FTC/DOJ Hearings on Health Care And Competition Law and Policy

Statement of Dennis I. Kelly

Executive Vice President of Development

And

Government Relations

MedCath Corporation

March 27, 2003

Washington, D.C.

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Introduction

My name is Dennis Kelly. I currently serve as Executive Vice President of Development and Government Relations for MedCath Corporation. MedCath is a national provider of cardiovascular services, publicly traded, and headquartered in Charlotte, North Carolina, with approximately 5,000 employees. We have projected revenue for 2003 of $550-$560 million.

Thank you for the opportunity to speak on behalf of our organization, our physician partners and other professional staff, and the patients who have utilized our hospitals and their services.

I want to especially thank the Commission staff (Sarah M. Mathias) for framing the following questions for our response:

- **WHAT FACTORS HAVE DRIVEN THE DEVELOPMENT OF OUR HOSPITALS?**
- **WHAT HAS BEEN THE EFFECT OF OUR HOSPITALS IN THE MARKET PLACE?**
- **HAVE OUR HOSPITALS ENHANCED QUALITY OF CARE?**

- **HAVE COSTS AND ACCESS DECREASED AS A RESULT OF OUR HOSPITALS?**

- **HOW HAS COMPETITION BEEN AFFECTED?**

- **WHAT ACTIONS HAVE COMPETITORS TAKEN IN RESPONSE TO THE COMPETITION FROM OUR HOSPITALS?**

- **DO ANY OF THESE ACTIONS INVOLVE ANTI-COMPETITIVE CONDUCT?**

I. UNDERSTANDING MEDCATH HOSPITALS

Our Chief Executive Officer summarizes MedCath's mission in the three parts of a triangle:

- Cardiovascular disease focus

- Partnership with physicians

- Patient focused care

- **We focus primarily on the diagnosis and treatment of cardiovascular disease.**

- **We design, develop, own and operate hospitals in partnership with local physicians that we believe have established reputations for clinical excellence, most of whom are cardiologists and cardiovascular surgeons.**

In some cases, in addition to physician partners, we have also partnered with an existing local hospital. For example, the Heart Hospital of South Dakota is owned equally by a MedCath affiliate, a physician practice and Avera McKenna Medical Center.

- **Each of our hospitals is a freestanding, licensed general acute care hospital that includes an emergency department, operating rooms, catherization laboratories, pharmacy, laboratory, radiology department, cafeteria and food service and is capable of providing a full complement of health services. Our license is the same as other general acute care hospitals in the applicable states.**

- **We focus primarily on serving the unique needs of patients suffering from cardiovascular disease.**

- **The medical staff at each of our hospitals is open to all qualified physicians performing healthcare services in the market, except for certain hospital-based physicians such as anesthesiologists, radiologists, emergency physicians and others to ensure appropriate coverage at the hospital.**

- **We are also committed to improving the productivity and work environment of physicians, nurses and other medical personnel providing care.**

- **We participate in Medicare and Medicaid. MedCath Heart Hospitals ranked near the middle of their respective markets for the total volume of inpatient cardiac care provided to Medicaid and uninsured patients.**

As of February 27, 2003, we owned and operated ten hospitals, located in Arizona, Arkansas, California, New Mexico, Ohio, South Dakota, Texas, and Louisiana, together with our physician partners, who own an equity interest in the hospital where they practice, as well as other investors. Our eleventh hospital will be a heart hospital located in San Antonio, Texas. Our twelfth hospital will be a heart hospital located in the city of Glendale, near Milwaukee, Wisconsin. Our thirteenth hospital will be a heart hospital located in Lafayette, Louisiana. A list of our hospitals is attached which shows opening date (or scheduled opening date), licensed beds, cath labs, and operating rooms.

The Secretary of Health and Human Services, Tommy G. Thompson, in a letter for the groundbreaking of the Heart Hospital of Milwaukee, aptly described what a MedCath hospital brings to a community:

* * *

> **As your governor for 14 years, nothing was more important to me than the health and well-being of my fellow Wisconsinites. Now, as Secretary of Health and Human Services, I'm focused on the health of all Americans. But I don't mind saying that it's still Wisconsin that holds a special place in my heart. That's why it's such a joy to know that Milwaukee and MedCath are joining to improve the quality of cardiovascular care in Wisconsin.**
>
> **This is the sort of public-private partnership, combining the resources of government with the innovation of the business world, that makes America great. In teaming together to find new ways to serve your fellow Americans, you truly have shown yourselves to be foot soldiers in what our President called "the armies of compassion." It's something to be proud of.**
>
> **As I said, this is a great day for Milwaukee and Wisconsin. On this site, you'll do more that just treat heart disease. You'll give a father another day with his daughter. You'll give a son a change to have his own children. You'll give a mother time to see her grandchildren. You'll save lives, my friends, and there is no higher calling.**
>
> **For all this, and on behalf of the President of the United States, let me say – thank you. And on my own behalf, congratulations on helping cement Milwaukee's status as a first-class American city.**

* * *

A copy of Secretary Thompson's letter is attached.

In addition to our hospitals, we provide cardiovascular care services in diagnostic and therapeutic facilities located in eight states and through mobile cardiac catheterization laboratories. Our mobile diagnostic facilities are typically leased to hospitals and used by physicians to evaluate the functioning of patients' hearts and coronary arteries and serve areas that do not have the patient volume to support a full-time facility. We also provide consulting and management services tailored primarily to cardiologists and cardiovascular surgeons.

II. WHAT IS THE MARKET FOR CARDIOVASCULAR CARE?

The American Heart Association estimates that total domestic expenditures for the treatment of cardiovascular disease were approximately $199.5 billion in 2002 and that these expenditures have grown at a rate of 5.8% annually since 1997. Of these expenditures, 63.2%, or approximately $126.1 billion, was spent on hospital and other facility-based charges. Cardiovascular disease is a progressive illness that develops without symptoms over a number of years and frequently goes undiagnosed until the patient suffers an acute episode such as a stroke or heart attack. Cardiovascular disease includes coronary heart disease, hypertensive disease - which is a risk factor for more serious cardiovascular diseases - rheumatic fever/rheumatic heart disease, stroke and congenital cardiovascular defects. The American Heart Association estimates that approximately 61.8 million Americans have one or more types of cardiovascular disease. Cardiovascular disease claimed 960,000 lives, representing 40.1% of all deaths, in the United States in 1999. This represented 116,800 more lives than the next five leading causes of death combined, including cancer, chronic obstructive pulmonary disease, accidents, pneumonia/influenza and diabetes mellitus.

