Statement

of the

American Medical Association

to the

Subcommittee on Federal Financial Management,
Government Information, and International Security
of the
Committee on Homeland Security and Governmental Affairs,
United States Senate

Overview of the Competitive Effects of Specialty Hospitals

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May 24, 2005

Chairman Coburn, Ranking Member Carper, and Members of the Subcommittee, the American Medical Association (AMA) appreciates the opportunity to provide our views regarding specialty hospitals and their role in a competitive marketplace.

The AMA strongly supports and encourages competition between and among health facilities as a means of promoting the delivery of high-quality, cost-effective health care. Specialty hospitals are key to that goal. They increase competition for hospital services by providing patients with more choices and by forcing general hospitals to innovate in order to stay competitive. Some general hospitals have even admitted that the entry of a specialty hospital in their area has been akin to a "wake-up" call. Specialty hospitals have improved care for Medicare beneficiaries and other patients, and patient and physician satisfaction with these hospitals is extremely high.

Hospitals that provide care for a specific type of patient or a defined set of services are not new. Specialty hospitals have been in existence for decades. For example, Delaware's Alfred I. DuPont Hospital for Children has provided specialty hospital care to thousands of children from across the country since its founding in 1940. Numerous market dynamics have led to the increase in physicians' desire to own and operate these hospitals in recent years. Since 1995, the number of hospitals that focus on cardiac, orthopedic and surgical services has

grown. This growth has led to concern among general hospitals who must compete with these facilities. The hospital associations and many general hospitals are vigorously attempting to eliminate this competition, employing anticompetitive practices to stifle competition.

Consistent with medical ethics, the AMA supports physician ownership of health facilities, and referrals by physician owners, if they directly provide care or services at the facility. The growth in specialty hospitals is an appropriate market-based response to a mature health care delivery system, as well as a logical response to incentives in the payment structure for certain services and the increasing medical needs of elderly patients.

Although general hospitals have not been harmed financially as a result of physician owned specialty hospitals, they claim that the playing field is not competitive because specialty hospitals take away lucrative services that general hospitals use to subsidize other community services. The Federal Trade Commission (FTC), the Department of Justice (DOJ), and many others, believe that cross-subsidization of services by general hospitals is a market distortion that must be eliminated to preserve competition. The AMA agrees.

Changes are needed in the inpatient and outpatient Medicare prospective payment systems to more accurately reflect the relative costs of hospital care, thus eliminating the need for cross-subsidization of services by general hospitals. The Medicare Payment Advisory Commission (MedPAC) has recommended specific changes to the Medicare hospital payment system to accomplish this end, and the AMA supports those recommendations. In addition, we support policy changes that would help ensure the financial viability of "safety-net" hospitals so they can continue to provide access to health care for indigent patients. Combined, these changes would ensure the continued financial stability of general and safety net hospitals, further enhancing competition in the market for hospital services.

For these reasons, the AMA urges this subcommittee to support competition, not an extension of the moratorium on physician referrals to specialty hospitals.

THE MORATORIUM ON SPECIALTY HOSPITALS SHOULD EXPIRE AND NOT BE REINSTATED

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) imposed an 18-month moratorium on referrals of Medicare and Medicaid patients by physicians investors in certain specialty hospitals not already in operation or under development as of November 18, 2003.[1] The MMA required the Medicare Payment Advisory Commission (MedPAC), in consultation with the Government Accountability Office (GAO), and the Secretary of the Department of Health and Human Services (HHS) to conduct studies of specialty hospitals and report their findings and recommendations to Congress.

[1] The MMA defined specialty hospitals as those primarily or exclusively engaged in cardiac, orthopedic, surgical procedures and any other specialized category of services designated by the Secretary.

According to the GAO,[2] there are 100 existing specialty hospitals that focus on cardiac, orthopedic, women's medicine, or on surgical procedures.[3] Of the 100 specialty hospitals identified by the GAO and 26 others under development in 2003, there were various owners/investors, including both hospitals and physicians. Seventy percent had some degree of physician ownership. One-third of these specialty hospitals were joint ventures with corporate partners, one-third were joint ventures with hospitals, and one-third were wholly owned by physicians.

The moratorium is due to expire on June 8, 2005. As of May 12, 2005, the GAO, HHS and MedPAC had all completed their MMA-required reports. Because these studies are complete and they demonstrate that specialty hospitals do not harm general hospitals—in fact, they show that specialty hospitals improve patient care—the AMA believes the moratorium should expire. There is no need for an extension of the moratorium, nor for imposition of a de facto moratorium as the Centers for Medicare and Medicaid Services (CMS) has indicated by its announcement to delay approval of applications for new specialty hospitals until 2006.

THE RECENT GROWTH OF SPECIALTY HOSPITALS IS A RESULT OF PATIENT AND PHYSICIAN NEED

There are numerous factors that have contributed to the growth of specialty hospitals, including:

- Many physicians are frustrated over hospital control of management decisions and investment decisions that affect their productivity and the quality of patient care. Physicians often have little or no involvement in governance and management, control over reinvestment of profits in new equipment, or influence over scheduling and staffing needs for cases performed in the operating room. They believe that hospitals are not collaborating with them to align hospital processes or engage in joint ventures. Physicians who invest in specialty hospitals are able to increase their productivity, improve scheduling of procedures for patients, maintain appropriate staffing levels, and purchase desired equipment—all of which improve the quality of patient care.

- Advances in technology (e.g., minimally invasive surgery) have allowed care to be provided in a variety of settings.

- Data shows that facilities that focus on certain procedures and perform a significant number of them have better quality outcomes.

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[2] *See* U.S. General Accounting Office, *Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served*, GAO-03-683R (April 18, 2003); and U.S. General Accounting Office, *Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance*, GAO-04-167 (October 22, 2003).

[3] This number excludes numerous other specialty hospitals that have been in existence for some time, such as eye and ear hospitals, children's hospitals, and those that specialize in psychiatric care, cancer, rehabilitation, and respiratory diseases.

- Business partners willing to provide capital and management expertise are more readily available.

SPECIALTY HOSPITALS DEMONSTRATE HIGH EFFICIENCY, QUALITY AND PATIENT SATISFACTION

For various reasons, specialty hospitals have achieved better quality, greater efficiency, and higher patient satisfaction than general hospitals. Specialty hospitals are able to achieve production economies by taking advantage of high volumes of a narrow scope of services, and by lowering fixed costs by reengineering the care delivery process. Managerial and clinical staff at specialty hospitals focus on a relatively narrow set of tasks, thus providing the capability to perfect those tasks and benefit from increased accountability for the quality of care provided to patients. **According to the Center for Studying Health System Change, the health services literature supports the premise that "focused factories" can lead to higher quality and lower costs as a result of more expert and efficient care.**[4]

Managers of specialty hospitals consistently report the factors they perceive as critical to achieving high quality patient outcomes: high volume and high nursing intensity.[5] Specialty hospitals tend to have higher nurse-patient ratios despite the fact that physicians at specialty hospitals contend that they spend about 30% of their operating expenses on labor, compared to 40 to 60% for general acute-care hospitals.

Physician control and facility design also increase productivity and quality. Specialty hospitals improve patient access to specialty care by providing additional operating rooms, cardiac-monitored beds, and diagnostic facilities. Specialty hospitals offer newer equipment, more staff assistance and more flexible operating room scheduling, thereby increasing productivity and physician autonomy over their schedules. Patients are therefore able to benefit from the higher productivity and increased flexibility in scheduling their procedures.

The 2005 HHS/CMS study suggests that measures of quality care at specialty heart hospitals were at least as good and in some cases better than general hospitals.[6] In addition, complication rates and mortality rates were lower at specialty hospitals, even when adjusted for severity. There were lower rates of readmission for moderately ill patients in orthopedic hospitals, and lower rates of infection due to medical care, post operative hip fracture, post operative deep vein thrombosis, and post operative sepsis in all specialty hospitals.[7] Furthermore, CMS found that patient satisfaction was extremely high in the specialty hospitals studied, and patients had very favorable perceptions of the clinical quality

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[4] Kelly J. Devers, Linda R. Brewster and Paul B. Ginsburg, *Specialty Hospitals: Focused Factories or Cream Skimmers?* HSC Issue Brief Number 62, April 2003.
[5] John E. Schneider, PhD, et al., *Economic Policy Analysis of Specialty Hospitals*, February 20, 2005.
[6] Study of Physician-owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Department of Health and Human Services, Centers for Medicare and Medicaid Services, (2005).
[7] *Id.*

of care they received.[8] Significantly higher nurse-to-patient ratios and very knowledgeable nurses contributed to the positive experiences noted by patients and their families.

