June 1, 2015

Rep. Kevin Brady
Chairman
House Ways and Means Health Subcommittee
301 Cannon Senate Office Building
United States House of Representatives
Washington, DC 20515

Rep. Jim McDermott
Ranking Member
House Ways and Means Health Subcommittee
1035 Longworth House Office Building
United States House of Representatives
Washington, DC 20515

Dear Chairman Brady and Ranking Member McDermott:

On behalf of over 48,000 members of the American Association of Nurse Anesthetists (AANA), I am writing to thank you for holding the first of several hearings **on improving Medicare access through increased competition. Advanced practice registered nurses (APRNs), including Certified Registered Nurse Anesthetists (CRNAs),** practicing to the full scope of their training and expertise ensures patient safety and access to safe, high-quality care, and promotes healthcare cost savings as well as increased competition in the healthcare marketplace and the Medicare program. **For your consideration, we are** enclosing a synopsis of two letters the AANA submitted to the Federal Trade Commission regarding their workshops on ''Examining Health Care Competition'' for further information.

Current reimbursement structures in Medicare impede full practice by CRNAs and add to waste in the program. Medicare reimburses CRNAs and anesthesiologists at the same rate for the same high quality service -- 100 percent of a fee for providing non-medically directed (CRNA) or personally performed (anesthesiologist) services. Medicare also operates a payment system for "anesthesiologist medical direction"[1] that provides a financial incentive for anesthesiologists to "medically direct" CRNAs who are already directly providing patient access to high quality anesthesia care themselves as part of the surgical team caring for the patient. The Centers for Medicare & Medicaid Services (CMS) has stated that medical direction is a condition of payment of anesthesiologist services and not a quality standard.[2] An anesthesiologist claiming medical direction services may be reimbursed 50 percent of a fee in each of up to four concurrent cases that the physician "medically directs", totaling 200 percent over a given period of time, twice what the anesthesiologist may claim when personally performing anesthesia services in one case. Under medical direction, the CRNA may claim the remaining 50 percent of a fee for his or her case. Peer-reviewed evidence demonstrates anesthesiologist medical direction increases healthcare costs without improving value.[3]

Furthermore, current Medicare regulations[4] contain a costly and unnecessary requirement for physician supervision of CRNA anesthesia services that do not support delivery of health care in a manner that allows states and healthcare

[1] 42 CFR §415.110. http://www.ecfr.gov/cgi-bin/text-idx?SID=5ce8cb6375c7d5c22c454c7ec1fe07de&node=42:3.0.1.1.2&rgn=div5#42:3.0.1.1.2.3.1.4
[2] 63 FR 58813, November 2, 1998, http://www.gpo.gov/fdsys/pkg/FR-1998-11-02/pdf/98-29181.pdf .
[3] P. Hogan et. al, "Cost Effectiveness Analysis of Anesthesia Providers." Nursing Economic$. 2010; 28:159-169. http://www.aana.com/resources2/research/Documents/nec_mj_10_hogan.pdf
[4] 42 CFR 482.52(a)(4) for hospitals (see http://www.ecfr.gov/cgi-bin/text-idx?SID=04387f6850fa030cb817311427be6f5f&mc=true&node=se42.5.482_152&rgn=div8), 42 CFR 485.639 (c) for CAHs (see

facilities nationwide to make their own decisions based on state laws and patient needs. These requirements are more restrictive than the majority of state laws and impede local communities from implementing the most innovative and competitive model of providing quality care. Given the growing population of persons in the United States requiring healthcare, particularly among Medicare eligible populations, physician supervision requirements stand in the way of deploying the vast workforce contained with the supply of APRNs. Unnecessary requirements for physician supervision of APRNs contribute to duplication and waste in the healthcare delivery system. Scientific peer-reviewed research underscores that such supervision does not affect quality or outcomes and increases healthcare costs and also illustrates how CRNAs consistently deliver safe, high-quality, cost-effective anesthesia care.[5]

CRNAs play a vital role in ensuring access to safe, high quality and cost effective anesthesia care. Congress and Medicare may advance patient access to care, reduce healthcare costs and waste in the Medicare program, while promoting competition, by eliminating policy barriers to the full use of CRNAs. We look forward to working with you on this important issue and should the Committee have any questions, please contact the AANA Senior Director of Federal Government Affairs, Frank Purcell, at 202.484.8400, fpurcell@aanadc.com.

Sincerely,

Sharon P. Pearce, CRNA, MSN
President

Attached: Addendum I: AANA Comments to Federal Trade Commission Health Care Workshop Request for Comment

http://www.ecfr.gov/cgi-bin/text-idx?SID=04387f6850fa030cb817311427be6f5f&mc=true&node=se42.5.485_1639&rgn=div8), and 42 CFR 416.42 (b)(2)for ASCs (see http://www.ecfr.gov/cgi-bin/text-idx?SID=8198c35c58c98715100eb32ff0046536&mc=true&node=se42.3.416_142&rgn=div8) .

[5] See American Association of Nurse Anesthetists, CRNAs: The Future of Anesthesia Care Today, http://www.future-of-anesthesia-care-today.com/research.php, and Christopher J. Conover and Robert Richards, "Economic Benefits of Less Restrictive Regulation of Advanced Practice Registered Nurses in North Carolina: An Analysis of Local and Statewide Effects on Business Activity, Duke University, February 2015, available at: http://chpir.org/wp-content/uploads/2015/02/Report-Final-Version.pdf.

Addendum I

The following comments were submitted in response to FTC Health Care Workshop, Project No. P131207 on March 10, 2014 and FTC Health Care Workshop, Project No. P13-1207 on February 16, 2015.

The AANA provided the FTC Health Care Workshop content covering the following areas:

I. Background of the AANA and Certified Registered Nurse Anesthetists (CRNAs)
II. Alternatives to Traditional Fee-for-Service Payment Models
III. Provider Network and Benefit Design
IV. Professional regulation of healthcare providers
V. Measuring and assessing quality of care
VI. Price transparency of healthcare services.

The content was composed so that each section could be read and considered independently by each workshop panel, therefore some material was repeated throughout the subject areas.

I. BACKGROUND OF THE AANA AND CRNAs

The AANA is the professional association for CRNAs and student nurse anesthetists. AANA membership includes more than 48,000 CRNAs and student registered nurse anesthetists representing over 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) and anesthesia professionals who safely administer more than 38 million anesthetics to patients each year in the United States, according to the 2012 AANA Practice Profile Survey. Nurse anesthetists have provided anesthesia care to patients in the U.S. for over 150 years, and high quality, cost effective and safe CRNA services continue to be in high demand. CRNAs are Medicare Part B providers and since 1989, have billed Medicare directly for 100 percent of the physician fee schedule amount for services.

CRNAs practice in every setting in which anesthesia is delivered: traditional hospital surgical suites and obstetrical delivery rooms; critical access hospitals; ambulatory surgical centers; the offices of dentists, podiatrists, ophthalmologists, plastic surgeons, and pain management specialists; and U.S. military, Public Health Services, and Department of Veterans Affairs healthcare facilities. CRNA services include providing a pre-anesthetic assessment, obtaining informed consent for anesthesia administration, developing a plan for anesthesia administration, administering the anesthetic, monitoring and interpreting the patient's vital signs, and managing the patient throughout the surgery. CRNAs also provide acute and chronic pain management services. CRNAs provide anesthesia for a wide variety of surgical cases and are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities.

Peer-reviewed scientific literature shows CRNA services ensure patient safety and access to high-quality care, and promote healthcare cost savings. According to a May/June 2010 study published in the journal of *Nursing Economic$*, CRNAs acting as the sole anesthesia provider are the most cost-effective model for anesthesia delivery, and there is no measurable difference in the quality of care between CRNAs and other anesthesia providers or by anesthesia delivery model.[i] Furthermore, an August 2010 study published in *Health Affairs* shows no differences in patient outcomes when anesthesia services are provided by CRNAs, physicians, or CRNAs supervised by physicians.[ii] Researchers studying anesthesia safety found no differences in care between nurse anesthetists and physician anesthesiologists based on an exhaustive analysis of research literature published in the United States and around the world, according to a scientific literature review prepared by the Cochrane Collaboration.[iii]

According to a 2007 Government Accountability Office (GAO) study, CRNAs are the predominant anesthesia provider where there are more Medicare beneficiaries and where the gap between Medicare and private pay is less.[iv] Nurse anesthesia predominates in Veterans Hospitals, the U.S. Armed Forces and Public Health Service. CRNAs work in every setting in which anesthesia is delivered including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers (ASCs), pain management facilities and the offices of dentists, podiatrists, and all types of specialty surgeons. As colleagues and competitors in the provision of anesthesia and pain management services, CRNAs and anesthesiologists have long been considered substitutes in the delivery of surgeries.[v]

In its landmark publication *The Future of Nursing: Leading Change, Advancing Health*, the Institute of Medicine made its first recommendation that advanced practice registered nurses (APRNs) such as CRNAs be authorized to practice to their

full scope, in the interest of patient access to quality care, and in the interest of competition to help promote innovation and control healthcare price growth.[vi]

II. ALTERNATIVES TO TRADITIONAL FEE-FOR-SERVICE PAYMENT MODEL

The AANA supports the FTC's efforts to better understand the potential benefits of alternative payment models and whether they can offer significant cost savings while maintaining, or helping to improve, quality of care. Under the current fee-for-service model, there are instances where the current model contributes to high costs without improving quality. Similar to general physician payment, Medicare reimburses CRNAs and anesthesiologists the same rate for the same high quality service -- 100 percent of a fee for providing non-medically directed (CRNA) or personally performed (anesthesiologist) services. It also includes a system for "anesthesiologist medical direction"[vii] that provides a financial incentive for anesthesiologists to "medically direct" CRNAs who are capable of and are often providing patient access to high quality anesthesia care unassisted. An anesthesiologist claiming medical direction services may be reimbursed 50 percent of a fee in each of up to four concurrent cases, a total of 200 percent over a given period of time, twice what the anesthesiologist may claim when personally performing anesthesia services in one case. Under medical direction, the CRNA may claim the remaining 50 percent of a fee for his or her case. Peer-reviewed evidence demonstrates anesthesiologist medical direction increases healthcare costs without improving value.[viii] Furthermore, the Centers for Medicare & Medicaid Services (CMS) has stated that medical direction is a condition of payment of anesthesiologist services and not a quality standard.[ix]

In demonstrating the increased costs, suppose that there are four identical cases: (a) has anesthesia delivered by a non-medically directed CRNA; (b) has anesthesia delivered by a CRNA medically directed at a 4:1 ratio by a physician overseeing four simultaneous cases and attesting fulfillment of the seven conditions of medical direction in each; (c) has anesthesia delivered by a CRNA medically directed at a 2:1 ratio; and (d) has anesthesia delivered by a physician personally performing the anesthesia service. (There are instances where more than one anesthesia professional is warranted; however, neither patient acuity nor case complexity is a part of the regulatory determination for medically directed services. The literature demonstrates that the quality of medically directed vs. non-medically directed CRNA services is indistinguishable in terms of patient outcomes, quality and safety.) Further suppose that the annual pay of the anesthesia professionals approximate national market conditions, $170,000 for the CRNA[x] and $540,314 for the anesthesiologist.[xi] Under the Medicare program and most private payment systems, practice modalities (a), (b), (c) and (d) are reimbursed the same. Moreover, the literature indicates the quality of medically directed vs. non-medically directed CRNA services is indistinguishable. However, the annualized labor costs (excluding benefits) for each modality vary widely. The annualized cost of practice modality (a) equals $170,000 per year. For case (b), it is ($170,000 + (0.25 x $540,314) or $305,079 per year. For case (c) it is ($170,000 + (0.50 x $540,314) or $440,157 per year. Finally, for case (d), the annualized cost equals $540,314 per year.

Anesthesia Payment Model	FTEs / Case	Clinician costs per year / FTE
(a) CRNA Nonmedically Directed	1.00	$170,000
(b) Medical Direction 1:4	1.25	$305,079
(c) Medical Direction 1:2	1.50	$440,157
(d) Anesthesiologist Only	1.00	$540,314
Anesthesiologist mean annual pay	*$540,314*	*MGMA, 2014*
CRNA mean annual pay	*$170,000*	*AANA, 2014*

If Medicare and private plans pay the same rate whether the care is delivered according to modalities (a), (b), (c) or (d), someone in the health system is bearing the additional cost of the medical direction service authorized under the Medicare regulations at 42 CFR §415.110. This additional cost is shifted onto hospitals and other healthcare facilities, and ultimately to patients, premium payers and taxpayers. With CRNAs providing over 38 million anesthetics in the U.S., and a considerable fraction of them being "medically directed," the additional costs of this medical direction service are substantial. In addition, the most recent peer-reviewed literature makes clear that the requirements of anesthesiologist medical direction are often not met in practice– and if anesthesiologists submit claims to Medicare for medical direction but did not perform all of the required services in each instance, then the likelihood of widespread Medicare fraud in this area is high. Lapses in anesthesiologist supervision of CRNAs are common even when an anesthesiologist is medically directing as few as two CRNAs, according to an important new study published in the journal *Anesthesiology*.[xii]

Another factor driving up the cost of healthcare under the current fee-for-service model is the practice of hospital subsidization of anesthesiology groups, in which hospitals pay high compensation to anesthesiology groups to offset the shortfall from decreasing reimbursement to these anesthesiology groups. According a nationwide survey of anesthesiology group subsidies,[xiii] hospitals pay an average of $160,096 per anesthetizing location to anesthesiology groups, an increase of 13 percent since the previous survey in 2008. An astounding 98.8 percent of responding hospitals in this national survey reported that they paid an anesthesiology group subsidy. Translated into concrete terms, a hospital with 20 operating rooms pays an average of $3.2 million in anesthesiology subsidy. Such payments from hospitals to anesthesiology groups do not appear on hospitals' Medicare cost reports or their billings to health plans, making information about them hard to come by except from survey information. Anesthesiology groups receive this payment from hospitals in addition to their direct professional billing. Without question, such subsidy payments to anesthesiology groups represent cost-shifting away from other critical services within the healthcare delivery system.

As the FTC examines the merits of alternative payment systems, we recommend ensuring that these alternatives are in the best interests of the patients receiving care, that they encourage improvements in patient care quality and efficiency, and that the alternative payment systems have been developed and deployed in a manner that healthcare professionals deem as valid.

Alternative payment systems should recognize and reward all qualified healthcare providers, not just physicians, for ensuring patient access to safe, cost-effective healthcare services. Bundled payment systems can reward care coordination and cost-efficiency, but without an equal and crucial focus on quality such systems can lead to a harmful "race to the bottom" when incentives to cut costs are not balanced with quality standards – an outcome that must be avoided. Bundled payment systems should recognize the full range of qualified healthcare providers delivering care, including CRNAs and other APRNs, and avoid physician-centricity that increases costs without improving quality or access.

Alternative payment models, such as bundled payment, have the potential to drive value-based healthcare delivery, particularly in anesthesia care and related services, and meet the triple health care aims of improving patient experience of care, improving population health and reducing health care costs. But certain alternative payment models do not follow these goals and instead lead to higher healthcare costs and decreased access to safe, high quality anesthesia providers such as CRNAs. One type of payment model that does not drive value-based healthcare delivery can be found in large group practices composed solely of anesthesiologists. Holding substantial market power, these large anesthesiologist-only group practices enter into exclusive single source contract service agreements with health systems, facilities and surgeons where the group practice's market power increases costs, limits choice of anesthesia provider, and imposes opportunity costs that deprive resources from delivery of other critical healthcare services. Such enterprises may use their market power to maximize their income without relation to the actual costs of performing the procedure.[xiv] For example, according to the New York Times, a patient was billed $8,675 for anesthesia during cardiac surgery. The anesthesia group accepted $6,970 from United Healthcare, $5,208.01 from Blue Cross and Blue Shield, $1,605.29 from Medicare and $797.50 from Medicaid.[xv] This type of model drives up healthcare costs and puts additional economic strain on consumers and the country.

III. PROVIDER NETWORK AND BENEFIT DESIGN

We have found that in some states, health plan networks operating in exchanges and in the private market conduct discriminatory behaviors based on provider licensure which violates the provider nondiscrimination provision in the Affordable Care Act and inhibits CRNAs' ability to practice to full extent of their scope of practice. The end result of these practices is increased healthcare costs, diminished competition and reduced patient choice for safe, high quality and cost-effective anesthesia and related services.

The federal provider nondiscrimination provision in the Patient Protection and Affordable Care Act (Sec. 1201, Subpart 1, creating a new Public Health Service Act Sec. 2706(a), "Non-Discrimination in Health Care, 42 USC §300gg-5),[xvi] which took effect January 1, 2014, states that "a group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any healthcare provider who is acting within the scope of that provider's license or certification under applicable State law." It also states that, "nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures."

Section 2706 is an important law because it promotes competition, consumer choice and high quality healthcare by prohibiting discrimination based on provider licensure that keeps patients from getting the care they need. To promote

patient access to high quality healthcare, market competition and cost efficiency, health insurance exchanges, health insurers and health plans must avoid discrimination against qualified, licensed healthcare professionals, such as CRNAs, solely on the basis of licensure. Proper implementation of the provider nondiscrimination provision is crucial because health plans have wide latitude to determine the quantity, type, and geographic location of healthcare professionals they include in their networks, based on the needs their enrollees. However, when health plans organize their healthcare delivery in such a way that they discriminate against whole classes of qualified licensed healthcare professionals by licensure -- by prohibiting reimbursement for anesthesia and pain management services provided by CRNAs, for example -- patient access to care is impaired, consumer choice suffers, and healthcare costs climb for lack of competition.

The provider nondiscrimination provision also respects local control and autonomy in the organization of healthcare delivery systems, health plans and benefits. It does not impose "any willing provider" requirements on health plans, and it does not prevent group health plans or health insurance issuers from establishing varying reimbursement rates based on quality or performance measures.

Types and Examples of Provider Discrimination

The AANA believes it is discrimination if health plans or health insurers have a policy that reimburses differently for the same services provided by different provider types solely on account of their licensure. Medicare reimburses CRNAs directly for their services and does so at 100 percent of the physician fee schedule amount for services, the same rate as physicians for the same services. The Omnibus Budget Reconciliation Act (OBRA) of 1986 authorized direct reimbursement of CRNA services under Medicare Part B beginning in 1989.[xvii] The Medicare regulation implementing the OBRA law, updated as part of a November 2012 final rule further clarifying the authorization of direct reimbursement of nurse anesthesia services within the provider's state scope of practice,[xviii] states, "Medicare Part B pays for anesthesia services and related care furnished by a certified registered nurse anesthetist who is legally authorized to perform the services by the State in which the services are furnished."[xix] The final rule also states, "Anesthesia and related care means those services that a certified registered nurse anesthetist is legally authorized to perform in the state in which the services are furnished." The agency also said in the rule's preamble, "In addition, we agree with commenters that the primary responsibility for establishing the scope of services CRNAs are sufficiently trained and, thus, should be authorized to furnish, resides with the states."[xx] Therefore, the Medicare agency stands on solid ground in clarifying that the nondiscrimination provision should apply to private plans in a way that is consistent with Medicare direct reimbursement of CRNA services where they are allowed to furnish those services under state law.

Unfortunately, we have heard from our members who state that certain health plans and insurers across the United States have policies that discriminate against CRNAs. In many of these cases, health plans or insurers either do not reimburse CRNAs at all for anesthesia services that are fully reimbursed when performed by anesthesiologists, or they reimburse CRNAs at a lower rate than anesthesiologists for performing the same services. For example, effective November 1, 2013, Regence Blue Shield of Idaho lowered CRNA reimbursement by 15 percent for anesthesia services. Its new policy states, "Physician conversion factor is $55.10. Certified Registered Nurse Anesthetist conversion factor is $46.84."[xxi] When justifying its rationale for setting the reimbursement rates for all non-physician healthcare providers, including CRNAs, at 85 percent of the physician rate, Regence stated in a letter to a CRNA that the decision was in part "based on the difference in education, training and scope of practice" between physician and non-physician providers. Regence did not identify any differences in "quality or performance measures" to explain the reimbursement differential. As we have shown above, the literature is clear in showing that no quality outcomes difference can be found between the models of CRNA anesthesia care, anesthesiologist services, or both professionals providing anesthesia care together.

If a health plan or health insurer network offers a specific covered service, Section 2706 requires that the health insurer or health plan network include all types of qualified licensed providers who can offer that service. If a health plan offers coverage for anesthesia services, it should allow all anesthesia provider types to participate in their networks and should not refuse to contract with CRNAs just based on their licensure alone. For example, as of April 2012, Blue Cross Blue Shield of South Carolina states in its anesthesia guidelines policy manual that it will not reimburse CRNAs for monitored anesthesia care (MAC), but it will pay anesthesiologists for these same services.[xxii] Specifically the policy states, "BlueCross may reimburse for modifiers QS, G8 and G9 if a physician personally performs the procedure (modifier AA) and if the procedure meets medical necessity criteria. BlueCross will not reimburse CRNAs for MAC."[xxiii]

The AANA views all of these policies outlined above as examples of discrimination against CRNAs based on their licensure and not based on CRNA quality and performance, and such discrimination clearly is prohibited by Section 2706. These policies impair patient access to care provided by CRNAs, and they expressly impair competition and choice, and

contribute to unjustifiably higher healthcare costs without improving quality or access to care. The negative impacts of provider discrimination can hit rural communities hardest, where CRNAs are the primary anesthesia professionals and often the sole anesthesia providers. The availability of CRNAs in rural America enables hospitals and other healthcare facilities to offer obstetrical, surgical, and trauma stabilization services to patients who otherwise might be forced to travel long distances for these essential care. As stated above, CRNAs have been providing safe and high-quality anesthesia care in the United States for 150 years and the AANA is a determined advocate for patients and CRNAs concerning issues such as access to quality healthcare services and patient safety.

We believe proper implementation of the provider nondiscrimination provision by preventing health plans and health insurers from discriminating against specific types of health providers, such as CRNAs, will ensure full access to anesthesia services and to the procedures and services that they make possible, efficient delivery and local management and optimization of these services, and equitable reimbursement for CRNA services based on quality and performance, rather than licensure. This is consistent with the FTC's and the public's interests in quality, access and cost-effectiveness. Ensuring that health plans and health insurers adhere to the provider nondiscrimination law will protect competition and patient choice and promote patient access to a range of beneficial, safe, and cost-efficient healthcare services, such as those provided by CRNAs.

IV. PROFESSIONAL REGULATION OF HEALTHCARE PROVIDERS

Several constraints in the legislative, regulatory, and practice arenas inhibit CRNAs' ability to practice to full extent of their scope, reducing competition and choice and increasing healthcare costs. CRNAs' ability to practice to their full scope is also affected by Medicare regulations associated with Medicare Part A Conditions of Participation and Conditions for Coverage (CoPs and CfCs). The Medicare CoPs and CfCs are federal regulations with which particular healthcare facilities must comply in order to participate in the Medicare program. While these regulations directly apply to facilities, they affect CRNA practice and impair competition and choice. In particular, the requirement for physician supervision of CRNA services is costly and unnecessary.[xxiv] This requirement is more restrictive than the majority of state laws and impedes local communities from implementing the most innovative and competitive model of providing quality care. Reforming the CfCs and the CoPs to eliminate the costly and unnecessary requirement for physician supervision of CRNA anesthesia services supports delivery of health care in a manner allowing states and healthcare facilities nationwide to make their own decisions based on state laws and patient needs, thus controlling cost, providing access and delivering quality care.

Though one common argument for additional regulation is to protect public safety, there is no evidence that physician supervision of CRNAs improves patient safety or quality of care. In fact, there is strong and compelling data showing that physician supervision does not have any impact on quality, and may restrict access and increase cost. Studies have repeatedly demonstrated the high quality of nurse anesthesia care, and a 2010 study published in *Health Affairs*[xxv] led researchers to recommend that costly and duplicative supervision requirements for CRNAs be eliminated. Examining Medicare records from 1999-2005, the study compared anesthesia outcomes in 14 states that opted-out of the Medicare physician supervision requirement for CRNAs with those that did not opt out. (To date, 17 states have opted-out.) The researchers found that anesthesia has continued to become safer in opt-out and non-opt-out states alike. In reviewing the study, the *New York Times* stated, "In the long run, there could also be savings to the health care system if nurses delivered more of the care."[xxvi]

Another restriction in the Part A CfC regulations impairs CRNAs' ability to evaluate the risk of anesthesia in ambulatory surgical centers (ASCs), which again constrains competition and choice and increases healthcare costs without improving quality. Performing the comprehensive preanesthetic assessment and evaluation of the risk of anesthesia is within the scope of practice of a CRNA.[xxvii] We have asked that CMS recognize CRNAs as authorized to evaluate the risk of anesthesia immediately before a surgical procedure performed in an ASC in the same manner that the agency recognizes both CRNAs and physicians conducting the final pre-anesthetic assessment of risk for a patient in the hospital. In actual practice, CRNAs evaluate patients preoperatively for anesthesia risk in the ASC environment. The CRNA has a duty to do so, consistent with Standard 1 of the Standards for Nurse Anesthesia Practice.[xxviii] The current ASC rule on preanesthesia examination is inconsistent with ASC rules regarding patient discharge, and with Medicare hospital CoPs in this same area. Under the hospital CoPs for anesthesia services (42 CFR§ 482.52 (b) (1)), CRNAs are recognized to perform the pre-anesthesia evaluation for hospital patients presenting with a greater range of complexity and multiple chronic conditions than ASC patients.

Yet another restrictive regulation in the CoPs is the requirement that a physician serve as the director of anesthesia

services. This requirement places regulatory burdens on hospitals where they need to pay a stipend for a physician "in name only" to serve as director of the anesthesia department instead of allowing the hospital to have the flexibility to retain those services if they so desired. In some cases, the existing regulation leads to confusion by placing into the hands of persons inexpert in anesthesia care a federal regulatory responsibility for directing the unified anesthesia service of a hospital solely because he or she is a doctor of medicine or of osteopathy. In other cases, the hospital may contract with and pay a stipend to an anesthesiologist for department administration only, solely because there is a federal regulation. There is no evidence supporting the requirement for a physician or osteopathic doctor to direct anesthesia services. Again, such a regulation impairs choice and competition, and increases healthcare costs without improving quality.

Constraints in the legislative, regulatory, and practice arena can ultimately result in anticompetitive practices and collusion, increasing healthcare costs and diminishing quality of care and patient choice. In the early 2000s, the FTC and DOJ conducted two years of hearings on healthcare and antitrust, yielding a landmark joint report entitled *Improving Health Care: A Dose of Competition.*[xxix] More recently, the IOM report entitled *The Future of Nursing: Leading Change, Advancing Health*[xxx] specifically recommended that the FTC examine how anticompetitive acts, such as limiting APRNs like CRNAs from providing care to the fullest extent of their education and skill, reduce patient choice and increase healthcare costs without improving quality.

