PHYSICAN-OWNED HOSPITALS
AND THEIR IMPACT ON COMMUNITY HOSPITALS
Testimony Submitted to the Senate Finance Committee by
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Good Morning. Mr. Chairman, Senator Baucus and members of the Committee, my name is Cindy Morrison and I am Vice President of Public Policy at Sioux Valley Health System in Sioux Falls, South Dakota. Located in the southeast corner of South Dakota, Sioux Valley is an integrated health system made of up 24 hospitals and over 300 physicians located in 4 States including South Dakota, Minnesota, Iowa and Nebraska. It is the largest health system between Minneapolis and Denver. South Dakota is a small state with a total population of roughly 750,000 but has 8 physician-owned specialty hospitals, some of which have been in operation for over 10 years.

I am here today on behalf of the Coalition of Full Service Hospitals, a grassroots organization that Sioux Valley founded in June of 2003 to raise awareness about problems associated with physician ownership of specialty hospitals, and attendant physician self-referral practices. The Coalition represents 20 states and its membership includes over 150 community full-service hospitals many of which have been directly affected by physician self-referral.

As a result of my personal experiences both in South Dakota and in 17 similarly affected States through the Coalition, I have been asked to testify before policy makers in states across the country regarding the effects of physician self-referral on community hospitals.

As I begin I would like to express my sincere appreciation to Chairman Grassley and Senator Baucus for their work on this issue and for allowing me to be here today to share the experiences of community hospitals. Community hospitals play a special role in both urban and rural communities as “equal opportunity” caregivers that provide full acute and sub-acute services with out discrimination based on insurance status or seriousness of condition. Specialty hospitals, by contrast, choose to provide only limited, high-revenue

services to select, usually well-insured, patients. Where community hospitals provide trauma, 24-hour emergency, surgical, obstetrics and other services, specialty hospitals usually perform only select services within specified subset of classes of care, i.e. cardiology, and orthopedics, etc.

Overview

In my testimony, I discuss the central issue in the debate over the appropriateness of physician-owned specialty hospitals---physician self-referral practices--- and how those practices impact community hospitals ability to provide high quality patient care and services. I also discuss the growth of physician-owned specialty hospitals; government proposals to reduce reimbursement for some procedures commonly performed in specialty hospitals; and conclude by calling for the elimination of one exception to federal law prohibiting physician self-referral that has allowed physician ownership of specialty hospitals to flourish.

Physician Admitting Power

Physicians alone are the only persons with the authority to admit a patient to a hospital. Hospitals cannot admit patients and neither can patients. This unique responsibility and trust is placed solely with the physician; and as a result puts the physician-owners of specialty hospitals in a position to "self-refer" patients away from community hospitals to be admitted to the specialty hospital they own. Physicians have a clear financial incentive to refer patients to facilities they own, like specialty hospitals, because while typical physicians get paid once for their professional services, physician-owners get paid twice, once for their professional fee and once for the technical fees traditionally paid to hospitals. Because hospitals cannot admit patients, physician self-referral practices put the community hospital at a tremendous competitive disadvantage. This unusual competitive set-up puts the hospital in a box. The hospital becomes in effect, a competitor whose mix of business (the patients) is controlled by its competitive rival (the physician-owned facility) through the incentives of those who make the referral (the physician investors who wear two hats).[1]

[1] William J. Lynk and Carina S. Longley, July/August 2002, Health Affairs "The Effect of Physician-Owned Surgicenters on Hospital Outpatient Surgery"

Community Hospitals and Competition

Some have claimed that community hospitals need competition. In fact, community hospitals and non physician-owned specialty hospitals such as children's hospitals and women's hospitals have been competing with each other since their inception and they welcome the competition and recognize that it has been a great catalyst for producing efficiencies and innovations. Although advocates for physician-owned specialty hospitals have hypothesized that the entrance of specialty hospitals into a market encourages the area's existing general hospitals to adopt changes and make them more efficient and better able to compete, the survey responses generated by the Government Accountability Office (GAO) largely did not favor this view.[2]

We know that in a functional free market, informed consumers make choices that force efficiency. When patients are faced with medical challenges however, they place their complete trust in their physician to prescribe and direct their care and when their physician directs or refers them to hospitals the physician owns, the patient's "free market" choice is eliminated and patients unknowingly forfeit their opportunity to weigh their options. In the community hospital setting, the financial incentive is lacking for a physician to direct the patients other than to the most capable provider is and the "free" market is retained.