Specialty hospitals are well positioned to address projected increases in demand for cardiac, orthopedic, and surgical services because they are a more efficient and effective way to deliver these services. In 2002, for example, 500,000 patients were diagnosed with congestive heart failure. With the estimated number of Americans at risk of cardiovascular disease projected to mushroom over the next decade, cardiovascular surgeons and cardiologists will need to see twice as many patients in ten years as they see today. Aging of the population, population growth, higher functioning and higher quality of life expectations associated with the baby boom generation are driving increased demand for cardiac, orthopedic, and surgical services. The greater efficiency of specialty hospitals will better enable physicians to care for these patients. Furthermore, the GAO found that 85 percent of specialty hospitals are located in urban areas and tend to locate in counties where the population growth rate far exceeds the national average.[9]

Patient satisfaction with specialty hospitals is extremely high. They enjoy relatively greater convenience and comfort, such as lack of waiting time for scheduled procedures, readily available parking, 24-hour visiting for family members, private rooms, more nursing stations that are closer to patient rooms, decentralized ancillary and support services located on patient floors, and minimized patient transport. Specialty hospitals have engaged in extensive collection of data on quality and patient satisfaction, and use the data to modify care processes. Because of the smaller size and narrow focus of specialty hospitals, they are more nimble and flexible to quickly respond to modify care processes as perceived necessary.

GENERAL HOSPITALS EMPLOY ANTICOMPETITIVE TACTICS IN RESPONSE TO INCREASED COMPETITION

As physicians began seeking greater involvement in the governance and management of patient services provided at hospitals, many who ultimately became investors in specialty hospitals tried initially to form joint ventures with hospitals to expand the availability of cardiology and orthopedic services. In many cases, the hospitals declined to enter into joint ventures with physicians. In other cases, the hospitals opened units or specialty hospitals of their own. By and large, however, general hospitals have become staunch opponents of physician owned specialty hospitals.

According to the GAO, the financial performance of specialty hospitals tended to equal or exceed that of general hospitals in fiscal year 2001.[10] The 55 specialty hospitals with available financial data tended to perform better than general hospitals when revenues and costs from all lines of business and all payers were included. When the focus was limited to Medicare inpatient business only, specialty hospitals appeared to perform about as well as general hospitals.[11]

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[8] *Id*.
[9] GAO, *supra* note 2.
[10] *Id*.
[11] *Id*.

Although they claim to support healthy competition, general hospitals have recently engaged in an aggressive assault on facilities owned and operated by physicians which they have characterized as "niche-providers" (e.g., ambulatory surgery centers, GI labs, imaging facilities, radiation oncology centers). The hospital industry has engaged in numerous focused strategies to prohibit physicians from opening a competing facility. Three core strategies the hospital industry is employing to address physician ownership of specialty hospitals are:

- Preemptive strike strategy—The hospital establishes its own specialty hospital and addresses some of the physician concerns, but does not offer physicians an opportunity for investment. Some hospitals also implement this strategy when a competing hospital or health system decides to build its own specialty hospital.

- Joint venture strategy with local physicians—The hospital recognizes a competitive threat from members of its medical staff or other local physicians and decides to engage in a joint venture with them rather than facing a reduction in the services.

- Roadblock strategy—Hospitals fights physicians that try to open a competing facility by building barriers and aggressively limiting the potential for developing competing services by implementing actions to restrict physicians' capabilities to do so (e.g., adopting "economic credentialing" or "exclusive credentialing" policies that revoke or refuse to grant medical staff membership or clinical privileges to any physicians who have an indirect or direct financial investment in a competing entity).

At the state level, hospitals have initiated several different types of anti-competitive strategies to limit physician-owned specialty hospitals. These initiatives include, but are not limited to, the following:

- Adopting legislation banning the creation of any facility that focuses on cardiac care, orthopedic services or cancer treatment (Florida).

- Proposing legislation prohibiting physicians from having a financial ownership in specialty hospitals (Ohio and Washington).

- Proposing legislation to expand Certificate of Need (CON) requirements to include other physician-owned facilities such as ambulatory surgery centers and diagnostic imaging facilities (Minnesota).

- Resisting efforts to repeal CON legislation (Iowa).

- Proposing legislation and/or regulations requiring specialty hospitals (but not other hospitals) to provide emergency departments and/or accept Medicare, Medicaid, and uninsured patients (Washington).

Individual general hospitals have also implemented a variety of anti-competitive strategies and tactics to discourage their medical staff from investing in competing specialty hospitals or to harm the medical practice of those who do make such investments. These initiatives include, but are not limited, to the following (See also Exhibit A attached to this statement):

- Adopting economic/exclusive credentialing/conflict of interest policies and medical staff development plans that revoke or refuse to grant medical staff membership or clinical privileges to any physicians or other licensed independent practitioner that has an indirect or direct financial investment in a competing entity.

- Hospital-owned managed care plans denying patient admissions to competing specialty hospitals.

- Requiring health plans to sign an exclusive managed care contract or otherwise discouraging them from contracting with competing facilities.

- Removing physicians that have a financial interest in a competing facility from their referral and on-call panels.

- Refusing to cooperate with specialty hospitals (i.e., refusing to sign transfer agreements).

- Requiring primary care physicians employed by the hospital or vertically integrated delivery system to refer patients to their facilities or those specialists that are closely affiliated with the hospital/health care delivery system regardless of the needs of the patient.

- Limiting access to operating rooms and cardiac catheterization labs of those physicians who have a financial interest in a competing entity.

- Removing competing physicians from extra assignments at the hospital, such as serving as department directors or reading EKGs, ultrasounds, echocardiography, and x-rays.

ETHICAL AND LEGAL SUPPORT FOR SPECIALTY HOSPITALS

The hospital industry's overarching message is that physicians who invest in a specialty hospital have a conflict of interest. They use this to justify their strategies to eliminate legitimate competition. **However, it is both ethical and legal for physicians to invest in and refer patients to health facilities.**

AMA ethical opinion E-8.032, "Conflicts of Interest: Health Facility Ownership by a Physician," delineates two scenarios where physicians may appropriately make patient referrals to health facilities in which they have an ownership interest. First, it sets forth a general rule that physicians may appropriately make such referrals if they directly provide care or services at the facility in which they have an ownership interest. Second, it describes a separate situation where physicians may appropriately make such referrals, which arises when

a needed facility would not be built if referring physicians were prohibited from investing in the facility. In the latter case, the appropriateness of the referrals would not depend upon whether the physicians have personal involvement with the provision of care at the facility, but whether there is a demonstrated need for the facility. Physician ownership of specialty hospitals and referral of patients for treatment at such facilities fits squarely within this ethical opinion.[12]

In addition, physicians are legally permitted to own health care facilities and refer patients to them. The physician self-referral law and the federal anti-kickback statute both set forth very broad prohibitions that generally prevent physicians from receiving any form of remuneration in exchange for referrals. Because the laws contain such broad prohibitions that effectively prevent many legitimate forms of remuneration, they also contain exceptions or safe harbors that define permissible forms of remuneration. Both laws permit physician ownership of treatment facilities and referrals to such facilities under various circumstances.[13] The physician self-referral law, the "Stark law," explicitly permits physician ownership of a hospital, and referral of patients to the hospital, if the physician is authorized to perform services at that hospital and the ownership interest is in the "hospital itself" and "not merely in a subdivision of the hospital."

The hospital associations, however, claim that physicians who own specialty hospitals should not be permitted to make referrals to those hospitals under that exception because they claim a specialty hospital is equivalent to a subdivision of a hospital. They call the use of this exception a "loophole" to bolster their efforts to eliminate competition from physician owned facilities.

This claim is simply unfounded. **Specialty hospitals are entire hospitals, not subdivisions of a hospital. They are independent legally-organized operating entities that provide a wide range of services for patients, from "beginning-to-end" of a course of treatment including specialty and sub-specialty physician services, and a full range of ancillary services.** A significant number of specialty hospitals also provide primary care, intensive care and emergency services.

The protection of referrals to an entire hospital, and not just a "subdivision of a hospital," was intended to prevent circumvention of the ban on referrals of laboratory services. As originally enacted, "Stark I," only prohibited referrals for laboratory services to facilities physician owned.[14] It would be counter-intuitive to prohibit ownership of and referral to a laboratory, but permit ownership of and referral to a hospital subdivision that provided only laboratory

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[12] The hospital associations, however, claim otherwise by distorting AMA ethical opinion E-8.032. They claim that it prohibits physician referrals to facilities in which they have an ownership interest unless there is a demonstrated need in the community. (July 6, 2004 letter to members of Congress from the Federation of American Hospitals (FAH) and the American Hospital Association (AHA)) The AMA quickly set the record straight, but the hospital associations continue to distort AMA policy. (August 4, 2004 letters from Michael D. Maves, MD, MBA to House Energy and Commerce Committee, House Ways and Means Committee and Senate Finance Committee.) Although a demonstrated need in the community is one ethical justification for a referral to a facility that one owns, it is a mischaracterization of AMA ethical opinion to state that it is the only justification.

