as well as north central Kansas. Our patient population is close to 50% Medicare and Medicaid. We are a multi-specialty hospital that offers specialized care for Orthopedics, General Surgery, Ophthalmology, Digestive Health Women's Health, Otolaryngology, Podiatry, Urology, and limited Neurosurgery.

Salina Surgical Hospital is proud to be a partially physician owned hospital. Physician ownership means that the physician owners play a major role in deciding how Salina Surgical Hospital is run and what equipment and supplies are purchased by the hospital. Physician ownership reinstates the physician

back into the decision-making role which allows our physicians to deliver the highest quality of dedicated service in the facility that they co-own.

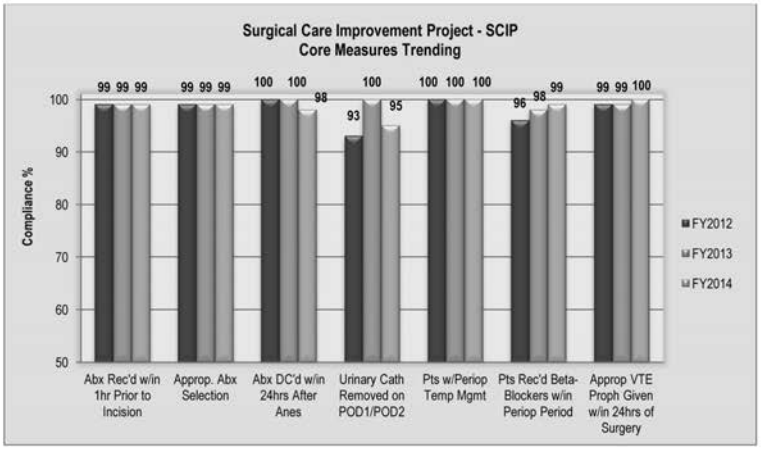
In addition, being partially physician owned sets us apart because our medical staff has a direct investment in the quality of care you receive. This ensures you are treated with respect, dignity, and the compassion you deserve. Our facility is comprised of four operating rooms, two endoscopy suites, and 16 staffed inpatient rooms (Licensed for 18 inpatient rooms).

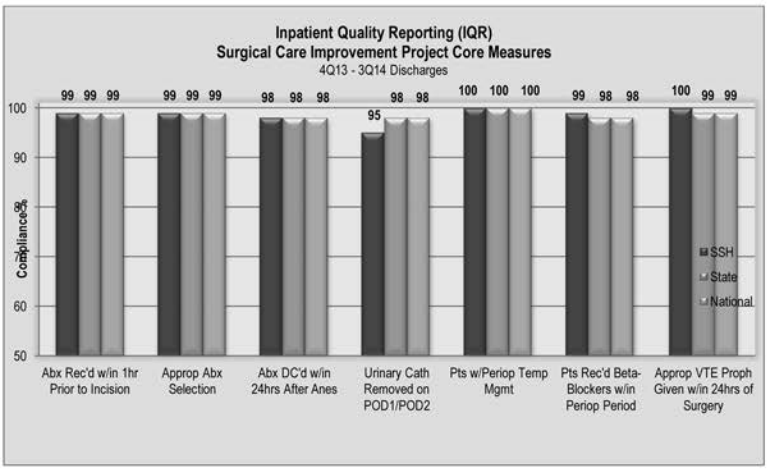
What also sets our facility apart is the partnership with our not-for-profit community hospital. Not only does our community hospital reap 50% of the revenue our facility creates, but we contract many services from our community hospital. An example of services contracted from our community hospital is physical therapy, occupational therapy, social services, pharmacist-in-charge services, and blood bank services. By contracting these services from our community hospital, we are helping to keep health care dollars in our direct community.

Quality at SSH

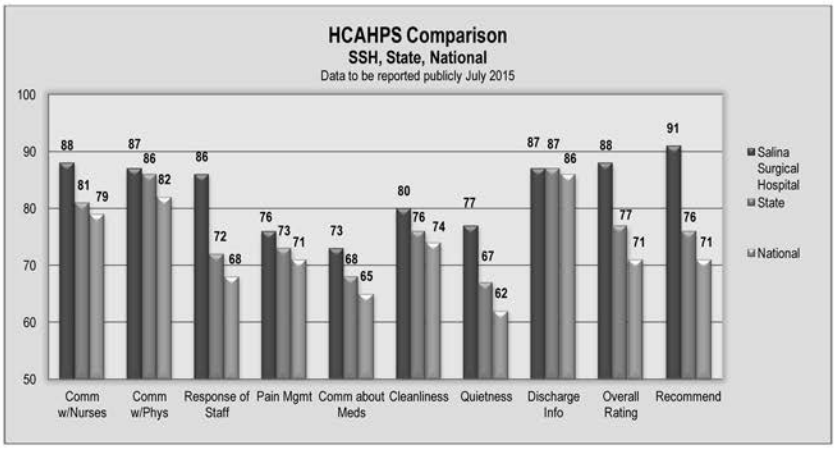
Quality care is what Salina Surgical Hospital (SSH) is about. SSH strives to provide the best quality care to every patient, every day, in the most efficient way. Because there are so many things that can impact quality of care, the hospital, its staff, and PHYSICIANS are continually looking for ways to improve the care they provide. Our high CMS quality measure scores, patient satisfaction, low infection rates, zero sentinel/never events, and achievements in the VBP program are a reflection of our hard work and commitment to excellence. The following charts showcase SSH achievements.