On the state level, the staff of the FTC's Office of Policy Planning, Bureau of Economics, and Bureau of Competition has submitted comment letters in response to proposed bills and a proposed rule that, if adopted, would impact the scope of practice of CRNAs and advanced practice nurses. In these letters, the FTC discouraged unnecessary restrictions on CRNA practice[xxxi] and supported eliminating requirements that advanced practice nurses collaborate with, or be supervised by, physicians.[xxxii]

The FTC has warned that unnecessary legislative or regulatory restrictions on CRNA pain management practice, if adopted, could reduce competition, raise the prices of pain management services, reduce the availability of these services, especially for the most vulnerable patients, and discourage healthcare innovation in this area. [xxxiii] Allowing CRNAs to practice to the full scope of their training and expertise in all areas of their practice will increase competition in the healthcare marketplace, as reflected by the FTC's own assessment of the competitive impact of various bills and proposed rules relating to regulatory restrictions on advanced practice nurses.

The FTC submitted letters commenting on restrictive pain management bills in Tennessee (2011), Missouri (2012) and Illinois (2013) respectively, expressing significant concern about overbroad state proposals that would prohibit or unduly restrict CRNA pain management practice, thereby raising prices and reducing availability of CRNA services.[xxxiv] In Tennessee and Missouri, the bills ultimately passed; however, the FTC comment letters generated discussion amongst the legislators and were cited during hearings. CRNAs utilized these letters as educational tools with legislators and as references during negotiations for more acceptable and less restrictive bill language. In Illinois, a restrictive pain management bill stalled at the committee level in 2013; a similar, revised restrictive pain management bill was introduced in Illinois in 2014 and is currently pending.[xxxv] The CRNAs are using the FTC's 2013 comment letter on the previous Illinois pain management bill in their efforts to educate legislators on the anti-competitive impacts of the bill.

In addition, the FTC commented favorably on bills in Connecticut (2013) and Massachusetts (2014) that proposed eliminating unnecessary restrictions on advanced practice registered nurses (APRNs).[xxxvi] The FTC stated that eliminating the requirement that APRNs have collaborative agreements with physicians in order to practice independently could benefit Connecticut health care consumers by expanding choices for patients, containing costs, and improving access to primary health care services (note that this collaborative agreement requirement does not apply to CRNAs).

V. PRICE TRANSPARENCY OF HEALTHCARE SERVICES

Anesthesia pricing is among the most opaque in all of healthcare, impairing competition and innovation. The medical direction payment model, in which an anesthesiologist performs seven specific tasks in each of up to four concurrent cases in exchange for 50 percent of a Medicare anesthesia fee, the CRNA providing the anesthesia service claiming the other 50 percent[xxxvii], is unique in healthcare, fails to fairly or accurately reflect the services provided to patients by each professional, and contributes significantly to healthcare cost growth. When a hospital employs CRNAs, and contracts with an anesthesiology group to provide anesthesiologist services, it is not uncommon for patients and plans to receive two bills for anesthesia services – or to learn, unpleasantly, that the anesthesiologist group is outside of the plan's network and demands full payment directly. The medical direction payment model introduces high costs of additional personnel that are not required to deliver an anesthesia service safely and effectively.

On account of the medical direction payment model, it is increasingly common that billings for anesthesia services do not represent all anesthesia costs in the system. One factor driving up the cost of healthcare is the practice of hospital subsidization of anesthesiology groups, in which hospitals pay high compensation to anesthesiology groups to offset the shortfall from decreasing reimbursement to these anesthesiology groups. According a nationwide survey of anesthesiology group subsidies,[xxxviii] hospitals pay an average of $160,096 per anesthetizing location to anesthesiology groups, an increase of 13 percent since the previous survey in 2008. An astounding 98.8 percent of responding hospitals in this national survey reported that they paid an anesthesiology group subsidy. Translated into concrete terms, a hospital with 20 operating rooms hospital pays an average of $3.2 million in anesthesiology subsidy. Anesthesiology groups receive this payment from hospitals in addition to their direct professional billing.

The agency also asked for examples where price transparency might facilitate price coordination among healthcare providers thereby damaging competition. Some anesthesia groups establish single source contracts with hospitals and healthcare facilities and the anesthesiology group does not negotiate with health plans. The group bills the patient directly for specific procedures, resulting in high out of pocket costs for the patient and curbing competition that could give patients more choices that may be less expensive.[xxxix] This type of model uses economic incentives and to drive up healthcare costs, while putting economic strains on consumers.

XI. MEASURING AND ASSESSING QUALITY OF HEALTH CARE

As we have stated previously, peer-reviewed scientific literature shows CRNA services ensure patient safety and access to high-quality care, and promote healthcare cost savings. According to a May/June 2010 study published in the journal of *Nursing Economic$*, CRNAs acting as the sole anesthesia provider are the most cost-effective model for anesthesia delivery, and there is no measurable difference in the quality of care between CRNAs and other anesthesia providers or by anesthesia delivery model.[xl] Furthermore, an August 2010 study published in *Health Affairs* shows no differences in patient outcomes when anesthesia services are provided by CRNAs, physicians, or CRNAs supervised by physicians.[xli]

In three significant aspects, Medicare billing modalities tend to significantly underrepresent the contributions that CRNAs and other APRNs make to healthcare delivery. In the field of anesthesia, billing services as "medically directed" suggests that in such cases anesthesiologists have performed each of the seven medical direction steps for which medical direction reimbursement is claimed. According to AANA member surveys and more importantly the American Society of Anesthesiologists journal *Anesthesiology*, medical direction frequently lapses[xlii] and one or more of the "medical direction" services are actually performed by the CRNA, just as they are performed when a service is billed nonmedically directed. Second, in many fields, the services of CRNAs, APRNs and other healthcare providers are frequently billed "incident-to" the services of a physician. Under "incident-to," the claim is paid at 100 percent, and the claim indicates that the service was provided by the physician not the CRNA or other APRN, without providing any modifier indicating who actually performed the service. "Incident-to" drives substantial underrepresentation of APRN services when claims data undergo examination. Last, not all Medicare Part B services provided by CRNAs are billed through Medicare Part B. In qualifying rural hospitals, Medicare Part A reimburses for the "reasonable cost" of CRNA services through a pass-through payment to the hospital. The CRNA may not bill Part B for services that the hospital bills Medicare through Part A. With CRNA services predominating in rural America, and many CRNA services noted not in Part B claims but embedded in Part A cost reports, ordinary Part B claims data underrepresents the anesthesia and pain management services CRNAs provide, particularly in rural and frontier parts of the United States.

With respect to registries, we strongly recommend that the infrastructure for quality reporting be accessible and transparent, particularly when it drives incentive payments from public benefit programs. Current registry procedures raise serious concerns about their accuracy and reliability with respect to reporting CRNA service provision. Under many registry practice rules the services that CRNAs and APRNs provide are often kept from being reported to registries organized and managed by medical specialty societies. When APRN services and data are reportable, the terms for participation and data submission are different from those that medical specialty society registries extend to physicians. In some cases physician organizations charge exorbitant fees for non-guild members to enroll in a registry, which is prohibitive to advanced practice nursing groups' participation. In this way, registries developed in response to public policy promoting healthcare quality may instead be used to justify illegitimate protection of guilds, higher healthcare costs, less competition and reduced access to care.

The FTC asked for a description of any challenges that are encountered when measuring quality. The AANA remains concerned over the use of EHR reporting, especially when CRNAs and other APRNs are ineligible for EHR incentives,

and note that this is a barrier to reporting of quality measures. We understand that the HITECH Act[xliii] did not include CRNAs as an "Eligible Professional," thus making them ineligible for incentive payments. However, CRNAs are "eligible professionals" under the Physician Quality Reporting System (PQRS) who regularly report quality measures and are eligible for incentive payments under that program. The AANA remains concerned that CRNAs must not be penalized in Medicare payment or in eligibility for PQRS incentives simply because they are currently ineligible for the EHR incentive program. We note that CMS seems to assume that CRNAs and other healthcare professionals will rely on the facilities where they work in order to adopt this technology. However, whole categories of healthcare facilities, such as ambulatory surgical centers (ASCs), are also ineligible for EHR incentive programs. Multiple levels of ineligibility cause an additional obstacle for providers, such as CRNAs, to have access to this technology in order to report quality measures electronically. Furthermore, the AANA is concerned that as CMS moves from claims based reporting to solely reporting through EHR-based reporting systems and through clinical registries, information on CRNAs will be underreported. As CMS expands the quality measures that can be reported through an EHR and ultimately ends the way that CRNAs predominately report measures, healthcare professionals such as CRNAs are at risk for being penalized and being placed at a disadvantage if they do not have access to report through a qualified EHR.

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[xvi] Patient Protection and Affordable Care Act, Sec. 1201, Subpart 1, creating a new Public Health Service Act Sec. 2706(a), Non-Discrimination in Healthcare (42 U.S.C. §.300gg-5). The statutory provision reads as follows: "(a) Providers.--A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any healthcare provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any healthcare provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures."

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

INTRODUCTION:

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

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

OBJECTIVE:

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

ADVANCED SURGICAL HOSPITAL:

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

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

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

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

QUALITY OF CARE AND ACCOMPLISHMENTS:

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

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

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

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

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

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

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

LOWER COSTS:

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

EMERGENCY CARE PROCESSES:

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

CONCLUSION:

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

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

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

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

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

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

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

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

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

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

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

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

Respectfully submitted,
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Statement for the Record

House Ways and Means Health Subcommittee

Chairman Kevin Brady (R-TX) and Ranking Member Jim McDermott (D-WA)

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

May 19, 2015

Good Morning. My name is Michael Torn and I am currently the CEO of Edgewood Surgical Hospital (ESH) a physician-owned, surgical hospital in Transfer, PA. I have been in this role for seven years and have over 20 years of experience in various leadership roles of Hospital Administration; in both for-profit and non-profit entities. I would like to thank Chairman Kevin Brady, Ranking Member Jim McDermott and the other members of the subcommittee for this opportunity to provide input on the important issue of changing the Affordable Care Act (ACA), improving competition and expanding access to quality healthcare.

In my professional opinion, it is crucial that we take this opportunity to end the discrimination against physician-owned hospitals which is legislated in the ACA. We desperately need to improve competition and increase access to quality health care in all areas of the country, but especially here in Western Pennsylvania. I believe an effective starting point would be to abolish the ACA and allow physician ownership of specialty hospitals again.

A project funded by the Centers for Medicare and Medicaid Services (CMS) found the following:

- Although the policy debate tends to focus on specialty hospitals' possible "unfair" competitive advantage, we found that they actually stimulate a competitive environment in some markets, which could have positive effects on quality of care. Cardiac specialty hospitals in general, and orthopedic specialty hospitals in small markets in particular, heightened local competition for patients.
- Patient satisfaction among Medicare beneficiaries treated in specialty hospitals was very high. Contrary to allegations made by competing hospitals, we found very little evidence of poor quality of care in specialty hospitals relative to community hospitals; instead, we found many instances of high-quality care that should be encouraged. Physicians'

commitment to and pride in their specialty hospitals are powerful positive forces that critics have underappreciated. http://content.healthaffairs.org/content/25/1/106.full

Sadly, the lobbying influence for the largest health systems has attempted to cover the reality of what is happening in our communities. Once patients see a physician that is employed by a hospital system, they lose the ability to choose a physician that is not affiliated with that system. For example, if they see a UPMC physician and need a referral to a specialist, they will only be referred to a specialist within the UPMC system. This is unfortunate because many people do not have the time or the means to travel at least 60 miles to Pittsburgh to receive care.

We cannot utilize the same tactics that created the problem to start with. To decrease costs and deliver a higher quality of care, we must allow for competition in the arena of healthcare. If we continue with the status quo, these mega-hospital systems will eliminate choice all together.

At ESH, we have 50 physicians on staff; only 17 are owners. We have been open for 11 years. In 2014, ESH paid $95,000 in property and school taxes. Our Financial Classes are:

Medicare	36%
Medicaid	5%
Commercial	48%
Workers Comp	3%
Self-Pay	8%

We are the only hospital in the region that has partnered with Primary Health Network, a Federal Qualifying Health Center [FQHC] to help them improve access for low-income patients to receive high quality care at a lower cost. The large local non-profit hospital has not partnered with them or made concessions for those who are financially challenged.

It is unfathomable that the ACA would discriminate against physician-owned hospitals. When you or your loved ones must go to a hospital, terms such as "profit", "non-profit" or "physician owned" don't matter. What does matter is receiving the highest quality of care at the most affordable price. It's not the size, shape or ownership structure that makes a hospital – it's the care. Plain and simple, Edgewood is providing higher quality of care at a lesser cost.

Edgewood Surgical Hospital:

- ✓ ***Lowest infection rate in the Valley***
- ✓ ***Highest patient satisfaction rates in the Valley***
- ✓ ***Lowest patient-to-nurse ratio in the Valley***

Other sources, such as Medicare, **Patient Satisfaction Scores HCAHPS:** (Hospital Consumer Assessment of Healthcare Providers and Systems) indicate that Edgewood consistently has the highest patient satisfaction scores in our region.

Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)

- ***Edgewood Surgical Hospital*** **92%**
- Sharon Regional Health system **65%**
- UPMC Horizon **62%**
- Jameson Memorial Hospital **52%**

Payors, such as Highmark, have started publishing the reimbursement cost of various diagnostic and surgical procedures. ESH continues to demonstrate that we can provide higher quality at a lower cost as demonstrated below.

Knee Replacement Surgery

(COST TO INSURANCE COMPANY AND/OR PATIENT)

EDGEWOOD SURGICAL HOSPITAL	SHARON REGIONAL HEALTH SYSTEM	UPMC HORIZON
$13,766 - $15,216	$17,911 - $19,797	$18,831 - $20,813

MRI of Lower Back without Contrast

EDGEWOOD SURGICAL HOSPITAL	SHARON REGIONAL HEALTH SYSTEM	UPMC HORIZON
$362 - $420	$615 - $679	$924 - $1,022

When I accepted the position of CEO in 2008, Edgewood was focused on growth and expansion and improving health care in this underserved community. Expansion plans for services and facilities were on the drawing board when the ACA came to pass. That brought everything to a halt and we were restricted from further growth. With the ACA in place, we have had to change our focus, and we cannot provide the range of services that we would like to for our community. However, if the ACA was lifted, we could change our direction and get back to growing our facilities and services.

Again, I would like to thank you for allowing me the opportunity to address this crucial issue that is interfering with the welfare of many of the members of our community. According to The Federal Trade Commission, "Competition in health care markets benefits consumers because it helps contain costs, improve quality, and encourage innovation." I couldn't agree more - if we want to do what is best for our patients, families, and community, we must change the laws oppressing physician-owned hospitals. It is time to get rid of the ACA, improve competition and expand access to healthcare.

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

Chairman Ryan and Subcommittee members, thank you for the opportunity to share testimony on the matter you weigh in this hearing. My name is David Lippert, and I am the Managing Member of Fresno Surgical Hospital (FSH) located in California. I am one of seven members which comprise the ownership of Physicians Surgery Centers, LLC, a minority owner and active management company for Fresno Surgical Hospital.

It is my desire to ensure that our facility, and those like it, is afforded the ability to continue to exist and grow as performance based markets would dictate.

Fresno Surgery Center was originally founded in 1984 as a physician owned ambulatory surgery center. Our center immediately rose in prominence based on the surgical outcomes, patient and physician satisfaction. In 1993 Fresno Surgical Hospital was licensed as an acute care hospital taking its quality of care to those surgical patients who needed care beyond the capability of an ambulatory surgery center. Over the years many market drivers have shaped and shifted the way that Fresno Surgical Hospital cared for our community, but none quite as drastically as the prohibitions laid out in the Affordable Care Act (ACA).

In the years leading up to the enactment of the ACA, FSH had achieved highest marks from many industry score keepers and demand by patients, insurers and physicians created the need to expand. This expansion would have allowed FSH to build an intensive care unit (ICU) along with additional inpatient beds and supporting facilities. Upon the enactment of the ACA the construction project had to be changed allowing only for the design improvements of operating rooms and patient beds currently in existence in 2010. FSH decided to enclose the structure that was slated to house the ICU and additional beds in hopes that it could at some point be filled. For many years now the second story shell of FSH has sat empty, in a region that CMS and the California Department of Health Services determined to have a looming hospital bed shortage.

While FSH continues to serve the broader community, it cannot do so to the extent that it, and the public it serves, would like. Currently 40% of the patients seen at FSH are Medicare or Medi-Cal (California Medicaid) participants. While the Hospital often loses money on these patients we consider it part of caring for the broader community, and do so with pride. With the current expansion prohibitions in place, patients have no choice but to go to other hospitals in the

region which have higher infection rates, worse outcome ratios, higher re-admission rates and cost patients, insurers and Medicare more money.

Approximately half of our admitting surgeons have no financial interest in FSH, but prefer to care for their patients at our facility based on outcomes, satisfaction and cost savings. All things equal, we simply do a better job at delivering better outcomes at lower prices than the large hospital systems. The increased transparency and data required under the ACA have borne this out.

Thank you for the opportunity to provide this testimony and for considering it in your evaluation of this proposed legislation.

Sincerely,

S. David Lippert
Managing Member, Fresno Surgical Hospital
6125 N. Fresno Street
Fresno, CA 93710
Cell (805) 701-3890 fax (559) 431-8242
david@psc-asc.com

Improving Competition in the Medicare Program by Lowering Supervision Levels and Creating Independent CMS Billing Code for Radiologist Assistants

By: Jason Leymeister MS,RRA

A Radiologist Assistant (RA) is a midlevel healthcare provider, similar to a physician assistant or nurse practitioner, which provides services to patients in the Radiology sector of healthcare. An RA is a registered radiologist assistant (R.R.A.) that is nationally certified by the American Registry of Radiologic Technologists (ARRT). The RA is currently licensed in 29 states and growing. They work under the supervision of a Physician at all times and do not prescribe or offer diagnosis on their own accord. The RA saves time and money by performing exams and minor procedures for the Radiologist. This allows the Radiologist to offer a more focused and better quality interpretation of imaging studies therefore reducing the number of missed diagnosis.

The reduction of supervision levels and independent CMS billing number would instantly save millions a year in Medicare payouts. These savings will continuously accumulate into the billions in only a short amount of time.

The solutions for these problems are as follows:

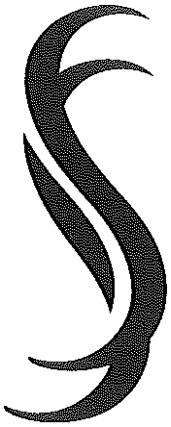
Reducing levels of supervision by amending the current Medicare laws to include:

- *Defines the term "advanced level radiographer" to be RAs who perform radiologic procedures under the supervision of a radiologist.*

- *Provides that state law governs the Medicare physician supervision requirements for advanced level radiographers. It allows states to determine appropriate radiologist supervision levels and scope of practice for radiologist assistants. Medicare will only reimburse for procedures that the state determines is within the radiologist assistant's clinical competency.*

Create an independent billing code for RA's in CMS:

- *Have congress strongly recommend that CMS create a fast track or pilot program.*



LAFAYETTE SURGICAL
SPECIALTY HOSPITAL
— PROUDLY PHYSICIAN OWNED —

June 2, 2015

The Honorable Kevin Brady
Chairman
Ways and Means Subcommittee on Health
U.S. House of Representatives
1102 Longworth House Office Building
Washington, D.C. 20515

The Honorable James McDermott
Ranking Member
Ways and Means Subcommittee on Health
U.S. House of Representatives
II 02 Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Brady and Ranking Member McDermott,

Chairman Brady, Ranking Member McDermott, members of the subcommittee, allow me to introduce myself. I am Thomas V. Betiuccini, MD, FACS, MBA, a practicing neurosurgeon in practice over 30 years in my community, Lafayette, LA. I am a founding member of Lafayette Surgical Specialty Hospital (LSSH), a hospital owned by physicians and our corporate partner, National Surgical Healthcare. I also serve on the Board of Directors of Physician Hospitals of America and am a former Chairman of the LSSH Board of Directors. I recognized and experienced the exemplary patient care this hospital model offers through professional and legislative activities during conceptualization and development of physician owned hospitals in Louisiana and across the country.

Physician ownership and focused patient care are not new health care models and have been successful since the mid twentieth century. The concept reemerged a dozen years ago or so as physicians grew increasingly frustrated and discouraged by the ineptitude, indifference and sclerotic bureaucracy of large community hospitals which failed to improve conditions, environment and care for patients for decades. Physicians were never allowed to have a substantive voice or influence in decisions affecting care despite endless serious attempts to do so.

The overwhelming success of physician owned hospitals (POHs) relative to care, outcomes and cost alone justifies legislative support of this model, without restriction, and at least passage of HR 976 and HR 2513 currently under consideration. Numerous independent CMS and other government agencies repeatedly show the superiority of this approach to patient care. Criticisms by our competitors are simply without merit when the facts are examined in an unbiased manner. As our second U.S. President reminded us: "Facts are stubborn things…"

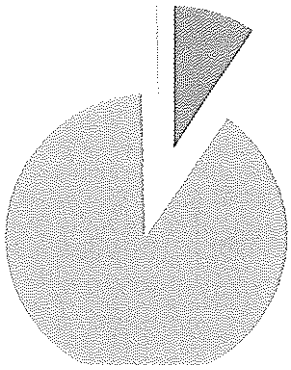
There is a bipmiisan suppmi for HR 976 as legislators recognize the benefits to patient care and communities in states where physician owned hospitals exist. Their careful analyses of the issues and statistics, discussions with physicians and administrative staff and hospital visits have surprised many; but all understand the value created by this innovative, competitive indushy and the importance the involvement of the men and women who know medicine and patient care best --- physicians.

Our Story

Lafayette Surgical Specialty Hospital (LSSH) is a 20-bed, 74,000 square foot physician-owned hospital located in Lafayette, LA. LSSH is a pmtnership of National Surgical Healthcare (NSH) and 34 individual physician investors. The Joint Commission accredited hospital consists of eight operating rooms and three procedure rooms where approximately 8,000 cases are performed annually. Since its inception in 2004, LSSH has been recognized as a state-of-the-art patient-focused facility that embraces specialized technology and equipment. The facility provides a wide scope of services including Neurosurgery, Orthopedics, ENT, General Surgery, Urology, Gynecology, Cosmetic Surgery, Bariatric Surgery, Pain Management, and Imaging and Diagnostic services.

LSSH is proud to maintain Joint Commission Accreditation year after year. This means that they continuously demonstrate safe, high-quality care, as determined by compliance with Joint Commission standards and National Patient Safety Goals. This deemed status accreditation ensures that LSSH meets the Centers for Medicare and Medicaid Services Conditions of Patticipation to care for Medicare and Medicaid patients.

LSSH contributes over $1.5 million annually to the Lafayette tax base through sales, propetty and payroll taxes and employs 215 people with annual salaries of approximately $10,000,000. LSSH is a good corporate citizen, active in the community and involved in charity work. They are a partner with the Lafayette Community Healthcare Clinic (LCHC) an organization that provides quality outpatient health care for the eligible working uninsured. Along with supplying manpower and sponsoring clinic sessions throughout the year, they also provide free services to LCHC clients in need. LSSH is a long time sponsor of their annual fundraiser "Silver Bell Soiree". LSSH also participates in and contributes to the following organizations: Affiliated Blind of Louisiana, Healing House, Family Tree, Festival International de Louisiane, Junior League of Lafayette, Lafayette Parish Medical Society, National Medical Association, UL Nursing Honor Society, and United Way of Acadiana.



"'Unpaid Cost of Medicaid Services($ 814,946)

1 Unpaid Cost of Medicare Services($ 7,682,730)

Charity Care & Donations ($47,716)

Payor Mix

	2013	2014	YTD April 2015
BCBS	37%	40%	41%
Medicare	28%	26%	28%
Comm/Out of Net	16%	15%	**11%**
WorkComp	10%	11%	12%
Medicaid	3%	2%	2%
In Network	2%	**1%**	2%
Legal	2%	3%	2%
SelfFay	1%	1%	**1%**
Govt	1%	1%	**1%**

Quality of Care

LSSH focuses on high quality and safety through patient-centered care delivered by highly skilled, dedicated and compassionate caregivers. Our measures of success include:

- Surgical Site Infection Rate of 0.40%, below the national benchmark of 0.90% (2013-2014)
- Hospital Wide Readmission Rate
    - Ranked 13'• in Louisiana (2012-2013)
    - Rate of 15.0%, below the national benchmark of 15.2% (2013-2014)
- Hand Hygiene Compliance Average of92% (2013-2014)
- Complication Rate after Total Joint Surgery 2.6%, below the national benchmark of 3.1% (2011-2014)

LSSH employs 215 people, 90 of which are registered nurses. All of our registered nurses maintain ACLS and PALS ce1tification as well as continuing education. The nurse to patient ratio is 1:4 or 1:5 based on acuity which allows for personal attention to the needs of each patient. These factors attribute to the low average length of stay of two days and patient satisfaction rates that are consistently 98% or higher.

Patients frequently comment on patient satisfaction surveys about the care they received at LSSH.

"Eve1yone was pleasant and caring. They explained in terms that I can understand. I really like the hospital and staff. I am glad my doctor is a part of such an excellent hospital!"

"The compassionate care, friendliness and attentiveness to my needs at your hospital were the best I've ever encountered at any hospital. Thank you for making my stay with you such a pleasant one. EveiJ>one made me feel right at home- true Southem hospitality."

"Every one of the medical staff was very ji-iendly and nice. I was treated with courtesy and respect. I will tell eve1yone that LSSH is the place to go and I will return if needed. I was ve1y pleased."

"Everyone is always so pleasant! I love the personal treatment we always receive. We are always so happy to return to LSSH due to that personal touch! Thank you for all that you do."

LSSH continues to work on performance improvement initiatives such as Wrong Site Surgery Prevention through the Joint Commission's Targeted Solutions project. In effmt to reduce surgical booking defects, the workgroup implemented the review of critical information (intake sheets, preference cards, consents and history and physicals) at different intervals for defects to ensure the accuracy of information. This allows for immediate resolution of issues and as a result, there was a decline in overall defects, a reduction in cancellations, and most importantly, no wrong site operations.

LSSH also implemented strategies from Project Joints, an Institute for Healthcare Improvement initiative focused on surgical site infection prevention. The project results prompted three evidenced based interventions, all of which were implemented for all adult surgical patients.

LSSH established a strong reputation and presence in the Acadiana community by exceeding patients' expectations for treatment, comfort, safety, and cost. CMS recently initiated a Star Rating for patient experience. Locally, LSSH is one of three hospitals in Lafayette which earned 5 Stars. Statewide, there were 17 hospitals that earned a 5-Star rating; eight of them are physician owned hospitals. LSSH is one of 251 hospitals nationwide to earn this ranking.