[13] *See generally* 42 U.S.C. 1395nn., 42 CFR 411.350- 411.361, 42 U.S.C. 1320a-7b, and 42 CFR 1001.952.

[14] Public Law 101-239, December 19, 1989.

services. The Centers for Medicare and Medicaid Services (CMS) (then HCFA) confirmed this intent in its 1992 proposed regulations interpreting the original Stark law. CMS explained that the exception protected referrals when the physician's ownership interest is in the entire hospital and "not merely a distinct part or department of the hospital, such as the laboratory."[15]

In the 1995 Final Rule, there is a protracted discussion of what constitutes a hospital and a distinct part or department of a hospital.[16] CMS defined "hospital" for purposes of the Stark law as "any separate legally-organized operating entity plus any subsidiary, related, or other entities that perform services for the hospital's patients and for which the hospital bills…"[17] A specialty hospital fits squarely within this definition.

In 1993, Congress enacted legislation, referred to as "Stark II," expanding the ban on physician referrals from just clinical laboratory services to an entire list of ancillary services referred to as "designated health services."[18] The hospital ownership exception was appropriately retained in Stark II, permitting physicians to refer patients to a hospital they own and where they practice medicine, but prohibiting referrals to a hospital "subdivision" they own. Thus, the referring physician could still refer patients to a hospital he or she owns for a course of treatment, but not circumvent the intent of the prohibition by referring patients to a subdivision of a hospital that only provides one or more of the designated ancillary services.

As noted, designated health services are ancillary services, not physician services.[19] **The Stark laws prevent referrals for ancillary services, not professional services performed by a physician.** Furthermore, the Stark laws specifically prohibit referrals of these services at locations where the referring physician is <u>not directly involved in the care of the patient</u>. Under the Stark laws, no referral restriction is imposed if the referring physician personally performs a service, even if it is an ancillary service that would otherwise be prohibited by the law. There is also an exception for referrals of ancillary services rendered by another physician in the referring physician's group practice, or supervised by that physician, as long as it is in the same building where the referring physician regularly practices or a centralized building used by the referring physician for some or all of the designated health services performed by the group practice. Thus, the Stark laws prohibit physicians from making referrals for ancillary services at facilities where they do not practice and that provide only ancillary services.

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[15] 57 Fed. Reg. 8588, 8598 (March 11, 1992).
[16] 60 Fed. Reg. 41913, 41956 (August 14, 1995).
[17] 60 Fed. Reg. at 41956-41957.
[18] Public Law 103-66, August 10, 1993. These ancillary services include clinical laboratory services, physical and occupational therapy, radiology services (including MRI, axial tomography, and ultrasound), radiation therapy services and supplies, durable medical equipment supplies (DME), parenteral/enteral nutrients, prosthetics/orthotics supplies, home health services, outpatient prescription drugs, and inpatient and outpatient hospital services.
[19] Radiation therapy and certain radiology services often encompass a professional component as well as a technical component, but there is no carve out for the professional service. CMS notes, however, that in most cases these services will fall under the exceptions for physician service or will not be a referral because they are personally performed by the physician.

A specialty hospital is an entire hospital that provides a wide range of services for patients. In addition, physicians who invest in these hospitals and refer patients to them also treat patients at the hospital. Moreover, specialty hospitals do not provide only ancillary services. As stated previously, specialty hospitals provide a spectrum of care, from "beginning-to-end" of a course of treatment, including specialty and sub-specialty physician services, a full range of ancillary services, and often including primary care, intensive care, and emergency services. Therefore, **a specialty hospital is not equivalent to a hospital subdivision.**

There is no credible evidence that physicians are inappropriately referring their patients to specialty hospitals. Physicians have an ethical and legal obligation to refer patients to the facility that best meets the needs of the individual patient. The HHS study did not conclude that physicians who have an investment interest in a specialty hospital inappropriately refer patients.[20]

In fact, it is disingenuous for the hospital industry to claim that physicians have a conflict of interest when many general hospitals engage in self-referral practices. One hospital association claims that a "community hospital that tried to buy admissions in this way would be outlawed."[21] Ironically, however, general hospitals often channel patients to their facilities and services. They do this mainly by acquiring primary care physician practices or by employing primary care physicians, and requiring those physicians to refer all of their patients to their facilities for certain services such as x-ray, laboratory, therapy, outpatient surgery, and inpatient admissions. They also require such referrals by physicians under certain contractual arrangements or by adopting policies that require members of the medical staff to utilize their facilities (See Exhibit A).

Hospitals value these controlled referral arrangements to such a degree that they maintain them despite the fact that many of the hospital owned primary care practices and other arrangements operate at a loss for the hospital. The hospitals are frequently willing to subsidize these practices with profits derived from other departments and services provided by the hospital or health system. Why? It is clear that they only maintain these revenue-losing groups to control referrals and avoid competition.

The AMA is very concerned about efforts by hospitals and health systems to control physician referrals as they pose a number of significant concerns. **By dictating to whom physicians may refer, the hospital governing body or administration takes medical decision-making away from physicians. This introduces financial concerns into the patient-physician relationship and can run counter to what the physician believes is in the best interest of the patient. These hospital self-referral practices also limit patient choice.**

To reduce this interference in the patient-physician relationship, the AMA believes that disclosure requirements for physician self-referral, where applicable, should also apply to hospitals and integrated delivery systems that own medical practices, contract with group

[20] CMS, *supra* note 6.
[21] Charles N. Kahn III, *A Health-Care Loophole*, Washington Times, February 3, 2005.

practices or faculty practice plans, or adopt policies requiring members of the medical staff to utilize their facilities and services.

Despite claims by the hospital associations that physician ownership of specialty hospitals is a conflict of interest, the data does not support their assertions. MedPAC found that overall utilization rates in communities with specialty hospitals were similar to utilization rates in other communities. In addition, of the specialty hospitals identified by the GAO with some degree of physician ownership, the average share owned by an individual physician was less than two percent. Of particular significance, the GAO found that the majority of physicians who provided services at specialty hospitals had no ownership interest in the facilities. Overall, approximately 73 percent of physicians with admitting privileges at specialty hospitals were not investors in those hospitals.[22] Therefore, the majority of physicians who admit patients to specialty hospitals receive no financial incentives to do so. Further, of those physicians who do have an ownership interest in the hospital, there is no evidence that their referrals are inappropriate or have increased utilization.

COMPETITION SHOULD BE PROMOTED AND MARKET DISTORTIONS SHOULD BE ELIMINATED

The AMA continues to have serious concerns about the tactics being employed by hospitals in their attempts to eliminate competition by prohibiting physician referrals to specialty hospitals in which they have an ownership interest. The AMA believes that the growth in specialty hospitals is an appropriate market-based response to a mature health care delivery system and a logical response to incentives in the payment structure for certain services. This type of market response will create an incentive for general hospitals to increase efficiencies to compete. In fact, it already has. Specialty hospitals have admittedly been a "wake-up" call for general hospitals in certain communities.[23]

General hospitals are not suffering financially as a result of the growth of physician owned specialty hospitals. **MedPAC found that the financial impact on community hospitals in the markets where physician owned specialty hospitals are located has been limited.** These hospitals have demonstrated financial performance comparable to other community hospitals.[24] Another study found that general hospitals residing in markets with at least one specialty hospital actually have higher profit margins than those that do not compete with specialty hospitals.[25]

The cross-subsidies that hospitals use from profitable services to provide unprofitable services should be eliminated by making payments adequate for all services. The FTC, the DOJ, the Center for Studying Health System Change, and others believe there are inherent problems in using higher profits in certain areas of care to cross-subsidize uncompensated care and essential community services. In the July 2004 FTC/DOJ Report on Competition and Health Care, Recommendation 3 states:

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[22] GAO, *supra* note 2.
[23] MedPAC, "MedPAC Report to the Congress: Physician-Owned Specialty Hospitals," March 2005.
[24] *Id*.
[25] Schneider, et al., *supra* note 5.