CMS Quality Measure Scores

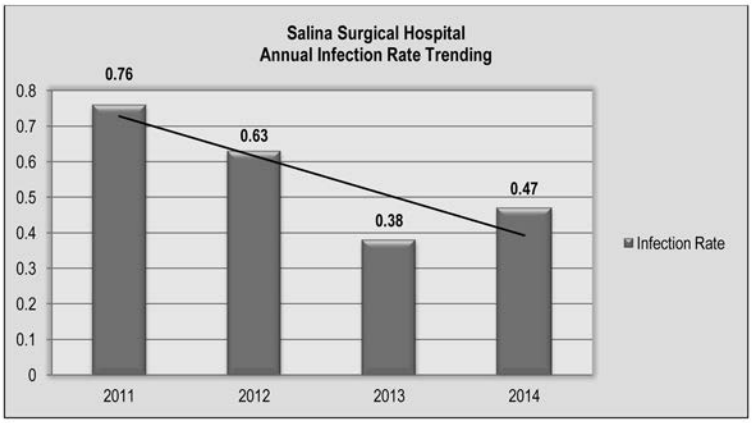




Patient Satisfaction



Infection Prevention



Value Based Purchasing

	FY2013	FY2014	FY2015	FY2016	FY2017 and Subsequent Years
Initial Base Operating DRG Payment Reduction	1.0	1.25	1.5	1.75	2.0
Clinical Process of Care	70%	45%	20%	10%	To be determined
Patient Experience of Care	30%	30%	30%	25%	
Outcomes	N/A	25%	30%	40%	
Efficiency	N/A	N/A	20%	25%	
# of Domains Required to Meet to Participate	2 Domains	3 Domains	2 Domains	2 Domains	
Value-Based Incentive Payment Percentage Earned by Salina Surgical Hospital	**1.3057** (0.3057 additional)	**Not Eligible** - Participation in 2 domains only	**3.1016** (1.6016 additional)	Pending	

Emergency Services

Salina Surgical Hospital is a POH that does not have an emergency department. It is the operating agreement between SSH and our community hospital partner that prohibits our hospital from

providing emergency services. Salina Surgical Hospital's scope of care, per our operating agreement, is limited to a surgical/procedural specialty hospital. Physicians are available on-call 24 hours a day, 7 days a week, but may not be on the premises. The nursing staff is trained in basic and advanced cardiac life support, as well as in the use of the full complement of available emergency equipment in the event an emergency should occur at SSH. Our patients understand that if they should need services not available at SSH, we have a transfer agreement and other affiliations with SRHC to provide these services. Transportation to and from SRHC will be arranged by SSH based on the level of care required. What enhances our ability to safely handle emergency situations are our staffing levels. SSH does not dilute our clinical staff with nurse extender positions. Our Inpatient unit is staffed predominantly with registered nurses and our patient to nurse ratio is 4:1 or less.

Conclusion

The BOTTOM LINE: ***It's all about CARING!*** Despite the fast pace and variety of cases that we perform, we consistently achieve high outcomes. From preadmission to discharge and beyond, our approach to the continuum of patient care is characterized by attention to detail, prevention rather than reaction and applying the best practices, all while being flexible and innovative. I would venture to say that this is the trademark for all physician owned hospitals.

Opposition to physician-owned hospitals did not come from patients. Patients flock to these facilities because of their positive outcomes and overall experience. The ban on physician-owned hospitals is not and never has been organic. It has come from the *Big Hospital* lobby which views any disruptive innovator as a threat to their bottom line. It is this group that has requested that Congress ban POH expansion. Patients are certainly not a focus in the pursuit of this policy.

It is time put sound policy before politics. Patients should always be the driving force behind providing hospital services. They should be able to seek treatment at hospitals that provide high quality outcomes and patient satisfaction at a low cost. Physicians want to ensure their patients receive the best possible care. The POH results speak for themselves.

Healthcare is changing. Every day, in every way. It requires true collaboration to solve the toughest issues-from revenue and cost pressures to compliance and technology hurdles. At Salina Surgical Hospital we strive to transform our top challenges into opportunities. There is no endpoint on our journey to continually maintain and improve our reputation of excellence and provide patients with quality service and the best outcomes.

Section 6001 has had a negative effect on patients as access to lower cost, high quality centers of excellence had been limited. I believe public policy should be implemented that align with quality patient care and the politics of David versus Goliath. I appreciate the Chairman for holding this hearing as the current policy simply stifles patient access to some of the best hospitals in the country. Salina Surgical Hospital asks Congress to repeal Section 6001 of the Affordable Care Act.

Heart Hospital, Letter and Exhibit A

The Heart Hospital
Baylor Plano

Joint ownership with physicians
Now part of Baylor Scott & White Health

June 1, 2015

The Honorable Kevin Brady
Chairman
House Committee on Ways and Means
Subcommittee on Health
United States House of Representatives
Washington, D.C. 20515

Dear Chairman Brady:

The Heart Hospital Baylor Plano would like to submit the following written comments for the record for the hearing titled *"Improving Competition in Medicare: Removing Moratoria and Expanding Access"* that your committee held on May 19, 2015. The Heart Hospital Baylor Plano strongly believes that Congress can improve competition and expand access by passing the *Patient Access to Higher Quality Health Care Act of 2015* (H.R. 976) to eliminate Section 6001 of the Affordable Care Act ("ACA"), which prohibits (i) new physician-owned hospitals from treating Medicare and Medicaid patients, and (ii) the expansion of physician-owned hospitals that presently exist. This would not only improve competition and expand access, it would also improve the quality of health care and increase overall patient satisfaction.