Who are the Community Hospitals They Impact?

The effects of self-referral and the presence of physician-owned specialty hospitals can affect community hospitals of all types and sizes; non-profit, for-profit, in rural and urban communities ranging from Spearfish, South Dakota – Population 8,800 to Oklahoma City, Oklahoma – Population 500,000.

[2] GAO, April 2006, Operational and Clinical Changes Largely Unaffected by Presence of Competing Specialty Hospitals

A 2003 GAO report determined that physician-owned facilities, like specialty hospitals are concentrated in States where Certificate of Need (CON) regulation does not exist.[3] State CON regulations typically require health care facilities to apply for and obtain a certificate that evidences a community need for the designated health service. Such laws are intended to avoid "costly duplication of services" but not all states retain CON laws.[4] Locating in specific regions of the country allows the physician-owners to skirt the scrutiny that a CON process would present. But some community hospitals located in CON states have not been protected because border cities find themselves affected as physician-owners locate their facilities across the border in neighboring non-CON states. An example of this can be found in Sioux City, Iowa, a CON state. Physician-owners that traditionally practiced at the community hospitals in Sioux City, Iowa built a specialty hospital just over the border (less than six miles) into South Dakota, a non-CON state and steer patients away from the community hospital in Iowa to their facility located in Dakota Dunes, South Dakota.

Community Hospital Impact

Staff Reductions, Weakened Financial Condition

Ruston, Louisiana

Lincoln General Hospital, located in Ruston, Louisiana was a financially strong community hospital with historical operating margins in the 3-4 percent range according to Tom Stone, CEO. In 2003, a physician-owned specialty hospital, Green Clinic Surgical opened. The owners of this physician-owned specialty hospital, which is located directly adjacent to Lincoln General, represent 65 percent of Lincoln's active medical staff.

Lincoln General recognized the potential impact of the loss of their profitable surgical business. In an attempt to return some of their profitable procedures, they added two general surgeons. Despite the addition of these two new surgeons, Lincoln General saw their surgical patient volume drop by 35 percent. This was the result of physician steering

[3] GAO-04-167 (October 22, 2003), pg. 15 "Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance."
[4] Ellen Jan Schneiter, Trish Riley, Jill Rosenthal, Rising Health Care Costs: State Health Cost Containment Approaches, National Academy for State Health Policy, June 2002

of surgical business away from the community hospital to the physician-owned specialty hospital.

In their last fiscal year, Lincoln General has lost over $8 million in operating margins as a result of the physician-owned specialty hospital. This rapid decline in operating margins impacted the community hospital negatively in several ways:

Lincoln General is having difficult meeting debt service and bond covenant ratios
In April 2006, Moody's Investor Services downgraded Lincoln General's bond rating citing "increased competitive pressure, primarily from a large physician group."[5]

In response to the downgrade and covenant requirement, Lincoln General faces difficult decisions ahead. Drastic expense reductions are being made, including a 20 percent staff reduction, in an attempt to improve financial performance.

West Bend, Kansas

Great Bend, Kansas is a small rural community located in Central, Kansas with approximately 15,000 people and one community hospital. Prior to the opening of the physician-owned Surgical and Diagnostic Center, the community hospital, Central Kansas Medical Center performed approximately 3,300 outpatient surgeries. After the opening of the physician-owned facility, the community hospital lost 60 percent of their outpatient surgeries and was forced to downsize their workforce by over 100 full-time equivalents. The community hospital is operating at a -0.2 percent margin while the physician-owned specialty hospital is enjoying a 17 percent margin according to cost reports filed in 2005 and 2004, respectively.