> Governments should reexamine the role of subsidies in health-care markets in light of their inefficiencies and the potential to distort competition. Health-care markets have numerous cross subsidies and indirect subsidies. Competitive markets compete away the higher prices and profits needed to sustain such subsidies. Competition cannot provide resources to those who lack them, and it does not work well when providers are expected to use higher profits in certain areas to cross-subsidize uncompensated care. In general, it is more efficient to provide subsidies directly to those who should receive them to ensure transparency.[26]

Paul Ginsburg, president of the Center for Studying Health System Change offered the following theory at a recent conference on the topic of specialty hospitals:

> In a perfect world, competition might be the best system. But if you have a lot of market distortions, competition may not make you better off, and you have to decide either not to have the competition, or work on fixing the distortions.[27]

The AMA agrees and believes that pricing distortions that force hospitals to cross-subsidize should be eliminated so that competition can thrive. Cross-subsidization is not the appropriate method to fund community health and medical services. Support for specialty hospitals in no way diminishes the important role of the general hospital in the community. Emergency and safety net care are important and necessary aspects of hospital care. **To ensure that hospital payments better compensate for these services so that safety-net hospitals receive proper funding, HHS should make changes to the Medicare hospital prospective payment system to minimize the need for cross-subsidization and accurately reflect relative costs of hospital care.**

MedPAC recommends that CMS improve payment accuracy in the hospital inpatient prospective payment system (PPS) by refining the hospital Diagnosis Related Group (DRG) payments to more fully capture differences in severity of illness among patients, basing the DRG relative weights on the estimated cost of providing care rather than on charges, and basing the weights on the national average of hospitals' relative values in each DRG. MedPAC also recommends that DRG relative weights be adjusted to account for differences in the prevalence of high cost outlier cases.[28] The AMA supports such recommendations and believes that such payment changes will ensure full and fair competition in the market for hospital services.

The AMA also believes that further policy changes are necessary to ensure continued provision of uncompensated care and to protect America's public safety net hospitals. Nonprofit hospitals are exempt from federal and state income taxes and local property taxes and have access to tax-exempt financing to help support their provision of uncompensated

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[26] Federal Trade Commission and Department of Justice, *Improving Health Care: A Dose of Competition,* July 23, 2004.
[27] *Update Conference Report: Specialty Hospitals , Ambulatory Surgical Centers, and General Hospitals, Charting a Wise Public Policy Course*, Health Affairs (May/June 2005).
[28] See MedPAC, supra, note 23.

care to patients. Most nonprofit hospitals also receive Medicare and Medicaid Disproportionate Share Hospital (DSH) payments to help defray the costs of uncompensated care. Specialty hospitals, most of which are for-profit entities, provide support to the community in various other ways. In fact, according to findings from the CMS study, the total proportion of net revenue that specialty hospitals devote to both uncompensated care and taxes "significantly exceeds" the proportion of net revenues general hospitals devote to uncompensated care.[29]

Public hospitals in the largest metropolitan areas are considered key safety-net hospitals. These hospitals make up only about 2% of all the nation's hospitals, yet they provide more than 20% of all uncompensated care. Safety-net hospitals provide a significant level of care to low-income, uninsured, and/or vulnerable populations. Compared with other urban general hospitals, safety-net hospitals are nearly five times as likely to provide burn care, four times as likely to provide pediatric intensive care, and more than twice as likely to provide neonatal intensive care. Safety-net hospitals are also more likely than other urban general hospitals to offer HIV/AIDS services, crisis prevention, psychiatric emergency care, and other specialty care.

Safety-net hospitals rely on a variety of funding sources. However, to finance the significant portion of uncompensated care, safety-net hospitals rely on local or state government subsidies, Medicaid and Medicare DSH payments, cost shifting, and other programs. As a group, safety-net hospitals are in a precarious financial position because they are uniquely reliant on governmental sources of financing.

The AMA recognizes the special mission of public hospitals and supports federal financial assistance for such hospitals, and believes that where special consideration for public hospitals is justified in the form of national or state financial assistance, it should be implemented. **CMS should correct the flawed methodology for allocating DSH payments to help ensure the financial viability of safety-net hospitals so they can continue to provide access to health care for indigent patients.** In addition, the current reporting mechanism should be modified to accurately monitor the provision of care by hospitals to economically disadvantaged patients so that policies and programs targeted to support the safety net and the populations these hospitals serve can be reviewed for effectiveness. Medicare and Medicaid subsidies and contracts related to the care of economically disadvantaged patients should be sufficiently allocated to hospitals on the basis of their service to this population in order to prevent the loss of services provided by these facilities.

CONCLUSION

There is no evidence that general hospitals are suffering as a result of the growth of physician owned specialty hospitals. Specialty hospitals increase competition in the hospital industry and provide patients with more choice – forcing existing hospitals to innovate to keep consumers coming to them. This is a win-win situation for patients. Supporting health

[29] CMS, *supra* note 6.

delivery innovations that enhance the value of health care for patients is the only way to truly improve quality of care while reigning in health care costs.

Based on the MedPAC, CMS and FTC/DOJ findings and recommendations, the AMA recommends the following:

- **Patients will be better served if Congress does <u>not</u> act to extend the moratorium on physician referrals to specialty hospitals in which they have an ownership interest.**
- **CMS should make payment and policy changes outlined above to eliminate pricing distortions in the market for hospital services.**
- **While these payment and policy changes take effect, MedPAC, HHS and others should continue to monitor specialty hospitals and the impact on general hospitals and patient care, not stifle healthy competition.**

We appreciate the opportunity to testify on this important issue. We urge the Subcommittee and the Senate to consider the recommendations we have discussed today. We are happy to work with Congress as it considers these important matters.

Exhibit A

American Medical Association
March 8, 2005

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January 30, 2004

Aurora Medical Group has been using you and your group as a referral source for our patients with , for some time now. To date, we have been very pleased with the care you give our patients.

As Aurora Medical Group physicians, we are dedicated to Aurora Health Care and its efforts in Care Management and continuity of care. The employers we contract with have come to expect excellence in both of these areas. We have installed an extensive infrastructure so that we can deliver on our promise.

For these reasons, we expect you and your group to use Aurora facilities for all of our referrals. This includes, but is not limited to: outpatient surgery and procedures, all imaging and laboratory work, therapy, and inpatient admissions.

We would like our current relationship to continue, and we anticipate your full cooperation.

Sincerely,

Daniel J. Miota, D.O.
Metro Region Director of Medical Operations

February 3, 2004

Dear Member of the West Allis Memorial Hospital Medical Staff:

As you know, the WAMH Board of Directors recently voided the results of my election to be Chief of Internal Medicine at our hospital. I accepted the nomination for this office primarily to work with my colleagues to improve the care of our patients at our hospital. I wanted to let you know that my motivation and intentions have not changed. I will support our new department chief and remain committed to the physicians and patients at our hospital.

It is unfortunate that the WAMH administration has chosen to punish me because of my limited association with another hospital system. Aurora has not only dismissed me from leadership in the Medical Staff but has also removed me from all cardiology panels, directed my referrals to other cardiologists, interfered with long established professional relationships and has cancelled my lease for the office space, ending a relationship that has existed since my partner Gerry McInerney opened an office at our hospital in 1964.

Some of you may own your own offices, share in imaging centers, GI labs or outpatient surgical centers or have other financial interests which are independent of Aurora. These are legitimate business decisions. American Medical Association policy opposes economic credentialing by hospitals, which punishes members of a hospital staff for owning their own businesses or having independent financial interests.

I truly appreciate the support you have given. I have no intention of leaving our hospital and will continue to be available to see your patients at West Allis Memorial Hospital. As physicians, it is important that we not lose sight of our primary commitment to our patients.

Sincerely,

Lisa L. Armaganian, MD

Wisconsin Heart and Vascular Clinics, S.C.

Comprehensive Cardiac & Peripheral Vascular Medicine

2424 S. 90th St.
Suite 306
West Allis, WI 53227
414 328 8720
FAX 414 328 8724
Lisa L. Armaganian, M.D., F.A.C.C.

James F. King, M.D., F.A.C.C., F.S.C.A.I.
Jack C. Manley, M.D., F.A.C.C., F.S.C.A.I.
Gerald T. McInerney, M.D., F.A.C.C.
L. Samuel Wann, M.D., F.A.C.C.
Frank E. Cummins, M.D., F.A.C.C.
Charles K. Hellman, M.D., F.A.C.C.
Timothy Vaitkus, M.D., F.A.C.C., F.S.C.A.I.
T. Edward Hastings, D.O., F.A.C.C.
David K. Ashpole, M.D., F.A.C.C.
James T. Moran, M.D., F.A.C.C.
Krishna Kumar, M.D., F.A.C.C.
James B. Gossel, M.D.
Mark W. Mawissen, M.D.
Henry H. Gale, M.D., F.R.C.P. (C)
Gerald E. Auger, M.D.
Shirley Y. Higginbotham, M.D.