Most of the invasive procedures physicians perform to treat patients with cardiovascular disease, such as coronary artery angioplasties with stent placement and coronary artery bypass graft surgery, are performed in hospitals on an inpatient basis. Cardiovascular disease creates the largest demand for hospital bed use in the United States, being the first listed diagnosis of 6.3 million inpatients in 1999. Approximately 12.6 million of the estimated 61.8 million Americans suffering from cardiovascular disease have coronary heart disease, which generates the single greatest demand for cardiac diagnostic and therapeutic procedures.

According to the American Heart Association, it is estimated that physicians performed the following number of procedures to diagnose and treat cardiovascular disease in 1999:

- 571,000 coronary artery bypass graft operations,
- 601,000 coronary artery angioplasty procedures,
- 1.4 million inpatient cardiac catheterization procedures, and
- 472,000 outpatient cardiac catheterization procedures.

The demand for cardiology and cardiovascular disease diagnosis and treatment procedures is expected to increase in the future as people age 55 and older, the primary recipients of cardiac care services, increase in number and represent a growing proportion of the total population. According to the 2000 census by the U.S. Census Bureau, the proportion of Americans over age 55 was 21.1% and is expected to increase to 27.5% by 2015. Additionally, demand for cardiac care services continues to grow as a result of advances in technology. Medical devices in development are expected to increase the options available to physicians to treat cardiovascular disease and increase the number of procedures performed.

III. WHAT IS THE MEDCATH HOSPITAL MODEL?

We focus primarily on the diagnosis and treatment of cardiovascular disease. We develop, own and operate hospitals in partnership with physicians with the goal of improving the quality of care and enhancing the overall experience of patients and physicians. Key elements of our model include:

- *Cardiovascular Disease Focus*

We design and operate our hospitals with a focus primarily on serving the unique needs of patients suffering from cardiovascular disease and improving the work environment of physicians, nurses and other medical personnel providing care. We have developed an innovative facility design and infrastructure specifically tailored to the cardiovascular care delivery system that combines staff, equipment and physical layout to deliver high-quality, cost-effective care. Because the clinical protocols and procedures for treatment of patients with cardiovascular disease are generally the same throughout the United States, we are able to use

our standard facility design - with only small variations - in each of the markets in which we develop a hospital.

By focusing primarily on a single disease category, we are able to schedule patient procedures more efficiently and allow our physicians, nurses, medical technicians and other staff members to concentrate on and enhance their professional cardiovascular care skills, thereby better serving the needs of patients in the community. We are also able to invest our available funds primarily in equipment and technology for cardiovascular care, rather than allocating those funds among the equipment and technology needs of many different healthcare services as occurs at general acute care hospitals. We believe our focused approach increases patient, physician and staff satisfaction and allows us to provide high-quality, cost-effective patient care.

- *Patient-Focused Care*

Our philosophy, developed in partnership with physicians, is to center care around the patient rather than expect the patient to adapt to our facilities and staff. We have designed our hospitals, particularly the patient rooms, around the requirements of our patients in order to improve their experience and the quality of their care. Our large, single-patient rooms are capable of handling all of our patients' needs during their entire stay, including critical care, telemetry and post-surgical care. This allows us to reduce moving our patients repeatedly and to have their care provided by the same group of staff members during their entire stay. For patients and their families, this creates a familiarity with, and a high level of trust in, their care providers while enabling the care providers to understand each patient's needs on an individual basis. The design of our rooms and our unlimited visiting hours also allow patients' family members to be involved in their care. For example, the size of our patient rooms lets us provide sleeping arrangements for a family member who desires to stay with the patient during the patient's recovery. In most general acute care facilities, which have a limited number of rooms with cardiovascular monitoring capabilities, patients are required to be transferred repeatedly within the facility during the course of their stay. Moving patients almost always involves risk to the patient, new care providers and an unsettling reorientation period for the patient and the patient's family. We believe moving patients also reduces physician efficiency, results in delays in providing the services patients need and can lead to a longer patient stay.

We believe our patient care staffing ratios are equal to or better than those of our competitors. We also believe that our patient care staff is more available to our patients because of our unique facility design and our investments in technology. For example, we invest in technology that facilitates communication between patients and care providers by:

- allowing patients and their family members to easily contact and directly communicate with specific members of the nursing staff regardless of where the nurse is located at that time, and
- electronically providing information about the patient's medical condition directly to the members of the nursing staff providing care to the patient rather than through a central monitoring station.

IV. HOW DO PATIENTS RESPOND TO OUR HOSPITALS?

We monitor and evaluate patient satisfaction in our hospitals by conducting patient surveys from all discharged patients. For our mature hospitals, we have 3 to 5 years of data. The results of our 2000 patient satisfaction surveys were as follows:

- Care Coordination 94%
- Info./Education/Community 98%
- Family Involvement 99%
- Physical Comfort 99%
- Emotional Support 98%
- Physician Interface 97%
- Special Needs 97%
- Would you return? 98%

These performance surveys have consistently demonstrated a high level of patient satisfaction with our facilities, staff and care coordination.

V. HOW PARTNERING WITH CARDIOLOGISTS AND CARDIOVASCULAR SURGEONS IS INTEGRAL TO MAINTAINING QUALITY OF CARE

We partner with cardiologists, cardiovascular surgeons, and other physicians that we believe have established reputations for clinical excellence. These physician partners, who own an equity interest in the hospital where they practice, as well as other investors including other hospitals, participate in decisions on strategic matters at that hospital such as site selection, facility size and layout, selection of the management team, and the hospital marketing plan and community outreach programs. There is broad physician participation from our physician partners, as well as the numerous other physicians providing services in our hospitals, who participate in decisions on a wide range of operational matters such as the development of clinical care protocols, supply selection and usage, equipment purchases, patient procedure scheduling and local staff. Our physician partners are empowered by their role in the development of a new hospital and in the strategic decisions affecting the hospital. We believe that our physician partners take greater pride and interest in a hospital they view as their own and that the influence they have over decisions in the hospital motivates them to provide patient-focused care on a cost-effective basis. The opportunity to have a role in how our hospitals are managed encourages our physician partners to share new ideas, concepts and practices.

Many of our physician partners were eager to participate personally in this conference but unable to do so because of the Commission's understandable time limitations. As an alternative, two of our physician partners have asked to have written statements submitted, which are attached to my statement.