Value Based Purchasing incentives exceeded expectations for FY 2015. LSSH was eligible for pmticipation in the four domains of care; clinical process, patient experience, outcomes, and efficiency. Scores in these domains earned LSSH back the 1.5% payment reduction, plus an additional 0.858% (compared to only 0.19% in 2013) to yield a Value -Based Incentives Payment Percentage of 2.3589%.

LSSH continuously receives awards from various organizations for their quality and patient satisfaction. In 2011, the hospital received the Louisiana Hospital Capstone Quality Award, presented by eQHealth Solutions, the Medicare Quality Improvement Organization for Louisiana. LSSH was presented the award for improving the quality of health care for patients in the clinical area of surgical care. The one year project was aimed at achieving a 99% compliance rate with antibiotic cases for mthopedic and neurosurgery cases. It only took the hospital five months to reach their goal. LSSH received the 2013 National Surgical Healthcare (NSH) Quality Award for achieving and exceeding benchmark goals in patient satisfaction, infection prevention, medication administration and patient safety in addition to having no sentinel events. This is the highest award given to one of the 14 NSH acute care hospitals for overall improvement in their CMS quality scores.

Other LSSH awards for high quality and patient satisfaction include:

- America's Best Hospitals for 01thopedics- WomenCe1tified (2015)
- Outstanding Patient Experience Award – Healthgrades (2014, 2015)
- America's 100 Best Hospitals for Patient Experience- WomenCertified (2011, 2012,2014, 2015)
- Specialty Hospital of the Year- Louisiana State Nurses Foundation (2014)
- Best Specialty Hospital in Acadiana- The Times of Acadiana Readers' Poll (2013, 2014)
- Integrity Award- Better Business Bureau of Acadiana (2014)
- National Surgical Healthcare Satisfaction Award (2014)
- Hospital of the Year- Louisiana State Nurses Foundation (2007-2010)

It has been proven that happy employees make happy patients and LSSH is a shining example of employee satisfaction. They received the 100 Great Places to Work 2013- Becker's Hospital Review and Best Places to Work in Healthcare 2010, 20 II, & 2014 – Modern Healthcare Magazine. LSSH employees have a voice, have autonomy to do their jobs, and are engaged in the family atmosphere encouraged by management.

Lower Cost

LSSH continuously looks for opportunities to lower cost to patients. Currently we participate in cost reduction initiatives such as reprocessing of select supplies, pricing formularies with vendors, and working with a Group Purchasing Organization (GPO) to ensure lowest cost for supplies.

Need to Expand and Hospital Preference

Excellent patient care and outcomes have resulted in an outstanding reputation for LSSH and increasing demand for services such that we can no longer accommodate patients and their surgeons unless we expand the number of operating rooms at our facility. Patients and surgeons either lose choice of hospital or delay their care, neither of which is satisfactory. None of us would prefer or easily accept that circumstance.

The eight physicians, myself included, who conceived of and built LSSH had three objectives: optimum patient care, highly qualified and satisfied employees and a better working environment for physicians. We achieved this by establishing high standards and committing to staying involved in major decisions relative to those goals. Despite the significant financial risk we simply wanted a better hospital to care for our patients. Any surgical care I can safely provide for my patients is done at LSSH as I trust the reliability and excellence of care provided there and can influence decisions affecting such care. That is not possible elsewhere in Lafayette.

Emergency Care

Emergency care at our hospital is provided by physician specialists who are available within minutes and by a highly competent nursing staff trained in emergency procedures and available constantly due to a low patient to nurse ratio. When necessary, transfer to a tertiary facility can be done rapidly. Due to rigorous patient screening standards developed by our anesthesia physicians this is rarely necessary. We do not have an Emergency Depattment (ED) by design. The criticism that many POH's lack emergency departments is a specious one. Designated EO/trauma centers serve the public best as concentrated high volume care by specialists creates excellence. The American College of Surgeons endorses this model and all metropolitan centers have adopted it. Requiring all hospitals to have an ED would not only waste resources but would be excessively costly and dilute focused care.

Conclusion

It is abundantly clear that physician owned hospitals provide outstanding health care to our citizens all of whom we want to have access to the best care. There was a valid reason this health care model developed and there are valid reasons it should be allowed to grow. This cannot be gainsaid.

Imitation is the sincerest form of flattery. Thus, large community hospitals across the country have emulated our model as they know and have said that focused care and physician involvement in health care decisions improves patient care. Indeed, LSSH has raised health care standards in our community, compelling the large community hospitals to improve their standards in order to remain competitive, as is the case with other cities in which physician owned hospitals exist. Criticism of the AHA and hospitals they represent, therefore, are disingenuous, at best, when claiming financial gain tlu·ough self referral is the primary goal of our hospitals and physicians. If that were the case, practice patterns (greater volume of surgical cases, for example) would have changed for individual surgeons. This argument has not been made as there is no data that could suppmt such a claim.

Competition has always been the lifeblood of progress and excellence in our country, both personally and in business. To limit it when there is no valid reason, especially in health care, is a disservice to those we provide service to for their well being and worse when one's life is on the line. I urge your serious, unbiased consideration and suppmt of HR 976 and HR 2513 and rescission of moratoria restricting greater access to care through expansion of physician owned hospitals.

Sincerely,

Thomas V. Be1tuccini, MD, FACS, MBA

MEDICARE RIGHTS CENTER
Getting Medicare right

May 19, 2015

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

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

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

Dear Chairman Brady and Ranking Member McDermott:

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

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

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

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[1] GAO, "Bidding Results from CMS's Durable Medical Equipment Competitive Bidding Program," (November 2014), available at: http://www.gao.gov/assets/670/666806.pdf

[2] GAO, "Review of the First Year of CMS's Durable Medical Equipment Competitive Bidding Program's Round 1 Rebid," (May 2012), available at: http://www.gao.gov/assets/600/590712.pdf

[3] GAO, "Second Year Update for CMS's Durable Medical Equipment Competitive Bidding Program Round 1 Rebid," (March 2014), available at: http://www.gao.gov/assets/670/661474.pdf

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

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

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

Sincerely,

Joe Baker
President
Medicare Rights Center

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

My name is David L. Sappenfield, MD and I am an ophthalmologist practicing for the last 26 years in Durham, North Carolina. I am currently an investor and approximately 1.5% owner in North Carolina Specialty Hospital (NCSH), a part physician-owned acute care surgical hospital also in Durham. Most importantly, however, I am a staff physician proudly and actively treating patients at NCSH. I started practice at McPherson Hospital and clinics, a private practice specializing in eye, ear, nose and throat care. Our practice was originally founded in the early 1900's here at a time when patient bills were sometimes satisfied by bartering for goods rather than cash payments. Our specialty hospital facility predated by many years all others in our region (including the now well-known Duke Hospital). Our doctors have taken great pride in treating all who need to be seen in a way each of us would want to be treated. Medical care has markedly changed over the last century and our hospital, in order to survive, has begun offering new services including orthopedic care. In 1998, our affiliation with Triangle Orthopedic Associates led to the founding of NCSH with the bed licenses formerly utilized by McPherson Hospital. Although our hospital name and scope of practice changed, our goal of always providing state-of-the-art care in a patient-centered environment never wavered.

As detailed in other testimony provided by Dr. Richard Bruch, a retired orthopedist who serves as Board Chair of NCSH, our hospital provides superb care as documented by the ratings of CMS and other entities. Currently NCSH ranks 10th in the nation under the CMS combined ratings for Value-Based Purchasing Program and the Hospital-Acquired Conditions Program. The CMS 30 day Readmission rating is released quarterly and NCSH always ranks #1 - #4 in the state. NCSH is one of only 251 hospitals in the nation to hold a 5 star CMS Patient Satisfaction rating. Consumer Reports Health assigned NCSH its highest rating for safest hospitals to have surgery, one of only two North Carolina hospitals to earn this designation.

How is this quality achieved? NCSH has a patient to nurse ratio of 4:1. All nurses must achieve ACLS and PALS certification within 6 months of employment. NCSH has an employee turnover rate of 7% annually; this rate is 1/3 the rate in the Triangle North Carolina region. Hospitalist physicians, who are Internists, are on site 24 hours per day, 7 days per week and they see every inpatient twice daily and record chart entries for these visits. A physician Anesthesiologist is present for every surgery performed. Medication reconciliation is performed on every inpatient by a licensed pharmacist. This is unique in the hospital industry and helps to make certain that every patient receives their medications correctly. As a result of this quality care, patient transfers to another hospital are low. During the past year, the patient transfer rate was 0.14%, 14 patient transfers with 10,056 patients treated.

NCSH provides lower cost care than other hospitals in the Raleigh-Durham-Cary-Chapel Hill area. For the same procedure, inpatient CMS reimbursement is more than 18% less than at the "non-profit" hospitals. For example, DRG Code 470 includes total knee replacement surgery. The Raleigh-Durham-Cary-Chapel Hill region has 8 hospitals performing these surgeries. NCSH Medicare payment for these surgeries is $10,102. The average Medicare payment for the remaining 7 hospitals in the region is $12,448. NCSH performs the same surgery at a lower cost and provides higher patient satisfaction and outcomes than our competition.

As a private, “for-profit” hospital, NCSH’s potential growth has been restrained by the near strangle-hold “non-profit” Duke University Health System now holds on our local marketplace. NCSH has also been severely affected by Section 6001 of the Affordable Care Act. While Duke has been allowed to grow nearly unfettered, thereby allowing them to impose their own restrictions on access to care, greatly needed expansion NCSH might have considered has been stymied. We are therefore unable to offer any greater completion to Duke which could then drive down patient/payor costs and improve access/quality.

I therefore implore you to repeal or amend the Affordable Care Act Section 6001 so that existing hospitals with physician ownership may provide needed quality care to Medicare, Medicaid and Tricare patients. H.R. 976 begins the process of allowing hospitals with physician ownership to provide additional outstanding care at substantial savings to our patients and to government/private payors. Why should we continue to deny our great nation better care at lower cost while monopolistic “health systems” limit access/quality and drive up prices?

Thank you for your interest and support!

David L. Sappenfield, MD
NC Eye, Ear, Nose & Throat
4102 N. Roxboro St.
Durham, NC 27704
Office phone (919) 595-2000
Office fax (919) 595-2182
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House Ways and Means Subcommittee
Chairman Kevin Brady (R-TX and Ranking Member Jim McDermott (D-WA)
"Improving Competition in Medicare: Removing Moratoria and Expanding Access"
May 19, 2015
Statement for the Record
Frederic E. Liss, M.D.
Founder, Chairman and Chief Medical Officer
Physicians Care Surgical Hospital

17 May 2015

Dear Chairman Brady, Ranking Member McDermott and members of the Ways and Means Subcommittee on Health,

Thank you for convening this hearing to examine the critically important issue of improving competition in Medicare, and for the opportunity to submit this statement for the record of this proceeding. My name is Frederic Liss and I am the founder, Chairman of the Board and Chief Medical Officer of Physicians Care Surgical Hospital, in Royersford, PA, in the western suburbs of Philadelphia. I am an actively practicing, full time orthopaedic hand and upper extremity surgeon with the Rothman Institute, a 120-physician group, providing comprehensive musculoskeletal care throughout all of southeastern Pennsylvania and New Jersey.

OBJECTIVE:
(A) To provide the Subcommittee with factual information and to present the committee's members with compelling reasons to reassess and change federal law that is currently reducing competition in Medicare through discrimination against hospitals with physician ownership.
(B) To urge the committee's members to take action to increase Medicare and Medicaid patient access to care and choice, reduce the cost and raise the quality of healthcare by ending the moratorium on physician owned hospitals, all of which can be accomplished with the bipartisan HR 976, already introduced in the House.

ABOUT PHYSICIANS CARE SURGICAL HOSPITAL:

- "PCSH" is a physician owned hospital whose ownership structure is 85% physicians and 15% Nueterra Healthcare. We have a management contract with Nueterra.
- PCSH was founded in 2010, after development over 2-3 years before that.
- Our mission was to create a patient cantered hospital and to provide *all* of our patients with the choice of the lowest cost, highest quality surgical care possible.
- 24 physicians set out on this mission because we were disillusioned with the quality of care that was being provided by the publically held "for profit" hospital system (Community Health Systems) that purchased the two main hospitals and several other hospitals where I have practiced for the last 20 years, here in

southeast Pennsylvania. After these acquisitions we witnessed a steep decline in hospital employee satisfaction that lead to poor efficiency of surgical operations an unpleasant work environment and ultimately a very significant decline in patient satisfaction.

- We opened in October of 2010 and received our Medicare licensure before passage of the Affordable Care Act (ACA), which eliminated the hospital exception for physician ownership of hospitals that was in place in the Social Security Act.
- PCSH has 5 operating rooms, 12 inpatient beds, a 1 bed emergency area, laboratory, x-ray department, pharmacy, pathology and physical therapy
- We are a multispecialty hospital that includes ENT, Orthopedics, Ophthalmology, Gynecology, Pain Management, and General Surgery
- We have 24/7/365 in house physician hospitalist coverage for inpatient and walk in emergencies.
- We have 104 employees
- We have approximately 50 physicians on staff, only about ½ of whom are owners
- We accept Medicare, Medicaid, Tricare, workman's compensation, and most commercial insurances. In Pennsylvania, we ***pay*** a surcharge per year for the right to treat Medicaid patients and we treat the uninsured with greater flexibility to absorb than the local community hospitals. Local hospitals require vetting processes that often unacceptably delay surgeries on the uninsured.
- PCSH employees, administration and staff are actively engaged in charity projects that serve the greater good of the community in which we live and operate. This is part of the mission statement and fiber of PCSH.
- Our commitment to every employee at PCSH is that whenever we distribute profits to the owners, part of that goes to them, and we base it on performance. This leads to very engaged and motivated staff, so that they too, have "ownership" of our success
- Employee satisfaction is far above national averages at our facility

QUALITY AND COST/THE VALUE PROPOSITION:

- We have learned from data released by CMS, that we perform total joint replacements and spinal surgeries at ½ the cost to Medicare of other hospitals in our community and at less than ¼ the cost to Medicare compared to the University hospitals in our market area in Greater Philadelphia.
- We have also learned that as much as 50% of the cost of an episode of total joint replacement or spinal surgery may come after the surgical admission, when a patient goes to rehabilitation. We have instituted pre-operative education for the patients and have learned that very few patients need to have in-patient or even in home rehabilitation.
- PCSH was ranked 3rd *in the entire United States* for 2013, on the top box score for HCAHPS ("I would definitely recommend this hospital").
- PCSH was ranked with 5 Stars by Medicare for 2014 one of only 2 hospitals in southeastern Pennsylvania and one of only 83 hospitals in the United States.

- We are not alone in our accomplishments. Although POHs represent only 6% of US hospitals, physician owned hospitals account for 52 of the top 100 performers across the nation on the Value Based Purchasing Program legislated in the AHCA, 22 of the top 25 hospitals on HCAHPS, and when grouped together, account for over $3 billion in savings for the Medicare program over 10 years as per the Schneider Report now under review by the CBO.

PROBLEM WITH RESTRICTION ON EXPANSION:

- Physicians Care is in high demand by patients who live in our community
- Medicare patients love PCSH because we represent the values and quality in healthcare with which our elderly were raised and accustomed. We are convinced that this is why our HCAHPS and Star ratings are so high.
- Unfortunately, we have had to turn patients away because we do not have enough inpatient beds to meet the demand in our community.
- Our staff physicians prefer to operate at PCSH because there patients receive the best care in the country AND because they have the best experience operating there over any other facility
    - 97% on time OR starts
    - Top notch anesthesia department with excellent post operative pain management for their patients
    - Almost a zero infection rate
    - 24/7 inpatient hospitalist coverage for their patients
    - Nurse to patient ratio usually 1:2, maximum 1:4
    - A very happy and engaged staff

CONCLUSIONS:

- PCSH and physician owned hospitals as a group have demonstrated unprecedented quality, patient satisfaction, employee satisfaction and substantial savings for Medicare and healthcare in general.
- Competition in the marketplace is what stimulates improvement of quality and lowering of cost. Patients deserve access to this type of quality of care, and Americans have the choice to drive the healthcare marketplace.
- Physician owned hospitals have embraced the tenants of the ACA, and for all of these reasons we deserve the right to expand, compete in the marketplace and to drive value into what Americans get in return for their healthcare dollars.
- We urge the committee's members to end the moratorium on physician owned hospitals by eliminating section 6001 from the ACA.

Thank you again for the opportunity to present this information. I remain at the Subcommittee's disposal as a resource, should any further information be needed.

Respectfully Submitted,

Frederic E. Liss, M.D.

CHAIRMAN AND MEDICAL DIRECTOR

PHYSICIANS CARE SURGICAL HOSPITAL

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ROTHMAN FIRST

ROTHMAN INSTITUTE

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

My name is Michael E. Russell II, M.D., orthopedic spine surgeon and one of the physician owners of Texas Spine & Joint Hospital (TSJH). Thank you Chairman Brady, Ranking Member McDermott and the subcommittee members for considering testimony in this important hearing. Texas Spine & Joint Hospital seeks an end to federal discrimination of physician-owned hospitals and encourages you to support H.R. 976 as a means to increase patient access to physician-owned hospitals.

Founded in 2002 in Tyler, TX, Texas Spine & Joint Hospital is a physician-owned hospital specializing in orthopedic and spine surgery, procedures, and tests. Serving the largest rural community in the state of Texas, TSJH includes a licensed acute care hospital, an outpatient surgery center, two walk-in clinics, and an ancillary imaging center. With 40 physician owners and a total medical staff of over 196, TSJH employs 300 full and part-time employees.

Much of the east Texas area is designated as rural, poor and medically underserved according to the United States Department of Health and Human Services. This includes multiple counties in the immediate service area of Texas Spine & Joint Hospital. Despite serving patients in such a rural and economically disadvantaged area, Texas Spine & Joint Hospital continues to receive distinguished rankings from both government agencies and private benchmarking firms. Recent honors include:

- 5-Star ranking from www.medicare.gov Hospital Compare for HCAHPS patient surveys
- Texas Medical Foundation Health Quality Institute's Gold Award for Texas Hospital Quality Improvement 2014
- Ranked in the 99th percentile nationally for patient satisfaction according to Press Ganey
- Top 100 in Nation and #1 in Market for Medical Excellence in Spinal Fusion and Spinal Surgery according to CareChex 2015
- #1 in Market for Patient Safety in Major Orthopedic Surgery according to CareChex 2015
- Top 100 in Nation and #1 in Market for Patient Satisfaction in Overall Hospital Care, Overall Medical Care and Overall Surgical Care according to CareChex 2015
- Becker's Hospital Review "125 Hospitals with Great Orthopedic Programs" in 2014
- Becker's Hospital Review "100 Hospitals with Great Neurosurgery and Spine Programs" in 2014
- Becker's Hospital Review "82 Physician-Owned Hospitals to Know" in 2014

These rankings and recognition, based on actual patient data, were earned while serving a patient base that is over 60% Medicare and Medicaid. Annually, TSJH performs over 2400 inpatient surgeries and over 15,000 spinal interventions. Additionally, TSJH ranks in the top 7% nationally in value-based purchasing, according to the American Hospital Association.

With a limited number of licensed beds, the hospital routinely operates at maximum capacity. At times, patients are unable to access much needed services because, simply put, the hospital is full. Unfortunately, under section 6001 of the healthcare bill, Texas Spine & Joint Hospital is unable to expand despite overwhelming support and need from the local community. By enabling expansion, more patients will be able to access the high-quality, lower-cost healthcare provided by TSJH.

As a physician-owned hospital, Texas Spine & Joint Hospital pays millions of dollars in local, state and national taxes. This is unlike major medical centers and large hospital systems that enjoy non-profit status while receiving additional state and national funding for serving medically underserved areas. TSJH operates in the same medically underserved areas, cares for a similar percentage of Medicare and Medicaid patients, and provides free services to Bethesda Health Clinic, a local clinic for the working poor, yet receives no governmental assistance.

The physicians and staff of Texas Spine & Joint Hospital implore the subcommittee members to acknowledge the vital role this hospital plays in the care of east Texans by lifting the ban on physician-owned hospitals. Again, I thank you for your time and consideration of this important topic.

Respectfully,

Michael E. Russell, II, M.D.
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MER:jm

June 1, 2015

Rep. Kevin Brady
Chairman
House Ways and Means Health Subcommittee
301 Cannon Senate Office Building
United States House of Representatives
Washington, DC 20515

Rep. Jim McDermott
Ranking Member
House Ways and Means Health Subcommittee
1035 Longworth House Office Building
United States House of Representatives
Washington, DC 20515

Dear Chairman Brady and Ranking Member McDermott:

On behalf of over 48,000 members of the American Association of Nurse Anesthetists (AANA), I am writing to thank you for holding the first of several hearings **on improving Medicare access through increased competition. Advanced practice registered nurses (APRNs), including Certified Registered Nurse Anesthetists (CRNAs),** practicing to the full scope of their training and expertise ensures patient safety and access to safe, high-quality care, and promotes healthcare cost savings as well as increased competition in the healthcare marketplace and the Medicare program. **For your consideration, we are** enclosing a synopsis of two letters the AANA submitted to the Federal Trade Commission regarding their workshops on ''Examining Health Care Competition'' for further information.

Current reimbursement structures in Medicare impede full practice by CRNAs and add to waste in the program. Medicare reimburses CRNAs and anesthesiologists at the same rate for the same high quality service -- 100 percent of a fee for providing non-medically directed (CRNA) or personally performed (anesthesiologist) services. Medicare also operates a payment system for "anesthesiologist medical direction"[1] that provides a financial incentive for anesthesiologists to "medically direct" CRNAs who are already directly providing patient access to high quality anesthesia care themselves as part of the surgical team caring for the patient. The Centers for Medicare & Medicaid Services (CMS) has stated that medical direction is a condition of payment of anesthesiologist services and not a quality standard.[2] An anesthesiologist claiming medical direction services may be reimbursed 50 percent of a fee in each of up to four concurrent cases that the physician "medically directs", totaling 200 percent over a given period of time, twice what the anesthesiologist may claim when personally performing anesthesia services in one case. Under medical direction, the CRNA may claim the remaining 50 percent of a fee for his or her case. Peer-reviewed evidence demonstrates anesthesiologist medical direction increases healthcare costs without improving value.[3]

Furthermore, current Medicare regulations[4] contain a costly and unnecessary requirement for physician supervision of CRNA anesthesia services that do not support delivery of health care in a manner that allows states and healthcare

[1] 42 CFR §415.110. http://www.ecfr.gov/cgi-bin/text-idx?SID=5ce8cb6375c7d5c22c454c7ec1fe07de&node=42:3.0.1.1.2&rgn=div5#42:3.0.1.1.2.3.1.4
[2] 63 FR 58813, November 2, 1998, http://www.gpo.gov/fdsys/pkg/FR-1998-11-02/pdf/98-29181.pdf .
[3] P. Hogan et. al, "Cost Effectiveness Analysis of Anesthesia Providers." Nursing Economic$. 2010; 28:159-169. http://www.aana.com/resources2/research/Documents/nec_mj_10_hogan.pdf
[4] 42 CFR 482.52(a)(4) for hospitals (see http://www.ecfr.gov/cgi-bin/text-idx?SID=04387f6850fa030cb817311427be6f5f&mc=true&node=se42.5.482_152&rgn=div8), 42 CFR 485.639 (c) for CAHs (see

facilities nationwide to make their own decisions based on state laws and patient needs. These requirements are more restrictive than the majority of state laws and impede local communities from implementing the most innovative and competitive model of providing quality care. Given the growing population of persons in the United States requiring healthcare, particularly among Medicare eligible populations, physician supervision requirements stand in the way of deploying the vast workforce contained with the supply of APRNs. Unnecessary requirements for physician supervision of APRNs contribute to duplication and waste in the healthcare delivery system. Scientific peer-reviewed research underscores that such supervision does not affect quality or outcomes and increases healthcare costs and also illustrates how CRNAs consistently deliver safe, high-quality, cost-effective anesthesia care.[5]

CRNAs play a vital role in ensuring access to safe, high quality and cost effective anesthesia care. Congress and Medicare may advance patient access to care, reduce healthcare costs and waste in the Medicare program, while promoting competition, by eliminating policy barriers to the full use of CRNAs. We look forward to working with you on this important issue and should the Committee have any questions, please contact the AANA Senior Director of Federal Government Affairs, Frank Purcell, at 202.484.8400, fpurcell@aanadc.com.

Sincerely,

Sharon P. Pearce, CRNA, MSN
President

Attached: Addendum I: AANA Comments to Federal Trade Commission Health Care Workshop Request for Comment

http://www.ecfr.gov/cgi-bin/text-idx?SID=04387f6850fa030cb817311427be6f5f&mc=true&node=se42.5.485_1639&rgn=div8), and 42 CFR 416.42 (b)(2)for ASCs (see http://www.ecfr.gov/cgi-bin/text-idx?SID=8198c35c58c98715100eb32ff0046536&mc=true&node=se42.3.416_142&rgn=div8) .

[5] See American Association of Nurse Anesthetists, CRNAs: The Future of Anesthesia Care Today, http://www.future-of-anesthesia-care-today.com/research.php, and Christopher J. Conover and Robert Richards, "Economic Benefits of Less Restrictive Regulation of Advanced Practice Registered Nurses in North Carolina: An Analysis of Local and Statewide Effects on Business Activity, Duke University, February 2015, available at: http://chpir.org/wp-content/uploads/2015/02/Report-Final-Version.pdf.

Addendum I

The following comments were submitted in response to FTC Health Care Workshop, Project No. P131207 on March 10, 2014 and FTC Health Care Workshop, Project No. P13-1207 on February 16, 2015.

The AANA provided the FTC Health Care Workshop content covering the following areas:

I. Background of the AANA and Certified Registered Nurse Anesthetists (CRNAs)
II. Alternatives to Traditional Fee-for-Service Payment Models
III. Provider Network and Benefit Design
IV. Professional regulation of healthcare providers
V. Measuring and assessing quality of care
VI. Price transparency of healthcare services.

The content was composed so that each section could be read and considered independently by each workshop panel, therefore some material was repeated throughout the subject areas.

I. BACKGROUND OF THE AANA AND CRNAs

The AANA is the professional association for CRNAs and student nurse anesthetists. AANA membership includes more than 48,000 CRNAs and student registered nurse anesthetists representing over 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) and anesthesia professionals who safely administer more than 38 million anesthetics to patients each year in the United States, according to the 2012 AANA Practice Profile Survey. Nurse anesthetists have provided anesthesia care to patients in the U.S. for over 150 years, and high quality, cost effective and safe CRNA services continue to be in high demand. CRNAs are Medicare Part B providers and since 1989, have billed Medicare directly for 100 percent of the physician fee schedule amount for services.