Brookfield
19475 West North Avenue
Suite 304
Brookfield, WI 53045
262 780 4400
FAX 414 398 8724

Burlington
249 McHenry St.
Burlington, WI 53105
262 767 3094
FAX 262 767 8095

Greenfield
4448 W. Loomis Rd.
Suite 302
Greenfield, WI 53220
414 281 0228
FAX 414 281 1593

Milwaukee – St. Luke's
2801 W. Kinnickinnic River Pkwy.
Suite 575
Milwaukee, WI 53215-3671
414 649 3593
FAX 414 649 8740

Milwaukee – St. Luke's
2801 W. Kinnickinnic River Pkwy.
Suites 512 & 514
Milwaukee, WI 53215
414 649 3580
FAX 414 649 8740

Sheboygan
2414 Kohler Memorial Dr.
Sheboygan, WI 53081
920 459 1440
FAX 920 459 1447

West Allis
2424 S. 90th St.
Suite 306
West Allis, WI 53227
414 328 8720
FAX 414 328 8724

Corporate Office
1087 Dennison Avenue Columbus, Ohio 43201-3201 (614) 544-5424 fax 544-5244 www.ohiohealth.com

December 17, 2003

On October 1, 2002, upon the recommendation of a task force comprised of community volunteers, physicians, and administrators, the OhioHealth Board adopted a policy that a physician who has a direct or indirect investment in a competing inpatient facility has a conflict of interest that precludes the physician from being eligible to apply for medical staff privileges at an OhioHealth hospital. In the case of a physician who currently has medical staff privileges at an OhioHealth hospital, the conflict causes a voluntary resignation of such privileges.

You are identified on the public website of the investor-owned New Albany Surgical Hospital as a "Founding Physician." The OhioHealth conflict of interest policy would apply not only to an investment by you personally, but also to an investment by your employer, business partner, family member or other economically related person. For your information I am enclosing the "Procedures to Implement Board Policy on Practitioner Conflicts of Interest" that includes applicable definitions.

Under the conflict of interest policy, NASH investors at OhioHealth hospitals resign their privileges effective after the New Albany Surgical Hospital begins inpatient operations. To permit affected physicians ample time to schedule surgeries appropriately and notify their patients, OhioHealth has determined to accept NASH-investor resignations at **11:00** P.M., Saturday, January 31, 2004.

Under the OhioHealth Board policy, there will be an appeal process from the initial determination on the issue of whether you have a direct or indirect investment.
The appeal guidelines are also enclosed. In light of the upcoming holiday season, we are modifying the timelines applicable to the appeal process. If you wish to file an appeal it must be received by OhioHealth's General Counsel by 12:00 noon December 29, 2003. The appeal hearings should be completed by January 22, 2004.

If there is additional information that you would like us to consider at this time, or if you decide to file an appeal, please forward it to the OhioHealth Sr. V .P. & General Counsel, Frank T. Pandora II, at 3722 Olentangy River Road, Suite K, Columbus, Ohio 43214.

On a personal basis, we regret that these circumstances have brought you within the purview of the Board's conflict of interest policy. OhioHealth values the contribution you and your colleagues have made in the past, and we are grateful for the care you give to patients at OhioHealth hospitals.

Very truly yours,

David P. Blom
President and Chief Executive Officer
OhioHealth

PHYSICIANS >> *Susanna Duff*

Not a team player

Maine cardiac center wants to limit docs to performing surgeries only at its facility

In the latest battle for profitable cardiac cases, a controversial physician contract for a Maine heart center slated to open next year has angered some local cardiologists and state officials.

Central Maine Medical Center in Lewiston plans to open a 16-bed cardiology center in April 2003, more than two years after winning certificate-of-need approval.

Local cardiologists may apply for privileges only if they agree in writing to not participate in a competing cardiac-surgery center. Central Maine Medical Center would not release a written copy of the contract it's asking physicians to sign.

Chuck Gill, spokesman for the 172-bed hospital, said the facility wants a dedicated team that will attract a steady stream of patients to pay for the approximately $6.5 million capital cost of the heart center, as required by its CON.

"You can't be on two teams at the same time," he said.

Representatives of Maine Medical Center in Portland, which operates one of two existing heart programs in the state, and some local cardiologists argue the policy amounts to "economic credentialing" because it dictates where physicians may admit patients. They claim the policy is a way to retaliate against opponents of the hospital's CON petition.

Weiss may no longer be able to treat patients at Central Maine Medical Center.

Economic credentialing is opposed by the American Medical Association, which defines it as the "use of economic criteria unrelated to quality of care or professional competency" in determining qualifications for hospital privileges.

Among the opponents was 560-bed Maine Medical Center, which annually performs more than 1,600 open-heart surgeries and 2,000 angioplasties.

"There is no need to have another cardiology center only 40 miles away. It is a duplicative program that doesn't improve access and quite likely raises costs,"

RESOLUTION OF THE BOARD OF DIRECTORS

OF

ST. JOHN'S MERCY HEALTH SYSTEM

WHEREAS, St. John's Mercy Health System ("SJMHS") owns and operates St. John's Mercy Hospital (the "Hospital"), a nonprofit, charitable hospital in Washington, Missouri;

WHEREAS, SJMHS is committed to meeting the health care needs of the community it serves (the "Community");

WHEREAS, the SJMHS Board of Directors has a duty to preserve and protect the health care charitable assets of the Hospital so that it may fulfill its charitable mission and its healthcare ministry in the Community;

WHEREAS, the recent growth in for-profit, physician-owned specialty hospitals and ambulatory surgery centers across the nation has raised concerns that such facilities and other similar physician-owned ventures are intended to divert patient care from general acute-care, charitable hospitals, thus eroding the financial viability of neighboring general hospitals, and impairing their ability to provide emergency care and other essential community services;

WHEREAS, the investment of physicians in specialty hospitals, ambulatory surgery centers or other limited-service Hospital competitors creates financial incentives that may inappropriately affect investing physicians' clinical and referral behavior;

WHEREAS, the Board of Directors believes that the creation of such specialty hospitals, ambulatory surgery centers, or other physician-owned competing ventures will seriously impair the ongoing charitable mission of the Hospital;

WHEREAS, based on requests from physicians and other Community members, SJMHS is planning to invest more than $18 million in the Hospital to enhance the delivery of patient care and provide needed capacity for healthcare in the Community;

WHEREAS, the Board of Directors believes that certain competing investments by medical staff members are incompatible with the mission of the Hospital and conflict with the Hospital's goals to (i) care for all patients, regardless of ability to pay; (ii) maintain quality programs and facilities, including those programs that cannot be operated at a profit but that are beneficial to the overall health of the Community; and (iii) maintain an adequate and dedicated work force to achieve those goals;

WHEREAS, the Board of Directors believes that certain competing investments by individual medical staff members made on or after January 1, 2004 may create an unacceptable physician-investor conflict of interest that threatens the continued existence of the Hospital in the Community;

WHEREAS, the Board of Directors has the obligation and the moral responsibility for privileging the Hospital's medical staff in the a manner that supports the quality and availability of care and the financial survival of the Hospital's facilities and its healthcare ministry; and

WHEREAS, after considering the opportunities to enhance and maintain the mission of the Hospital, SJMHS has concluded that affecting staff membership and privileges is the only viable way to protect the Community and the assets of this charitable Hospital from physician-investors conflicting interests.

NOW, THEREFORE, BE IT RESOLVED, that this Board adopts and approves the St. John's Mercy Hospital Conflict of Interest Policy ("Policy"), which is attached to and hereby incorporated in this Resolution of the Board.

FURTHER RESOLVED, that as required by the Policy, all applications for appointment or reappointment to the Medical Staff be accompanied by the Conflict of Interest Disclosure Statement and that any failure of an applying or reapplying physician to submit the Conflict of Interest Disclosure Statement will cause the application to be incomplete and incapable of being reviewed and approved;

FURTHER RESOLVED, that the Policy be communicated to all relevant Medical Staff members and that the importance of the Hospital's continuing care to the Community be included in such communication; and

FURTHER RESOLVED, that the appropriate officers of SJMHS be and hereby are authorized and directed to perform such acts as may be necessary or appropriate to effectuate the Policy and the foregoing resolutions.