VI. PATIENTS BENEFIT FROM COMPETITION BY MEDCATH HOSPITALS AS EVIDENCED BY OUR CLINICAL OUTCOMES

We Measure and Report on Our Clinical Outcomes

We believe that by focusing primarily on diagnosing and treating cardiovascular disease we can improve the quality of cardiovascular care. We assess the quality of cardiovascular care - that is, the degree to which our services increase the likelihood of desired patient outcomes - by monitoring several key criteria, including mortality rates, patient acuity, average length of stay

and patient satisfaction. We believe our hospitals generally achieve lower mortality rates and a shorter average length of stay for patients with generally higher acuity levels as compared to our competitors in each of our markets. Over the last couple of years, we have engaged the Lewin Group, a national health and human services consulting group, to conduct an objective study on cardiovascular patient outcomes, using publicly available Medicare data from 2000. For the study prepared and released last year, based on MedPar data for FY 2000, the Lewin Group reviewed records for 1,139 hospitals that perform open heart surgery in the United States. The hospitals in this study included 193 Major Teaching hospitals with interns and residents-to bed of at least 0.25 and Peer Community hospitals, which include all other hospitals in the study. The FY 2000 Lewin study found the following:

- *Length of stay* – on average, our hospitals have a 17.4% shorter length of stay (adjusted for severity) for cardiac cases than Peer Community hospitals and a 22.4% shorter length of stay than Major Teaching hospitals.

- *Mortality rates* – after adjusting for risk of mortality, our hospitals, on average, exhibit 12.1% lower mortality rates than Peer Community hospitals and 9.4% lower mortality rates than Major Teaching hospitals.

- *Severity case mix index* – on average, patients arriving at our hospitals have a more severe case mix index of 1.48 compared to 1.19 at Peer Community hospitals and 1.26 at Major Teaching hospitals.

- MedCath heart hospitals discharge a higher proportion of patients to their homes as compared to the peer community hospitals (89.6% vs. 72.4%) and transfer a lower proportion of patients to other facilities or home health agencies (7.8% vs. 23.3%). This resulted in approximately $12.2 to $15.2 million in reduced aggregate Medicare expenditures in FY 2000 for patients treated in MedCath facilities *as compared to the peer group.* This is based on an actual savings of $922-$1,145 per discharge.

Recently, the Lewin Group completed a similar study based on MedPar data for FY 2001. For this study, the Lewin Group reviewed records for 1,192 hospitals that perform open heart surgery in the United States. The hospitals in this study included 210 Major Teaching hospitals with interns and residents-to bed of at least 0.25 and Peer Community hospitals, which include all other hospitals in the study. The FY 2001 Lewin Study found the following:

- *Length of stay* – on average, our hospitals have a 19% shorter length of stay (adjusted for severity) for cardiac cases than Peer Community hospitals and a 24.11% shorter length of stay than Major Teaching hospitals.

- *Mortality rates* – after adjusting for risk of mortality, our hospitals, on average, exhibit 17.44% lower mortality rates than Peer Community hospitals and 15.28% lower mortality rates than Major Teaching hospitals.

- *Severity case mix index* – on average, patients arriving at our hospitals have a more severe case mix index of 1.44 compared to 1.18 at Peer Community hospitals and 1.25 at Major Teaching hospitals.

- MedCath hospitals discharge a higher proportion of patients to the home compared to peer group hospitals and a lower proportion of patients are transferred to other facilities or a home health agency. In a prior study, Lewin found this reduced aggregate Medicare expenditures for MedCath patients.

We operate all of our hospitals under a quality improvement program to provide an objective assessment of the quality of the services we provide. All of our hospitals are accredited by the Joint Commission on Accreditation of Healthcare Organizations, an independent accrediting organization that is widely recognized in the hospital industry, with the following scores on the most recent surveys:

Hospital	Scores
Arkansas Heart Hospital	94%
Tucson Heart Hospital	94%
Arizona Heart Hospital	98%
Heart Hospital of Austin	94%
Dayton Heart Hospital	92%
Bakersfield Heart Hospital	94%
Heart Hospital of New Mexico	97%
Heart Hospital of South Dakota	94%

Recently, the Arizona Heart Hospital was included in the "Solucient 100 Top Hospitals," 2002 study. Solucient is a national healthcare data tracking company that recognizes top performing hospitals across the nation. The report identifies industry benchmarks and recognizes hospitals and management teams that demonstrate superior clinical, operational and financial performance in cardiovascular services. Key indicators in the report include survival

rates and adjusted costs. In all categories, the Arizona Heart Hospital performed better than its peers.

VII. AS A RESULT OF COMPETITION FROM MEDCATH HOSPITALS, PATIENTS, FEDERAL AND STATE PROGRAMS AND PRIVATE PAYORS BENEFIT FROM REDUCED COSTS

Savings Result from Our Clinical Outcomes and our Methods of Operation

The entry of a MedCath hospital into a market results in lower hospital costs for patients, Medicare and Medicaid and for private payors. These savings result from:

1. Our ability to discharge patients sooner on average than our competition;

2. The fact that a higher percentage of our patients are discharged to their homes rather than to other health care facilities; and

3. The unique manner in which we efficiently deliver hospital services.

As discussed above, the FY 2001 Lewin study found the following with respect to points 1 and 2 above.

- *Length of stay* – on average, our hospitals have a 19% shorter length of stay (adjusted for severity) for cardiac cases than Peer Community hospitals and a 24.11% shorter length of stay than Major Teaching hospitals.

- MedCath hospitals discharge a higher proportion of patients to the home compared to peer group hospitals and a lower proportion of patients are transferred to other facilities or a home health agency. In a prior study, Lewin found this reduced aggregate Medicare expenditures for MedCath patients.

Additionally, cost savings result from our hospitals having different operating characteristics than traditional general acute care hospitals. For example, in our hospital division, our labor costs represent approximately 30% of our net revenue (based on our fiscal year ended September 30, 2002) as compared, we believe, to approximately 40% of net revenue in the average for-profit hospital and approximately 45% to 50% in the average not-for-profit hospital. We achieve our cost-effective operating results in a number of ways, including:

- Designing our hospitals to reduce the labor costs associated with transporting patients, equipment and supplies. The delays and lack of coordination associated with transporting patients around a large general acute care hospital also hinders the physicians' ability to provide quality care on a timely basis and can result in patient dissatisfaction,

- Eliminating duplicative layers of administrative and support personnel,

- Staffing our hospitals with only four non-caregiving executive employees, including a president, vice president of finance, vice president of clinical services and vice president of business development. This staffing model greatly reduces administrative costs associated with traditional general acute care hospitals.

- Using working team leaders to supervise our nurses and medical technical personnel at each of our hospitals. These team leaders spend a majority of their time providing patient care services. This working team leader approach reduces the need for supervisory personnel.

- Centralizing our non-clinical hospital support services, such as finance, management information systems, regulatory compliance and managed care contracting, as appropriate, and

- Investing in technology and training for our physicians, nurses and other staff members so that they are familiar with all details of quality cardiovascular care, can work more efficiently, and provide patient-focused care.