The Heart Hospital Baylor Plano

The Heart Hospital Baylor Plano is a 116 bed specialty hospital located in Plano, Texas that is dedicated to providing the highest quality cardiovascular care. Although focused on cardiovascular care, The Heart Hospital Baylor Plano has a full functioning emergency department with the ability to care for and stabilize emergent patients. We are the ninth largest cardiac surgery center in the United States and rank first out of approximately 23 cardiovascular specialty hospitals nation-wide as measured by patient volume. In April of this year, The Heart Hospital Baylor Plano was one of only 13 North Texas hospitals to be awarded a five-star rating by the Centers for Medicare and Medicaid Services ("CMS"). We were also rated as one of the top 15 heart surgery programs in the United States last year by *Consumer Reports*. Locally, The Heart Hospital Baylor Plano, as noted by the Dallas-Fort Worth Hospital Council, is the largest heart surgery center out of 39 similar programs in the Dallas-Fort Worth Metroplex.

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469-81HEART (469.814.3278) • 877.814.4488 • 469.814.3521 Fax
TheHeartHospitalBaylor.com

Our commitment to patient service has also been repeatedly recognized. *Becker's Hospital Review* named The Heart Hospital Baylor Plano to its list of "54 Best Overall Patient-Rated Hospitals," "Top 55 Hospitals Patients Would Definitely Recommend," and "100 Hospitals and Health Systems with Great Heart Programs." The Heart Hospital Baylor Plano was also named a 2014 "Beacon of Excellence Award" and "Guardian of Excellence Award" winner by Press Ganey Associates. In 2012, for the fourth consecutive year, we earned an "Outstanding Patient Experience Award" as determined by the HealthGrades Quality Study, which places us in the top 5% in the nation for the Outstanding Patient Experience.[1]

CMS Data Shows Physician-Owned Hospitals Provide Higher-Quality Care

Although The Heart Hospital Baylor Plano has earned numerous awards for the high quality care we provide to our patients, we are not the only physician-owned hospital that has been recognized as a center of excellence within the American health care system. Seven of the top 10 hospitals awarded bonus payments for higher quality of care through the Hospital Value-Based Purchasing program in FY 2015 were physician-owned, as were 43 of the top 100. This is even more impressive when you consider that less than 5% of program participants were physician-owned hospitals. In 2005, CMS issued a report that found physician-owned hospitals also performed better than general hospitals in complication rates. When CMS compared 14 areas, including complications of anesthesia and infections due to medical care, physician-owned hospitals led in 13 of the 14 areas, in some cases by wide margins.

Section 6001 Prevents Competition

Despite an outstanding and established record of performance, Section 6001 of the ACA prohibits physician-owned hospitals from building new facilities that would treat Medicare and Medicaid beneficiaries. It also includes overly burdensome requirements that prevent existing physician-owned hospitals from adding any additional inpatient beds, operating rooms, or procedure rooms, even when the community in which they are located has an ongoing need for expanded services. When the federal government's own data shows that physician-owned hospitals can deliver care that is higher in quality than care provided by general hospitals, it makes no sense to leave a prohibition in place that prevents physician-owned hospitals from competing in the health care marketplace.

We are a good example of the current law's adverse impact on a community. Recent market data indicates that the Dallas-Fort Worth Metroplex is growing by approximately 100,000 residents per year. Given our community's exponential growth, the demand for heart and vascular care will continue to increase. However, The Heart Hospital Baylor Plano constantly operates at full capacity today and the prohibition against expansion will limit our ability to grow in the future to meet the increased need for care in our community.

[1] A list of quality and service accomplishments for The Heart Hospital Baylor Plano can be found at Exhibit A.

Competition Leads to Innovation

Competition leads to innovation and The Heart Hospital Baylor Plano has been a leader in innovation. In 2011, we opened The Center of Innovation, a 10,000-square-foot facility that consists of an advanced training facility with a bioskills lab. The integrated services offered at the Center include medical education, staff development, student educational experiences, health care preceptorships and hands-on training events for medical professionals across the health care industry. The Center is not merely a resource for The Heart Hospital Baylor Plano's staff and invited guests, but an important center of learning that focuses on a variety of specialties, beyond just cardiovascular care. We would welcome the entry of new competitors in the market because we believe the additional competition would only help us to provide even better quality to our patients.

Again, thank you for the opportunity to provide comment on how to improve competition in the Medicare program. The Heart Hospital Baylor Plano strongly supports adoption of H.R. 976 to end the prohibition against the development of new physician-owned hospitals and the expansion of existing physician-owned hospitals. This law would spur competition in the Dallas-Fort Worth market and provide patients with greater access to high-quality health care. We would like to extend an invitation to you, and any of your colleagues to visit our facility and engage in a dialogue as to why we believe physician-owned facilities will continue to increase the efficiency and quality of care to all patients. We look forward to working closely with you to see that this important legislation becomes law.

Sincerely,

Mark A. Valentine
President
The Heart Hospital Baylor Plano

The Heart Hospital
Baylor Plano

Joint ownership with physicians
Now part of Baylor Scott & White Health

EXHIBIT A

THE HERAT HOSPITAL BAYLOR PLANO
QUALITY AND SERVICE ACCOMPLISHMENTS

QUALITY

- The **American Heart Association** recognizes The Heart Hospital Baylor Plano for achieving 85% or higher compliance with all Get With The Guidelines®-Heart Failure Achievement Measures and 75% or higher compliance with four or more Get With The Guidelines®-Heart Failure Quality Measures for consecutive 12 month intervals to improve quality of patient care and outcomes. Recognition valid from 2014 to 2015.