IN THE CIRCUIT COURT OF PULASKI COUNTY, ARKANSAS
THIRTEENTH DIVISION

04 MAR 22 PM 3:55
CIRCUIT-COUNTY CLERK

BRUCE E. MURPHY, M.D.,
SCOTT L. BEAU, M.D.,
DAVID C. BAUMAN, M.D.,
D. ANDREW HENRY, M.D.,
DAVID M. MEGO, M.D., AND
WILLIAM A. ROLLEFSON, M.D. — PLAINTIFFS

VS. — NO. CV2004-2002

BAPTIST HEALTH — DEFENDANT

ORDER GRANTING PRELIMINARY INJUNCTION

On this day, comes before the Court the Plaintiffs' Motion for Temporary Restraining Order or Alternatively for Preliminary Injunction, and the Court, after reviewing all pleadings before it, doth find and order as follows:

Doctor Bruce Murphy and the other plaintiffs, all of them specialized heart doctors, have sued Baptist Health asking that Baptist be enjoined from preventing the doctors from practicing medicine at its hospitals. The court hereby grants the preliminary injunction that the doctors request.

STATEMENT OF THE CASE

Baptist Health adopted an Economic Conflict of Interest Policy (Economic Credentialing) in May, 2003. That policy mandates denial of initial or renewed professional staff appointments or clinical privileges at any Baptist Health hospital to any practitioner who, directly or indirectly, acquires or holds an ownership or investment interest in a competing hospital.

Baptist Health is a non-profit operation. Baptist and its board of trustees have a fiduciary duty to the community they serve. Baptist argues that it is only able to provide charity care if it can offset its loss with more profitable cases. James Harris, testifying in the federal court proceeding on behalf of Baptist stated,

> Maintaining a trauma center and emergency room for all hospitals is not a profitable line of service...but it's something we must do to fulfill the mission. Low birth weight babies, those are often difficult cases, and it's not a profitable line of service....another one is psychiatric care, which Baptist Health has continued to do, even though it's a very difficult issue statewide...

According to Baptist, Economic Credentialing was implemented to ensure long term viability and ability to provide such charity care.

Heart surgery and other expensive surgeries stand as high profit procedures for Baptist. The profits from these procedures are used to subsidize unprofitable operations at its hospitals.

Baptist, relying on *Mahan v. Avera St. Luke's*, 2001 S.D.9, 621 N.W.2d 150 (2001), asserts that it is in the best interest of the community that physicians who have an ownership interest in a competing hospital should not be extended privileges at Baptist facilities. The argument is that the physician's natural tendency would be to refer patients to the physician's hospital thereby jeopardizing the "charitable" activities of the enterprise to the detriment of the community. I cannot answer the question of whether the economic loss due to the "free" services is so great as to offset the revenue generated by Baptist's more lucrative activities.

Historically, all of the plaintiffs have been granted privileges by Baptist to practice in their hospitals. In March, 1997, the plaintiffs founded Arkansas Heart Hospital, which can compete with Baptist for patient referrals. Drs. Murphy and Beau were notified by Baptist Health that because of a violation of Baptist's Economic Credentialing, their privileges at Baptist Health hospitals would not be renewed effective February 26, 2004. The Plaintiffs first brought suit in federal court, however, the federal court dismissed their case for lack of jurisdiction.

The Plaintiffs filed their Motion for Temporary Restraining Order or Alternatively for Preliminary Injunction in this Court on February 25, 2004, stating that Baptist Health's policy of conditioning privileges to physicians based only on Economic Credentialing is contrary to the federal Anti-Kickback Statute, 42, U.S.C. §1320a-7b(b), the Arkansas Medicaid Fraud Act, ACA §5-55-111, the Arkansas Medicaid Fraud False Claims Act, ACA §20-77-902, and is contrary to public and

regulatory policy in violation of the Arkansas Deceptive Trade Practices Act, ACA § 4-88-101 *et seq.*

Under the Plaintiffs' interpretation of the facts in this case, Baptist's granting privileges to physicians is remuneration in exchange for possible referrals and is, therefore, a violation of the statutes cited above. The Plaintiffs allege that these acts of Baptist are contrary to the above-cited laws and interfere with the right of a patient to be admitted to a hospital and be treated by a doctor of his or her choice. Therefore, the Plaintiffs allege that Baptist's Economic Credentialing policy tortiously interferes with the Plaintiffs' relationships with their patients and tortiously interferes with the Plaintiffs' relationships with referring physicians.

In order to obtain a preliminary injunction, Plaintiffs' must prove under Rule 65 of the Arkansas Rules of Civil Procedure both irreparable harm to themselves and a likelihood of success on the merits. Plaintiffs allege that without an injunction, Baptist's enforcement of their policy will irreparably harm Plaintiffs in three ways: 1) by harming the doctor/patient relationship; 2) by causing irreparable harm to patients through inconsistent health care; and 3) by irreparably damaging the reputation of the Plaintiffs.

DISCUSSION

I. Irreparable Harm

1. The Doctor/Patient Relationship

The relationship of doctor-patient is unique. The loss of this relationship, even temporarily, causes irreparable damage to the doctor and the patient. There is no adequate remedy at law because the loss is a loss of a one-time opportunity.

Moreover, Arkansas Department of Health Rules and Regulations for Hospitals and Related Institutions in Arkansas, Section 5 (A)(10)states that. "The bylaws [of an institution] shall ensure admission of patients by a physician[,] patient choice of physician and/or dentist and emergency care by a physician." I interpret this to mean that an otherwise qualified doctor must be granted access to his patient for the purpose of treating his patient, if that is what both the doctor and patient want. Or, stated another way, a hospital cannot deny the services of a physician of the patient's choice if the hospital admits the patient and accepts the patient's insurance company or Health Maintenance Organization to cover any part

of the patient's hospital expenses.

2. The Harm to Patients through Inconsistent Healthcare

The physicians raise the possibility of having patients that cannot be referred to Arkansas Heart Hospital because the patient's insurance plan or health maintenance organization does not cover medical services provided at AHH or only provides coverage for services at a Baptist facility. The effect of Economic Credentialing therefore is to prevent a prospective or existing patient from being treated at the only facility available through insurance to them by the doctor of their choice, possibly resulting in inconsistent healthcare.

3. The Reputation of the Plaintiffs

Baptist states that the granting of the injunction requested by the doctors will harm Baptist's reputation because the only inference to be drawn is that Baptist has violated state and federal statutes. The doctors state that, on the other hand, in addition to the disruption to the doctor-patient privilege, their reputations will be harmed if they are not granted privileges or renewal of their privileges because the non-renewal must be disclosed to insurance companies and to other hospitals. A real possibility exists that the denial of privileges to a doctor on purely economic grounds would be interpreted by patients as reflective on the doctor's competency as a physician and disrupt the doctor-patient relationship. Both sides have valid points. However, the fracture of the doctor-patient relationship is paramount, and, therefore, the equities and public policy weigh in favor of the doctors.

II. Bar to Enjoining Criminal Activity

Baptist cites the bar to enjoining criminal activity. However, as the doctors point out, Justice Robert A. Leflar was quoted by the by the Arkansas Supreme Court in *Masterson v. State Ex Rel. Bryant*, 329 Ark. 443, 949 S.W.2d 63 at 64 (Ark. 1997), stating:

> That equity will not act to restrain ordinary violations of the criminal law, but will leave the task of enforcing the criminal laws to courts having criminal jurisdiction, is basic learning in our legal system. But it is equally

> basic that if grounds for equity jurisdiction exist in a given case, the fact that the act to be enjoined is incidentally violative of a criminal enactment will not preclude equity's action to enjoin it.

Baptist argues that Dr. Leflar went further in his analysis, stating that injunctions against criminal acts are sustained when the threat of punishment is not a deterrent, or because it is difficult to obtain a jury conviction. However, as pointed out by the Plaintiffs, Baptist would not voluntarily delay enacting its policy until the conclusion of the court proceedings, and apparently will not be deterred short of an injunction.

* * *

On all of these points, it appears likely that the plaintiffs will ultimately prevail at trial.

* * *

Therefore, it is hereby ordered and adjudged that until a full hearing on the merits of this case, defendants are enjoined from enforcing its Economic Credentialing policy against the plaintiffs and must grant them privileges at its hospitals if, but for the Economic Credentialing policy, the doctors meet the criteria for privileges.

IT IS SO ORDERED.

Collins Kilgore

COLLINS KILGORE

DATE MAR 2 2 2004

St. Rita's Medical Center

December 1, 2004

To All Medical Staff Members:

St. Rita's Medical Center Board of Trustees has approved the addition of a Financial Conflict of Interest policy to our Medical Staff Development Plan in an effort to strengthen relationships with committed and independent physicians who support our mission.

The policy, which is effective immediately, reserves medical staff membership and privileges for those physicians who can partner with us to advance hospital / community goals as well as insure patient choice of hospital/treatment facility. For example, staff members who have entered into employment agreements with competing health systems or whose medical practice is managed by a competing health system which results in material conflict of interest may not be eligible for appointment or reappointment to the medical staff.