MedCath has also joined General Electric, Sun Microsystems, and other corporations with their health care quality initiatives, by applying "Six Sigma" principles to make efficient and effective decisions. For example, by using these principles we can isolate factors that can improve patient safety. Improving patient safety means systematically reducing the length of stay in the hospital, improving accuracy with each intervention, and minimizing the need for invasive treatments.

VIII. WE ENHANCE COMPETITION IN OUR MARKETS BY SHARING AND APPLYING OUR EXPERIENCE ACROSS OUR HOSPITALS AND WITH OTHERS

Our cost-effective operations reflect the impact of shared experiences of physicians and hospital management at each of our hospitals. We encourage our hospital management and physician partners to regularly share information and implement best practices, which is made easier by our standard facility design, common information system infrastructure, and operational similarities. We share information through regular meetings of our hospital management teams to enable them to discuss new practices and methodologies such as supply selection and management as well as scheduling efficiencies. We also coordinate opportunities for our physician partners to discuss - both on an informal basis and at our periodic meetings of our physician partners - such matters as clinical protocols, patient management and procedure techniques. These efforts have allowed our hospitals to benefit from the innovations that occur at one hospital and our hospital managers and physicians to become more efficient and productive.

Recently, our Heart Hospital of New Mexico hosted a representative of the Japanese Government's Ministry of Health, Labor and Welfare, to study our unique and successful patient-focused care model.

IX. WHO IS OUR COMPETITION?

We compete primarily with other cardiovascular care providers, principally for-profit and not-for-profit general acute care hospitals. We also compete with other companies pursuing

strategies similar to ours, and with not-for-profit general acute care hospitals that may elect to develop a heart hospital. In some of our markets, such as Sioux Falls, South Dakota, we may have only one competitor. In other markets, such as Phoenix, Arizona, our hospitals compete for patients with the heart programs of numerous other hospitals in the same market. In most of our markets we compete for market share of cardiovascular procedures with three to six hospitals. Many of these hospitals are part of large for profit or not-for-profit hospital systems with greater financial resources than we have available to us, and all of them have been operating in the markets they serve for many years. We believe that all eight of our hospitals in operation as of September 30, 2002 rank first or second in market share of key cardiovascular surgical procedures performed in their markets. The principal competitors of each of our hospitals in operation as of September 30, 2002 are identified below.

Arkansas Heart Hospital

- Baptist Medical Center
- St. Vincent Infirmary Medical Center

Dayton Heart Hospital

- Good Samaritan Hospital
- Kettering Memorial Hospital

Tucson Heart Hospital

- Tucson Medical Center
- University Medical Center

Bakersfield Heart Hospital

- Bakersfield Memorial Hospital
- San Joaquin Community Hospital

Arizona Heart Hospital

- Good Samaritan Medical Center
- Phoenix Regional Medical Center

Heart Hospital of New Mexico

- Presbyterian Hospital
- Lovelace Health Systems

Heart Hospital of Austin

- Seton Medical Center
- St. David's Hospital

Heart Hospital of South Dakota

- Sioux Valley Hospital

Louisiana Heart Hospital

- Lakeview Hospital
- North Shore

X. WHAT ACTIONS HAVE SOME COMPETITORS TAKEN IN RESPONSE TO COMPETITION FROM OUR HOSPITALS?

An increasing number of hospitals are adopting credentialing criteria, the primary purpose of which appears to be to discourage competition, since these criteria relate to a physician's financial relationship with another provider rather than to the physician's education, experience or clinical competency. These policies are being adopted across the country by hospitals from Maine to South Carolina to South Dakota, and are typically referred to as "economic credentialing." "Economic credentialing" policies are defined by the AMA as "the use of economic criteria unrelated to quality of care or professional competency in determining an individual's qualifications for initial or continuing hospital medical staff membership or privileges."[1]

There are various types of economic credentialing policies, and the breadth of their prohibitions has expanded exponentially over recent years. I believe it is relevant to this hearing to address those economic credentialing policies designed to decrease competition by influencing physicians to refer their patients to the economic credentialing hospital rather than to competing specialty hospitals and alternate care providers such as ambulatory surgery centers ("ASCs") and outpatient imaging centers. Some of these policies relate to physician ownership of competing facilities, while others encompass a wide range of compensation relationships. As a result, physicians may lose existing staff privileges, if they have virtually any type of direct or indirect financial relationship with another provider, particularly one that is perceived to be a potential competitor. Further, the prohibitions often go far beyond the physician to encompass financial relationships involving members of the physician's family or even other members of his or her group medical practice.

Initially, most of these economic credentialing policies denied privileges to new applicants. However, an increasing number of especially pernicious policies revoke staff

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1 AMA House of Delegates Resolution, H-230.975.

privileges from physicians who have been respected members of a hospital's medical staff for years because of fear that the physician's financial arrangements with a competitor (actual or potential) will lead to fewer referrals to the credentialing hospital. In these instances, especially where the hospital is threatening to terminate a physician's existing medical staff privileges, the hospital using economic credentialing is offering an inducement – the continuation of staff privileges – in exchange for continued referrals to that hospital. Thus, forcing the physician to make a decision based upon criteria other than what's in the best interest for the patient.

The effect and purpose of these policies, therefore, is to discourage support, and use of, a new hospital competitor in the marketplace.

The proponents of economic credentialing claim they are justified by criticizing specialty providers for "cherry-picking" the most profitable ("easy to treat") patients and services, and for failure to provide emergency care or treatment for indigent patients. These are unproven rationalizations. There is credible evidence to demonstrate that these economic credentialing policies are largely concerned with protecting and enhancing their own revenues from the loss of referrals by preventing their physicians from having privileges at competing providers.

Over the years and in a number of communities in which MedCath has either opened hospitals or considered opening hospitals, existing hospital competitors have used a variety of means in an effort to dissuade potential investor physicians from participating in a MedCath hospital, which would become a new competitor in the marketplace, with the ability to improve clinical outcomes and to save costs. Those means include:

- Removing investor or potential investor physicians from extra assignments under the control of the hospital under which the physicians have the opportunity to earn professional fees (*e.g.*, removing physicians from "graphics panels" that read X-rays, EKGs and ultrasound that help determine needed care; removing from post as Chief of Cardiology at the competing hospital), reserving these opportunities only for physicians that do not support competition.

- Using discretionary authority over hospital assets to make life for the practicing physician at that hospital more difficult (*e.g.*, making operating room and Cath Lab scheduling difficult or less convenient by limiting access to preferred operating room times).

- Requiring public disclosure of investment in a MedCath hospital by changing staff credentialing renewal process to require disclosure by physicians seeking renewal or new credentialing of investment by physician in any competing healthcare facility.

- Attempting to split apart cardiac groups that may have signed up with MedCath as potential investor MDs by targeting younger members, suggesting they break off and form their own group, with the hospital system or integrated healthcare network offering a salary guarantee for some period of time (*e.g.*, 2 years) if they do.