CRNAs practice in every setting in which anesthesia is delivered: traditional hospital surgical suites and obstetrical delivery rooms; critical access hospitals; ambulatory surgical centers; the offices of dentists, podiatrists, ophthalmologists, plastic surgeons, and pain management specialists; and U.S. military, Public Health Services, and Department of Veterans Affairs healthcare facilities. CRNA services include providing a pre-anesthetic assessment, obtaining informed consent for anesthesia administration, developing a plan for anesthesia administration, administering the anesthetic, monitoring and interpreting the patient's vital signs, and managing the patient throughout the surgery. CRNAs also provide acute and chronic pain management services. CRNAs provide anesthesia for a wide variety of surgical cases and are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities.

Peer-reviewed scientific literature shows CRNA services ensure patient safety and access to high-quality care, and promote healthcare cost savings. According to a May/June 2010 study published in the journal of *Nursing Economic$*, CRNAs acting as the sole anesthesia provider are the most cost-effective model for anesthesia delivery, and there is no measurable difference in the quality of care between CRNAs and other anesthesia providers or by anesthesia delivery model.[i] Furthermore, an August 2010 study published in *Health Affairs* shows no differences in patient outcomes when anesthesia services are provided by CRNAs, physicians, or CRNAs supervised by physicians.[ii] Researchers studying anesthesia safety found no differences in care between nurse anesthetists and physician anesthesiologists based on an exhaustive analysis of research literature published in the United States and around the world, according to a scientific literature review prepared by the Cochrane Collaboration.[iii]

According to a 2007 Government Accountability Office (GAO) study, CRNAs are the predominant anesthesia provider where there are more Medicare beneficiaries and where the gap between Medicare and private pay is less.[iv] Nurse anesthesia predominates in Veterans Hospitals, the U.S. Armed Forces and Public Health Service. CRNAs work in every setting in which anesthesia is delivered including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers (ASCs), pain management facilities and the offices of dentists, podiatrists, and all types of specialty surgeons. As colleagues and competitors in the provision of anesthesia and pain management services, CRNAs and anesthesiologists have long been considered substitutes in the delivery of surgeries.[v]

In its landmark publication *The Future of Nursing: Leading Change, Advancing Health*, the Institute of Medicine made its first recommendation that advanced practice registered nurses (APRNs) such as CRNAs be authorized to practice to their

full scope, in the interest of patient access to quality care, and in the interest of competition to help promote innovation and control healthcare price growth.[vi]

II. ALTERNATIVES TO TRADITIONAL FEE-FOR-SERVICE PAYMENT MODEL

The AANA supports the FTC's efforts to better understand the potential benefits of alternative payment models and whether they can offer significant cost savings while maintaining, or helping to improve, quality of care. Under the current fee-for-service model, there are instances where the current model contributes to high costs without improving quality. Similar to general physician payment, Medicare reimburses CRNAs and anesthesiologists the same rate for the same high quality service -- 100 percent of a fee for providing non-medically directed (CRNA) or personally performed (anesthesiologist) services. It also includes a system for "anesthesiologist medical direction"[vii] that provides a financial incentive for anesthesiologists to "medically direct" CRNAs who are capable of and are often providing patient access to high quality anesthesia care unassisted. An anesthesiologist claiming medical direction services may be reimbursed 50 percent of a fee in each of up to four concurrent cases, a total of 200 percent over a given period of time, twice what the anesthesiologist may claim when personally performing anesthesia services in one case. Under medical direction, the CRNA may claim the remaining 50 percent of a fee for his or her case. Peer-reviewed evidence demonstrates anesthesiologist medical direction increases healthcare costs without improving value.[viii] Furthermore, the Centers for Medicare & Medicaid Services (CMS) has stated that medical direction is a condition of payment of anesthesiologist services and not a quality standard.[ix]

In demonstrating the increased costs, suppose that there are four identical cases: (a) has anesthesia delivered by a non-medically directed CRNA; (b) has anesthesia delivered by a CRNA medically directed at a 4:1 ratio by a physician overseeing four simultaneous cases and attesting fulfillment of the seven conditions of medical direction in each; (c) has anesthesia delivered by a CRNA medically directed at a 2:1 ratio; and (d) has anesthesia delivered by a physician personally performing the anesthesia service. (There are instances where more than one anesthesia professional is warranted; however, neither patient acuity nor case complexity is a part of the regulatory determination for medically directed services. The literature demonstrates that the quality of medically directed vs. non-medically directed CRNA services is indistinguishable in terms of patient outcomes, quality and safety.) Further suppose that the annual pay of the anesthesia professionals approximate national market conditions, $170,000 for the CRNA[x] and $540,314 for the anesthesiologist.[xi] Under the Medicare program and most private payment systems, practice modalities (a), (b), (c) and (d) are reimbursed the same. Moreover, the literature indicates the quality of medically directed vs. non-medically directed CRNA services is indistinguishable. However, the annualized labor costs (excluding benefits) for each modality vary widely. The annualized cost of practice modality (a) equals $170,000 per year. For case (b), it is ($170,000 + (0.25 x $540,314) or $305,079 per year. For case (c) it is ($170,000 + (0.50 x $540,314) or $440,157 per year. Finally, for case (d), the annualized cost equals $540,314 per year.

Anesthesia Payment Model	FTEs / Case	Clinician costs per year / FTE
(a) CRNA Nonmedically Directed	1.00	$170,000
(b) Medical Direction 1:4	1.25	$305,079
(c) Medical Direction 1:2	1.50	$440,157
(d) Anesthesiologist Only	1.00	$540,314
Anesthesiologist mean annual pay	*$540,314*	*MGMA, 2014*
CRNA mean annual pay	*$170,000*	*AANA, 2014*

If Medicare and private plans pay the same rate whether the care is delivered according to modalities (a), (b), (c) or (d), someone in the health system is bearing the additional cost of the medical direction service authorized under the Medicare regulations at 42 CFR §415.110. This additional cost is shifted onto hospitals and other healthcare facilities, and ultimately to patients, premium payers and taxpayers. With CRNAs providing over 38 million anesthetics in the U.S., and a considerable fraction of them being "medically directed," the additional costs of this medical direction service are substantial. In addition, the most recent peer-reviewed literature makes clear that the requirements of anesthesiologist medical direction are often not met in practice– and if anesthesiologists submit claims to Medicare for medical direction but did not perform all of the required services in each instance, then the likelihood of widespread Medicare fraud in this area is high. Lapses in anesthesiologist supervision of CRNAs are common even when an anesthesiologist is medically directing as few as two CRNAs, according to an important new study published in the journal *Anesthesiology*.[xii]

Another factor driving up the cost of healthcare under the current fee-for-service model is the practice of hospital subsidization of anesthesiology groups, in which hospitals pay high compensation to anesthesiology groups to offset the shortfall from decreasing reimbursement to these anesthesiology groups. According a nationwide survey of anesthesiology group subsidies,[xiii] hospitals pay an average of $160,096 per anesthetizing location to anesthesiology groups, an increase of 13 percent since the previous survey in 2008. An astounding 98.8 percent of responding hospitals in this national survey reported that they paid an anesthesiology group subsidy. Translated into concrete terms, a hospital with 20 operating rooms pays an average of $3.2 million in anesthesiology subsidy. Such payments from hospitals to anesthesiology groups do not appear on hospitals' Medicare cost reports or their billings to health plans, making information about them hard to come by except from survey information. Anesthesiology groups receive this payment from hospitals in addition to their direct professional billing. Without question, such subsidy payments to anesthesiology groups represent cost-shifting away from other critical services within the healthcare delivery system.

As the FTC examines the merits of alternative payment systems, we recommend ensuring that these alternatives are in the best interests of the patients receiving care, that they encourage improvements in patient care quality and efficiency, and that the alternative payment systems have been developed and deployed in a manner that healthcare professionals deem as valid.

Alternative payment systems should recognize and reward all qualified healthcare providers, not just physicians, for ensuring patient access to safe, cost-effective healthcare services. Bundled payment systems can reward care coordination and cost-efficiency, but without an equal and crucial focus on quality such systems can lead to a harmful "race to the bottom" when incentives to cut costs are not balanced with quality standards – an outcome that must be avoided. Bundled payment systems should recognize the full range of qualified healthcare providers delivering care, including CRNAs and other APRNs, and avoid physician-centricity that increases costs without improving quality or access.

Alternative payment models, such as bundled payment, have the potential to drive value-based healthcare delivery, particularly in anesthesia care and related services, and meet the triple health care aims of improving patient experience of care, improving population health and reducing health care costs. But certain alternative payment models do not follow these goals and instead lead to higher healthcare costs and decreased access to safe, high quality anesthesia providers such as CRNAs. One type of payment model that does not drive value-based healthcare delivery can be found in large group practices composed solely of anesthesiologists. Holding substantial market power, these large anesthesiologist-only group practices enter into exclusive single source contract service agreements with health systems, facilities and surgeons where the group practice's market power increases costs, limits choice of anesthesia provider, and imposes opportunity costs that deprive resources from delivery of other critical healthcare services. Such enterprises may use their market power to maximize their income without relation to the actual costs of performing the procedure.[xiv] For example, according to the New York Times, a patient was billed $8,675 for anesthesia during cardiac surgery. The anesthesia group accepted $6,970 from United Healthcare, $5,208.01 from Blue Cross and Blue Shield, $1,605.29 from Medicare and $797.50 from Medicaid.[xv] This type of model drives up healthcare costs and puts additional economic strain on consumers and the country.

III. PROVIDER NETWORK AND BENEFIT DESIGN

We have found that in some states, health plan networks operating in exchanges and in the private market conduct discriminatory behaviors based on provider licensure which violates the provider nondiscrimination provision in the Affordable Care Act and inhibits CRNAs' ability to practice to full extent of their scope of practice. The end result of these practices is increased healthcare costs, diminished competition and reduced patient choice for safe, high quality and cost-effective anesthesia and related services.

The federal provider nondiscrimination provision in the Patient Protection and Affordable Care Act (Sec. 1201, Subpart 1, creating a new Public Health Service Act Sec. 2706(a), "Non-Discrimination in Health Care, 42 USC §300gg-5),[xvi] which took effect January 1, 2014, states that "a group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any healthcare provider who is acting within the scope of that provider's license or certification under applicable State law." It also states that, "nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures."

Section 2706 is an important law because it promotes competition, consumer choice and high quality healthcare by prohibiting discrimination based on provider licensure that keeps patients from getting the care they need. To promote

patient access to high quality healthcare, market competition and cost efficiency, health insurance exchanges, health insurers and health plans must avoid discrimination against qualified, licensed healthcare professionals, such as CRNAs, solely on the basis of licensure. Proper implementation of the provider nondiscrimination provision is crucial because health plans have wide latitude to determine the quantity, type, and geographic location of healthcare professionals they include in their networks, based on the needs their enrollees. However, when health plans organize their healthcare delivery in such a way that they discriminate against whole classes of qualified licensed healthcare professionals by licensure -- by prohibiting reimbursement for anesthesia and pain management services provided by CRNAs, for example -- patient access to care is impaired, consumer choice suffers, and healthcare costs climb for lack of competition.

The provider nondiscrimination provision also respects local control and autonomy in the organization of healthcare delivery systems, health plans and benefits. It does not impose "any willing provider" requirements on health plans, and it does not prevent group health plans or health insurance issuers from establishing varying reimbursement rates based on quality or performance measures.

Types and Examples of Provider Discrimination

The AANA believes it is discrimination if health plans or health insurers have a policy that reimburses differently for the same services provided by different provider types solely on account of their licensure. Medicare reimburses CRNAs directly for their services and does so at 100 percent of the physician fee schedule amount for services, the same rate as physicians for the same services. The Omnibus Budget Reconciliation Act (OBRA) of 1986 authorized direct reimbursement of CRNA services under Medicare Part B beginning in 1989.[xvii] The Medicare regulation implementing the OBRA law, updated as part of a November 2012 final rule further clarifying the authorization of direct reimbursement of nurse anesthesia services within the provider's state scope of practice,[xviii] states, "Medicare Part B pays for anesthesia services and related care furnished by a certified registered nurse anesthetist who is legally authorized to perform the services by the State in which the services are furnished."[xix] The final rule also states, "Anesthesia and related care means those services that a certified registered nurse anesthetist is legally authorized to perform in the state in which the services are furnished." The agency also said in the rule's preamble, "In addition, we agree with commenters that the primary responsibility for establishing the scope of services CRNAs are sufficiently trained and, thus, should be authorized to furnish, resides with the states."[xx] Therefore, the Medicare agency stands on solid ground in clarifying that the nondiscrimination provision should apply to private plans in a way that is consistent with Medicare direct reimbursement of CRNA services where they are allowed to furnish those services under state law.

Unfortunately, we have heard from our members who state that certain health plans and insurers across the United States have policies that discriminate against CRNAs. In many of these cases, health plans or insurers either do not reimburse CRNAs at all for anesthesia services that are fully reimbursed when performed by anesthesiologists, or they reimburse CRNAs at a lower rate than anesthesiologists for performing the same services. For example, effective November 1, 2013, Regence Blue Shield of Idaho lowered CRNA reimbursement by 15 percent for anesthesia services. Its new policy states, "Physician conversion factor is $55.10. Certified Registered Nurse Anesthetist conversion factor is $46.84."[xxi] When justifying its rationale for setting the reimbursement rates for all non-physician healthcare providers, including CRNAs, at 85 percent of the physician rate, Regence stated in a letter to a CRNA that the decision was in part "based on the difference in education, training and scope of practice" between physician and non-physician providers. Regence did not identify any differences in "quality or performance measures" to explain the reimbursement differential. As we have shown above, the literature is clear in showing that no quality outcomes difference can be found between the models of CRNA anesthesia care, anesthesiologist services, or both professionals providing anesthesia care together.

If a health plan or health insurer network offers a specific covered service, Section 2706 requires that the health insurer or health plan network include all types of qualified licensed providers who can offer that service. If a health plan offers coverage for anesthesia services, it should allow all anesthesia provider types to participate in their networks and should not refuse to contract with CRNAs just based on their licensure alone. For example, as of April 2012, Blue Cross Blue Shield of South Carolina states in its anesthesia guidelines policy manual that it will not reimburse CRNAs for monitored anesthesia care (MAC), but it will pay anesthesiologists for these same services.[xxii] Specifically the policy states, "BlueCross may reimburse for modifiers QS, G8 and G9 if a physician personally performs the procedure (modifier AA) and if the procedure meets medical necessity criteria. BlueCross will not reimburse CRNAs for MAC."[xxiii]

The AANA views all of these policies outlined above as examples of discrimination against CRNAs based on their licensure and not based on CRNA quality and performance, and such discrimination clearly is prohibited by Section 2706. These policies impair patient access to care provided by CRNAs, and they expressly impair competition and choice, and

contribute to unjustifiably higher healthcare costs without improving quality or access to care. The negative impacts of provider discrimination can hit rural communities hardest, where CRNAs are the primary anesthesia professionals and often the sole anesthesia providers. The availability of CRNAs in rural America enables hospitals and other healthcare facilities to offer obstetrical, surgical, and trauma stabilization services to patients who otherwise might be forced to travel long distances for these essential care. As stated above, CRNAs have been providing safe and high-quality anesthesia care in the United States for 150 years and the AANA is a determined advocate for patients and CRNAs concerning issues such as access to quality healthcare services and patient safety.

We believe proper implementation of the provider nondiscrimination provision by preventing health plans and health insurers from discriminating against specific types of health providers, such as CRNAs, will ensure full access to anesthesia services and to the procedures and services that they make possible, efficient delivery and local management and optimization of these services, and equitable reimbursement for CRNA services based on quality and performance, rather than licensure. This is consistent with the FTC's and the public's interests in quality, access and cost-effectiveness. Ensuring that health plans and health insurers adhere to the provider nondiscrimination law will protect competition and patient choice and promote patient access to a range of beneficial, safe, and cost-efficient healthcare services, such as those provided by CRNAs.

IV. PROFESSIONAL REGULATION OF HEALTHCARE PROVIDERS

Several constraints in the legislative, regulatory, and practice arenas inhibit CRNAs' ability to practice to full extent of their scope, reducing competition and choice and increasing healthcare costs. CRNAs' ability to practice to their full scope is also affected by Medicare regulations associated with Medicare Part A Conditions of Participation and Conditions for Coverage (CoPs and CfCs). The Medicare CoPs and CfCs are federal regulations with which particular healthcare facilities must comply in order to participate in the Medicare program. While these regulations directly apply to facilities, they affect CRNA practice and impair competition and choice. In particular, the requirement for physician supervision of CRNA services is costly and unnecessary.[xxiv] This requirement is more restrictive than the majority of state laws and impedes local communities from implementing the most innovative and competitive model of providing quality care. Reforming the CfCs and the CoPs to eliminate the costly and unnecessary requirement for physician supervision of CRNA anesthesia services supports delivery of health care in a manner allowing states and healthcare facilities nationwide to make their own decisions based on state laws and patient needs, thus controlling cost, providing access and delivering quality care.

Though one common argument for additional regulation is to protect public safety, there is no evidence that physician supervision of CRNAs improves patient safety or quality of care. In fact, there is strong and compelling data showing that physician supervision does not have any impact on quality, and may restrict access and increase cost. Studies have repeatedly demonstrated the high quality of nurse anesthesia care, and a 2010 study published in *Health Affairs*[xxv] led researchers to recommend that costly and duplicative supervision requirements for CRNAs be eliminated. Examining Medicare records from 1999-2005, the study compared anesthesia outcomes in 14 states that opted-out of the Medicare physician supervision requirement for CRNAs with those that did not opt out. (To date, 17 states have opted-out.) The researchers found that anesthesia has continued to become safer in opt-out and non-opt-out states alike. In reviewing the study, the *New York Times* stated, "In the long run, there could also be savings to the health care system if nurses delivered more of the care."[xxvi]

Another restriction in the Part A CfC regulations impairs CRNAs' ability to evaluate the risk of anesthesia in ambulatory surgical centers (ASCs), which again constrains competition and choice and increases healthcare costs without improving quality. Performing the comprehensive preanesthetic assessment and evaluation of the risk of anesthesia is within the scope of practice of a CRNA.[xxvii] We have asked that CMS recognize CRNAs as authorized to evaluate the risk of anesthesia immediately before a surgical procedure performed in an ASC in the same manner that the agency recognizes both CRNAs and physicians conducting the final pre-anesthetic assessment of risk for a patient in the hospital. In actual practice, CRNAs evaluate patients preoperatively for anesthesia risk in the ASC environment. The CRNA has a duty to do so, consistent with Standard 1 of the Standards for Nurse Anesthesia Practice.[xxviii] The current ASC rule on preanesthesia examination is inconsistent with ASC rules regarding patient discharge, and with Medicare hospital CoPs in this same area. Under the hospital CoPs for anesthesia services (42 CFR§ 482.52 (b) (1)), CRNAs are recognized to perform the pre-anesthesia evaluation for hospital patients presenting with a greater range of complexity and multiple chronic conditions than ASC patients.

Yet another restrictive regulation in the CoPs is the requirement that a physician serve as the director of anesthesia

services. This requirement places regulatory burdens on hospitals where they need to pay a stipend for a physician "in name only" to serve as director of the anesthesia department instead of allowing the hospital to have the flexibility to retain those services if they so desired. In some cases, the existing regulation leads to confusion by placing into the hands of persons inexpert in anesthesia care a federal regulatory responsibility for directing the unified anesthesia service of a hospital solely because he or she is a doctor of medicine or of osteopathy. In other cases, the hospital may contract with and pay a stipend to an anesthesiologist for department administration only, solely because there is a federal regulation. There is no evidence supporting the requirement for a physician or osteopathic doctor to direct anesthesia services. Again, such a regulation impairs choice and competition, and increases healthcare costs without improving quality.

Constraints in the legislative, regulatory, and practice arena can ultimately result in anticompetitive practices and collusion, increasing healthcare costs and diminishing quality of care and patient choice. In the early 2000s, the FTC and DOJ conducted two years of hearings on healthcare and antitrust, yielding a landmark joint report entitled *Improving Health Care: A Dose of Competition.*[xxix] More recently, the IOM report entitled *The Future of Nursing: Leading Change, Advancing Health*[xxx] specifically recommended that the FTC examine how anticompetitive acts, such as limiting APRNs like CRNAs from providing care to the fullest extent of their education and skill, reduce patient choice and increase healthcare costs without improving quality.

On the state level, the staff of the FTC's Office of Policy Planning, Bureau of Economics, and Bureau of Competition has submitted comment letters in response to proposed bills and a proposed rule that, if adopted, would impact the scope of practice of CRNAs and advanced practice nurses. In these letters, the FTC discouraged unnecessary restrictions on CRNA practice[xxxi] and supported eliminating requirements that advanced practice nurses collaborate with, or be supervised by, physicians.[xxxii]

The FTC has warned that unnecessary legislative or regulatory restrictions on CRNA pain management practice, if adopted, could reduce competition, raise the prices of pain management services, reduce the availability of these services, especially for the most vulnerable patients, and discourage healthcare innovation in this area. [xxxiii] Allowing CRNAs to practice to the full scope of their training and expertise in all areas of their practice will increase competition in the healthcare marketplace, as reflected by the FTC's own assessment of the competitive impact of various bills and proposed rules relating to regulatory restrictions on advanced practice nurses.

The FTC submitted letters commenting on restrictive pain management bills in Tennessee (2011), Missouri (2012) and Illinois (2013) respectively, expressing significant concern about overbroad state proposals that would prohibit or unduly restrict CRNA pain management practice, thereby raising prices and reducing availability of CRNA services.[xxxiv] In Tennessee and Missouri, the bills ultimately passed; however, the FTC comment letters generated discussion amongst the legislators and were cited during hearings. CRNAs utilized these letters as educational tools with legislators and as references during negotiations for more acceptable and less restrictive bill language. In Illinois, a restrictive pain management bill stalled at the committee level in 2013; a similar, revised restrictive pain management bill was introduced in Illinois in 2014 and is currently pending.[xxxv] The CRNAs are using the FTC's 2013 comment letter on the previous Illinois pain management bill in their efforts to educate legislators on the anti-competitive impacts of the bill.

In addition, the FTC commented favorably on bills in Connecticut (2013) and Massachusetts (2014) that proposed eliminating unnecessary restrictions on advanced practice registered nurses (APRNs).[xxxvi] The FTC stated that eliminating the requirement that APRNs have collaborative agreements with physicians in order to practice independently could benefit Connecticut health care consumers by expanding choices for patients, containing costs, and improving access to primary health care services (note that this collaborative agreement requirement does not apply to CRNAs).

V. PRICE TRANSPARENCY OF HEALTHCARE SERVICES

Anesthesia pricing is among the most opaque in all of healthcare, impairing competition and innovation. The medical direction payment model, in which an anesthesiologist performs seven specific tasks in each of up to four concurrent cases in exchange for 50 percent of a Medicare anesthesia fee, the CRNA providing the anesthesia service claiming the other 50 percent[xxxvii], is unique in healthcare, fails to fairly or accurately reflect the services provided to patients by each professional, and contributes significantly to healthcare cost growth. When a hospital employs CRNAs, and contracts with an anesthesiology group to provide anesthesiologist services, it is not uncommon for patients and plans to receive two bills for anesthesia services – or to learn, unpleasantly, that the anesthesiologist group is outside of the plan's network and demands full payment directly. The medical direction payment model introduces high costs of additional personnel that are not required to deliver an anesthesia service safely and effectively.

On account of the medical direction payment model, it is increasingly common that billings for anesthesia services do not represent all anesthesia costs in the system. One factor driving up the cost of healthcare is the practice of hospital subsidization of anesthesiology groups, in which hospitals pay high compensation to anesthesiology groups to offset the shortfall from decreasing reimbursement to these anesthesiology groups. According a nationwide survey of anesthesiology group subsidies,[xxxviii] hospitals pay an average of $160,096 per anesthetizing location to anesthesiology groups, an increase of 13 percent since the previous survey in 2008. An astounding 98.8 percent of responding hospitals in this national survey reported that they paid an anesthesiology group subsidy. Translated into concrete terms, a hospital with 20 operating rooms hospital pays an average of $3.2 million in anesthesiology subsidy. Anesthesiology groups receive this payment from hospitals in addition to their direct professional billing.

The agency also asked for examples where price transparency might facilitate price coordination among healthcare providers thereby damaging competition. Some anesthesia groups establish single source contracts with hospitals and healthcare facilities and the anesthesiology group does not negotiate with health plans. The group bills the patient directly for specific procedures, resulting in high out of pocket costs for the patient and curbing competition that could give patients more choices that may be less expensive.[xxxix] This type of model uses economic incentives and to drive up healthcare costs, while putting economic strains on consumers.

XI. MEASURING AND ASSESSING QUALITY OF HEALTH CARE

As we have stated previously, peer-reviewed scientific literature shows CRNA services ensure patient safety and access to high-quality care, and promote healthcare cost savings. According to a May/June 2010 study published in the journal of *Nursing Economic$*, CRNAs acting as the sole anesthesia provider are the most cost-effective model for anesthesia delivery, and there is no measurable difference in the quality of care between CRNAs and other anesthesia providers or by anesthesia delivery model.[xl] Furthermore, an August 2010 study published in *Health Affairs* shows no differences in patient outcomes when anesthesia services are provided by CRNAs, physicians, or CRNAs supervised by physicians.[xli]

In three significant aspects, Medicare billing modalities tend to significantly underrepresent the contributions that CRNAs and other APRNs make to healthcare delivery. In the field of anesthesia, billing services as "medically directed" suggests that in such cases anesthesiologists have performed each of the seven medical direction steps for which medical direction reimbursement is claimed. According to AANA member surveys and more importantly the American Society of Anesthesiologists journal *Anesthesiology*, medical direction frequently lapses[xlii] and one or more of the "medical direction" services are actually performed by the CRNA, just as they are performed when a service is billed nonmedically directed. Second, in many fields, the services of CRNAs, APRNs and other healthcare providers are frequently billed "incident-to" the services of a physician. Under "incident-to," the claim is paid at 100 percent, and the claim indicates that the service was provided by the physician not the CRNA or other APRN, without providing any modifier indicating who actually performed the service. "Incident-to" drives substantial underrepresentation of APRN services when claims data undergo examination. Last, not all Medicare Part B services provided by CRNAs are billed through Medicare Part B. In qualifying rural hospitals, Medicare Part A reimburses for the "reasonable cost" of CRNA services through a pass-through payment to the hospital. The CRNA may not bill Part B for services that the hospital bills Medicare through Part A. With CRNA services predominating in rural America, and many CRNA services noted not in Part B claims but embedded in Part A cost reports, ordinary Part B claims data underrepresents the anesthesia and pain management services CRNAs provide, particularly in rural and frontier parts of the United States.