Physicians who are impacted by the policy and have utilized Medical Center services can retain eligibility for staff status. The policy, which has been established by the Board of Trustees, asks for self-disclosure of relationships as part of the application process for appointment or reappointment to the medical staff.

The attached information is being provided to assist you in understanding this policy. If you have questions that remain unanswered, please do not hesitate to contact me (419.226.9100).

Sincerely,

Jim Reber
President and CEO

ST. RITA'S MEDICAL CENTER

FINANCIAL CONFLICT OF INTEREST CREDENTIALING POLICY

DATE ADOPTED: September 24, 2004

POLICY

A. Prohibition Against Material Financial Relationships

It is the policy of St. Rita's Medical Center ("SRMC") to prohibit members of SRMC's Medical Staff from having a material financial relationship with any health care system or hospital (or an entity controlled by a health care system or hospital) or any other provider of health care services (i.e., an ASC, a physician group practice, an IDTF, or a clinical lab) not affiliated with SRMC that competes with SRMC. All members of the Medical Staff and applicants for appointment or reappointment to the Medical Staff are required to disclose to SRMC all material financial relationships.

All applicants for appointment or reappointment to SRMC's Medical Staff shall fully and truthfully complete the Conflict of Interest Questionnaire attached to this policy disclosing all material financial relationships to SRMC. If an applicant for appointment or reappointment to the Medical Staff is determined to have a material financial relationship with any health care system or hospital (or an entity controlled by a health care system or hospital) or any other provider of health care services not affiliated with SRMC that competes with SRMC, such applicant's application for appointment or reappointment to the Medical Staff of SRMC may be denied.

All individuals on the Medical Staff of SRMC shall have a duty to supplement the attached Conflict of Interest Questionnaire attached to this policy within fifteen (15) days of the adoption of this policy or entering into a material financial relationship. If an individual currently on the Medical Staff of SRMC currently has or enters into a material financial relationship with any health care system or hospital (or an entity controlled by a health care system or hospital) or any other provider of health care services not affiliated with SRMC that competes with SRMC during the term of his/her appointment to the Medical Staff of SRMC his/her Medical Staff privileges and/or membership appointment may be revoked immediately. Revocation of Medical Staff privileges and/or membership appointment for violation of this policy is not an event reportable to the National Practitioner Data Bank.

B. Definition of Material Financial Relationships

For purposes of this policy a material financial relationship shall include, but is not limited to the following:

(1) *Employment Relationship*: An employment relationship with a hospital or health care system (or an entity controlled by a health care system or hospital) or any other health care provider not affiliated with SRMC that competes with SRMC.

(2) *Independent Contractor Relationship*: An independent contractor relationship (such as paid medical director, paid consultant or income guarantee) whereby the individual receives more than de minimis compensation from a hospital or health care system (or an entity controlled by a health care system or hospital) or any other health care provider not affiliated with SRMC that competes with SRMC. An individual providing services on an infrequent basis will not be deemed to have such a material financial relationship.

(3) *Contractual Relationship*: A contractual relationship pursuant to which an individual's professional practice or the professional practice employing the individual is managed by a health care system or hospital (or an entity controlled by a health care system or hospital) not affiliated with SRMC.

(4) *Investment Interest*: Holding a partnership interest, membership interest, shareholder interest or other ownership or investment interest directly or through a group practice in any hospital or health care system (or an entity controlled by a health care system or hospital) or any other health care provider not affiliated with SRMC that competes with SRMC

Membership alone on the medical staff of another hospital or health care system not affiliated with SRMC is not a material financial relationship for purposes of this policy.

C. Exceptions

The Chief Executive Officer of SRMC may grant individual exceptions to this policy prohibiting members of the Medical Staff from having a material financial relationship with a health care system or hospital (or an entity controlled by a health care system or hospital) or any other provider of health care services not affiliated with SRMC that competes with SRMC. In determining whether or not to grant an exception to this policy the factors to be considered shall include, but shall not be limited to, community need, availability of services, scope of the conflict, and staffing needs for effective operation of SRMC. The reasons for such exceptions will be documented in writing and the benefits accruing to SRMC must sufficiently outweigh the risks presented by the conflict of interest caused by the material financial relationship present between the practitioner and the competing health care entity.

October 25, 2004
The Medical Executive Committee
Lawwood Regional Medical Center,
Fort Pierce, Florida

To Whom It May Concern,

This letter is to document why I have chosen to resign my position at Lawnwood Pavilion. I have concerns about my authority to make clinical decisions regarding patient care, and feel that I have been pressured to pursue treatment for patients that is financially rewarding to the hospital, but not necessarily in the patient's best interest. My concerns became more apparent when it was implied that my employment at the hospital was conditional on my agreement to proceed with Electroconvulsive therapy in the future.

Electroconvulsive therapy can be beneficial to some patients, but in my opinion it should be the treatment of last resort and should not be used without careful analysis of the risks and benefits. Since I felt threatened when I made a decision to hold on proceeding with ECT (Electroconvulsive Therapy) training, I had serious concerns about my authority to decide who would be a good candidate for this therapy. Furthermore, those who were pressuring me to obtain ECT training for future use were not physicians and not responsible for the well being of the patient. I feel this situation has several conflicts of interest and ethical considerations that could potentially harm patients.

It was therefore necessary for me to submit my letter of resignation effective sixty days from October 21, 2004 pursuant to Paragraph 3.2 of the Employment Agreement dated April 1, 2004 between Lawnwood Medical Center, Inc. and Ed Jackson, M.D. I believe that Lawnwood Medical Center, Inc. has clearly violated the provisions of Paragraph 11 of the referenced agreement "Patient Care" by failing to allow me to exercise complete control over the treatment of patients. I would, however, like to thank my colleagues in Psychiatry and in the Medical Executive Committee for their support and guidance.

Sincerely,

Ed Jackson MD

Ed Jackson M.D.

ARTICLE II

GUIDELINES FOR EVALUATING CANDIDATES FOR PRIVILEGES IN OPEN SPECIALTIES

A. Mission

Eastern Idaho Regional Medical Center is committed to providing to the community a full range of health care services of the highest quality. This mission is furthered by the selection and retention of qualified practitioners on the medical staff who share the Medical Center's mission. Specifically, in furtherance of this mission, the Medical Center seeks:

(1) To select and retain qualified practitioners who are:

(a) able to provide timely care to their patients;

(b) committed to care for all Medical Center patients, regardless of their ability to pay;

(c) committed to utilize the Medical Center's facilities to the fullest extent possible consistent with sound medical judgment and their patients' medical needs, so as to permit the ongoing monitoring and evaluation of their practices; and

(d) willing to make an active commitment to assist the Medical Center in continually overseeing and improving the Medical Center's facilities and services;

(2) To have appropriate facilities and equipment and ensure that they are used efficiently and cost-effectively by selecting and retaining only those clinically competent practitioners who intend to use them appropriately; and

(3) To continually monitor the quality of the services that the Medical Center provides.

B. Threshold Criteria

Only those applicants who satisfy the following threshold criteria shall be eligible for medical staff appointment and clinical privileges at Eastern Idaho Regional Medical

Center.

(1) The applicant must have an unrestricted Idaho license and federal DEA number and Idaho controlled substance registration (if needed to practice in his or her specialty).

(2) The applicant must be willing and able to provide timely care to his or her patients, as defined in bylaws, policies or rules and regulations.

(3) The applicant must have professional liability insurance coverage in form and amounts that are satisfactory to the Medical Center and no unusual malpractice litigation history.

(4) The applicant must be board certified by the appropriate board of the American Board of Medical Specialties,[1] the American Board of Oral and Maxillofacial Surgery, or the American Board of Podiatric Surgery, or have completed the educational and clinical requirements for an application for certification in his or her specialty to be accepted by one of those boards and be working toward board certification. If the applicant is not board certified at the time of the initial inquiry, board certification must be obtained within five years of the completion of the educational and clinical requirements in order for the individual to be eligible to apply for appointment or reappointment and clinical privileges.

(5) The applicant must possess excellent professional credentials. As a threshold, the individual must demonstrate:

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[1]The equivalent of certification by the American Board of Medical Specialties may also be considered. Equivalency should be measured by the education, training and experience required to take the examination, as well as the comprehensiveness of the examination process. This requirement does not apply to current members of the medical staff. Practitioners currently maintaining membership on the medical staff and applying for re-application must demonstrate current competence in their respective fields, ability to perform the clinical privileges requested and an adherence to the standards of character and ethics established in their respective professions. Any qualification requirements in this article or any other article of this plan not required by law or by governmental regulation may be waived at the discretion of the medical center and the Board of Trustees upon recommendation of the Executive Committee, upon determination that such waiver shall serve the best interests of the patients at the medical center.