- December 18, 2014 Baylor Scott & White Health announced an **alliance with Cleveland Clinic's Sydell and Arnold Miller Family Heart & Vascular Institute.** The alliance creates a collaboration involving the academic, clinical and research components of Cleveland Clinic and three Baylor Scott & White Health hospitals:
    - Baylor Jack and Jane Hamilton Heart and Vascular Hospital
    - Baylor University Medical Center at Dallas
    - The Heart Hospital Baylor Plano

- The Heart Hospital Baylor Plano: Recognized as a **"Top 10 Cardiovascular Specialty Hospital in the Country"** based on volume as reported by TRG Health Care Solutions.

- **The Society of Thoracic Surgeons (STS)** star ratings received for calendar year 2014 in Adult Cardiac Procedures: The Heart Hospital Baylor Plano received 3 stars, the highest rating an organization can receive, in Isolated Aortic Valve Replacement (ranks in the top 7.89% of facilities receiving 3 stars for AVR) and Aortic Valve Replacement + Coronary Artery Bypass Graft (ranks in the top 7.53% of facilities receiving 3 stars for AVR+CABG).

- **The Society of Thoracic Surgeons (STS)** star ratings place The Heart Hospital Baylor Plano in the top 2.8% of the nation for facilities receiving 3 stars in AVR and AVR + CABG. The 3 star ratings consist of absence of Mortality and absence of Morbidity. Morbidity includes, but is not limited to, reoperations, post-op strokes, renal failure and prolonged intubation.

- April 16, 2015 The Heart Hospital Baylor Plano was one of only 13 North Texas hospitals to be **awarded a five-star rating, the highest rating possible, by the Centers for Medicare and**

Medicaid Services (CMS). Additionally, The Heart Hospital was one of only 251 hospitals out of more than 3,500 U.S. hospitals to receive the five-star rating.

- June 27, 2014 ***Consumer Reports*** **rated The Heart Hospital Baylor Plano as one of the top 15 heart surgery programs in the United States**. The organization rated hundreds of heart surgery programs on two common types of heart surgery: surgical aortic valve surgery and coronary artery bypass graft surgery as well as on patient outcomes, including survival and complication rates.

- **Poster presentations at the national NCDR conference** in San Diego (March 2015): Subjects included "Code STEMI: Taking a Team Approach to Expedite Reperfusion Therapy"

- Participate in **submitting our quality outcomes in more than 25 databases, registries and governing bodies** that include, but are not limited to the following: Centers for Medicare and Medicaid Services (CMS), The Joint Commission, NCDR (National Cardiovascular Data Registry), The Society of Thoracic Surgeons, and VQI (Vascular Quality Initiative)

- **Pathway to Excellence®** designation 2010

- **Magnet® designation** – February 2011

- The **Joint Commission Accreditation** recertification 2013 zero deficiencies

- The Joint Commission **Advanced Heart Failure Certification** – April 2011

- The Joint Commission **Ventricular Assist Device (VAD) Certification** – June 2011 recertification, 2013

- Inter-societal Accreditation Commission Vascular Laboratories **(ICAVL) Vascular Ultrasound; Venous** and **Carotid Imaging** accreditation at the CACC and THE HEART HOSPITAL Baylor Plano

- Inter-societal Accreditation Commission Echocardiography Laboratories **(ICAEL) Cardiac ECHO** accreditation at the Center for Advanced Cardiovascular Care

- The Society of Cardiovascular Patient Care (SCPC) **Chest Pain Accreditation** Cycle IV +PCI – May 2014

- Designated as an **Institute of Quality (IOQ)** for **Cardiovascular Surgery and Cardiac Medical Intervention** May 1, 2013. Designated IOQ facilities demonstrate excellence in care, a commitment to continuous improvement and represent an exceptional value to Aetna's members. IOQ facilities are recognized in Aetna's DocFind® online provider directory to assist members with choosing facilities providing consistently high quality and high value care.

- Ranked **#1** out of 121 programs in Texas by **CARECHEX** in their Hospital Quality Ratings 2013, Cardiac Surgery (Major) Category. CARECHEX is one of the nation's largest privately-held healthcare information services companies.

- The Joint Commission **Top Performers on Key Quality Measures™** for 2012.

- The Joint Commission published this recognition in its "Improving America's Hospitals" annual report: "**As a Top Performer on Key Quality Measures, your hospital is among 620 hospitals, the top 18%.**" September 19, 2012
- American Heart Association Heart Failure **Gold Plus Quality Achievement Award**
- American Heart Association Mission Lifeline (STEMI) **Bronze Award** 2011
- American Heart Association Mission: Lifeline® Receiving Center – **SILVER Level Recognition Award 2012**. This award is based upon our Mission: Lifeline achievements through the ACTION Registry GWTG™ 2012 calendar year.
- Action (STEMI/NSTEMI) Registry **Platinum Award** 2013
- **#1 heart surgery program in the Dallas/Ft. Worth Metroplex**, performing one of every four heart surgeries last year. Nearest competitor performed approximately half as many as The Heart Hospital Baylor Plano.
- **First in the World** to merge two high-tech systems for atrial fibrillation therapy. The procedure combined multi-electrode mapping (MEM) software with the Epoch™ platform, an advanced computer-controlled technology that allows physicians to navigate within the patient's heart with robotic precision.
- **First in the World** to merge three high-tech systems for atrial fibrillation therapy. The procedure combined multi-electrode mapping (MEM) software with GE ultrasound and BioSense Webster Carto® 3D mapping for advanced computer mapping
- Developed **Plano Campus Thoracic Program** encompassing clinics, oncology and thoracic surgery in 2013