With respect to registries, we strongly recommend that the infrastructure for quality reporting be accessible and transparent, particularly when it drives incentive payments from public benefit programs. Current registry procedures raise serious concerns about their accuracy and reliability with respect to reporting CRNA service provision. Under many registry practice rules the services that CRNAs and APRNs provide are often kept from being reported to registries organized and managed by medical specialty societies. When APRN services and data are reportable, the terms for participation and data submission are different from those that medical specialty society registries extend to physicians. In some cases physician organizations charge exorbitant fees for non-guild members to enroll in a registry, which is prohibitive to advanced practice nursing groups' participation. In this way, registries developed in response to public policy promoting healthcare quality may instead be used to justify illegitimate protection of guilds, higher healthcare costs, less competition and reduced access to care.

The FTC asked for a description of any challenges that are encountered when measuring quality. The AANA remains concerned over the use of EHR reporting, especially when CRNAs and other APRNs are ineligible for EHR incentives,

and note that this is a barrier to reporting of quality measures. We understand that the HITECH Act[xliii] did not include CRNAs as an "Eligible Professional," thus making them ineligible for incentive payments. However, CRNAs are "eligible professionals" under the Physician Quality Reporting System (PQRS) who regularly report quality measures and are eligible for incentive payments under that program. The AANA remains concerned that CRNAs must not be penalized in Medicare payment or in eligibility for PQRS incentives simply because they are currently ineligible for the EHR incentive program. We note that CMS seems to assume that CRNAs and other healthcare professionals will rely on the facilities where they work in order to adopt this technology. However, whole categories of healthcare facilities, such as ambulatory surgical centers (ASCs), are also ineligible for EHR incentive programs. Multiple levels of ineligibility cause an additional obstacle for providers, such as CRNAs, to have access to this technology in order to report quality measures electronically. Furthermore, the AANA is concerned that as CMS moves from claims based reporting to solely reporting through EHR-based reporting systems and through clinical registries, information on CRNAs will be underreported. As CMS expands the quality measures that can be reported through an EHR and ultimately ends the way that CRNAs predominately report measures, healthcare professionals such as CRNAs are at risk for being penalized and being placed at a disadvantage if they do not have access to report through a qualified EHR.

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[vii] 42 CFR §415.110. http://www.gpo.gov/fdsys/pkg/CFR-2003-title42-vol2/pdf/CFR-2003-title42-vol2-sec415-130.pdf

[viii] Hogan, *op cit*

[ix] 63 FR 58813, November 2, 1998, http://www.gpo.gov/fdsys/pkg/FR-1998-11-02/pdf/98-29181.pdf.

[x] AANA member survey, 2014

[xi] MGMA Physician Compensation and Production Survey, 2014. www.mgma.com

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[xiv] Rosenthal, E.. (2013, June 1). The $2.7 Trillion Medical Bill. *The New York Times,* pp. A1, A4. http://www.nytimes.com/2013/06/02/health/colonoscopies-explain-why-us-leads-the-world-in-health-expenditures.html?_r=0

[xv] Ibid.

[xvi] Patient Protection and Affordable Care Act, Sec. 1201, Subpart 1, creating a new Public Health Service Act Sec. 2706(a), Non-Discrimination in Healthcare (42 U.S.C. §.300gg-5). The statutory provision reads as follows: "(a) Providers.--A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any healthcare provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any healthcare provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures."

[xvii] Pub.L. 99-509 (42 U.S.C. § 1395 l(a)(1)(H), 42 U.S.C. § 1395 x(s)(11)).

[xviii] 77 Fed. Reg. 68892 (November 16, 2013).

[xix] 42 C.F.R. § 410.69(a).

[xx] Ibid.

[xxi] Regence Blue Shield of Idaho Professional Fee Schedule 2013 Supplemental Information: http://www.assets.regence.com/idreg/library/docs/2013-11-01/supplemental-information.pdf

[xxii] Blue Cross Blue Shield of South Carolina Anesthesia Guidelines: http://web.southcarolinablues.com/UserFiles/scblues/Documents/Providers/Anesthesia%20Guidelines_2012.pdf

[xxiii] Ibid.

[xxiv] *See* 42 CFR §§ 482.52, http://www.ecfr.gov/cgi-bin/text-idx?SID=fc767cbd4a62741e97f60fae03464e62&node=42:5.0.1.1.1&rgn=div5#42:5.0.1.1.1.4.4.2, , 482.639http://www.ecfr.gov/cgi-bin/text-idx?SID=fc767cbd4a62741e97f60fae03464e62&node=42:5.0.1.1.4&rgn=div5#42:5.0.1.1.4.4.7.16 , 416.42, http://www.ecfr.gov/cgi-bin/text-idx?SID=fc767cbd4a62741e97f60fae03464e62&node=42:3.0.1.1.3&rgn=div5#42:3.0.1.1.3.3.1.3 .

[xxv] Dulisse, *op cit*

[xxvi] Who should provide anesthesia care? (Editorial) *New York Times*, Sept. 6, 2010, http://www.nytimes.com/2010/09/07/opinion/07tue3.html?_r=0 .

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[xxviii] American Association of Nurse Anesthetists. Standards for Nurse Anesthesia Practice. Adopted 1974, Revised 2013. http://www.aana.com/resources2/professionalpractice/Documents/PPM%20Standards%20for%20Nurse%20Anesthesia%20Practice.pdf .

[xxix] Department of Justice and Federal Trade Commission op. cit..

[xxx] Institute of Medicine, *op cit*

[xxxi] *See* FTC November 3, 2010 letter to the Alabama State Board of Medical Examiners at http://www.ftc.gov/opa/2010/11/alabamarule.shtm .

[xxxii] *See* FTC March 19, 2013 letter to Connecticut State Representative Theresa W. Conroy at http://www.ftc.gov/news-events/press-releases/2013/03/ftc-staff-connecticut-should-consider-expanding-advance-practice and FTC January 23, 2014 letter to Massachusetts State Representative Kay Khan at http://www.ftc.gov/news-events/press-releases/2014/01/ftc-staff-massachusetts-should-consider-removing-physician.

[xxxiii] *See* FTC November 3, 2010 letter to the Alabama State Board of Medical Examiners at http://www.ftc.gov/opa/2010/11/alabamarule.shtm , FTC September 28, 2011 letter to Tennessee Representative Gary Odom at http://www.ftc.gov/opa/2011/10/nursestennessee.shtm , FTC March 27, 2012 letter to Missouri Representative Jeanne Kirkton at http://www.ftc.gov/opa/2012/03/missouripain.shtm , and FTC April 19, 2013 letter to Illinois Senator Heather Steans at http://www.ftc.gov/news-events/press-releases/2013/04/ftc-approves-final-order-settling-competition-charges-against .

[xxxiv] *See* FTC September 28, 2011 letter to Tennessee Representative Gary Odom at http://www.ftc.gov/opa/2011/10/nursestennessee.shtm , FTC March 27, 2012 letter to Missouri Representative Jeanne Kirkton at http://www.ftc.gov/opa/2012/03/missouripain.shtm , and FTC April 19, 2013 letter to Illinois Senator Heather Steans at http://www.ftc.gov/news-events/press-releases/2013/04/ftc-approves-final-order-settling-competition-charges-against .

[xxxv] *See* FTC April 19, 2013 letter to Illinois Senator Heather Steans at http://www.ftc.gov/news-events/press-releases/2013/04/ftc-approves-final-order-settling-competition-charges-against .

[xxxvi] *See* FTC March 19, 2013 letter to Connecticut State Representative Theresa W. Conroy at http://www.ftc.gov/news-events/press-releases/2013/03/ftc-staff-connecticut-should-consider-expanding-advance-practice and FTC January 23, 2014 letter to Massachusetts State Representative Kay Khan at http://www.ftc.gov/news-events/press-releases/2014/01/ftc-staff-massachusetts-should-consider-removing-physician .

[xxxvii] 42 CFR §415.110. http://www.gpo.gov/fdsys/pkg/CFR-2003-title42-vol2/pdf/CFR-2003-title42-vol2-sec415-130.pdf

[xxxviii] Healthcare Performance Strategies. Anesthesia Subsidy Survey 2012. http://drivinghp.com/consulting/2012-anesthesia-subsidy-survey-report-now-available/

[xxxix] Rosenthal, *op cit*

[xl] Hogan, *op cit.*

[xli] Dulisse, *op cit*

[xlii] Epstein, *op cit*

[xliii] American Recovery and Reinvestment Act of 2009. Pub. L. No. 110-275. http://www.gpo.gov/fdsys/pkg/PLAW-111publ309/html/PLAW-111publ309.htm

June 1, 2015

Rep. Kevin Brady
Chairman
House Ways and Means Health Subcommittee
301 Cannon Senate Office Building
United States House of Representatives
Washington, DC 20515

Rep. Jim McDermott
Ranking Member
House Ways and Means Health Subcommittee
1035 Longworth House Office Building
United States House of Representatives
Washington, DC 20515

Dear Chairman Brady and Ranking Member McDermott:

On behalf of over 48,000 members of the American Association of Nurse Anesthetists (AANA), I am writing to thank you for holding the first of several hearings on improving Medicare access through increased competition. Advanced practice registered nurses (APRNs), including Certified Registered Nurse Anesthetists (CRNAs), practicing to the full scope of their training and expertise ensures patient safety and access to safe, high-quality care, and promotes healthcare cost savings as well as increased competition in the healthcare marketplace and the Medicare program. For your consideration, we are enclosing a synopsis of two letters the AANA submitted to the Federal Trade Commission regarding their workshops on ''Examining Health Care Competition'' for further information.

Current reimbursement structures in Medicare impede full practice by CRNAs and add to waste in the program. Medicare reimburses CRNAs and anesthesiologists at the same rate for the same high quality service -- 100 percent of a fee for providing non-medically directed (CRNA) or personally performed (anesthesiologist) services. Medicare also operates a payment system for "anesthesiologist medical direction"[1] that provides a financial incentive for anesthesiologists to "medically direct" CRNAs who are already directly providing patient access to high quality anesthesia care themselves as part of the surgical team caring for the patient. The Centers for Medicare & Medicaid Services (CMS) has stated that medical direction is a condition of payment of anesthesiologist services and not a quality standard.[2] An anesthesiologist claiming medical direction services may be reimbursed 50 percent of a fee in each of up to four concurrent cases that the physician "medically directs", totaling 200 percent over a given period of time, twice what the anesthesiologist may claim when personally performing anesthesia services in one case. Under medical direction, the CRNA may claim the remaining 50 percent of a fee for his or her case. Peer-reviewed evidence demonstrates anesthesiologist medical direction increases healthcare costs without improving value.[3]

Furthermore, current Medicare regulations[4] contain a costly and unnecessary requirement for physician supervision of CRNA anesthesia services that do not support delivery of health care in a manner that

[1] 42 CFR §415.110. http://www.ecfr.gov/cgi-bin/text-idx?SID=5ce8cb6375c7d5c22c454c7ec1fe07de&node=42:3.0.1.1.2&rgn=div5#42:3.0.1.1.2.3.1.4
[2] 63 FR 58813, November 2, 1998, http://www.gpo.gov/fdsys/pkg/FR-1998-11-02/pdf/98-29181.pdf .
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[4] 42 CFR 482.52(a)(4) for hospitals (see http://www.ecfr.gov/cgi-bin/text-idx?SID=04387f6850fa030cb817311427be6f5f&mc=true&node=se42.5.482_152&rgn=div8), 42 CFR 485.639 (c) for CAHs (see http://www.ecfr.gov/cgi-bin/text-idx?SID=04387f6850fa030cb817311427be6f5f&mc=true&node=se42.5.485_1639&rgn=div8),

allows states and healthcare facilities nationwide to make their own decisions based on state laws and patient needs. These requirements are more restrictive than the majority of state laws and impede local communities from implementing the most innovative and competitive model of providing quality care. Given the growing population of persons in the United States requiring healthcare, particularly among Medicare eligible populations, physician supervision requirements stand in the way of deploying the vast workforce contained with the supply of APRNs. Unnecessary requirements for physician supervision of APRNs contribute to duplication and waste in the healthcare delivery system. Scientific peer-reviewed research underscores that such supervision does not affect quality or outcomes and increases healthcare costs and also illustrates how CRNAs consistently deliver safe, high-quality, cost-effective anesthesia care.[5]

CRNAs play a vital role in ensuring access to safe, high quality and cost effective anesthesia care. Congress and Medicare may advance patient access to care, reduce healthcare costs and waste in the Medicare program, while promoting competition, by eliminating policy barriers to the full use of CRNAs. We look forward to working with you on this important issue and should the Committee have any questions, please contact the AANA Senior Director of Federal Government Affairs, Frank Purcell, at 202.484.8400, fpurcell@aanadc.com.

Sincerely,

Sharon P. Pearce, CRNA, MSN
President

Attached: Addendum I: AANA Comments to Federal Trade Commission Health Care Workshop Request for Comment

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and 42 CFR 416.42 (b)(2)for ASCs (see http://www.ecfr.gov/cgi-bin/text-idx?SID=8198c35c58c98715100eb32ff0046536&mc=true&node=se42.3.416_142&rgn=div8).

[5] See American Association of Nurse Anesthetists, CRNAs: The Future of Anesthesia Care Today, http://www.future-of-anesthesia-care-today.com/research.php, and Christopher J. Conover and Robert Richards, "Economic Benefits of Less Restrictive Regulation of Advanced Practice Registered Nurses in North Carolina: An Analysis of Local and Statewide Effects on Business Activity, Duke University, February 2015, available at: http://chpir.org/wp-content/uploads/2015/02/Report-Final-Version.pdf.

Addendum I

The following comments were submitted in response to FTC Health Care Workshop, Project No. P131207 on March 10, 2014 and FTC Health Care Workshop, Project No. P13-1207 on February 16, 2015.

The AANA provided the FTC Health Care Workshop content covering the following areas:

I. Background of the AANA and Certified Registered Nurse Anesthetists (CRNAs)
II. Alternatives to Traditional Fee-for-Service Payment Models
III. Provider Network and Benefit Design
IV. Professional regulation of healthcare providers
V. Measuring and assessing quality of care
VI. Price transparency of healthcare services.

The content was composed so that each section could be read and considered independently by each workshop panel, therefore some material was repeated throughout the subject areas.

I. BACKGROUND OF THE AANA AND CRNAs

The AANA is the professional association for CRNAs and student nurse anesthetists. AANA membership includes more than 48,000 CRNAs and student registered nurse anesthetists representing over 90 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) and anesthesia professionals who safely administer more than 38 million anesthetics to patients each year in the United States, according to the 2012 AANA Practice Profile Survey. Nurse anesthetists have provided anesthesia care to patients in the U.S. for over 150 years, and high quality, cost effective and safe CRNA services continue to be in high demand. CRNAs are Medicare Part B providers and since 1989, have billed Medicare directly for 100 percent of the physician fee schedule amount for services.

CRNAs practice in every setting in which anesthesia is delivered: traditional hospital surgical suites and obstetrical delivery rooms; critical access hospitals; ambulatory surgical centers; the offices of dentists, podiatrists, ophthalmologists, plastic surgeons, and pain management specialists; and U.S. military, Public Health Services, and Department of Veterans Affairs healthcare facilities. CRNA services include providing a pre-anesthetic assessment, obtaining informed consent for anesthesia administration, developing a plan for anesthesia administration, administering the anesthetic, monitoring and interpreting the patient's vital signs, and managing the patient throughout the surgery. CRNAs also provide acute and chronic pain management services. CRNAs provide anesthesia for a wide variety of surgical cases and are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities.

Peer-reviewed scientific literature shows CRNA services ensure patient safety and access to high-quality care, and promote healthcare cost savings. According to a May/June 2010 study published in the journal of *Nursing Economic$*, CRNAs acting as the sole anesthesia provider are the most cost-effective model for anesthesia delivery, and there is no measurable difference in the quality of care between CRNAs and other anesthesia providers or by anesthesia delivery model.[i] Furthermore, an August 2010 study published in *Health Affairs* shows no differences in patient outcomes when anesthesia services are provided by CRNAs, physicians, or CRNAs supervised by physicians.[ii] Researchers studying anesthesia safety found no differences in care between nurse anesthetists and physician anesthesiologists based on an exhaustive analysis of research literature published in the United States and around the world, according to a scientific literature review prepared by the Cochrane Collaboration.[iii]

According to a 2007 Government Accountability Office (GAO) study, CRNAs are the predominant anesthesia provider where there are more Medicare beneficiaries and where the gap between Medicare and private pay is less.[iv] Nurse anesthesia predominates in Veterans Hospitals, the U.S. Armed Forces and Public Health Service. CRNAs work in every setting in which anesthesia is delivered including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers (ASCs), pain management facilities and the offices of dentists, podiatrists, and all types of specialty surgeons. As colleagues and competitors in the provision of anesthesia and pain management services, CRNAs and anesthesiologists have long been considered substitutes in the delivery of surgeries.[v]

In its landmark publication *The Future of Nursing: Leading Change, Advancing Health*, the Institute of Medicine made its first recommendation that advanced practice registered nurses (APRNs) such as CRNAs be authorized to practice to their full scope, in the interest of patient access to quality care, and in the interest of competition to help promote innovation and control healthcare price growth.[vi]

II. ALTERNATIVES TO TRADITIONAL FEE-FOR-SERVICE PAYMENT MODEL

The AANA supports the FTC's efforts to better understand the potential benefits of alternative payment models and whether they can offer significant cost savings while maintaining, or helping to improve, quality of care. Under the current fee-for-service model, there are instances where the current model contributes to high costs without improving quality. Similar to general physician payment, Medicare reimburses CRNAs and anesthesiologists the same rate for the same high quality service -- 100 percent of a fee for providing non-medically directed (CRNA) or personally performed (anesthesiologist) services. It also includes a system for "anesthesiologist medical direction"[vii] that provides a financial incentive for anesthesiologists to "medically direct" CRNAs who are capable of and are often providing patient access to high quality anesthesia care unassisted. An anesthesiologist claiming medical direction services may be reimbursed 50 percent of a fee in each of up to four concurrent cases, a total of 200 percent over a given period of time, twice what the anesthesiologist may claim when personally performing anesthesia services in one case. Under medical direction, the CRNA may claim the remaining 50 percent of a fee for his or her case. Peer-reviewed evidence demonstrates anesthesiologist medical direction increases healthcare costs without improving value.[viii] Furthermore, the Centers for Medicare & Medicaid Services (CMS) has stated that medical direction is a condition of payment of anesthesiologist services and not a quality standard.[ix]

In demonstrating the increased costs, suppose that there are four identical cases: (a) has anesthesia delivered by a non-medically directed CRNA; (b) has anesthesia delivered by a CRNA medically directed at a 4:1 ratio by a physician overseeing four simultaneous cases and attesting fulfillment of the seven conditions of medical direction in each; (c) has anesthesia delivered by a CRNA medically directed at a 2:1 ratio; and (d) has anesthesia delivered by a physician personally performing the anesthesia service. (There are instances where more than one anesthesia professional is warranted; however, neither patient acuity nor case complexity is a part of the regulatory determination for medically directed services. The literature demonstrates that the quality of medically directed vs. non-medically directed CRNA services is indistinguishable in terms of patient outcomes, quality and safety.) Further suppose that the annual pay of the anesthesia professionals approximate national market conditions, $170,000 for the CRNA[x] and $540,314 for the anesthesiologist.[xi] Under the Medicare program and most private payment systems, practice modalities (a), (b), (c) and (d) are reimbursed the same. Moreover, the literature indicates the quality of medically directed vs. non-medically directed CRNA services is indistinguishable. However, the annualized labor costs (excluding benefits) for each modality vary widely. The annualized cost of practice modality (a) equals $170,000 per year. For case (b), it is ($170,000 + (0.25 x $540,314) or $305,079 per year. For case (c) it is ($170,000 + (0.50 x $540,314) or $440,157 per year. Finally, for case (d), the annualized cost equals $540,314 per year.

Anesthesia Payment Model	FTEs / Case	Clinician costs per year / FTE
(a) CRNA Nonmedically Directed	1.00	$170,000
(b) Medical Direction 1:4	1.25	$305,079
(c) Medical Direction 1:2	1.50	$440,157
(d) Anesthesiologist Only	1.00	$540,314
Anesthesiologist mean annual pay	*$540,314*	*MGMA, 2014*
CRNA mean annual pay	*$170,000*	*AANA, 2014*

If Medicare and private plans pay the same rate whether the care is delivered according to modalities (a), (b), (c) or (d), someone in the health system is bearing the additional cost of the medical direction service authorized under the Medicare regulations at 42 CFR §415.110. This additional cost is shifted onto hospitals and other healthcare facilities, and ultimately to patients, premium payers and taxpayers. With CRNAs providing over 38 million anesthetics in the U.S., and a considerable fraction of them being "medically directed," the additional costs of this medical direction service are substantial. In addition, the most recent peer-reviewed literature makes clear that the requirements of anesthesiologist medical direction are often not met in practice– and if anesthesiologists submit claims to Medicare for medical direction but did not perform all of the required services in each instance, then the likelihood of widespread Medicare fraud in this area is high. Lapses in anesthesiologist supervision of CRNAs are common even when an anesthesiologist is medically directing as few as two CRNAs, according to an important new study published in the journal *Anesthesiology*.[xii]

Another factor driving up the cost of healthcare under the current fee-for-service model is the practice of hospital subsidization of anesthesiology groups, in which hospitals pay high compensation to anesthesiology groups to offset the shortfall from decreasing reimbursement to these anesthesiology groups. According a nationwide survey of anesthesiology group subsidies,[xiii] hospitals pay an average of $160,096 per anesthetizing location to anesthesiology groups, an increase of 13 percent since the previous survey in 2008. An astounding 98.8 percent of responding hospitals in this national survey reported that they paid an anesthesiology group subsidy. Translated into concrete terms, a hospital with 20 operating rooms pays an average of $3.2 million in anesthesiology subsidy. Such payments from hospitals to anesthesiology groups do not appear on hospitals' Medicare cost reports or their billings to health plans, making information about them hard to come by except from survey information. Anesthesiology groups receive this payment from hospitals in addition to their direct professional billing. Without question, such subsidy payments to anesthesiology groups represent cost-shifting away from other critical services within the healthcare delivery system.

As the FTC examines the merits of alternative payment systems, we recommend ensuring that these alternatives are in the best interests of the patients receiving care, that they encourage improvements in patient care quality and efficiency, and that the alternative payment systems have been developed and deployed in a manner that healthcare professionals deem as valid.

Alternative payment systems should recognize and reward all qualified healthcare providers, not just physicians, for ensuring patient access to safe, cost-effective healthcare services. Bundled payment systems can reward care coordination and cost-efficiency, but without an equal and crucial focus on quality such systems can lead to a harmful "race to the bottom" when incentives to cut costs are not balanced with quality standards – an outcome that must be avoided. Bundled payment systems should recognize the full range of qualified healthcare providers delivering care, including CRNAs and other APRNs, and avoid physician-centricity that increases costs without improving quality or access.

Alternative payment models, such as bundled payment, have the potential to drive value-based healthcare delivery, particularly in anesthesia care and related services, and meet the triple health care aims of improving patient experience of care, improving population health and reducing health care costs. But certain alternative payment models do not follow these goals and instead lead to higher healthcare costs and decreased access to safe, high quality anesthesia providers such as CRNAs. One type of payment model that does not drive value-based healthcare delivery can be found in large group practices composed solely of anesthesiologists. Holding substantial market power, these large anesthesiologist-only group practices enter into exclusive single source contract service agreements with health systems, facilities and surgeons where the group practice's market power increases costs, limits choice of anesthesia provider, and imposes opportunity costs that deprive resources from delivery of other critical healthcare services. Such enterprises may use their market power to maximize their income without relation to the actual costs of performing the procedure.[xiv] For example, according to the New York Times, a patient was billed $8,675 for anesthesia during cardiac surgery. The anesthesia group accepted $6,970 from United Healthcare, $5,208.01 from Blue Cross and Blue Shield, $1,605.29 from Medicare and $797.50 from Medicaid.[xv] This type of model drives up healthcare costs and puts additional economic strain on consumers and the country.

III. PROVIDER NETWORK AND BENEFIT DESIGN

We have found that in some states, health plan networks operating in exchanges and in the private market conduct discriminatory behaviors based on provider licensure which violates the provider nondiscrimination provision in the Affordable Care Act and inhibits CRNAs' ability to practice to full extent of their scope of practice. The end result of these practices is increased healthcare costs, diminished competition and reduced patient choice for safe, high quality and cost-effective anesthesia and related services.

The federal provider nondiscrimination provision in the Patient Protection and Affordable Care Act (Sec. 1201, Subpart 1, creating a new Public Health Service Act Sec. 2706(a), "Non-Discrimination in Health Care, 42 USC §300gg-5),[xvi] which took effect January 1, 2014, states that "a group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any healthcare provider who is acting within the scope of that provider's license or certification under applicable State law." It also states that, "nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures."

Section 2706 is an important law because it promotes competition, consumer choice and high quality healthcare by prohibiting discrimination based on provider licensure that keeps patients from getting the care they need. To promote patient access to high quality healthcare, market competition and cost efficiency, health insurance exchanges, health insurers and health plans must avoid discrimination against qualified, licensed healthcare professionals, such as CRNAs, solely on the basis of licensure. Proper implementation of the provider nondiscrimination provision is crucial because health plans have wide latitude to determine the quantity, type, and geographic location of healthcare professionals they include in their networks, based on the needs their enrollees. However, when health plans organize their healthcare delivery in such a way that they discriminate against whole classes of qualified licensed healthcare professionals by licensure -- by prohibiting reimbursement for anesthesia and pain management services provided by CRNAs, for example -- patient access to care is impaired, consumer choice suffers, and healthcare costs climb for lack of competition.

The provider nondiscrimination provision also respects local control and autonomy in the organization of healthcare delivery systems, health plans and benefits. It does not impose "any willing provider" requirements on health plans, and it does not prevent group health plans or health insurance issuers from establishing varying reimbursement rates based on quality or performance measures.

Types and Examples of Provider Discrimination

The AANA believes it is discrimination if health plans or health insurers have a policy that reimburses differently for the same services provided by different provider types solely on account of their licensure. Medicare reimburses CRNAs directly for their services and does so at 100 percent of the physician fee schedule amount for services, the same rate as physicians for the same services. The Omnibus Budget Reconciliation Act (OBRA) of 1986 authorized direct reimbursement of CRNA services under Medicare Part B beginning in 1989.[xvii] The Medicare regulation implementing the OBRA law, updated as part of a November 2012 final rule further clarifying the authorization of direct reimbursement of nurse anesthesia services within the provider's state scope of practice,[xviii] states, "Medicare Part B pays for anesthesia services and related care furnished by a certified registered nurse anesthetist who is legally authorized to perform the services by the State in which the services are furnished."[xix] The final rule also states, "Anesthesia and related care means those services that a certified registered nurse anesthetist is legally authorized to perform in the state in which the services are furnished." The agency also said in the rule's preamble, "In addition, we agree with commenters that the primary responsibility for establishing the scope of services CRNAs are sufficiently trained and, thus, should be authorized to furnish, resides with the states."[xx] Therefore, the Medicare agency stands on solid ground in clarifying that the nondiscrimination provision should apply to private plans in a way that is consistent with Medicare direct reimbursement of CRNA services where they are allowed to furnish those services under state law.