<u>Emergency Room Crises and Recruitment Challenges</u>

Rapid City, South Dakota

The entrance of physician-owned specialty hospitals has placed some trauma and emergency services in the community hospital at risk.[6] Across the country, physician

[5] Moody's, April 24, 2006, New York, "Moody's downgrades to Ba1 from Baa3 Lincoln Health System's Bond Rating"

specialists such as neurosurgeons, cardiac surgeons and orthopedic surgeons are increasingly unwilling to participate in community hospital's "on call" lists.[7] This problem is further intensified by the entrance of physician-owned specialty hospitals because physician-owners are less apt to care for emergency patients in the community hospitals and often rely on the resources of the community hospital's emergency room when a patient in their facility experiences complications that they are not equipped to handle. An example of this happened in the Black Hills of South Dakota with disturbing consequences for patients and for the community hospital. Before the physician owners built their own specialty hospital, they provided emergency room neurosurgical coverage for the community hospital. When the neurosurgeon-owners of the Black Hills Surgery Center abandoned taking ER call at Rapid City Regional, the local full-service community hospital, the community hospital was left with insufficient neurosurgery coverage. Community hospital officials attempted to remedy the situation by using locum tenens physicians (physicians who practice intermittently within the State but reside outside elsewhere) and two hospital-employed physicians to provide coverage, but this situation proved difficult to maintain and was very costly with expenses reaching nearly a million dollars. Recruitment of permanent neurosurgeons was also a challenge because there were already six neurosurgeons in the community. Because the Black Hills region is home to only one tertiary medical center ER, patients with immediate neurosurgical needs were transferred hundreds of miles away when gaps in neurosurgical coverage occurred. Ironically, this all occurred during the time of the annual Sturgis Motorcycle Rally when over 500,000 motorcycle enthusiasts converge in the Black Hills. South Dakota does not have a helmet law and the incidence of head injuries and trauma typically increases during this time making adequate neurosurgical coverage in the emergency room even more critical. This South Dakota experience demonstrates the access, recruitment, and emergency room challenges that physician-owned specialty hospitals exacerbate.

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[6] February 2005, McManis Study, "The Impact of Physician-owned Limited-Service Hospitals: A summary of Four Case Studies

[7] November 2001, Maguire, Phyllis, "Wanted: Doctors Willing to Take ER Call", ACP-SIM Observer, American College of Physicians-American Society of Internal Medicine

Checks and Balances in a Community Hospital vs. a Physician-Owned Hospital

Certain checks and balances present in the community hospital are not present in a physician-owned specialty hospital. Since the physicians own the hospital and are therefore the employers, nurses, other employees and even other physicians are reluctant, fearful or do not have a mechanism to report or deal with disruptive conduct or clinical incompetence on the part of physician-owners. Further, in most communities where physician-owned facilities exist, the physician-owners remain on the staff of the community hospital. The conflicted interests of the physician-owners causes them to disrupt operations of the community hospital, some examples of which include "insider recruiting" of key staff, disparaging the community hospital leadership and their management decisions to employees, and encouraging other non-physicians to become investors and pull their business from the community hospital. Physician-owners who continue to practice at the community hospital also have access to key inside information that may be helpful to their hospital at the expense of the community hospital.

Growth of Physician-Owned Specialty Hospitals

In November of 2003, Congress approved the Medicare Prescription Drug Improvement and Modernization Act which included an 18-month moratorium on new physician-owned facilities along with a number of limits on grandfathered facilities. The moratorium effectively prevented the expansion of physician-investors and/or additional beds to existing physician-owned specialty hospitals. The grandfathering exception also permitted referrals to physician-owned, limited service facilities determined by the Secretary to be in operation or "under development" as of November 18, 2003. Congress also directed the Medicare Payment Advisory Commission (MedPAC) and the Department of Health and Human Services to conduct studies during the moratorium and to recommend legislative and administrative changes. [8]

A number of activities occurred during the moratorium. The moratorium slowed the growth of physician-owned specialty hospitals but almost immediately, prospective

[8] Medicare Prescription Drug, Improvement, and Modernization Act of 2003

physician-owners, consultants and attorneys began looking at ways around the moratorium. The federal Centers for Medicare and Medicaid (CMS) received claims for payment from some specialty hospitals who believed they met the guidelines for "under development" as of November 18, 2003. Clearly, at least one physician-owned specialty hospital, Northeast Portland Physician's Hospital was operating in violation of the moratorium.