SERVICE

- Becker's Hospital Review has named The Heart Hospital Baylor Plano as one of the organizations on its 2014-15 edition list: **"100 Hospitals and Health Systems with Great Heart Programs."** The hospitals on this list lead the nation in cardiovascular and thoracic healthcare.
- June 24, 2014 Becker's Hospital Review named The Heart Hospital Baylor Plano as **one of the "Top 55 Hospitals Patients Would Definitely Recommend."**
- On December 10, 2014 The Heart Hospital Baylor Plano was named a **2014 Beacon of Excellence Award® and Guardian of Excellence Award® winner by Press Ganey Associates, Inc.** The Beacon of Excellence Award is presented annually to organizations representing the nation's three top-performing health care facilities by category that have achieved and consistently maintained high levels of excellence in the patient experience. The Guardian of Excellence Award is presented annually and honors Press Ganey clients who consistently sustained performance in the top five percent of all Press Ganey clients for each reporting period

during the course of one year. Press Ganey is the nation's leading health care performance improvement company and partners with more than 11,000 health care facilities, including more than half of all U.S. hospitals, to improve the patient experience.

- The Heart Hospital Baylor Plano was named **one of the "54 Best Overall Patient-Rated Hospitals" by Becker's Hospital Review**. Data was pulled from the Hospital Compare website and is based on data from January through December of 2013, the most recent information available.

- Becker's Hospital Review named The Heart Hospital Baylor Plano as **one of the "150 Great Places to Work in Healthcare"** in the United States.

- Press Ganey 2013 **Beacon of Excellence Award** winner (Inpatient & Emergency Department) for maintaining consistently high levels of excellence in patient satisfaction May 2010 – April 2013. Awarded to the top three performers in the United States: Inpatient category of 100 – 199 bed and the top three performers in Emergency Department

- Press Ganey **Inpatient Summit Award:** 2009, 2010, 2011, 2012

- Press Ganey **Emergency Department Summit Award:** 2010, 2011, 2102

- Press Ganey **Guardian of Excellence Award.** Emergency Department, Inpatient and HCAHPS categories 2013

- **Becker's Hospital Review** (August 20, 2013) listed The Heart Hospital Baylor Plano as one of the "Top 51 Hospitals Patients Would Definitely Recommend"

- **Outstanding Patient Experience Award™** as determined by the 2012 HealthGrades Quality Study for the **fourth consecutive year** which places The Heart Hospital Baylor Plano in the **top 5% in the nation** for the Outstanding Patient Experience.

Richard Bruch, Statement

Statement for the Record

House Ways and Means Health Subcommittee

Chairman Kevin Brady (R-TX) and Ranking Member Jim McDermott (D-WA)

Improving Competition in Medicare: Removing Moratoria and Expanding Access

May 19, 2015

I am Richard Bruch, M.D., an orthopedic surgeon and serve as Board Chair of North Carolina Specialty Hospital (NCSH), a hospital with physician ownership which is unable to expand due to the limitations imposed by Section 6001 of the Affordable Care Act. I am a 1.31 % owner of NCSH.

Chairman Brady, Ranking Member McDermott and members of the House Ways and Means Health Subcommittee, thank you for accepting testimony regarding the issue of physician ownership of hospitals. As a general rule, physician owned hospitals provide great medical care with great patient satisfaction and provide this care at less expense than our competitors. H.R. 976 begins the process of allowing hospitals with physician ownership to provide additional great care at substantial savings to our patients.

NCSH located in Durham, North Carolina is licensed as a general acute hospital, the same licensure as all other North Carolina hospitals. NCSH has 18 licensed inpatient rooms and 4 licensed operating rooms. This represents 1.4% of Durham's licensed inpatient rooms and 5.3% of Durham's licensed operating rooms.

McPherson Hospital, the forerunner of North Carolina Specialty Hospital, opened in 1926. McPherson was a physician owned eye and ear hospital. As eye and ear surgeries became outpatient procedures the hospital inpatient census dwindled and the hospital was losing money. In 1998 Triangle Orthopaedic Associates, P.A. rescued McPherson Hospital which was then renamed North Carolina Specialty Hospital. Currently the majority of patients treated, both inpatient and outpatient, at NCSH are orthopedic and eye and ear patients. But NCSH also provides general surgery, bariatric surgery, plastic surgery, oral surgery, podiatry surgery, wound care, anesthesiology and pain management care.

NCSH treats the public. Current payer mix comprises 50% governmental funded patients including Medicare, Medicaid and Tricare. NCSH also treats indigent patients, providing free care via Project Access Durham County. Lincoln Community Health Center (LCHC) located in Durham is a federally qualified health center serving the uninsured and underinsured population. NCSH accepts the financial screen that LCHC assigns and Lincoln patients treated at NCSH need not go through any additional financial screening to determine their billing status.

NCSH provides superb care as documented by the ratings of CMS and other entities. Currently NCSH ranks 10th in the nation under the CMS combined ratings for Value-Based Purchasing Program and the Hospital-Acquired Conditions Program. The CMS 30 day Readmission rating is released quarterly and NCSH always ranks #1-#4 in the state. NCSH is one of only 251 hospitals in the nation to hold a 5 star CMS Patient Satisfaction rating. Consumer Reports Health assigned NCSH its highest rating for safest hospitals to have surgery, one of only two North Carolina hospitals to earn this designation.