(a) a reputation for good character and ethical practice, as well as an ability to work cooperatively and harmoniously with others;

(b) no history of criminal conviction nor disciplinary action by any licensure board or government agency; and

(c) no history of disciplinary action or revocation, suspension or restriction of clinical privileges at this Medical Center or any other Medical Center.

(6) The applicant must be willing to actively utilize the Medical Center's facilities so as to permit reasonable monitoring and evaluation of his/her practice in accordance with the Medical Center's quality assessment/performance improvement plan and JCAHO standards, and to promote and ensure familiarity with the Medical Center's facilities and practices.

(7) The applicant must disclose if s/he has a contract, employment or investment interest with an entity that would cause his or her financial interests to be substantially in conflict with the Medical Center's commitment to the community or provide a significant economic incentive for the practitioner to refer patients to other facilities or otherwise discriminate against the Medical Center in the referral of patients for reasons unrelated to patient preference or medical needs. The Medical Center will utilize the process detailed in Section C of this Article to request this information from the applicant.

(8) Applicants must be willing to have a full-time practice in the Medical Center's service area. A full-time practice shall be defined to be a minimum of 40 weeks per year and a minimum of three days per week.[2]

(9) The applicant must satisfy all of the specialty-specific criteria that exist in the specialty in which he or she wishes to practice.

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[2]This threshold criterion does not apply when the Medical Staff Development Plan indicates that a specialty is open for someone other than a full-time practitioner and the potential applicant seeks to fill such an opening.

(10) If an initial applicant is determined to be ineligible for appointment, his or her application shall not be processed and appointment will not be granted. If an applicant for reappointment is determined to be ineligible for reappointment, his or her current medical staff appointment shall continue until its natural expiration.

(11) A determination of ineligibility to seek initial appointment and clinical privileges shall not be considered an adverse professional review action, and shall not be subject to the hearing and appeal provisions under the Appointment Policy nor considered a denial of appointment. Similarly, such a determination shall not be reportable to the National Practitioner Data Bank or the State Medical Board.

(12) Nothing in this Medical Staff Development Plan or in the Medical Staff Bylaws requires the Board of Trustees to grant privileges to a physician who satisfies the minimum criteria set forth in this Plan or in the Medical Staff Bylaws.

C. <u>Credentialing Physicians with Competing Interests</u>

(1) During the pre-application, application, or re-application process, a copy of these criteria shall be provided to all applicants and they will be asked to indicate whether or not they have a financial relationship with or concerning, or an investment interest in, a Competing Entity.[3] If the applicant replies in the affirmative, s/he shall be required to supply appropriate information concerning that financial relationship or investment interest (hereinafter "Financial Relationship") to the Board. Failure to provide relevant information to the Medical Center will result in the application being deemed incomplete. Incomplete applications will not be processed. The purpose of

[3]The term "competing entity" means any competing facility, hospital, provider/payor organization or its affiliated organizations with which a practitioner has a compensation arrangement or an investment interest.

the information will be to assist the Board in determining whether the Financial Relationship is significant and is inconsistent with, or detrimental to, the interests of the Medical Center.

(2) The Board, or a designated subcommittee, shall review the information collected pursuant to the above provisions to determine the implementation of the provisions of Article II, Part C, Section 3.

(a) If the Board, or its subcommittee, makes the determination that the applicant has a significant economic conflict, it shall notify the individual that the applicant is not eligible to vote or to hold leadership positions as described in Article II, Part C, Section 3.

(b) If the Board is unable to reach a definitive decision about whether the applicant has a significant conflict or if the Board determines that an applicant who is already a member of the Medical Staff of the Medical Center and is re-applying for medical staff appointment and clinical privileges has a significant conflict, it may specify that appointment and clinical privileges are subject to the following terms:

(i) any person who resides within the Medical Center's primary service area and is in need of services available at the Medical Center, inpatient or outpatient, will not be referred by the physician to the Medical Center or to a Competing Entity solely on the basis of economic incentives resulting from the physician's Financial Relationship with a Competing Entity. Referrals to a Competing Entity that are unrelated to patient preference, specific medical needs, or third party payor requirements will be presumed to be motivated by the physician's Financial Relationship with the Competing Entity;

(ii) prior to referring any patient to another facility, the physician will advise the patient of whether the same or similar services

are available at the Medical Center;

(c) Noncompliance with any of the above terms will be deemed to constitute a voluntary and unilateral relinquishment of appointment and clinical privileges by the physician.

(3) Practitioners who are appointed to the medical staff having a Financial Relationship with a Competing Entity are subject to the following terms:

(a) Such practitioners are ineligible to vote or hold office or serve as chairperson of any clinical department or medical staff committee for as long as the Financial Relationship with the Competing Entity exists. If an applicant for reappointment has already been elected or appointed to a leadership position for his or her next term of appointment, or has already begun to serve a term as an elected or appointed officer or committee member, s/he shall be considered to have voluntarily resigned that position as of the effective date of the Financial Relationship with the Competing Entity.

(b) Such practitioners may be assigned to take ER and service call[4] by the decision of the Board or by the decision of the administration of the Hospital in accordance with Medical Center policy. The call schedule is the property of the Medical Center. Service on the call roster is an obligation, not a privilege. The call service is intended to serve the best interests of patients in the community by providing round-the-clock response to patients' emergent medical needs. The call roster is not a physician referral service and is not to be treated as such. It is the policy of this Medical Center to treat each patient arriving at the

[4]The call schedule is a list of medical staff physicians who are on call for duty in three situations: (1) if the emergency department needs specialized assistance in determining if an emergency medical condition exists; (2) if an emergency condition exists and the Medical Center needs an on call physician to assist in treating the patient; and (3) if a Medical Center patient is in need of specialized assistance in the course of their care and treatment.

ER as having made a choice to receive treatment at this Medical Center. Practitioners serving on the call roster are expected to observe this policy.

If the Board determines that a practitioner is using the call roster to divert patients to other facilities for reasons related to that practitioner's financial or other gain, it may, in its discretion, remove that practitioner from the call list. Since service on the call list is not a clinical privilege or a benefit of medical staff appointment, such a determination shall not implicate the hearing and appeal provisions under the Appointment Policy or be considered a denial of appointment.

(c) If the Board determines by objective criteria that a practitioner is diverting patients to other facilities for reasons related to that practitioner's financial or other gain, it may, in its discretion, remove that practitioner's appointment and clinical privileges.

(d) Upon a Board determination that a practitioner has diverted patients consistent with the above terms, that practitioner will be deemed to have voluntarily and unilaterally relinquished his appointment and clinical privileges.

(4) To avoid the possibility of ineligibility for medical staff leadership or participation on the ER or service call schedule, an applicant may provide the Board with a letter of intent, prior to entering into any Financial Relationship, that describes his or her intended Financial Relationship with an entity that may compete with the Medical Center. The Board will review the letter and request additional information, if necessary or helpful. The Board will provide the applicant with a response as to whether the arrangement would constitute a Financial Relationship with a Competing Entity.

(5) If after application and before re-application a physician acquires a financial

relationship with or concerning, or an investment interest in, a competing entity, the physician shall within thirty (30) days advise the Board of Trustees of such fact and provide to the Board of Trustees the necessary information concerning that financial relationship or investment interest.

ARTICLE III

GUIDELINES FOR DETERMINING NEED FOR ADDITIONAL FRACTITIONERS ON AN ANNUAL BASIS AS AN EXTENSION OF THE MEDICAL CENTER'S LONG-RANGE PLANNING PROCESS

A. Each determination shall be based on the Medical Center's need or plan to:

(1) provide better or more comprehensive services;

(2) promote the efficient utilization of its facilities; and

(3) enhance its financial viability and thus its ability to serve.

(4) determine what new services should be offered;

(5) determine what services should be phased out;

(6) determine what services should be expanded or reduced;

(7) determine what additional specialties are needed; and

(8) determine what geographic or demographic areas should be served.

B. The reports and information provided by each department chief are critical to the periodic reevaluation of practitioner utilization and medical staffing needs. The Medical Staff Development Committee or its designated representative shall solicit information from time to time from each department chief regarding Medical Center and patient needs. Information sought from each department chief will relate not only to his or her department, but to perceived needs within the Medical Center and community generally.

C. Active Staff practitioners shall be surveyed periodically to determine their views on services needed, current utilization of facilities and medical staffing needs.

D. The Chief Executive Officer of the Medical Center or his designee shall report