Unfortunately, we have heard from our members who state that certain health plans and insurers across the United States have policies that discriminate against CRNAs. In many of these cases, health plans or insurers either do not reimburse CRNAs at all for anesthesia services that are fully reimbursed when performed by anesthesiologists, or they reimburse CRNAs at a lower rate than anesthesiologists for performing the same services. For example, effective November 1, 2013, Regence Blue Shield of Idaho lowered CRNA reimbursement by 15 percent for anesthesia services. Its new policy states, "Physician conversion factor is $55.10. Certified Registered Nurse Anesthetist conversion factor is $46.84."[xxi] When justifying its rationale for setting the reimbursement rates for all non-physician healthcare providers, including CRNAs, at 85 percent of the physician rate, Regence stated in a letter to a CRNA that the decision was in part "based on the difference in education, training and scope of practice" between physician and non-physician providers. Regence did not identify any differences in "quality or performance measures" to explain the reimbursement differential. As we have shown above, the literature is clear in showing that no quality outcomes difference can be found between the models of CRNA anesthesia care, anesthesiologist services, or both professionals providing anesthesia care together.

If a health plan or health insurer network offers a specific covered service, Section 2706 requires that the health insurer or health plan network include all types of qualified licensed providers who can offer that service. If a health plan offers coverage for anesthesia services, it should allow all anesthesia provider types to participate in their networks and should not refuse to contract with CRNAs just based on their licensure alone. For example, as of April 2012, Blue Cross Blue Shield of South Carolina states in its anesthesia guidelines policy manual that it will not reimburse CRNAs for monitored anesthesia care (MAC), but it will pay anesthesiologists for these same services.[xxii] Specifically the policy states, "BlueCross may reimburse for modifiers QS, G8 and G9 if a physician personally performs the procedure (modifier AA) and if the procedure meets medical necessity criteria. BlueCross will not reimburse CRNAs for MAC."[xxiii]

The AANA views all of these policies outlined above as examples of discrimination against CRNAs based on their licensure and not based on CRNA quality and performance, and such discrimination clearly is prohibited by Section 2706. These policies impair patient access to care provided by CRNAs, and they expressly impair competition and choice, and contribute to unjustifiably higher healthcare costs without improving quality or access to care. The negative impacts of provider discrimination can hit rural communities hardest, where CRNAs are the primary anesthesia professionals and often the sole anesthesia providers. The availability of CRNAs in rural America enables hospitals and other healthcare facilities to offer obstetrical, surgical, and trauma stabilization services to patients who otherwise might be forced to travel long distances for these essential care. As stated above, CRNAs have been providing safe and high-quality anesthesia care in the United States for 150 years and the AANA is a determined advocate for patients and CRNAs concerning issues such as access to quality healthcare services and patient safety.

We believe proper implementation of the provider nondiscrimination provision by preventing health plans and health insurers from discriminating against specific types of health providers, such as CRNAs, will ensure full access to anesthesia services and to the procedures and services that they make possible, efficient delivery and local management and optimization of these services, and equitable reimbursement for CRNA services based on quality and performance, rather than licensure. This is consistent with the FTC's and the public's interests in quality, access and cost-effectiveness. Ensuring that health plans and health insurers adhere to the provider nondiscrimination law will protect competition and patient choice and promote patient access to a range of beneficial, safe, and cost-efficient healthcare services, such as those provided by CRNAs.

IV. PROFESSIONAL REGULATION OF HEALTHCARE PROVIDERS

Several constraints in the legislative, regulatory, and practice arenas inhibit CRNAs' ability to practice to full extent of their scope, reducing competition and choice and increasing healthcare costs. CRNAs' ability to practice to their full scope is also affected by Medicare regulations associated with Medicare Part A Conditions of Participation and Conditions for Coverage (CoPs and CfCs). The Medicare CoPs and CfCs are federal regulations with which particular healthcare facilities must comply in order to participate in the Medicare program. While these regulations directly apply to facilities, they affect CRNA practice and impair competition and choice. In particular, the requirement for physician supervision of CRNA services is costly and unnecessary.[xxiv] This requirement is more restrictive than the majority of state laws and impedes local communities from implementing the most innovative and competitive model of providing quality care. Reforming the CfCs and the CoPs to eliminate the costly and unnecessary requirement for physician supervision of CRNA anesthesia services supports delivery of health care in a manner allowing states and healthcare facilities nationwide to make their own decisions based on state laws and patient needs, thus controlling cost, providing access and delivering quality care.

Though one common argument for additional regulation is to protect public safety, there is no evidence that physician supervision of CRNAs improves patient safety or quality of care. In fact, there is strong and compelling data showing that physician supervision does not have any impact on quality, and may restrict access and increase cost. Studies have repeatedly demonstrated the high quality of nurse anesthesia care, and a 2010 study published in *Health Affairs*[xxv] led researchers to recommend that costly and duplicative supervision requirements for CRNAs be eliminated. Examining Medicare records from 1999-2005, the study compared anesthesia outcomes in 14 states that opted-out of the Medicare physician supervision requirement for CRNAs with those that did not opt out. (To date, 17 states have opted-out.) The researchers found that anesthesia has continued to become safer in opt-out and non-opt-out states alike. In reviewing the study, the *New York Times* stated, "In the long run, there could also be savings to the health care system if nurses delivered more of the care."[xxvi]

Another restriction in the Part A CfC regulations impairs CRNAs' ability to evaluate the risk of anesthesia in ambulatory surgical centers (ASCs), which again constrains competition and choice and increases healthcare costs without improving quality. Performing the comprehensive preanesthetic assessment and evaluation of the risk of anesthesia is within the scope of practice of a CRNA.[xxvii] We have asked that CMS recognize CRNAs as authorized to evaluate the risk of anesthesia immediately before a surgical procedure performed in an ASC in the same manner that the agency recognizes both CRNAs and physicians conducting the final pre-anesthetic assessment of risk for a patient in the hospital. In actual practice, CRNAs evaluate patients preoperatively for anesthesia risk in the ASC environment. The CRNA has a duty to do so, consistent with Standard 1 of the Standards for Nurse Anesthesia Practice.[xxviii] The current ASC rule on preanesthesia examination is inconsistent with ASC rules regarding patient discharge, and with Medicare hospital CoPs in this same area. Under the hospital CoPs for anesthesia services (42 CFR§ 482.52 (b) (1)), CRNAs are recognized to perform the

pre-anesthesia evaluation for hospital patients presenting with a greater range of complexity and multiple chronic conditions than ASC patients.

Yet another restrictive regulation in the CoPs is the requirement that a physician serve as the director of anesthesia services. This requirement places regulatory burdens on hospitals where they need to pay a stipend for a physician "in name only" to serve as director of the anesthesia department instead of allowing the hospital to have the flexibility to retain those services if they so desired. In some cases, the existing regulation leads to confusion by placing into the hands of persons inexpert in anesthesia care a federal regulatory responsibility for directing the unified anesthesia service of a hospital solely because he or she is a doctor of medicine or of osteopathy. In other cases, the hospital may contract with and pay a stipend to an anesthesiologist for department administration only, solely because there is a federal regulation. There is no evidence supporting the requirement for a physician or osteopathic doctor to direct anesthesia services. Again, such a regulation impairs choice and competition, and increases healthcare costs without improving quality.

Constraints in the legislative, regulatory, and practice arena can ultimately result in anticompetitive practices and collusion, increasing healthcare costs and diminishing quality of care and patient choice. In the early 2000s, the FTC and DOJ conducted two years of hearings on healthcare and antitrust, yielding a landmark joint report entitled *Improving Health Care: A Dose of Competition.*[xxix] More recently, the IOM report entitled *The Future of Nursing: Leading Change, Advancing Health*[xxx] specifically recommended that the FTC examine how anticompetitive acts, such as limiting APRNs like CRNAs from providing care to the fullest extent of their education and skill, reduce patient choice and increase healthcare costs without improving quality.

On the state level, the staff of the FTC's Office of Policy Planning, Bureau of Economics, and Bureau of Competition has submitted comment letters in response to proposed bills and a proposed rule that, if adopted, would impact the scope of practice of CRNAs and advanced practice nurses. In these letters, the FTC discouraged unnecessary restrictions on CRNA practice[xxxi] and supported eliminating requirements that advanced practice nurses collaborate with, or be supervised by, physicians.[xxxii]

The FTC has warned that unnecessary legislative or regulatory restrictions on CRNA pain management practice, if adopted, could reduce competition, raise the prices of pain management services, reduce the availability of these services, especially for the most vulnerable patients, and discourage healthcare innovation in this area. [xxxiii] Allowing CRNAs to practice to the full scope of their training and expertise in all areas of their practice will increase competition in the healthcare marketplace, as reflected by the FTC's own assessment of the competitive impact of various bills and proposed rules relating to regulatory restrictions on advanced practice nurses.

The FTC submitted letters commenting on restrictive pain management bills in Tennessee (2011), Missouri (2012) and Illinois (2013) respectively, expressing significant concern about overbroad state proposals that would prohibit or unduly restrict CRNA pain management practice, thereby raising prices and reducing availability of CRNA services.[xxxiv] In Tennessee and Missouri, the bills ultimately passed; however, the FTC comment letters generated discussion amongst the legislators and were cited during hearings. CRNAs utilized these letters as educational tools with legislators and as references during negotiations for more acceptable and less restrictive bill language. In Illinois, a restrictive pain management bill stalled at the committee level in 2013; a similar, revised restrictive pain management bill was introduced in Illinois in 2014 and is currently pending.[xxxv] The CRNAs are using the FTC's 2013 comment letter on the previous Illinois pain management bill in their efforts to educate legislators on the anti-competitive impacts of the bill.

In addition, the FTC commented favorably on bills in Connecticut (2013) and Massachusetts (2014) that proposed eliminating unnecessary restrictions on advanced practice registered nurses (APRNs).[xxxvi] The FTC stated that eliminating the requirement that APRNs have collaborative agreements with physicians in order to practice independently could benefit Connecticut health care consumers by expanding choices for patients, containing costs, and improving access to primary health care services (note that this collaborative agreement requirement does not apply to CRNAs).

V. PRICE TRANSPARENCY OF HEALTHCARE SERVICES

Anesthesia pricing is among the most opaque in all of healthcare, impairing competition and innovation. The medical direction payment model, in which an anesthesiologist performs seven specific tasks in each of up to four concurrent cases in exchange for 50 percent of a Medicare anesthesia fee, the CRNA providing the anesthesia service claiming the other 50 percent[xxxvii], is unique in healthcare, fails to fairly or accurately reflect the services provided to patients by each professional, and contributes significantly to healthcare cost growth. When a hospital employs CRNAs, and contracts with

an anesthesiology group to provide anesthesiologist services, it is not uncommon for patients and plans to receive two bills for anesthesia services – or to learn, unpleasantly, that the anesthesiologist group is outside of the plan's network and demands full payment directly. The medical direction payment model introduces high costs of additional personnel that are not required to deliver an anesthesia service safely and effectively.

On account of the medical direction payment model, it is increasingly common that billings for anesthesia services do not represent all anesthesia costs in the system. One factor driving up the cost of healthcare is the practice of hospital subsidization of anesthesiology groups, in which hospitals pay high compensation to anesthesiology groups to offset the shortfall from decreasing reimbursement to these anesthesiology groups. According a nationwide survey of anesthesiology group subsidies,[xxxviii] hospitals pay an average of $160,096 per anesthetizing location to anesthesiology groups, an increase of 13 percent since the previous survey in 2008. An astounding 98.8 percent of responding hospitals in this national survey reported that they paid an anesthesiology group subsidy. Translated into concrete terms, a hospital with 20 operating rooms hospital pays an average of $3.2 million in anesthesiology subsidy. Anesthesiology groups receive this payment from hospitals in addition to their direct professional billing.

The agency also asked for examples where price transparency might facilitate price coordination among healthcare providers thereby damaging competition. Some anesthesia groups establish single source contracts with hospitals and healthcare facilities and the anesthesiology group does not negotiate with health plans. The group bills the patient directly for specific procedures, resulting in high out of pocket costs for the patient and curbing competition that could give patients more choices that may be less expensive.[xxxix] This type of model uses economic incentives and to drive up healthcare costs, while putting economic strains on consumers.

XI. MEASURING AND ASSESSING QUALITY OF HEALTH CARE

As we have stated previously, peer-reviewed scientific literature shows CRNA services ensure patient safety and access to high-quality care, and promote healthcare cost savings. According to a May/June 2010 study published in the journal of *Nursing Economic$*, CRNAs acting as the sole anesthesia provider are the most cost-effective model for anesthesia delivery, and there is no measurable difference in the quality of care between CRNAs and other anesthesia providers or by anesthesia delivery model.[xl] Furthermore, an August 2010 study published in *Health Affairs* shows no differences in patient outcomes when anesthesia services are provided by CRNAs, physicians, or CRNAs supervised by physicians.[xli]

In three significant aspects, Medicare billing modalities tend to significantly underrepresent the contributions that CRNAs and other APRNs make to healthcare delivery. In the field of anesthesia, billing services as "medically directed" suggests that in such cases anesthesiologists have performed each of the seven medical direction steps for which medical direction reimbursement is claimed. According to AANA member surveys and more importantly the American Society of Anesthesiologists journal *Anesthesiology*, medical direction frequently lapses[xlii] and one or more of the "medical direction" services are actually performed by the CRNA, just as they are performed when a service is billed nonmedically directed. Second, in many fields, the services of CRNAs, APRNs and other healthcare providers are frequently billed "incident-to" the services of a physician. Under "incident-to," the claim is paid at 100 percent, and the claim indicates that the service was provided by the physician not the CRNA or other APRN, without providing any modifier indicating who actually performed the service. "Incident-to" drives substantial underrepresentation of APRN services when claims data undergo examination. Last, not all Medicare Part B services provided by CRNAs are billed through Medicare Part B. In qualifying rural hospitals, Medicare Part A reimburses for the "reasonable cost" of CRNA services through a pass-through payment to the hospital. The CRNA may not bill Part B for services that the hospital bills Medicare through Part A. With CRNA services predominating in rural America, and many CRNA services noted not in Part B claims but embedded in Part A cost reports, ordinary Part B claims data underrepresents the anesthesia and pain management services CRNAs provide, particularly in rural and frontier parts of the United States.

With respect to registries, we strongly recommend that the infrastructure for quality reporting be accessible and transparent, particularly when it drives incentive payments from public benefit programs. Current registry procedures raise serious concerns about their accuracy and reliability with respect to reporting CRNA service provision. Under many registry practice rules the services that CRNAs and APRNs provide are often kept from being reported to registries organized and managed by medical specialty societies. When APRN services and data are reportable, the terms for participation and data submission are different from those that medical specialty society registries extend to physicians. In some cases physician organizations charge exorbitant fees for non-guild members to enroll in a registry, which is prohibitive to advanced practice nursing groups' participation. In this way, registries developed in response to public

policy promoting healthcare quality may instead be used to justify illegitimate protection of guilds, higher healthcare costs, less competition and reduced access to care.

The FTC asked for a description of any challenges that are encountered when measuring quality. The AANA remains concerned over the use of EHR reporting, especially when CRNAs and other APRNs are ineligible for EHR incentives, and note that this is a barrier to reporting of quality measures. We understand that the HITECH Act[xliii] did not include CRNAs as an "Eligible Professional," thus making them ineligible for incentive payments. However, CRNAs are "eligible professionals" under the Physician Quality Reporting System (PQRS) who regularly report quality measures and are eligible for incentive payments under that program. The AANA remains concerned that CRNAs must not be penalized in Medicare payment or in eligibility for PQRS incentives simply because they are currently ineligible for the EHR incentive program. We note that CMS seems to assume that CRNAs and other healthcare professionals will rely on the facilities where they work in order to adopt this technology. However, whole categories of healthcare facilities, such as ambulatory surgical centers (ASCs), are also ineligible for EHR incentive programs. Multiple levels of ineligibility cause an additional obstacle for providers, such as CRNAs, to have access to this technology in order to report quality measures electronically. Furthermore, the AANA is concerned that as CMS moves from claims based reporting to solely reporting through EHR-based reporting systems and through clinical registries, information on CRNAs will be underreported. As CMS expands the quality measures that can be reported through an EHR and ultimately ends the way that CRNAs predominately report measures, healthcare professionals such as CRNAs are at risk for being penalized and being placed at a disadvantage if they do not have access to report through a qualified EHR.

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[xv] Ibid.
[xvi] Patient Protection and Affordable Care Act, Sec. 1201, Subpart 1, creating a new Public Health Service Act Sec. 2706(a), Non-Discrimination in Healthcare (42 U.S.C. §.300gg-5). The statutory provision reads as follows: "(a) Providers.--A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any healthcare provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any healthcare provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures."
[xvii] Pub.L. 99-509 (42 U.S.C. § 1395 l(a)(1)(H), 42 U.S.C. § 1395 x(s)(11)).
[xviii] 77 Fed. Reg. 68892 (November 16, 2013).
[xix] 42 C.F.R. § 410.69(a).
[xx] Ibid.
[xxi] Regence Blue Shield of Idaho Professional Fee Schedule 2013 Supplemental Information: http://www.assets.regence.com/idreg/library/docs/2013-11-01/supplemental-information.pdf
[xxii] Blue Cross Blue Shield of South Carolina Anesthesia Guidelines: http://web.southcarolinablues.com/UserFiles/scblues/Documents/Providers/Anesthesia%20Guidelines_2012.pdf
[xxiii] Ibid.
[xxiv] *See* 42 CFR §§ 482.52, http://www.ecfr.gov/cgi-bin/text-idx?SID=fc767cbd4a62741e97f60fae03464e62&node=42:5.0.1.1.1&rgn=div5#42:5.0.1.1.1.4.4.2, , 482.639http://www.ecfr.gov/cgi-bin/text-idx?SID=fc767cbd4a62741e97f60fae03464e62&node=42:5.0.1.1.4&rgn=div5#42:5.0.1.1.4.4.7.16 , 416.42, http://www.ecfr.gov/cgi-bin/text-idx?SID=fc767cbd4a62741e97f60fae03464e62&node=42:3.0.1.1.3&rgn=div5#42:3.0.1.1.3.3.1.3 .
[xxv] Dulisse, *op cit*
[xxvi] Who should provide anesthesia care? (Editorial) *New York Times*, Sept. 6, 2010, http://www.nytimes.com/2010/09/07/opinion/07tue3.html?_r=0 .
[xxvii] American Association of Nurse Anesthetists Scope of Nurse Anesthesia Practice 2013, http://www.aana.com/resources2/professionalpractice/Documents/PPM%20Scope%20of%20Nurse%20Anesthesia%20Practice.pdf
[xxviii] American Association of Nurse Anesthetists. Standards for Nurse Anesthesia Practice. Adopted 1974, Revised 2013. http://www.aana.com/resources2/professionalpractice/Documents/PPM%20Standards%20for%20Nurse%20Anesthesia%20Practice.pdf .
[xxix] Department of Justice and Federal Trade Commission op. cit..
[xxx] Institute of Medicine, *op cit*
[xxxi] *See* FTC November 3, 2010 letter to the Alabama State Board of Medical Examiners at http://www.ftc.gov/opa/2010/11/alabamarule.shtm .
[xxxii] *See* FTC March 19, 2013 letter to Connecticut State Representative Theresa W. Conroy at http://www.ftc.gov/news-events/press-releases/2013/03/ftc-staff-connecticut-should-consider-expanding-advance-practice and FTC January 23, 2014 letter to Massachusetts State Representative Kay Khan at http://www.ftc.gov/news-events/press-releases/2014/01/ftc-staff-massachusetts-should-consider-removing-physician.
[xxxiii] *See* FTC November 3, 2010 letter to the Alabama State Board of Medical Examiners at http://www.ftc.gov/opa/2010/11/alabamarule.shtm , FTC September 28, 2011 letter to Tennessee Representative Gary Odom at http://www.ftc.gov/opa/2011/10/nursestennessee.shtm , FTC March 27, 2012 letter to Missouri Representative Jeanne Kirkton at http://www.ftc.gov/opa/2012/03/missouripain.shtm , and FTC April 19, 2013 letter to Illinois Senator Heather Steans at http://www.ftc.gov/news-events/press-releases/2013/04/ftc-approves-final-order-settling-competition-charges-against .
[xxxiv] *See* FTC September 28, 2011 letter to Tennessee Representative Gary Odom at http://www.ftc.gov/opa/2011/10/nursestennessee.shtm , FTC March 27, 2012 letter to Missouri Representative Jeanne Kirkton at http://www.ftc.gov/opa/2012/03/missouripain.shtm , and FTC April 19, 2013 letter to Illinois Senator Heather Steans at http://www.ftc.gov/news-events/press-releases/2013/04/ftc-approves-final-order-settling-competition-charges-against .
[xxxv] *See* FTC April 19, 2013 letter to Illinois Senator Heather Steans at http://www.ftc.gov/news-events/press-releases/2013/04/ftc-approves-final-order-settling-competition-charges-against .
[xxxvi] *See* FTC March 19, 2013 letter to Connecticut State Representative Theresa W. Conroy at http://www.ftc.gov/news-events/press-releases/2013/03/ftc-staff-connecticut-should-consider-expanding-advance-practice and FTC January 23, 2014 letter to Massachusetts State Representative Kay Khan at http://www.ftc.gov/news-events/press-releases/2014/01/ftc-staff-massachusetts-should-consider-removing-physician .
[xxxvii] 42 CFR §415.110. http://www.gpo.gov/fdsys/pkg/CFR-2003-title42-vol2/pdf/CFR-2003-title42-vol2-sec415-130.pdf
[xxxviii] Healthcare Performance Strategies. Anesthesia Subsidy Survey 2012. http://drivinghp.com/consulting/2012-anesthesia-subsidy-survey-report-now-available/
[xxxix] Rosenthal, *op cit*
[xl] Hogan, *op cit.*
[xli] Dulisse, *op cit*
[xlii] Epstein, *op cit*
[xliii] American Recovery and Reinvestment Act of 2009. Pub. L. No. 110-275. http://www.gpo.gov/fdsys/pkg/PLAW-111publ309/html/PLAW-111publ309.htm

Statement

of the

American Medical Association

to the

Committee on Ways & Means
Subcommittee on Health
United States House of Representatives

Re: Improving Competition in Medicare

May 19, 2015

Division of Legislative Counsel
(202) 789-7428

Statement

of the

American Medical Association

to the

Committee on Ways and Means
Subcommittee on Health
United States House of Representatives

Re: Improving Competition in Medicare

May 19, 2015

The American Medical Association (AMA) appreciates the Ways and Means Committee, Subcommittee on Health for conducting this hearing on improving competition in Medicare.

The AMA strongly supports and encourages competition between and among health care providers and facilities as a means of promoting the delivery of high quality, cost-effective health care. Providing patients with more choices for health care services stimulates innovation and incentivizes improved care, lower costs, and expanded access.

Potential of Alternative Payment Models to Foster Competition

The Medicare Access and CHIP Reauthorization Act, or MACRA, which was signed into law on April 16, 2015, provides incentives and a pathway for physicians to develop and participate in new models of health care delivery and payment. Physicians with sufficient revenue or patients related to qualifying alternative payment models (APMs) will receive a five-percent bonus in 2019 through 2024, and slightly higher payment updates beginning in 2026. Qualifying APMs will include Center for Medicare and Medicaid Innovation models (other than health care innovation awards), accountable care organizations (ACOs) under the Medicare Shared Savings Program, Health Care Quality Demonstration Programs, and

demonstrations required by federal law. A new Physician-Focused Payment Model Technical Advisory Committee will make recommendations on physician-focused payment models.

Properly-structured APMs can foster competition in several ways. When payments are made for larger "bundles" of services, they give physicians greater flexibility to design their care in the most effective and efficient way, rather than being constrained to deliver only the specific services which are eligible for payment. This enables development of more innovative approaches to care delivery, which in turn will result in more and better choices for patients.

By using Procedural Episode Payments and Condition-Based Payments, a single price and relevant quality/outcome measures are defined for all of the services associated with delivery of a specific procedure or for treatment of a specific condition. This enables patients and purchasers to easily make understandable, apples-to-apples comparisons among providers, rather than being forced to estimate total costs based on the prices of individual services, rates of complications, etc.

Procedural Episode Payments and Condition-Based Payments allow independent physicians in single-specialty and smaller multi-specialty groups to take accountability for the costs and quality of care they deliver without the need to consolidate with hospitals or other physician groups as is required in ACO and global payment models. Episode and Condition-Based Payment models can also be managed with far fewer patients than are needed for an ACO or global payment structure, which enables smaller practices to participate. In addition, these payment models can empower small physician groups to manage total spending for patients if they wish to, by allowing them to purchase care for specific conditions from other providers when needed at a predictable price.

Finally, condition-based payment models focus competition on what patients most need and want—high-quality, affordable care for the specific health problems they are facing—rather than on the prices of specific procedures which they may not need.

Restoring Competition in Hospital Markets

Another way of unleashing the potential of competition in Medicare is to lift restrictions on physician-owned hospitals so that they can meet the growing patient demand for high quality care. Section 6001 of the Affordable Care Act, or ACA (42 USC 1395nn), eliminated the Stark law's "whole hospital exception" for physicians who have an ownership interest in an entire hospital and are authorized to perform services there, and prevents physician-owned hospitals from expanding their treatment capacity unless certain restrictive exceptions can be met. Thus, as health law Professor Thomas Greaney observes, "the ACA all but put an end to one source of new competition in hospital markets by banning new physician-owned hospitals that depend on Medicare reimbursement."[1]

This lost source of competition is especially missed because the physician-owned hospital has developed an enviable track record for high quality and low cost care. A Centers for Medicare & Medicaid Services (CMS) study in 2005 found that measures of quality at physician-owned cardiac hospitals are generally at least as good, and in some cases better, than at local community hospitals.[2] According to CMS, specialty hospitals offer very high patient satisfaction and high quality of care. More recently, the comparative efficiencies of physician-owned hospitals have been shown in the results of CMS' Hospital Value-Based

[1] Thomas L. Greaney, *The Affordable Care Act and Competition Policy: Antidote or Placebo?*, 89 OR. L. REV. 811, 841 (2011).
[2] Study of Physician-Owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization act of 2003 (CMS Report) at 36-55, *available at:* http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/RTC-StudyofPhysOwnedSpecHosp.pdf.