How is this quality achieved? NCSH has a patient to nurse ratio of 4:1. All nurses must achieve ACLS and PALS certification within 6 months of employment. NCSH has an employee turnover rate of 7% annually; this rate is 1/3 the rate in the Triangle North Carolina region. Hospitalist physicians, who are Internists, are on site 24 hours per day, 7 days per week and they see every inpatient twice daily and record chart entries for these visits. A physician Anesthesiologist is present for every surgery performed. Medication reconciliation is performed on every inpatient by a licensed pharmacist. This is unique in the hospital industry and helps to make certain that every patient receives their medications correctly. As a result of this quality care, patient transfers to another hospital are low. During the past year, the patient transfer rate was 0.14%, 14 patient transfers with 10,056 patients treated.

NCSH has 160 credentialed physicians: of these, only 33 (21%) are active physician owners; 127 physicians are not owners. The majority of physicians practicing at the hospital have no financial incentive to do so; they choose to practice at NCSH because of the quality and efficiency of care and the cost savings to their patients.

NCSH provides lower cost care than other hospitals in the Raleigh-Durham-Cary-Chapel Hill area. For the same procedure, inpatient CMS reimbursement is more than 18% less than at the "non-profit" hospitals. For example, DRG Code 470 includes total knee replacement surgery. The Raleigh-Durham-Cary-Chapel Hill region has 8 hospitals performing these surgeries. NCSH Medicare payment for these surgeries is $10,102. The average Medicare payment for the remaining 7 hospitals in the region is $12,448. NCSH performs the same surgery at a lower cost and provides higher patient satisfaction and outcomes than our competition.

NCSH is proudly a for profit hospital. The hospital pays property taxes and the hospital's owners pay state and federal income taxes on the hospital's profits. This results in an approximately 7 % net community benefit using HHS's criteria.

Routinely NCSH is full, causing patient surgeries to be delayed or cancelled. NCSH has 6 observation rooms that have been constructed to full hospital inpatient room standards. Minimal expenditure would be required to convert these observation rooms, increasing NCSH inpatient capability from 18 to 24 beds. Additionally according to the North Carolina State Medical Facilities Plan, NCSH current surgery volume requires 6.31 operating rooms. NCSH has 4 licensed operating rooms and has a clear need for additional licensed operating rooms.

Durham County is dominated by the Duke University Health System which controls 98.6% of licensed hospital rooms and 94.7% of licensed operating rooms. NCSH serves as the sole competition in Durham County to Duke University Health System but lacks the ability to expand to serve the public. Without NCSH, 100% of hospital medical and surgical care in Durham County would be controlled by one entity.

Our nation is seeking better patient medical care at a lower cost point. Hospitals with physician ownership meet this need. Additionally the CMMS Innovations Center is piloting programs which align incentives for physicians to provide great medical care at a lower cost point. NCSH already accomplishes this goal.

Please release the shackles and allow higher quality and lower cost hospitals like North Carolina Specialty Hospital to expand their medical and surgical capabilities. Currently Section 6001 constraints cause discrimination against Medicare and Medicaid patients who cannot choose the highest ranking

hospitals because these hospitals lack the capacity to treat them. In Durham these patients are discriminated against by the predominance of one health system and the inability of NCSH to expand. Please repeal or amend Affordable Care Act Section 6001 so that existing hospitals with physician ownership may provide needed quality care to Medicare, Medicaid and Tricare patients. Please allow new hospitals with physician ownership to treat Medicare, Medicaid and Tricare patients. The ability of patients to choose their doctors and their hospitals is uniquely American. The present restraints on patients are un-American!

Thank you.

Richard F. Bruch, M.D., Consultant to Triangle Orthopaedic Associates, P.A.

Board Chair, North Carolina Specialty Hospital, 3916 Ben Franklin Blvd., Durham, NC 27704

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rbruch@triangleortho.com or rich.bruch@gmail.com

Edward Ray, Letter

The Honorable Kevin Brady, Chairman,
Health Subcommittee
United States House of Representatives
Committee on Ways & Means

Re: Improving Competition in Medicare: Removing Moratoria and Expanding Access

May 18, 2015

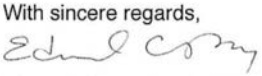
Dear Mr. Brady,

I would like to take this opportunity to provide my written testimony as a surgeon and non-owner that operates at a physician-owned surgical facility, namely, **North Carolina Specialty Hospital** in Durham, NC. I am a Plastic and Reconstructive Surgeon, caring for breast and skin cancer patients, as well as those with a wide range of burns, wounds and deformities requiring reconstruction. For the last six years, I have performed the vast majority of my surgical procedures at this facility, despite having staff privileges at two other nearby facilities, including a University-managed community hospital and its separate surgical center. When asked to choose a facility for their surgery, my patients have, with virtually no exception, favored the physician-owned facility due to its efficiency, cleanliness, friendly atmosphere and close attention to their needs. Patients tell me that they see the larger facility (even when under the care of the same doctor) as treating them as a "number," with less attention to quality standards, noisier patient floors, and a perceived lack of empathy. I have been a patient at this hospital, as well, and have never felt so well cared for at any other facility.

While hospitals vary widely in their qualities and attributes, physician-owned facilities are uniquely motivated to maintain a positive patient experience since they present an *option* to the public. They succeed because they take this role very seriously. America has always embraced competition as a healthy market force to maintain quality and reduce cost in almost every branch of our economy. Because Healthcare represents one of the largest segments of our economy, it would stand to reason that allowing hospitals to compete with one another, rather than limiting their ability to do so, would be in the best interest of patients and payors alike.