- Contracting primary care physicians and advising them not to refer patients.

- Removing the physician from on-call coverage rotation for the emergency department.

XI. COMPETITOR ACTIONS TO DISCOURAGE COMPETITION

The Ohio Health Example

Attached to my statement are documents relating to the Ohio Health Corporation/Doctors Ohio Health Corporation Board of Directors Resolution Regarding Restrictions on Medical Staff Appointments ("the Credentialing Resolution"). These documents indicate that in considering and ultimately enacting an economic credentialing policy, the Ohio Health hospitals were clearly motivated by fear of competition, and by concerns that a significant percentage of their hospital revenues could be at risk as a result of this competition. The "Discussion Draft" of the Credentialing Resolution ("the Draft Resolution") proposes to terminate the privileges of any physician simply for investing, directly or indirectly, in a competing hospital. This credentialing criteria is not related to quality of care but rather is an effort to discourage competition. There is no basis to indicate that the physician's investments have any impact at all on his or her clinical competence and skill.

Further, the attached "Issue Briefing" clearly demonstrates that a primary intention of the Credentialing Resolution was to protect and increase revenues for the economic credentialing hospitals by inducing physicians to refer to them, rather than to competitors. The Issue Brief describes how "for-profit limited service hospitals pull revenues away from full-service community hospitals," citing estimates that 35%-45% of hospital revenues could be at risk due to competition from specialty providers. Thus while other motivations are also cited, a clear intent of the Credentialing Resolution is to protect Ohio Health hospital revenues by influencing physician referrals in exchange for staff privileges.

The Aurora Health Care Metro Example

While many economic credentialing policies completely deny a physician any access to the medical staff, other such policies prohibit a physician with a financial relationship with a competitor from providing certain types of services at the credentialing hospital. These policies are also designed to provide an inducement and to earn professional fees to the physician for referrals– that is, the right to provide certain services at the credentialing hospital in exchange for patient referrals. One such policy (copy attached to my statement) denies physicians the opportunity to provide certain graphics interpretations at several hospitals if the physician:

> either him/herself or through any family member of such physician or through any physician in the same group practice, directly or indirectly (including as a trustee or beneficiary of a trust, through a partnership or other entity or through the group practice with which the physician provides service or through other physicians in the same group practice), hold any ownership, investment or debt relationship, or a position as officer, director or medical directorship with, an entity that owns or operates a hospital in Wisconsin that is primarily involved with care or the treatment of the patients with heart problems or issues (a "Competing Entity"). . . . And, if the contracting person is an entity (such as a service corporation) then the foregoing requirement will apply to all officers, directors, shareholders, members or partners of the entity contracting for such service.

In this context, the loss of this privilege would likely lead to the loss of substantial compensation each year making it unlikely that a physician could afford to have such a privilege revoked. See December 4, 2002 letter from Aurora Health Care Metro, Inc. [redacted] re "Graphics at St. Luke's Medical Center and St. Luke's South Shore, attached.

Other Restrictive Credentialing Policies

Some hospitals are reportedly adopting economic credentialing policies which allow medical staff members who invest in specialty providers to conditionally retain their privileges. However, these physician's future referrals are to be monitored to ensure that they are not referring the "good cases," to other hospitals, and the privileges are subject to revocation. The application for medical staff privileges at another hospital requires a physician to disclose: (i)

whether the physician owns a significant interest in a surgicenter, diagnostic facility or other inpatient facility that competes directly for patients within the primary or secondary service area; and (ii) whether the physician is employed by a direct competitor of the health system. The clear implication is that such applications for privileges will be viewed as "tainted" and likely rejected if the physician has any such financial relationship with a competing provider. As a result, such credentialing policies have a chilling effect on physician investment and other types of legitimate financial relationships because of unstated – but strongly implied – consequences. All of which have the effect of raising the barrier to entry for a new competitor.

Exclusion from Managed Care Networks

Access to staff privileges at a particular hospital can be critical today in the era of managed care networks. Participation in a health plan of a managed care company often requires staff membership at a particular hospital. Without such privileges, physicians may be unable to care for his or her patients who are members of certain health plans. In addition, the inability to participate in such managed care networks can greatly impact a physician's income, giving the economic credentialing hospital even greater leverage over the physician and his or her referrals. It is immaterial that the network is initially created by the managed care organization. Hospitals with economic credentialing policies use that limited network to exploit the system.

In Dayton, Ohio, the largest hospital system in Dayton told the largest health insurer that it would not contract as a hospital provider if the health insurer also contracted with our Heart Hospital. Recently, this same hospital system told this insurer that they would agree to rejoin the plan if the insurer would remove the Heart Hospital.

In Canton, Ohio, as an example, a competing hospital integrated with a managed care insurance plan that covers Medicare patients told cardiac patients that it would not contract with a proposed MedCath hospital.

In Little Rock, Arkansas, a health insurer, which is 50% owned by the principal hospital system in Little Rock, will not contract through their managed care plans with a MedCath

hospital or the physicians who are investors in the hospital, even for patient care provided in their primary office or at one of the competing hospitals where they have admitting privileges.

In some markets, the integrated delivery network has sponsored its own managed care organization with the intent of controlling patient referrals.

XII. OUR HOSPITALS HAVE 24/7 EMERGENCY DEPARTMENTS AND IMPROVE PATIENT ACCESS

In February of 2003, we responded to a GAO survey with the following information on our emergency departments:[2]

Question	Arkansas Heart Hospital	Tucson Heart Hospital	Arizona Heart Hospital	Heart Hospital of Austin	Dayton Heart Hospital	Bakersfield Heart Hospital	Heart Hospital of New Mexico	Heart Hospital of South Dakota
How many patients does your emergency department treat in a typical month?	329	928	424	556	211	531	264	121
What proportion of your emergency visits are for medical conditions or services outside your hospital's area(s) of specialty?	35%	75%	69%	62%	33%	60%	37%	49%
What proportion of your emergency visits are transferred to other facilities?	4%	8%	6%	5%	4%	9%	4%	5%
How is your emergency department (ED) staffed at different times of the hospital day?	Physicians in the ED 24 hours	Physicians in the ED 24 hours	Physicians in the ED 24 hours	Physicians in the ED 24 hours	Physicians in the ED 24 hours	Physicians in the ED 24 hours	Physicians in the ED 24 hours	Physicians in the ED 24 hours

2 Although our Louisiana and Harlingen hospitals did not participate in the survey, their emergency departments are staffed 24/7.