Purchasing Program. Nine of the top 10 performing U.S. hospitals listed in late 2012 by CMS were physician-owned. Of the 238 physician-owned hospitals in the U.S., 48 were ranked in the top 100.[3]

Additional studies show that many of the physician-owned hospital facilities achieve greater patient satisfaction, reduce costs, and improve infection rates. Research by economics Professor Ashley Swanson finds that treatment at a physician-owned hospital "can lead to substantial improvements in mortality risks for cardiac patients."[4] She concludes that "the results suggest that banning of further physician ownership as part of the ACA may have detrimental effects on patient health."

Accounting for the high performance of physician-owned hospitals is a number of efficiencies that CMS identified in its 2005 report. They include: specialization, improved nursing staff ratios and expertise, patient amenities, patient communication and education, emphasis on quality monitoring, and clinical staff perspectives on physician ownership. For example, physician-owned hospital staff has the ability to focus on a limited number of procedures and diseases. Nurses do not have to be pulled to different types of inpatient wards to care for patients with a broad range of clinical problems. Clayton M. Christensen, a noted Harvard scholar on disruption in industry, projects that specialty hospitals could reduce costs for hospitalizations by 15 to 20 percent and is the disruptive solution for health care.[5]

However, limiting the viability of physician-owned hospitals puts them at a significant competitive disadvantage, ultimately redounding to the detriment of patient choice, community health needs, and the costs borne by the Medicare program itself. Ensuring seniors' access to care by allowing these high-performing hospitals to meet consumer demands would empower patients and tap the benefits of competition within Medicare.

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[3] *See* American Medical News (April 29, 2013).
[4] Ashley Swanson, PhD, *Physician Investment in Hospitals: Specialization, Incentives, and the Quality of Cardiac Care* (December 18, 2013), *available at*: http://econ.berkeley.edu/sites/default/files/swanson_poh_curr%20(1).pdf.
[5] *See* Clayton M. Christensen, Jerome Grossman, and Jason Hwang, THE INNOVATOR'S PRESCRIPTION: A DISRUPTIVE SOLUTION FOR HEALTH CARE (New York: McGraw-Hill, 2009).

Lifting the ban on physician-owned hospitals could also allow physicians who run other new care models to acquire hospitals, better control hospital costs, and supervise the overall health care product sold. Physician-owned hospitals represent a potential alternative to the existing hospital-dominated integration, but only so long as they are permitted to expand and remain competitive. This opportunity is particularly timely because of the avenues afforded by MACRA to leverage APMs to increase competition and improve health care quality.

Conclusion

The AMA applauds the Subcommittee's efforts to enhance Medicare access, choice, and quality through improved competition. The recently enacted MACRA legislation provides a unique opportunity to foster competition through properly-structured APMs. Lifting restrictions on physician-owned hospitals offers another opportunity to increase quality and lower costs through improved competition. We appreciate the opportunity to provide our comments on this important topic, and we look forward to working with the Subcommittee and Congress on achieving high quality, cost-effective care for seniors and all Americans.

House Ways and Means Subcommittee
Chairman Kevin Brady (R-TX and Ranking Member Jim McDermott (D-WA)
"Improving Competition in Medicare: Removing Moratoria and Expanding Access"
May 19, 2015
Statement for the Record
Frederic E. Liss, M.D.
Founder, Chairman and Chief Medical Officer
Physicians Care Surgical Hospital

17 May 2015

Dear Chairman Brady, Ranking Member McDermott and members of the Ways and Means Subcommittee on Health,

Thank you for convening this hearing to examine the critically important issue of improving competition in Medicare, and for the opportunity to submit this statement for the record of this proceeding. My name is Frederic Liss and I am the founder, Chairman of the Board and Chief Medical Officer of Physicians Care Surgical Hospital, in Royersford, PA, in the western suburbs of Philadelphia. I am an actively practicing, full time orthopaedic hand and upper extremity surgeon with the Rothman Institute, a 120-physician group, providing comprehensive musculoskeletal care throughout all of southeastern Pennsylvania and New Jersey.

OBJECTIVES:
(A) To provide the Subcommittee with factual information and to present the committee's members with compelling reasons to reassess and change federal law that is currently reducing competition in Medicare through discrimination against hospitals with physician ownership.
(B) To urge the committee's members to take action to increase Medicare and Medicaid patient access to care and choice, reduce the cost and raise the quality of healthcare by ending the moratorium on physician owned hospitals, all of which can be accomplished with the bipartisan HR 976, already introduced in the House.

ABOUT PHYSICIANS CARE SURGICAL HOSPITAL:

- "PCSH" is a physician owned hospital whose ownership structure is 85% physicians and 15% Nueterra Healthcare. We have a management contract with Nueterra.
- PCSH was founded in 2010, after development over 2-3 years before that.
- Our mission was to create a patient centered hospital and to provide *all* of our patients with the choice of the lowest cost, highest quality surgical care possible.
- 24 physicians set out on this mission because we were disillusioned with the quality of care that was being provided by the publically held "for profit" hospital system (Community Health Systems) that purchased the two main hospitals and several other hospitals where I have practiced for the last 20 years, here in southeast Pennsylvania. After these acquisitions we witnessed a steep decline in hospital employee satisfaction that led to poor efficiency of surgical operations an unpleasant work environment and ultimately a very significant decline in patient satisfaction.
- We opened in October of 2010 and received our Medicare licensure before the grandfathering deadline imposed by the Affordable Care Act (ACA), marking the elimination of the hospital exception for physician ownership of hospitals that was in place in the Social Security Act.

- PCSH has 5 operating rooms, 12 inpatient beds, a 1 bed emergency area, laboratory, x-ray department, pharmacy, pathology and physical therapy
- We are a multispecialty hospital that includes ENT, Orthopedics, Ophthalmology, Gynecology, Pain Management, and General Surgery
- We have in-house physician hospitalist coverage for inpatient and walk in emergencies 24 hours a day, 7 days a week, 365 days a year.
- We have 104 employees
- We have approximately 50 physicians on staff, only about ½ of whom are owners
- We accept Medicare, Medicaid, Tricare, workman's compensation, and most commercial insurances. In Pennsylvania, we ***pay*** a surcharge per year for the right to treat Medicaid patients and we treat the uninsured with greater flexibility to absorb than the local community hospitals. Local hospitals require vetting processes that often unacceptably delay surgeries on the uninsured.
- PCSH employees, administration and staff are actively engaged in charity projects that serve the greater good of the community in which we live and operate. This is part of the mission statement and fiber of PCSH.
- Our commitment to every employee at PCSH is that whenever we distribute profits to the owners, part of that goes to them, and we base it on performance. This leads to very engaged and motivated staff, so that they too, have "ownership" of our success
- Employee satisfaction is far above national averages at our facility

QUALITY AND COST/THE VALUE PROPOSITION:

- We have learned from data released by CMS, that we perform total joint replacements and spinal surgeries at ½ the cost to Medicare of other hospitals in our community and at less than ¼ the cost to Medicare compared to the University hospitals in our market area in Greater Philadelphia.
- We have also learned that as much as 50% of the cost of an episode of total joint replacement or spinal surgery may come after the surgical admission, when a patient goes to rehabilitation. We have instituted pre-operative education for the patients and have learned that very few patients need to have in-patient or even in home rehabilitation.
- PCSH was ranked 3rd *in the entire United States* for 2013, on the top box score for HCAHPS ("I would definitely recommend this hospital").
- PCSH received the highest score (a 5 star rating) by CMS in its new rating system for hospitals, used to evaluate patient experiences. Our hospital was only one of 2 hospitals in southeastern Pennsylvania to receive 5 stars and one of 251 in the entire United States.
- We are not alone in our accomplishments. Although POHs represent only 6% of US hospitals, in 2015 physician owned hospitals account for 43 of the top 100 performers across the nation on the Value Based Purchasing Program legislated in the ACA, 22 of the top 25 hospitals on HCAHPS, and account for over $3 billion in savings for the Medicare program over 10 years according to CMS reimbursement data per DRG, now under review by the CBO.

PROBLEM WITH RESTRICTION ON EXPANSION:

- Physicians Care is in high demand by patients who live in our community
- Medicare patients love PCSH because we represent the values and quality in healthcare with which our elderly were raised and accustomed. We are convinced that this is why our HCAHPS and Star ratings are so high.
- Unfortunately, we have had to turn patients away because we do not have enough inpatient beds to meet the demand in our community. In order to meet demand capacity for our facility, we need to add 10 inpatient beds.
- Our staff physicians prefer to operate at PCSH because their patients receive the best care in the country AND because they have the best experience operating there over any other facility
    - 97% on time Operating Room starts
    - Top notch anesthesia department with excellent post operative pain management for their patients
    - Almost a zero infection rate
    - 24/7 inpatient hospitalist coverage for their patients
    - Nurse to patient ratio usually 1:2, maximum 1:4
    - A very happy and engaged staff
- The problems we are experiencing as a direct result of section 6001 of the ACA:
    - We can not fully accommodate the demand of patients in our community
    - When we have a bed shortage (occurs every month), then we must tell surgeons to limit the number of cases they can do on given days. This sometimes results in surgeons taking an entire day of surgery to another facility in order that they meet the needs of all of their patients. It is not feasible for surgeons to run between facilities on surgical days. This adds stress and inefficiency to the system and to our patient's and our lives.
    - The bed shortage also limits our ability to accommodate emergency admissions
    - These are unfair effects of section 6001 of the ACA.

CONCLUSIONS:

- PCSH and physician owned hospitals as a group have consistently demonstrated unprecedented quality, patient satisfaction, employee satisfaction and substantial savings for Medicare and healthcare in general.
- Competition in the marketplace is what stimulates improvement of quality and lowering of cost. Patients deserve access to this type of quality of care, and Americans have the choice to drive the healthcare marketplace.
- Physician owned hospitals have embraced the tenants of the ACA, and for all of these reasons we deserve the right to expand, compete in the marketplace and to drive value into what Americans get in return for their healthcare dollars.
- We urge the committee's members to end the moratorium on physician owned hospitals by eliminating section 6001 from the ACA.

Thank you again for the opportunity to present this information. I remain at the Subcommittee's disposal as a resource, should any further information be needed.

Respectfully Submitted,

Frederic E. Liss, M.D.

CHAIRMAN AND MEDICAL DIRECTOR

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

My name is Mark McDonald, MD, CEO and Medical Staff President for the Institute for Orthopaedic Surgery (IOS), and I am writing this letter to request support for H.R. 976 which calls for removal of the moratoria on physician-owned hospitals. I would like to thank Chairman Kevin Brady (R-TX), Ranking Member Jim McDermott (D-WA) and other members of the House Ways and Means Health Subcommittee for their consideration of this request.

The members of the Physician Hospital Association (PHA), and the patients we serve, would greatly appreciate the House Ways and Means Health Subcommittee's support on H.R. 976, that would eliminate Section 6001 from the Affordable Care Act. H.R. 976 would allow physicians to treat Medicare and Medicaid patients at new and expanded hospitals in which they have an ownership interest.

The Institute for Orthopaedic Surgery (IOS) is one of 9 physician-owned hospitals throughout Ohio and approximately 250 physician-owned hospitals across the United States providing high-quality, low-cost care to patients. As a member of the Ways & Means Committee with jurisdiction over Medicare, it is of the utmost importance that House Ways and Means Health Subcommittee recognizes these hospitals as centers of excellence and allows them to expand.

IOS was one of the first orthopedic surgical specialty hospitals in the state and nation. IOS is an accredited specialty hospital designed specifically to meet the orthopaedic and musculoskeletal needs of patients and their families. As a facility that focuses exclusively on orthopaedics, we distinguish ourselves as a specialty hospital, accredited by the *Joint Commission*. Created in 1998 as an ambulatory surgery center, IOS converted to an acute care hospital in 2002. IOS provides comprehensive orthopedic services in one location from diagnosis to treatment to surgery and post-surgery rehabilitation. Following the transition from an ambulatory surgery center to and acute care hospital, IOS entered into a joint venture ownership agreement with a non-physician owned community hospital to expand the caliber of services provided to the patients in our community. IOS now serves a diverse population of residents within a 10 county region in Northwest Ohio.

As a specialty hospital, we believe we deliver incredibly *special care to our patients* and our patients support this. Our patient satisfaction survey scores show our patients rank our hospital in the 99 percentile of all hospitals and 99% of our patients would recommend us to others. Safe, quality, state-of-the-art patient care is our focus**.** From surgery to rehab, the physicians, nurses and clinical team at IOS concentrate on providing the best cutting edge orthopedic care. It is what we're committed to doing, day-in and day-out, each and everyday.

Earlier this month the Centers of Medicare and Medicaid Services released star ratings based on Patient satisfaction and experience. IOS was ranked among the top seven percent of the 3,553 hospitals rated. IOS was one of the 251 hospitals that received a five-star rating. The ratings are the result of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) a comprehensive survey administered to a random sample of patients continuously throughout the year. Medicare's new summary star rating is based on 11 facets of patient experience, including how well doctors and nurses communicated, how well patients believed their pain was addressed, and whether they would recommend the hospital to others.

Although there have been accusations by the opponents of physician-owned hospitals that we only accept high paying cases and defer low paying cases to other hospitals, this is not true. If this were an accurate assessment, there would be a discrepancy between the payor mix in our physician office and IOS. The payor mix in both facilities includes approx 36% of patients covered by Medicare and Medicaid. The following is the payor mix for IOS as of April 2015,

- **Medicare 30%**
- **Medicaid 7%**
- Blue Cross 25%
- Commercial 35%
- Other 3%

Physician-owned hospitals, such as IOS, have proven greater efficiency in their ability to identify and implement improvements in patient care. Multiple patient safety initiatives have been implemented at IOS and then copied by community hospitals. Some examples of these patient safety initiatives include the following,

- MRSA screening protocols to avoid post-op surgical site infections
- Use of Tranexamic Acid to decrease blood transfusions
- Screening for sleep apnea which has improved patient safety
- Decreased length of stay following total joint replacement surgery and spine surgery

The payor mix for patients receiving care at IOS indicates our desire and willingness to serve patients who are covered by Medicare and Medicaid. IOS would like to provide care to Medicare and Medicaid patients even though our ability to do so is being restricted by the moratorium placed on physician owned hospitals in 2005.

Studies have shown the positive learning effect associated with higher procedural volumes for specific types of cases performed in physician-owned hospitals. Patients who receive care in physician-owned hospitals have been able to recognize the beneficial impact on the quality of care provided. By focusing on specific areas of medicine, physician-owned specialty hospitals are able to identify opportunities to improve quality and lower costs. In September of 2013, IOS was recognized by Consumer reports as one

of the top 11 hospitals in the state of Ohio. A variety of factors were considered in the study, including patient outcomes, complication rates, patient safety and patient satisfaction.

Patient safety is the highest priority in every hospital, including physician-owned hospitals. Although many physician-owned hospitals don't offer the services of a dedicated emergency department, there are policies in place to appropriately manage emergency situations for every patient treated in physician-owned hospitals. A key component of being able to manage emergency situations, is to have the appropriate medical staff available. IOS has dedicated Medical staff, including physicians on-call 24 hr/day to provide medical care in the event of an emergency situation. The medical staff at IOS is comprised of a diverse array of specialists, including Internal Medicine specialists, Cardiologists, Infectious Disease specialists, Anesthesiologists and Orthopaedic Surgeons. In addition to the highly qualified medical staff, IOS has contractual agreements with two other hospitals for situations in which a patient requires services that are not provided at IOS.

As demonstrated by the HCAHPS program, IOS ranks in the 99 percentile for patients who would recommend our facility. Our patients have clearly stated that they prefer to receive their care at IOS, even though the Federal government has placed restrictions on physician-owned hospitals to prevent further growth. In the current climate of value based purchasing and pay-for-performance, it makes complete sense to promote the growth of physician owned hospitals, as they continue to lead the way in performance measures. The patient is the ultimate benefactor when physician-owned hospitals are allowed to expand. There will be greater access to high quality care, and more patients will be able to receive their care in physician-owned hospitals. In addition, there would be increased pressure on the under-performing hospitals to improve their quality or accept a cut in payments through the value-based-purchasing program. The most appropriate decision is to remove the restrictions on physician-owned hospitals and allow the highest performing hospitals to expand. We greatly appreciate your consideration of this request and the assistance you can provide to expand access to high quality care for patients.

k+s consulting

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

May 27, 2015

My name is Jakob Kohl and I am the COO of K+S Consulting, a patient focused and physician driven, management and investment company that in conjunction with physician investors owns, operates and oversees hospitals, surgical centers and other healthcare providers in and around the Houston area. I would like to thank Chairman Brady, Ranking Member McDermott and other members of the subcommittee for the opportunity to submit comments in connection with improving competition in Medicare, with specific focus on removing moratoria and expanding access.

My purpose in presenting this statement is to support the effort to end discrimination in federal law against hospitals with physician ownership. We believe that all hospitals should compete on a level playing field where outcomes and quality measures drive decision making, regardless of the ownership type of the hospital. We believe that full transparency and fair competition within the hospital industry will drive excellence across the board, and the current restrictions within Medicare and Medicaid severely restrict this competition. The restrictions are denying Medicare beneficiaries access to the best facilities at a time when even more patients are entering the healthcare marketplace.

K+S Consulting partners with physicians in our communities to build and operate excellent hospitals and surgical centers. We employee nearly 450 individuals throughout greater Houston and have performed 7,417 cases in 2014 alone. Our facilities report outstanding patient safety data – with extremely low infection rates of less than .04 percent and patient satisfaction ranking consistently above 95 percent.

One of our facilities was in operation before the restrictions were put in place and two other facilities opened after the law was enacted. This means that our older facility can continue to see Medicare and Medicaid patients, but cannot grow with the community because any expansion would trigger additional restrictions according to existing law; and our two newer facilities simply cannot see these patients and be reimbursed for care provided. Our strategy focuses entirely on working with physicians in our community, and we believe that is a primary key to advancing quality health care services across the board.

When physicians are partners in hospitals, the entire team can focus on excellent patient services and quality outcomes. Medicare and Medicaid patients deserve the right to see the best providers willing to accept a contract. By denying the ability of our new facilities to participate in Medicare with our physician partners, our patients are having their rights severely limited.

Correcting this problem can be accomplished through a bi-partisan basis in H.R. 976, which we are requesting that you support. This bill will *fully restore* patient access to physician owned hospitals and allow all of us to compete on a level playing field.

Thank you for your attention to this issue, I am happy to respond to questions.

About K+S Consulting:

K+S Consulting is a management and investment company that owns, operates and oversees the operations of outpatient surgical centers, hospitals and other health care providers. Founded in 2003 and built around a culture of innovation, we develop and manage physician-driven operations with commitment to excellent care and service. Our physicians, staff and partners are an inspiration and share our investment in the innovative delivery of healthcare in greater Houston and beyond.

The partnerships fostered by K+S with local physicians leads to patient care that raises the bar in all key-performance indicators. By focusing on high patient satisfaction from our outstanding services and compassionate care, our team welcomes transparency of our operations. We believe that patients should have the choice to utilize quality services and facilities based on their own preferences and needs without artificial barriers imposed by government regulations. We look forward to working with our elected officials to find reasonable policies to facilitate fair and open competition.

K+S Consulting Entities:

- Humble Surgical Hospital
- Outreach Diagnostic Clinic and Eye Care
- Lake Woodlands Surgical
- Westside Surgical Hospital and Breast Center
- Spring Central Hospital

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

My name is Edward "Paul" Kerens Jr. I have been the Senior Executive Officer for Kansas City Orthopaedic Institute LLC, a physician own hospital since its inception. I was hired for the hospital project which was a joint venture between 14 orthopeadic surgeons and Saint Luke's Hospital. Kansas City Orthopaedic Institute, LLC (KCOI) is an acute care hospital licensed in the State of Kansas that focuses on orthopaedic care. I have worked in healthcare for 35 years, my entire career. My management experience has ranged from physician group practice management to large academic hospital health systems. The past 16 years at KCOI have been the most rewarding of my career. I attribute that to the high level of physician participation in the governance that controls all operations of the hospital but most importantly the focus on the patient first.

I would like to thank Chairman Brady, Ranking Member McDermott, and all the members of the subcommittee for this opportunity to submit my testimony in connection with the above-mentioned hearing.

My objective in submitting testimony is to educate the committee on the exceptional care provided in a physician owned hospital in hopes that an end can be brought to the unjust regulations put on physician owned hospitals. Physician owned hospitals as part of the Affordable Care Act are limited in growth, a stipulation that does not exist on other hospitals in this country. I ask this subcommittee and all members of the house to support H.R. 976 so that patients can continue to have access to some of the best health care delivered in this country today.

Kansas City Orthopaedic Institute was created in the late nineties when three groups of orthopeadic surgeons came together to build a hospital. The reason they felt the need to build a hospital was because these physician were frustrated by the inefficient care that was delivered at the other hospitals where they practiced. Much of their surgical day was spent standing around waiting. They also had to listen to patients complain about their wait times and how long it took for nurses to respond to their needs while in the hospital. So when they built their hospital the primary focus was to improve efficiency. They knew very little about running a hospital but they did know how to care for patients and that is where they placed their focus. They made sure that the nurse to patient ratio was better than in other hospitals where they practiced. At KCOI the nurse to patient ratio on the inpatient unit is one nurse for every two patients. At the other hospitals in town you will find as many as one nurse serving 10 to 12 patients. The result has been that KCOI is now the only five star rated hospital in the Kansas City market according to the new rating system released earlier this month by CMS. KCOI also scores very well under the CMS value base purchasing program. KCOI received the 15th highest score earlier this year out of over 3500 hospitals nationally. The patient satisfaction scores at KCOI are some of the highest as well. The post-surgical infection rate at KCOI is 15 times lower than the national average. This story, according to my colleagues, is similar at other physician owned hospitals around the country. It makes no sense that the government has passed legislation that restricts the growth of some the highest quality hospitals in this country. It does make sense that physicians, who ultimately are the

people responsible for the care of the patient, have the ability to own and govern the facilities where they proved the care to their patients.

Kansas City Orthopaedic Institute LLC has always been community minded and welcomes all patients. In addition to commercial insurance plans, KCOI participates with Medicare, Medicaid, and Tricare. KCOI has a charity policy that provides discounted or even free care to patients based on their ability to pay. In our community KCOI has signed an agreement that provide free care to patients living in Wyandotte and Johnson County who could not otherwise pay for their orthopaedic care.

The one thing that the physicians did not do properly when they opened their own hospital was build it big enough. They did not realize that patients would recognize such a difference and demand care at KCOI over other hospitals. KCOI is in need of additional inpatient beds and operating rooms to take care of the patients in the market. KCOI's growth should not be limited by the government. The only limit to the growth of KCOI should be by the demand of the patient like any other business. If KCOI continues to deliver a superior product they should be allowed to grow to accommodate the demand. This is why I am asking you to support and pass H.R. 976 which will increase patient access to physician owned hospitals.

Statement for the Record

House Ways and Means Health Subcommittee

Chairman Kevin Brady (R-TX) and Ranking Member Jim McDermott (D-WA)

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

May 19, 2015

My name is Mark W. Kennedy, Chief Executive Officer of Star Medical Center, located in the Dallas, Texas suburb of Plano, Texas. I have worked over the past 20+ years in healthcare as both an entrepreneur and as a senior manager involved in hospital management. Prior to my current employment, I successfully organized two Texas based physician owned acute care hospitals, served on numerous for profit and not for profit hospital boards, and developed over 10 contract managed not for profit acute care hospitals. My sincere thanks to Chairman Kevin Brady and the Ranking Member Jim McDermott and other esteemed members of the subcommittee, for this opportunity to submit my comments regarding the removal of the unfair barriers to physician and patient access to quality healthcare imposed through existing Moratoria on physician ownership of acute care hospitals.

The great motivator for me in writing this letter to the House Ways and Means Health Subcommittee is the hope that reason and the embrace of the truth, will prevail in its consideration of ending the discrimination in our federal laws against physician ownership of acute care hospitals. I believe that the current legislation, found in Section 6001 of the Affordable Care Act, unfairly singles out physicians and denies them the right to participate in the Free Enterprise System by prohibiting them from ownership in acute care hospitals. By denying this right to physicians, there now exists an extreme prejudice of the very body of professionals sworn to, "first, do no harm". There are those interests that apparently advance myths and distortions to argue against physicians being allowed to enjoy hospital ownership. Bottom line, there is no credible evidence that supports the notion that physicians, as a whole, cannot maintain their objectivity, ethics, and integrity in patient care, while owning a hospital in which they practice medicine. Of course, as in any profession, there are those exceptions that fail in their public trust. Examples of this are prevalent throughout the professional world, i.e. lawyers, accountants, business leaders, etc., in which egregious acts of malfeasance have been committed. And, the actions of such bad actors, has not resulted in federal legislation banning any of these professional groups from ownership in their respective places of business. The standard is not the same for physicians. Patients deserve the options of choice to where they may seek their healthcare needs. Likewise, physicians deserve the same rights of all Americans to,…"Life, Liberty, and the Pursuit of Happiness". Consequently, it is the objective of this letter to respectfully encourage the leadership of the House Ways and Means Health Committee to support legislation introduced on a bi-partisan basis, H.R. 976, to increase patient access to physician owned hospitals.

Our hospital is a relatively small facility (23,500 SF) that is jointly owned by approximately 40 physicians, comprised in an array of specialties including Spine, Orthopaedic, General Surgery, Gastroenterology, Pain Management, Gynecology, Urology, Ear, Nose, and Throat, Breast Reconstruction, Podiatry, Hand, and Family Practice. Our hospital opened in November 2013 with the expressed commitment by our physician owners to provide the safest, cost effective and highest quality of care to the patients we serve on a daily basis. The hospital employs approximately 80 skilled workers with an approximate $$ Million annual payroll The physician founder and physician investors of Star Medical Center identified the need for specialized healthcare care in the 1,000,000+ population, comprising its North Dallas/Plano/Richardson/Garland service area. Since opening in November 2013, our physician joint ventured for profit acute hospital has provided effective health care to over 3,000 patients. However, due to the provisions in Section 6001 of the Affordable Care Act, our physician owners of Star Medical Center are prohibited from participating in the any of the Federal Reimbursement patient care programs (i.e. Medicare, TriCare, Medicaid, etc.). Consequently, patients covered by these government programs are not allowed access to our hospital. Should the ban on physician owned hospitals be lifted, it is very likely our healthcare institution would apply for a Medicare Provider Number and extend care to this significant patient population. During January 2015, as a licensed acute care hospital we successfully achieved a full 3-year accreditation through one of the world's leading certification bodies, Det Norske Veritas – Germanischer Lloyd (DNV-GL). Of particular note, when our patients require admission for overnight stays, they experience unique 1:1 Nurse to Patient care, which results in high patient satisfaction and high physician satisfaction surveys. Additionally, our physician owned hospital promotes access to the public of our emergency services and is constantly marketing these ER services to the service area population through mailers, Open House events, and our prominent LED signage located on the heavily traveled Turnpike immediately adjacent to our hospital. Our efficiently sized facility, designed for today's patient environment, enables our physicians to provide the best care possible and an opportunity to often deliver at a price below nearby medical centers.