I stand in favor of allowing physician-owned hospitals, and surgical facilities in particular, to provide an option to patients in communities where large health-system facilities sacrifice patient care for a "check-box" healthcare mentality, investing in their bureaucracy rather than improving the patient experience. Congress should allow patients a choice, and thus drive down the cost of healthcare delivery by breaking the monopoly. Thank you.

With sincere regards,



Edward C. Ray, MD, FACS

Sheree E. Barak, Letter

To Whom It May Concern,

I have worked at North Carolina Specialty Hospital for 22 years, so I believe I can offer some qualified observations about the facility. When I came to work for our hospital back in 1993, it was still located on West Main Street, in a facility built in 1926. Having come from a previous position in acute care (a 500-bed hospital in Florida) I was pleasantly surprised to find a work setting that still had the small-town atmosphere of "Mayberry". And I mean this in a good sense. The staff really cared for patients, as if they were family and nurse to patient ratios were quite low so the staff could take time with each patient. I was impressed to learn how many patients had come to our hospital on previous occasions through the years, as had their parents and their children.

In May 2005, we moved into our new facility; a truly state-of-the-art, 18 bed hospital with 4 O.R.'s; a Same Day Surgery department as well as many other bells and whistles. I wondered if we would retain our "small town" culture and sense of "family". I am pleased to report that this has, in fact, been the case! We still have a closely-knit, well-qualified staff; many have worked in larger facilities and can appreciate the fact that here at NCSH, they can take time to give the care that they were trained to give. Our administrative staff is very attuned to the needs of those of us who are on the front lines and they back us up with resources and equipment whenever we ask. Our outcomes are great, our complication rates are among the lowest in the state and we have received outstanding rankings by groups that evaluate hospitals and issue grades.

Our patients are happy; we know this because they constantly compliment the facility, the care they receive, and yes--they are still coming back when they require a new procedure! Word of mouth has spread; I have had folks tell me how wonderful their loved one or friend's experience was when I am standing in line at the grocery store, or movie theater.

I could go on, but I think you get the point: when people are given the time, resources and opportunity to provide excellent care, they do what is really the most satisfying for them: they give excellent care.

Sincerely,
Sheree E. Barak

Harold Kernodle, Jr., Letter

DukeMedicine

Kernodle Clinic Mebane
101 Medical Park Drive
Mebane NC 27302-7639
Phone: 336-506-1214
Fax: 336-538-2396

To whom it May concern:

This letter is being written in support of North CarolinaSpecialty Hospital. I have been performing robotic assisted partial knee replacements at North Carolina Specialty Hospital for about 2-1/2 years. I chose the hospital because of the of the availability of the Mako robotic knee and hip system. The hospital had the vision to order this equipment about 5-6 years ago. There are only about 10 of these robotic systems in the state of North Carolina. I also chose this hospital because of its excellent reputation in regard to patient care.

I have been very pleased with the care my patients have received at North Carolina Specialty Hospital. My patients have repeatedly voiced their extreme satisfaction with the quality of care they have personally received at North Carolina Specialty Hospital.

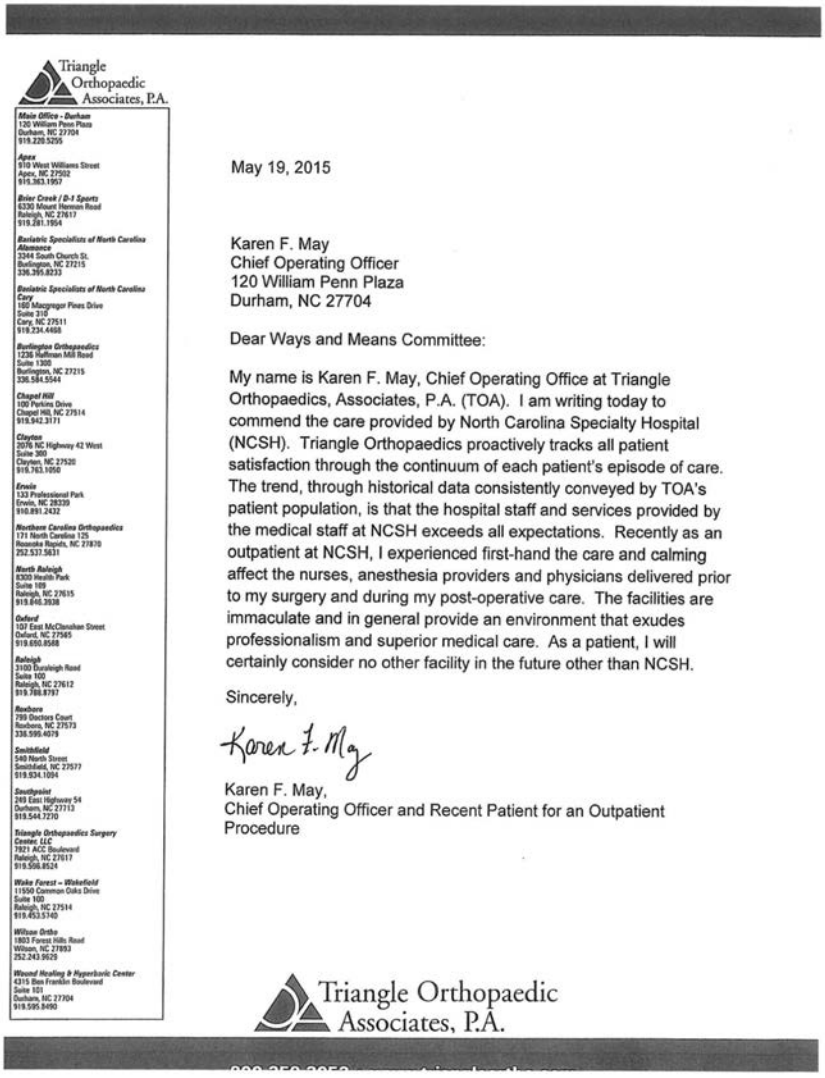
The hospital staff is very professional and courteous. My patients and I have been treated as customers in a way that should be exemplified by all hospitals.