The moratorium expired on June 8, 2005. Although CMS announced that they would not approve any new physician-owned specialty hospitals until February 2006, existing facilities began recruiting new investors, expanding services, and adding additional beds.[9]

Payment Changes Alone Will Not Address Physician Self-Referral

Although inpatient payment changes have been recommended that would remove some of the financial incentives associated with physician-owned specialty hospitals, coding and payment changes alone will not address the problem. In particular, CMS has proposed reducing reimbursement for select high-cost procedures commonly performed in specialty hospitals. But, physician-owners could compensate for lower procedure payments by recommending the patient undergo more outpatient procedures and ancillary tests that are paid separately from the procedure.[10] Further, physicians have the ability to react to payment changes that community hospitals do not because of their singular and unique role in prescribing treatment. This is evidenced in a recent report by an investment analysis company, Raymond James, discussing the proposed coding and payment changes' impact on MedCath, a for-profit surgical hospital company that focuses on cardiac procedures. It stated:

> We believe that in response to a severe cut to cardiovascular reimbursement, the company could temper its mix of procedures that utilize high-cost devices and are most vulnerable to payment pressure, effectively reducing supply expense (note,

[9] Sioux City Journal, Jenny Welp, February 26, 2006, "Health Care Business Blooming in the Dunes"
[10] Jean Mitchell, October 2005, Health Affairs "The Effects of Physician-Owned Limited-Service Hospitals"

procedures that use high-cost drug-eluting stents or implantable defibrillators would face the largest reimbursement cuts under the proposals).[11]

Beyond MedCath, a comparison of the proposal's impact, based on filed cost reports, with the publicly-reported margins of one specialty hospital company with facilities in South Dakota is noteworthy. The three specialty hospitals are owned by Medical Facilities Corporation, a publicly-traded Canadian company that reports its earnings in periodic filings accessible via the world-wide web.

- Sioux Falls Surgical Center, Sioux Falls, South Dakota
  - Impact of proposed changes -2.3%
  - Reported EBITDA margin 49.4%

- Dakota Plains Surgical Center, Aberdeen, South Dakota
  - Impact of proposed changes -2.8%
  - Reported EBITDA margin 38.0%

- Black Hills Surgery Center, Rapid City South Dakota
  - Impact of proposed changes -5.9%
  - Reported EBITDA Margin 45.6%[12]

While CMS promotes that their DRG payment proposals would make a significant impact on physician-owned specialty hospitals and therefore alter physician referral patterns, it is clear from these numbers that the nick of a small percent in terms of payments, does not come close to neutralizing the 35-50 percent margins that some physician-owned specialty hospitals enjoy. The financial realization that comes from self-referral is too powerful to be overcome by DRG changes along.

[11] Raymond James, April 19, 2006 MDTH: (MedCath): Preliminary Medicare Impact Assessment Suggests Manageable Downside Risk
[12] Medical Facilities Corporation (MFC), March 2004 – Initial Public Offering

Finally, payment changes do not address physician-owner's ability to continue to select and steer the most well insured patients to their hospitals, leaving the poor and under and uninsured patients for the community hospital to care for.

The Root of the Problem – Physician Self-Referral

Physicians are the gatekeepers to healthcare services. Only physicians have the unique ability to admit patients to hospitals, to prescribe treatment, and to order services. Physician-owned facilities by themselves are not the problem; the problem lies in physician self-referral practices that create conflicts of interest with disturbing results for both patients and community hospitals.

Congress has enacted prohibitions on physician self-referral laws, with certain exceptions and "safe harbors," in part to prevent such conflicts of interest and to ensure that patient needs are never compromised. Also, these laws were in part the result of Congressional concern over noted increases in service utilization, which generally result in higher costs, both to government insurance programs and to patients. Current self-referral prohibitions set a sound precedent by plainly prohibiting physicians from self-referring to facilities they own such as laboratories, pharmacies, etc.

Physicians self-referring to hospitals they own is no different than physicians self-referring to a laboratory they own. We believe Congress should enforce the letter and spirit of the current self-referral laws by eliminating a broad exception in the law known as the "whole hospital" exception, which has historically allowed physician investment in, and referral to, entities that qualify as "whole hospitals", i.e. not a specified hospital department or unit.

I would like to extend my sincere appreciation to the Committee for bringing these issues to light and for their continued efforts to address the problem of self-referral.