The above figures support our belief that MedCath hospitals improve patient access in a community; given the small percentage of emergency visits to our hospitals that are transferred to other facilities. Moreover, The Lewin studies discussed above, show that MedCath hospitals discharge a higher proportion of patients to the home compared to peer group hospitals and a lower proportion of patients are transferred to other facilities or a home health agency.

MedCath Heart Hospitals and Emergency Departments

- All of our operational hospitals have a 24/7 emergency department
- In fiscal year 2002 (10/1/01-9/30/02) in our 8 heart hospitals we treated a total of 40,370 patients in our emergency departments
- Of these 40,370 patients, 23,991 (59%) were non-cardiac patients
- Of these 23,991 non-cardiac ED patients, we transferred only 681 (2.84%) to another short-term hospital

Transfers to MedCath Heart Hospitals from other Short-Term Hospitals

- From 3/1/02-2/28/03, we received 7,167 in-patient admissions from another short-term hospital, representing 22.2% of our total in-patient admissions for this period.

When you review the high percentage of our emergency visits that are non-cardiac patients and the relatively low percentage of these we end up transferring to another short-term hospital, the data refutes any argument that we are adding to an overburdened network of emergency departments. The data suggests that the reverse is true. We are adding capacity to the emergency system and are able to treat a significant portion of the non-cardiac patients that come to our facility.

In addition, the high percentage of our admissions that are transferred from other short-term hospitals is also important. The data shows that our hospitals are providing a tremendous

service to the regional healthcare network by adding critical cardiac capacity to the system. We believe the majority of these transfers come from rural hospitals that are part of the 76% of all hospitals in the United States that don't have a full cardiac program.

XIII. WE HAVE A CODE OF ETHICS AND ACTIVE COMPLIANCE PROGRAMS

In February 1998, the Office of Inspector General of the Department of Health and Human Services issued compliance program guidance for hospitals. In response to the original 1998 guidelines, the Company adopted a Code of Ethics, designated compliance officers in the parent corporation and individual hospitals, established a toll free compliance line, which permits anonymous reporting, implemented various compliance training programs, and developed a process for screening all employees through applicable federal and state databases.

We have an established reporting system, auditing and monitoring programs, and a disciplinary system to enforce the Code of Ethics and other compliance policies. Auditing and monitoring activities include claims preparation and submission, and cover numerous issues such as coding, billing, cost reporting, and financial arrangements with physicians and other referral sources. These areas are also the focus of training programs.

It is our policy to require our officers and employees to participate in compliance training programs. Our Board of Directors has established a compliance committee, which oversees implementation of the compliance program. The committee consists of three outside directors, and is chaired by a director and former chief counsel for the Health Care Financing Administration (now known as the Centers for Medicare & Medicaid Services), where he was responsible for providing legal advice on federal healthcare programs, particularly Medicare and Medicaid. The compliance committee of the Board meets at least quarterly.

The MedCath Corporate Compliance Officer is appointed by its Board, and reports to the Chief Executive Officer and to the Compliance Committee of the Board at least quarterly on compliance matters involving the hospitals. The Corporate Compliance Officer is a senior vice president, and has a background in nursing and hospital administration.

Additionally, each hospital has its own compliance committee that reports to its governing body. The hospital president serves as the hospital's compliance officer. The Corporate Compliance Officer annually visits the hospitals for compliance reviews, provides an audit guide and arranges resources to be made available to the hospitals to evaluate compliance with our policies and procedures, and serves on the compliance committee of each hospital.

The objective of the program is to ensure that our operations at all levels are conducted in compliance with applicable federal and state laws regarding both public and private healthcare programs.

The Charlotte Chapter of the Society of Financial Service Professionals announced in April 2002 that MedCath was awarded its top award for commitment to ethical practices. The award "recognizes companies who exemplify high standards of ethical behavior in their everyday business conduct and in response to specific crises or challenges."

XIV. CONGRESS DID NOT INTEND TO PROHIBIT HOSPITAL/PHYSICIAN PARTNERSHIPS

Much of the debate over economic credentialing is apparently based on the assumption that physician investment in health care facilities and other financial relationships between hospitals and physicians is a conflict of interest which various laws prohibit. The legislative history of federal health policy developments refutes this assumption, and indicates strong Congressional support for various types of financial initiatives that improve quality of care and provide incentives for the health care industry to be more cost conscious and efficient, including hospital/physician partnerships. As discussed further below, Congress has adopted a law which expressly permits physician ownership of hospitals.

It should be noted that these issues were discussed as early as the 1983 debates on the legislation which first enacted the prospective payment system ("PPS") for hospitals. The legislative history contains numerous references to the intent of Congress to "reform the financial incentives hospitals face, promoting efficiency in the provision of services by

rewarding cost/effective hospital practices."[3] Moreover, a background paper prepared by the Health Care Financing Administration ("HCFA") specifically acknowledged that Congress had intended to reform the prior system where there were no incentives for hospitals to control costs and no rewards for improving efficiency, and that the prospective payment system was intended to enable hospitals to make a profit when their costs fell below the prospective payment rate.[4]

During these debates, Congress also indicated continued concern with quality of care issues and focused on those measures to be implemented at the federal level. Some of the quality of care measures are discussed in HCFA's background paper, which acknowledged that the administration had taken numerous steps under the new PPS system to help a hospital maintain its level of service to patients, including implementation of peer review organizations, a system of DRG verification, and the appointment of advisory commissions. Finally, there are references in the 1983 legislative history to the fact that Congress viewed the implementation of a PPS system for hospitals as a first step, and envisioned going forward with additional initiatives to promote cost efficiencies in the delivery of health care.

Significantly in one of these more recent initiatives, Congress specifically recognized that hospitals and physicians might enter into joint ventures involving hospital ownership. For example, the validity of these types of arrangements was incorporated into statutory language in the Stark Law which contains an exception to the general prohibition against physician self-referrals when the physician has an ownership interest in a hospital. This exception recognizes the legitimacy of such physician ownership as long as (i) the physician's investment is in the whole hospital, not in a subdivision, and (ii) the physician is authorized to perform services at the hospital. This provision in the Stark legislation clearly indicates that Congress did not intend to prohibit physician investments in hospitals, but rather recognized and accepted them as legitimate and appropriate.

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3 S. Rep. 98-23 (1983) *reprinted in* 1983 U.S.C.C.A.N. 132.

4 HCFA, Technical Facts on Medicare Prospective Payment System for Hospitals, (Background Paper) 1983 Medicare and Medicaid Guide (CCH) ¶ 33,072A.

Furthermore, the legitimacy of various types of joint venture arrangements between physicians and hospitals continues to be recognized and promoted by Congress. During the debates on the 1997 Omnibus Budget Reconciliation Act, it is noted with approval that the legislation "enables doctors and hospital and other providers to band together to set up provider service networks."[5] The statutory language and the legislative history thus clearly demonstrate Congressional intent to promote improvements in the health care industry including joint venture arrangements between hospitals and physicians.