I look forward to continuing my relationship with North Carolina Specialty Hospital.

Harold Kernodle, Jr.

Harold Kernodle,Jr. M.D.

Karen F. May, Letter



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May 19, 2015

Karen F. May
Chief Operating Officer
120 William Penn Plaza
Durham, NC 27704

Dear Ways and Means Committee:

My name is Karen F. May, Chief Operating Office at Triangle Orthopaedics, Associates, P.A. (TOA). I am writing today to commend the care provided by North Carolina Specialty Hospital (NCSH). Triangle Orthopaedics proactively tracks all patient satisfaction through the continuum of each patient's episode of care. The trend, through historical data consistently conveyed by TOA's patient population, is that the hospital staff and services provided by the medical staff at NCSH exceeds all expectations. Recently as an outpatient at NCSH, I experienced first-hand the care and calming affect the nurses, anesthesia providers and physicians delivered prior to my surgery and during my post-operative care. The facilities are immaculate and in general provide an environment that exudes professionalism and superior medical care. As a patient, I will certainly consider no other facility in the future other than NCSH.

Sincerely,

Karen F. May

Karen F. May,
Chief Operating Officer and Recent Patient for an Outpatient Procedure

Triangle Orthopaedic Associates, P.A.

Candy Johnston, Letter

May 18, 2015

To whom it may concern:

I am writing this letter in support of North Carolina Specialty Hospital. I have had three surgeries here in the past five years, and each one has had an outcome with no complications. When I compare surgical stories and other hospital experiences with friends or family, it is clear that NCSH towers above the rest. The care is exceptional, and as a patient you can tell that they really take pride in what they do for the community. My family members have seen several of the physicians who have ownership in North Carolina Specialty Hospital, and they have been very pleased.

I am also proud to say that I have been an employee at North Carolina Specialty Hospital for 12 years. I have been in charge of patient satisfaction survey administration and can attest to the fact that our patients LOVE our facility. We are consistently receiving comments that they will never go anywhere else for their care, and that NCSH needs to train other local area hospitals how to treat their patients. That in itself speaks great volumes about the outstanding care that is provided at NCSH.

The world needs more facilities like North Carolina Specialty Hospital. If every hospital ran as well and had the same quality scores and patient satisfaction ratings NCSH does, healthcare would be a lot better off.

Sincerely,

Candy Johnston

J. Mack Aldridge, Letter

To Whom It May Concern

I was asked to provide a personal testimony regarding the services rendered at the physician owned North Carolina Specialty Hospital. As a former assistant professor in an academic university hospital setting I have unique perspective in seeing two opposite ends of the spectrum of patient services. In no way do I intend to question the level of medicine rendered at a large university hospital setting, however, I can unequivocally attest to the equally, if not higher, level of care with a higher level of efficiency, rendered by NCSH. Whereas in my former life as an assistant professor or orthopaedic surgery, my days in the OR were at best challenging and at worse extremely frustrating in that the system prevented me from delivering the type of care that I was accustomed to providing to my patients. Conversely, working at NCSH is as stress free an environment as surgery can be, and is always an enjoyable environment. The patients are extremely satisfied with the level of care. The staff is unparalleled in their commitment to providing high level care in a compassionate manner, all of which makes my life easier. Given the efficiency, I am able to see and treat more patient's, which ultimately pleases the patients in clinic who have easier and quicker access to care. Barely a day in clinic goes by that a patient does not comment to me about the wonderful experience at the hospital, which needless to say these days is an uncommon occurrence in most hospital settings. Furthermore, such accolades from patients are accompanied by their disbelief in the tremendous cost savings versus the same procedure done at a larger hospital setting.

I could go on and on about the personal testimonies that I hear from patients, but suffice it to say, that I am unaware of any hospital in our state of NC that functions more efficiently and at a higher level while maintaining an unparalleled work –friendly environment than what we have at NCSH.

Sincerely

J. Mack Aldridge, MD

Kim Lyon, Letter

To: The Health Subcommittee

From: Kim Lyon, RT(R)

As a health care worker, I have had two wonderful opportunities to work at Duke University Medical Center and at North Carolina Specialty Hospital over the span of 36 years. 28 of those have been at Specialty. Both of these facilities provide excellent care for their patients. Both earn prestigious awards. Both are a valuable asset to Durham and the surrounding area. Both are needed in the community.

What sets Specialty apart is the small and intimate atmosphere that this type of facility can offer. There is a huge sense of pride from Environmental Services to the physicians, because we strive to do our best because in a sense, we all are owners. We hire the best, set high standards of care and work as a team to insure all of our patients receive exceptional care.

We strive to treat all patients with the best possible experience for them that we can give. From the time they are greeted at the front door, to the time they are discharged, we provide for all of their needs. Not everyone likes the hassle of a big facility. Some like the personal and unhurried attention that we can give because of our size.

I cannot imagine not having a choice in the City of Medicine for healthcare. There is room for a physician owned place. There is a need for a physician owned place and I am proud to serve the community in a physician owned place!

Sincerely,

Kim Lyon, Radiology Manager

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