Finally, in testimony before a House Ways and Means Subcommittee hearing on the self-referral law in May 1999, CMS concurred that "important exceptions to [the physician self-referral] limits are needed to protect beneficiaries' access to care and to take into account the many detailed financial arrangements in today's healthcare delivery system."[6] In addition, Rep. Nancy Johnson of Connecticut repeatedly acknowledged the benefits of hospital-physician collaboration, calling on CMS in drafting the final Stark Law regulations, to "make space for the development of the collaborative relationships that are essential." CMS' representative agreed on the need to promote collaboration, and told Rep. Johnson that "we think that the law actually allows a lot of collaboration, and that is one of the reasons why, although it has taken a long time [to draft the regulations], we have spent the time to work with [hospital and physician] organizations to try to make it possible for those kinds of legitimate arrangements that apply."[7]

XV. CONCLUSION

MedCath's hospitals create much needed competition to the benefit of patients and payors by introducing an innovative healthcare delivery model into the market place. As with innovation in many industries, existing competitors do not always welcome having to deal with a

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5 CONG. REC. H4559 (June 25, 1997).

6 *Medicare Self-Referral Laws: Hearing Before the House Comm. On Ways & Means, Subcomm. on Health*, 106th Cong. (1999) (testimony of Kathleen A. Buto, Deputy Director, Center for Health Plans and Providers, CMS).

7 *Medicare Self-Referral Laws: Hearing Before the House Comm. On Ways & Means, Subcomm. on Health*, 106th Cong. (1999) (comments of Rep. Nancy Johnson).

new competitor. We do so in compliance with the healthcare laws. Close scrutiny should be applied to the tactics, such as economic credentialing and restricting access to managed care contracts,, which existing hospitals are using to discourage competition, to thwart opportunities to achieve better clinical outcomes, and to jeopardize healthcare costs savings.

Hospital	**Location**	**Opening Date (Scheduled Opening Date)**	**Licensed Beds**	**Cath Labs**	**Operating Rooms**
Arkansas Heart Hospital	Little Rock, AR	Mar. 1997	84	6	3
Tucson Heart Hospital	Tucson, AZ	Oct. 1997	60	4	3
Arizona Heart Hospital	Phoenix, AZ	June 1998	59	4	3
Heart Hospital of Austin	Austin, TX	Jan. 1999	58	4	3
Dayton Heart Hospital	Dayton, Ohio	Sept. 1999	47	4	3
Bakersfield Heart Hospital	Bakersfield, CA	Oct. 1999	47	4	3
Heart Hospital of New Mexico	Albuquerque, NM	Oct. 1999	55	4	3
Heart Hospital of South Dakota	Sioux Falls, SD	Mar. 2001	55	3	3
Harlingen Medical Center	Harlingen, TX	Oct. 2002	112	2	7
Louisiana Heart Hospital	St. Tammany Parish, LA	(Feb. 2003)	58	3	4
Heart Hospital of San Antonio	San Antonio, TX	(October 2003)	60	4	4
The Heart Hospital of Milwaukee	Glendale, WI	(Winter 2003)	32	3	3
Heart Hospital of Lafayette	Lafayette, LA	(Winter 2003)	32	2	2

Aurora Health Care

December 4, 2002

Re: Graphics at St. Luke's Medical Center and St. Luke's South Shore

Dear Dr.

The contract Aurora Health Care Metro, Inc. ("Aurora Metro") has entered into with Cardiac Testing, Ltd. for graphics interpretations at St. Luke's Medical Center and St. Luke's South Shore expires on December 31, 2002. The goal is that over the next few months a new entity will be created that will contract with Aurora Metro to provide the interpretations at issue on an exclusive basis. The creation of such new entity, its structure, and negotiation of the contract all need to be resolved before the contract with such new entity can occur.

As a transition to the contract with the new entity and to ensure appropriate graphics coverage as of January 1, 2003, Aurora Metro is planning to contract with qualified cardiologists or a service corporation of qualified cardiologists to provide the graphics interpretations as of January 1, 2003. As part of that transition plan, Aurora Metro's strong desire is to contract only with cardiologists and/or their service corporations who have indicated an intent to be involved in the new entity and provide such interpretations through such new entity's contract with Aurora Metro.

If you are interested in being considered for the graphics panels we ask that you sign this letter below that reflects:

- your understanding that the initial intent is to provide graphics interpretations on a transition basis through a contract with Aurora Metro, with such arrangement terminating when a contract with the new entity is available;
- your intent to participate as part of the new entity to be created which, it is intended, as soon as the legal details can be resolved, will hold the graphics contract; and

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- your understanding that a requirement of the transition contract and the final contract with the new entity will be that no physician providing service may, either him/herself or through any family member of such physician or through any physician in the same group practice, directly or indirectly (including as a trustee or beneficiary of a trust, through a partnership or other entity or through the group practice with which the physician provides service or through other physicians in the same group practice), hold any ownership, investment or debt relationship, or a position as officer, director or medical directorship with, an entity that owns or operates a hospital in Wisconsin that is primarily involved with care or treatment of the patients with heart problems or issues (a "Competing Entity"). The intent is that no physician shareholder or member of the same service corporation or group practice may be an investor in such a Competing Entity. And, if the contracting person is an entity (such as a service corporation) then the foregoing requirement will apply to all officers, directors, shareholders, members or partners of the entity contracting for such service with Aurora Metro.

By signing below you signify your agreement to the foregoing. To be considered we ask that you return a signed original of this letter by December ___, 2002.

Sincerely,

Aurora Health Care Metro, Inc.

By:_____

The foregoing reflects the understanding of the undersigned.

Date: _____, 2002 _____

_____

OFFICE O

Date: 05

To:

From:

Re: Resolution re important investments competing with OhioHealth Hospitals

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Attached is a discussion draft copy of a resolution that will be initially considered by the OhioHealth Board of Directors at its May 14 meeting. It deals with conflicts of interest by medical staff members who invest in facilities that compete on an inpatient services basis with OhioHealth hospitals. The resolution, if adopted, would result in an automatic resignation from the hospital medical staff by physicians who invest in inpatient facilities. It would also disqualify physicians with existing conflicting investments from potential membership. The Staff Presidents are encouraged to distribute and discuss this resolution and the position of OhioHealth with their staffs. Also attached for your information is an Issue Briefing paper previously shared with the media relative to some issues surrounding the health and well-being of the overall community and the proliferation of for profit, limited service hospitals.

Management currently anticipates that this resolution would be reviewed for the first time at the May 14 Board meeting and be presented for action in July. In the interim, please forward any comments or suggestions on the resolution to me at your convenience. Thanks.

Frank

DISCUSSION DRAFT

Oh oHealth Corporation/Doctors OhioHealth Corporation
Board of Directors

RESOLUTION REGARDING RESTRICTIONS ON MEDICAL STAFF APPOINTMENTS

WHEREAS, Ohio Health Corporation and Doctors OhioHealth Corporation operate charitable hospitals in central Ohio; and

WHEREAS, as fiduciaries, the Board of Directors of OhioHealth Corporation and Doctors OhioHealth Corporation has a duty to preserve and protect the health care charitable assets of these entities to fulfill their charitable mission; and

WHEREAS, there has also been a recent movement nationally to establish for-profit specialty hospitals specifically directed toward referring physician investment that seek to divert revenue from general acute care, charitable hospitals; and

WHEREAS, the Board of Directors believes that the creation of such for-profit specialty hospitals will seriously impair the ongoing charitable mission of OhioHealth Corporation and Doctors OhioHealth Corporation and result in a reduced ability to provide state of the art acute care services for all residents of our community; and

WHEREAS, the Board of Directors believes that certain actions by individual medical staff members will be incompatible with the charitable mission of OhioHealth Corporation and Doctors OhioHealth Corporation and the goal of maintaining charitable hospitals that: (i) care for all patients, regardless of ability to pay, (ii) support education and research; (iii) maintain quality programs and facilities; and (iv) maintain an adequate, dedicated work force to achieve these goals; and

WHEREAS, the Board of Directors of OhioHealth Corporation and Doctors OhioHealth Corporation has determined that it must increase certain restrictions relating to medical staff membership at their combined charitable hospitals to fulfill their important charitable mission.

NOW THEREFORE, BE IT RESOLVED that any medical staff member:

1. who is or has committed to be an investor, directly or indirectly, or through a group practice, in an inpatient hospital facility that provides or will provide acute care inpatient services available at Grant Hospital, Riverside Methodist Hospitals, or Doctors Hospital (hereinafter "OhioHealth Hospital" or collectively "OhioHealth Hospitals"); or

2. who, in furtherance of any such investment interest in any inpatient hospital facility which competes or will compete with an OhioHealth Hospital, solicits staff for the purpose of leaving the employment of an OhioHealth Hospital; or

3. who, in furtherance of any such investment interest in any inpatient hospital facility which competes or will compete with an OhioHealth Hospital, engages in a pattern of selectively determining the situs of care based upon the patient's payment source or the profitability of the procedure,

shall be considered to have voluntarily withdrawn or voluntarily terminated his or her appointment and privileges at all OhioHealth Hospitals effective as of the date an OhioHealth Hospital learns or is otherwise put on notice of such activity.

BE IT FURTHER RESOLVED, that any applicant for Medical Staff membership or privileges:

1. who is or has committed to be an investor, directly or indirectly, or through a group practice, in an inpatient hospital facility that provides or will provide acute care inpatient services available at an OhioHealth Hospital; or

2. who, in furtherance of any such investment interest in any inpatient hospital facility which competes or will compete with an OhioHealth Hospital, solicits staff for the purpose of leaving the employment of an OhioHealth Hospital; or

3. who, in furtherance of any such investment interest in any inpatient hospital facility which competes or will compete with an OhioHealth Hospital, engages in a pattern of selectively determining the situs of care based upon the patient's payment source or the profitability of the procedure,

will not be eligible for consideration for Medical Staff membership or privileges at any OhioHealth Hospitals.

BE IT ALSO FURTHER RESOLVED, that lack of eligibility or lapse of appointment and privileges pursuant to this Board Policy shall not be reportable to the National Practitioner Data Bank or the Ohio State Medical Board. Nor such shall lack of eligibility or lapse of appointment and privileges give rise to any hearing rights pursuant to the Medical Staff Bylaws of an OhioHealth Hospital; provided, however, that a Medical Staff member or applicant for membership who believes that the above Policy is being incorrectly applied based upon inaccurate facts may request and will be granted the right to an administrative hearing pursuant to the Medical Staff Bylaws for the sole purpose of determining the actual facts and applicability of the Policy to such facts. The Policy itself and the rationale underlying the Policy shall not be subject to review in any such hearing.

Issue Briefing

The potential impact of for-profit limited service hospitals on health care in the Central Ohio community

- Greater Columbus is one of the largest metropolitan areas in the nation without a tax-supported city/county hospital system. In our community, we have been able to establish and maintain a single standard of care that applies to all citizens – including the medically indigent – without local tax levies. This health care standard is made possible by the offerings of four full-service community hospital systems – OhioHealth, Mount Carmel, OSU and Children's Hospital.

- For-profit limited service hospitals pull revenues away from full-service community hospitals. They weaken a community's access to basic services, especially emergency medical care, trauma centers, and poison and burn centers. In 2001, the full-service community hospitals provided $201 million in charity care and bad debt.

- For-profit limited service hospitals do not embrace a community mission. They are motivated – by design – to put wealth over wellness. They lack incentives to offer wellness or prevention services (such as immunization programs) that create long-term benefits for the community.

- These for-profit limited service inpatient facilities, in whatever form, have several things in common:

  - They "cherry pick" the patients they want – typically paying customers who have the least complicated cases, which are less expensive to treat.

  - They specialize in the most cash generating procedures, referring more medically complex cases to other community providers.

  - They attract investors with the prospect of sharing in the profits, making shareholder value a priority over caring for the community.

- The Health Care Advisory Board has estimated that 35 percent to 45 percent of hospital revenues may be at risk from investor-owned "boutique" facilities.[1]

- The effects of the national trend toward for-profit limited service facilities is evidenced in Florida, where these facilities account for 44 percent of all hospitals and provide only 6 percent of charity care, 20 percent of Medicaid patients and seven percent of education and research funding.[2]

- The mission of the full-service hospitals serving the local community has been to create a health care system that provides the highest quality care at affordable costs to the entire community. It is a mission that should not be sacrificed for profit.

- For additional information, please contact:

  - Laura McCoy, OhioHealth, 544-5150
  - Russ Kennedy, Mount Carmel, 234-2950
  - Sue Jablonski, OSU Medical Centers, 292-2220
  - Margie Pizzuti, Children's Hospital, 722-5975
  - Mary Yost, Ohio Hospital Association, 221-7614

[1] The Health Care Advisory Board is composed of more than 2,000 of the country's largest and most progressive health systems and medical centers. HCAB publishes 50 major studies and more than 3,000 customized research briefs each year on progressive management and clinical practices in health care. Its research focuses on the best (and worst) demonstrated practices, helping member institutions benefit from one another's learning curves.

[2] Based on data from the American Hospital Association.