In conclusion by removing this barrier to patient access and physician access of a physician owned hospital, as found in Section 6001 of the Affordable Care Act, we will be able to better serve our patients by offering our medical services to all segments (Medicare, Medicade, Managed Care, Private Pay) of the medical service area. By leveling the playing field for acute care services providers, our hospital can effectively compete and provide a viable differentiator in the marketplace. We believe our patients will ultimately benefit by having another desirable option in which to seek needed healthcare. We believe that through competition, the water level of quality and good patient economics will improve in our healthcare landscape. Further, we believe that as a result of our very effective model of physician ownership, that costs will be driven down for taxpayers, physicians will have an excellent environment by which to provide patient-centric medicine, and better outcomes will be increasingly realized by all stakeholders. Again, I respectfully request your full agreement and commitment to support the passing of H.R. 976.

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

My name is Robert Behar, MD, MBA and I am the CEO of North Cypress Medical Center in Cypress, Texas, a Northwest suburb of Houston, Texas. North Cypress Medical Center is a 139 bed licensed acute care hospital that is 100% physician owned and operated. I want to thank the Chairman, Ranking Member and other members of the subcommittee for the opportunity to submit comments in connection with the above-mentioned hearing.

The purpose of this testimony is to provide you with hard data and testimonials as to why we believe there should be an end to the law discriminating against physicians owning hospitals. We are also in support of the H.R. 976, bipartisan legislation that would end this discrimination and increase patient's access to some of the highest quality hospitals in the country.

North Cypress Medical Center opened its door to our community in January 2007.We started out as a 64 bed acute care facility. Within 36 months of opening, to meet the demand of Northwest Houston and Cypress we expanded to the present 139 beds, a 20 bed emergency room, and a 20 bed intensive care unit. Currently, North Cypress Medical Center has 361 physicians on staff; only 140 are investors.

From the onset, North Cypress Medical Center's mission was to care for the sickest patients regardless of age, or ability to pay. We felt the foundation of our success started with a goal and vision to provide the most advanced technologies to our community with superior and very personal customer service. We work tirelessly to deliver this to our community and our medical staff in everything we do.

Cypress, a suburb of Houston, for the two decades leading up to North Cypress Medical Center's opening, was completely devoid of an acute care facility. In fact to this day, North Cypress Medical Center stands alone as the only facility on Highway 290, the major thoroughfare of the Northwest Houston Corridor. By 2020, the population of Cypress is projected to reach over 1,000,000 people.

With the commitment to care for the sickest patients, our emergency rooms have been the nexus of our acute care delivery system.

- Our emergency rooms treated over 53, 000 patients in 2014.
- We are a fully Accredited Chest Pain and Stroke Center
- OVER 80 % of North Cypress Medical Center Hospital admissions originate from the Emergency Rooms
- We are the receiving hospital for six 911 EMS services in Northwest Houston with over 6000 ambulance patients transported to our facilities in 2014.

- We had less than 48 hours of 'EMS divert' status in 2014, with a full commitment to ensure ER services available through high census periods.
- Four Straight Years of Emergency Room Patient Satisfaction Scores in the Top National Quartile
- Active involvement in Regional Disaster/Trauma Response System
- Diverse array of Specialists who voluntarily take call for our emergency room, including Cardio-Thoracic Surgery, Cardiology ,Critical Care, Otolaryngology, Gastroenterology, General Surgery, Gynecology, Oncology, Infectious Disease, Internal Medicine, Nephrology, Neurology, Neurosurgery, Ophthalmology, Oral Surgery, Orthopedic Surgery, Pediatrics, Neuro-Vascular Interventional Radiology, Urology

As an institution we admitted over 14,700 patients in 2014. 57% of those patients represented Medicare/Medicaid/Tricare/Charity care. Additionally, our institution delivered $93,000,000 in uncompensated charity care in 2014.

Some of the services include:

- Active Cardiac Surgery and Neurosurgical Programs
- 1790 ICU admissions in 2014; 566 of those patient required ventilator support
- Comprehensive Oncology program with the most advanced instrumentation
- Robotic Assisted Surgical Program
- Robotic Assisted Cardiac Electrophysiology Program
- Extracorporeal Membrane Oxygenation for Severe Respiratory failure
- Epilepsy Monitoring Unit
- Comprehensive Orthopedic Joint Center
- Cardiac Interventional Program
- Neurovascular Interventional Program
- Pediatric Unit

The challenge to deliver these cutting-edge and very technical services requires the dedication of over 1,800 local employees who embody the facilities' commitment to excellence. This commitment is evidenced by the fact that other community hospitals are transferring patients to North Cypress Medical Center to receive these critical procedures and services. These transfers are made both for higher level of care and by patient request to be cared for at our facility.

North Cypress Medical Center prides itself on delivering high quality evidence-based care. Some of our awards include:

- *Rated one of the Top 100 hospitals in the nation for Coronary Interventions in 2015*
- *Healthgrade's Five-Star Recipient for Total Knee Replacement in 2015*

- *Healthgrade's Five-Star Recipient for Coronary Intervention Procedures in 2015*
- *Healthgrade's Five-Star Recipient for The Treatment of Respiratory failure in 2015*

The problem at hand is as follows. Since the 2010 restriction to build, North Cypress Medical Center is constantly at capacity. When the restriction took hold, NCMC was in the process of completing 4 state of the art cardio-thoracic operating rooms and 24 intensive care capable rooms. To this day, and to the disservice of this community, they sit empty, unused, while our aged Medicare patients wait to be treated in the precious few remaining licensed beds. With the facility virtually at constant capacity, an unnecessary burden is created, which would be relieved by our proposed expansion of medical beds and the licensing of those already built. As an institution we have made a commitment to serve our community at all cost, provided we can achieve this goal safely. In the effort to do so, we very rarely employ 'EMS divert', which represents less than a total of 48 hours in 2014. We believe that placing this institution on divert would be an enormous detriment to the community. The growing community deserves this expansion. As we have presented, we do not avoid caring for the sickest patients, regardless of their ability to pay. We want to continue to efficiently and safely do this as our community grows and ages over the coming years.

In our expansion plans we were also about to begin construction of obstetrical and neonatal care units, and additional cardiac catheterization suites when the 2010 legislation created the moratorium effecting physician owned facilities. This expansion is critical for North Cypress Medical Center to respond to the needs of our community. Both For-Profit and Not-For-Profit hospitals in Houston have taken the 'last to market' approach, choosing to provide well compensated services to ensure preservation of their bottom lines. It is well known that obstetrical services do not represent significant profit centers for hospitals, yet at the same time the Cypress community remains without an acute care facility to provide obstetrical services. This requires the transfer of all obstetrical patients to other facilities, which is inconvenient and can jeopardize the mother and her unborn child's safety. We managed over 1,000 pregnant patients in our emergency rooms in 2014. We find it unacceptable that North Cypress Medical Center serves over 200 square miles in Northwest Houston and the adjacent counties, yet is prohibited from offering obstetrical and neonatal services. This requires the transfer of laboring patients to other facilities to receive what is generally regarded as basic medical services. Given the opportunity to expand we will fill that void.

One solution suggested for our bed capacity issue was for NCMC to build a non-Medicare certified facility and thus serve only the needs of non-Medicare and Medicaid patients. This is contrary to the mission of NCMC, which has always been to serve the medical needs of all patients, of all ages, regardless of the economics of providing that care.

NCMC is a tax paying institution that has paid $62,000,000 in state and federal taxes since 2007. We are the second largest employer in Cypress, with over 1800 local employees.

We are asking for the passage of H.R. 976 to allow great facilities like ours to continue to meet the needs of our patients.

Thank you for your consideration.

Robert A. Behar, M.D., M.B.A.
CHAIRMAN OF THE BOARD
AND CHIEF EXECUTIVE OFFICER
NORTH CYPRESS MEDICAL CENTER
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Medicare Fraud:
Moratoria Miss the Mark

Statement for the Record

John R. Graham

Senior Fellow
National Center for Policy Analysis

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

Ways and Means Subcommittee on Health

May 19, 2015

Chairman Brady and members of the committee, thank you for the opportunity to submit written comments about ways to improve competition in the Medicare program. I am John R. Graham, a senior fellow at the National Center for Policy Analysis. We are a nonprofit, nonpartisan public policy research organization dedicated to developing and promoting private alternatives to government regulation and control, solving problems by relying on the strength of the competitive, entrepreneurial private sector.

Summary

Medicare fraud is a serious problem. The Medicare bureaucracy has the power to impose moratoria on new providers in geographic or program areas it deems susceptible to fraud. However, preventing new competitors from providing Medicare benefits reduces competition and cannot reduce fraud by incumbent providers. A better way would be to give Medicare beneficiaries a financial interest in combatting fraud.

Background

Last February, the Government Accountability Office issued its annual report on federal programs that it identifies as high risk due to their greater vulnerabilities to fraud, waste, abuse, and mismanagement. Medicare is a longstanding member of the list: "We designated Medicare as a high-risk program in 1990 due to its size, complexity, and susceptibility to mismanagement and improper payments". A quarter of a century has gone by and Medicare is still on the list.

In 2013, Medicare spent $586 billion taxpayer dollars. The FBI has estimated that three percent to 10 percent of all health spending is fraudulent. For Medicare, that would amount to at least $17 billion and up to almost $60 billion.

The Obama Administration has ramped up antifraud efforts, with notable success. Last year, the Government Accountability Office reported that Medicare had strengthened its antifraud activities considerably, but noted further progress was needed.

The U.S. Department of Health & Human Services and the U.S. Department of Justice collaborate on the Health Care Fraud and Abuse Control (HFAC) Program, which was established in 1997 and received a cash infusion from the Affordable Care Act (ACA) of 2010. In its 2014 annual report, the HFAC Program reported a return of $7.70 on every dollar spend on antifraud efforts, recovering $3.3 billion in 2014 and over $27.8 billion since 1997.

This success is largely due to good investigative work by the Department of Health & Human Services, Federal Bureau of Investigation, and other agencies. Despite their efforts, they are only catching no more than one fifth of the dollars lost to Medicare fraud.

The (ACA) gave the Secretary of Health & Human Services a new power to combat fraud: The authority to impose temporary moratoria on new providers if the geographic area or applicant type indicates a significant risk of fraud, waste, or abuse. Some in Congress have been frustrated that the Secretary has not used this power enough. In 2011, Senators Hatch and Grassley wrote a letter to former Secretary Sebelius insisting that she start imposing them. They followed up with

a letter on March 28, 2013, which noted that despite the moratoria rule having been in force for over two years, none had yet been imposed.

In July 2013, the CMS issued its first set of moratoria. Further announcements were made in January 2014, July 2014 and January 2015.

More and Different Provider Regulation Unlikely To Stop Fraud

Moratoria are unlikely to prevent fraud and likely to have unintended consequences by reducing competition. It is a little like solving bank robberies by preventing people from entering banks. Indeed, effective fraud protection and prevention should encourage, not prevent, new providers from entering Medicare and shaking up the *status quo*. If the only way to reduce fraud is to prevent new providers from entering a market, it suggests that the market itself is perversely structured to invite fraud.

Imposing moratoria is the extreme case of focusing antifraud efforts on regulating providers. While this focus has improved recovery, the burden of compliance has become so great that it is interfering with honest providers' ability to do business with Medicare. Enrollment by providers is already highly bureaucratized. The ACA actually made honest providers pay explicitly for auditing fraud by imposing a new application fee of $505 for enrolling each new practice location.

Many trade and professional associations have complained that the burden of antifraud compliance is increasing their members' costs and frustrating their businesses. Many complaints address Recovery Audit Contractors (RACS), to whom Medicare pays a share of the spoils from claims they challenge. This has resulted backlog of 500,000 denied claims being appealed. Although honest providers are susceptible to the temptation to "upcode" claims, it is unlikely that this backlog comprises many claims from actual fraudsters, who are unlikely to appeal a denied claim.

Indeed, the bureaucratic burden might have become counterproductive. The largest Medicare fraud in history was uncovered in 2012 and executed by a Texas doctor who billed Medicare $375 million for care that was not provided. He recruited homeless people and paid them $50 to sign forms evincing that they had received treatment from him. "Jack Fernandez, a Florida lawyer who formerly prosecuted healthcare fraud for the federal government, whistled out loud when he heard the dollar amount in the Roy case. But he said the red tape and complex laws and regulations that come with filing Medicare claims made it easy to slip false claims through the system," according to the *Los Angeles Times*.

Dialing up the pressure on providers even more, to the extreme of imposing moratoria on new entrants, is unlikely to improve fraud recovery and prevention for two reasons: Fraud is a common feature of insurance markets; and government does not have the right incentives to prevent fraud. Combining these results in a toxic brew in which fraudsters can breed happily.

In proper markets, insurance only comes into play for unforeseen and catastrophic events. This is because third-party payments are unavoidably susceptible to attempted fraud. Consider the classic case of a businessman who has unsold inventory, hires someone to torch his warehouse,

and submits a claim to his property insurer. The desperate and unethical businessman has to take extreme measures to defraud the insurer. In Medicare, and U.S. health care in general, so many low-cost and routine items and services are run through insurance claims that fraudsters can easily pick holes in the system.

Because Medicare is spending taxpayers' money, not its own, it cannot have the right incentives to effectively prevent and recover from fraud. Private insurers invest in effective measures, because their investors require it. When people spend their own money directly, they are also vigilant against fraudsters.

A Better Way: Reward Beneficiaries for Preventing Fraud

Medicare makes a faint-hearted attempt to enlist seniors' support in preventing fraud. Between 1997 and 2012, Senior Medicare Patrols have resulted in saving Medicare more than $106 million. That is good work for volunteers, but it is only $7 million annually – a drop in the bucket.

A better way to prevent fraud from the demand side would be to give beneficiaries direct control of more of the money Medicare spends on their behalf. Consider an obvious example: Certain categories of medical equipment are notoriously susceptible to Medicare fraud. Durable Medical Equipment (DME) incudes power wheelchairs, electrical hospital beds and diabetic test strips. In 2011, Medicare began a competitive bidding program for these items. Since then, DME bidding has saved $2 billion for Medicare.

Note that all these savings accrue to the government: They are invisible to Medicare beneficiaries. Much more could be saved if Secretary Burwell were able to tell America's seniors something like this:

> "Medicare has been paying over $4,000 for your power wheelchairs. We know that they can be purchased for around $3,000, or even less in some parts of the country. So, go find a power wheelchair for less than $4,000, send Medicare the invoice, and we'll add a share of the savings to your Social Security deposit, Medical Savings Account, or Health Savings Account as soon as we've verified the transaction."

Of course, this means that Medicare beneficiaries have to control more Medicare spending directly, as recommended by NCPA Senior Fellow and former Medicare trustee Tom Saving. Currently, Medicare beneficiaries can enroll in Medicare plans with Medical Savings Accounts, but these have limited availability. Further, current Medicare beneficiaries do not have access to savings in fast-growing Health Savings Accounts, because they are only a decade old.

Optimizing Medicare beneficiaries' ability to combat Medicare fraud through prudent purchasing power will require reforms that include shifting a significant proportion of current Medicare spending away from providers who submit claims to federal Medicare contractors and into seniors' Health Savings Accounts and Medical Savings Accounts.

Continuing to focus antifraud efforts solely on playing whack-a-mole with fraudsters, to the extreme of preventing new competitors by imposing moratoria, is unlikely to reduce fraud much further.

Thank you for the opportunity to submit these written comments.

Statement for the Record
House Ways and Means Health Subcommittee
Chairman Kevin Brady (R-TX) and Ranking Member Jim McDermott (D-WA)
"Improving Competition in Medicare: Removing Moratoria and Expanding Access"
May 19, 2015
Submitted by Blake Curd, MD
CEO, Sioux Falls Specialty Hospital
President, Physician Hospitals of America

Physician Owned Hospitals: Beacons in Healthcare

Dear Chairman Brady, Ranking Member McDermott and distinguished members of the Subcommittee, I want to thank you for holding this hearing focused on improving competition within Medicare. Physician Hospitals of America believes that if physician-owned hospitals (POH) are able to fairly compete in the delivery of healthcare services, patients will benefit from greater access to high quality, lower cost healthcare. As the Federal Trade Commission (FTC) recently reiterated during a February 24, 2015 workshop on healthcare competition, "The FTC has long argued that consumers benefit from health care competition….Numerous studies confirm that vigorous competition in healthcare markets helps to reduce costs, improve quality, and expand access for consumers."

The POH industry is an important component and competitive force within our healthcare system that ensures patients receive the highest quality of care. Recent government data supports the fact the POHs are centers of excellence that have lower costs. Yet current law both prohibits newly constructed physician owned hospitals from being able to treat Medicare and Medicaid patients and restricts the Medicare-licensed physician owned hospitals that were grandfathered under the law from growing to meet community need. This anti-competitive policy is bad for our health care system, bad for Medicare and most important, bad for patients. We strongly urge Congress to allow hospitals with physician ownership to compete on a level playing field with every other hospital in the country, particularly when it comes to growth. While current law provides a process for expansion, it is so restrictive that only one hospital has received CMS approval to add to its current capacity.

History of Physician Ownership

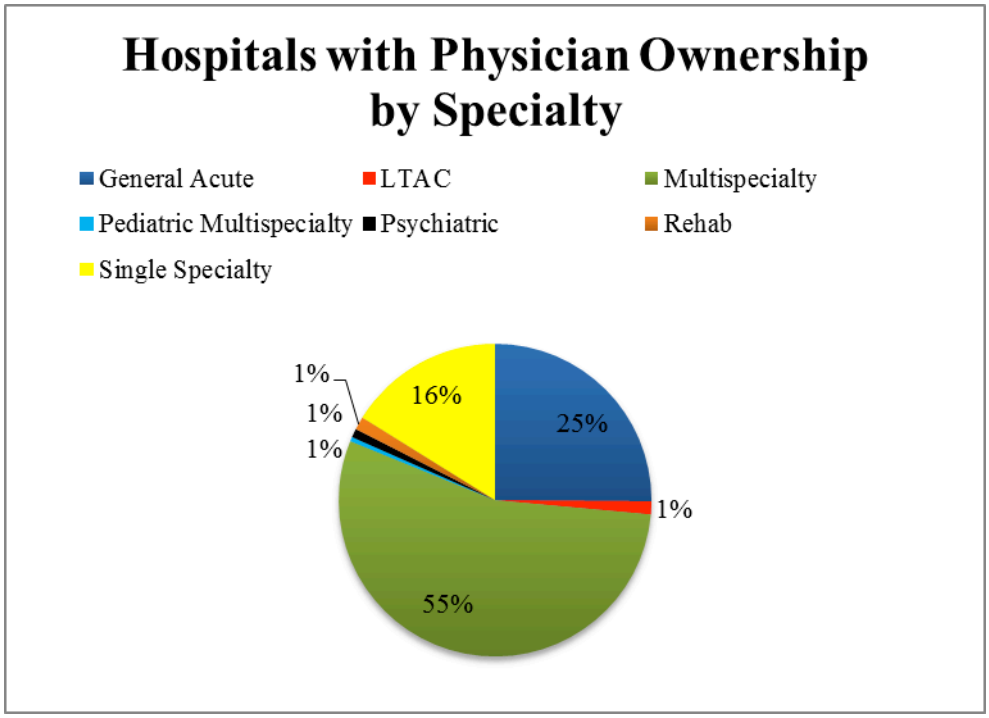
Throughout the first half of the twentieth century, it was common for physicians to own and manage hospitals, stemming from the practice of physicians caring for patients in their own homes. In-home care eventually evolved towards community hospitals. Then continuing into the 1940s-1980s, other hospital models began to emerge including large religious and secular non-profits as well as the corporate for-profit model. The physician-ownership model later emerged in the 1990s as a natural consequence of healthcare specialization and the need for more efficient care. Doctors who were specialists found it very difficult to be productive and efficient in large, general hospitals.

Surgical specialists soon led the way for physician-owned surgical specialty hospitals and other specialties soon followed. Today the single specialty model is the exception within the industry as they make up only about 16% of hospitals with physician ownership. The model is attractive for many

reasons, chief among them is that with doctors being in charge with a financial stake in the success of the hospital, there are lower complications, better outcomes and lower costs.

What does the current POH Industry look like?

Today there are approximately 250 hospitals with some form of physician ownership and the services they offer are varied according to community needs. The following chart shows the current make-up of the POH industry:



Ownership Model Varies

There are also varying models of ownership by physicians in hospitals. Some hospitals are owned in full by physicians, some are joint ventures with tax-exempt hospitals where physicians own just a percentage of the hospital, and some are joint ventures with for-profit companies. What all of these models have in common is a belief that patients benefit from higher quality of care when physicians have a financial stake in a hospital, thereby having more control in how care is delivered.

CMS Data Confirms POHs as Centers of Excellence

The new Medicare Hospital Value-Based Purchasing program (VBP) was enacted to either reward or penalize hospitals based on the quality of care they provide to patients based on a number of quality indicators. In 2013, the first year of this program, 9 of the top 10 and 53 of the top 100 bonus recipients were POHs. 27% of the POHs participating were in the top 100 performers compared to only about 1% of the participating non physician-owned hospitals (NPOHs). 60% of POHs received bonus payments while only 22% of NPOHs did. Moreover, only 20% of POHs were penalized compared to 64% for

NPOHs. These numbers are striking if one considers POHs only made up about 5% of the hospitals that were eligible to participate.

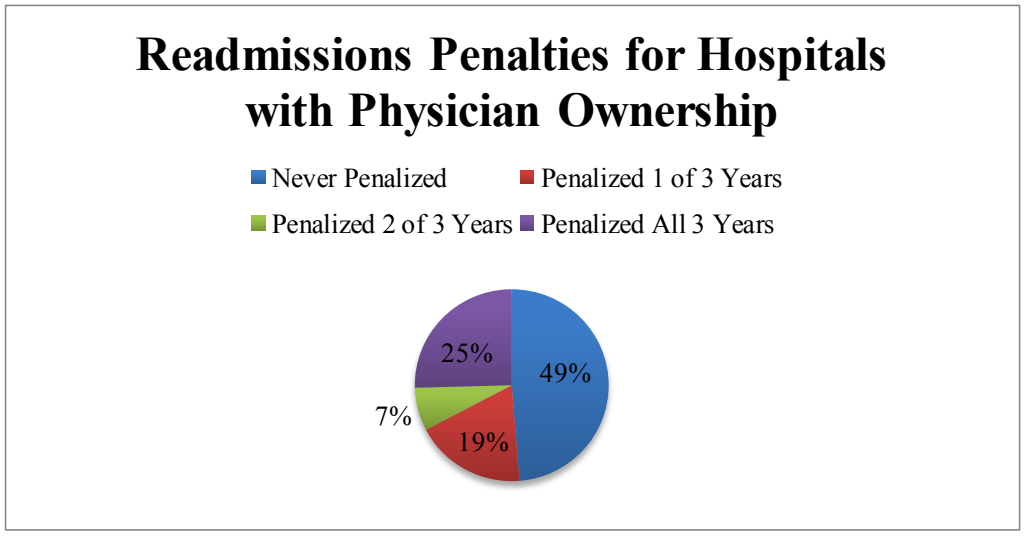
In 2014, CMS added mortality rates to the program as a quality indicator and most POHs could not qualify to participate as their hospitals lacked the minimum number of patient deaths.

For Fiscal Year 2015, additional data was added to VBP that could be utilized for scoring instead of the mortality rates, including readmissions and hospital-acquired conditions (HACs). Most POHs were again able to participate. POHs remained the standout performers. Seven of the top 10 hospitals awarded bonus payments were physician-owned, as were 43 of the top 100. 67% have never been penalized in their VBP adjustment compared with 36% of NPOHs. Only 8% of POHs have been penalized all three years of the program compared to 19% of NPOHs. In the three years for which CMS provides data (FY 2013, 2014, and 2015), 49% of POHs have never been penalized for readmissions, while an additional 19% have only been penalized 1 out of the 3 years. On the other hand, only 17% of NPOHs have never been penalized for readmissions during this same period.

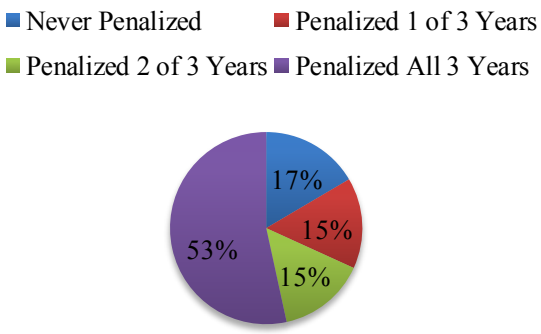
The HAC program identifies a group of reasonably preventable conditions, including infections, that patients did not have upon admission to a hospital, but which developed during the hospital stay. Only 10% of POHs received a penalty in FY 2015 (the only year for which CMS published HAC data). Conversely, 21% of NPOHs received a penalty for HACs.

In 2015, CMS also released Summary Star Ratings for hospitals based on their Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS), which measures patient satisfaction with their care and overall experience. Once again, POHs stood above the competition. 42% of POHs received a 5-star rating compared to 5% of NPOHs. 84 of the 251 (or 33%) hospitals receiving a 5-star rating were POHs, despite comprising approximately 5% of the total number of participating hospitals.

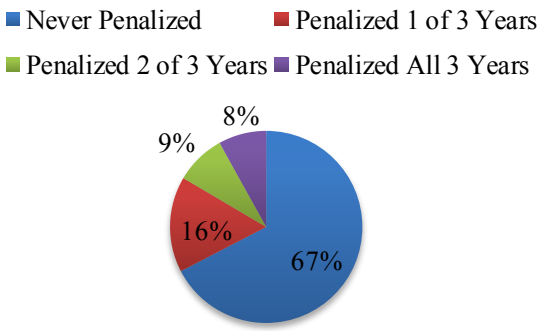
The CMS data is irrefutable in quantifying the quality POHs provide.[i] Patients don't just do better when treated at a POH, they do significantly better.



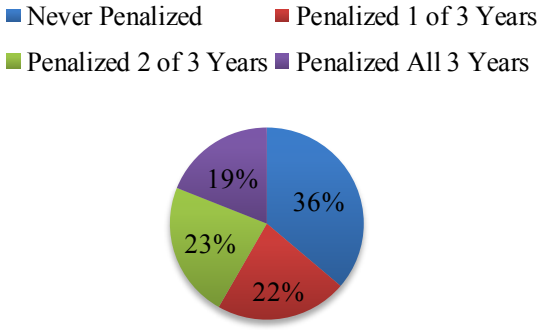
Readmissions Penalties for All Other Participating Hospitals

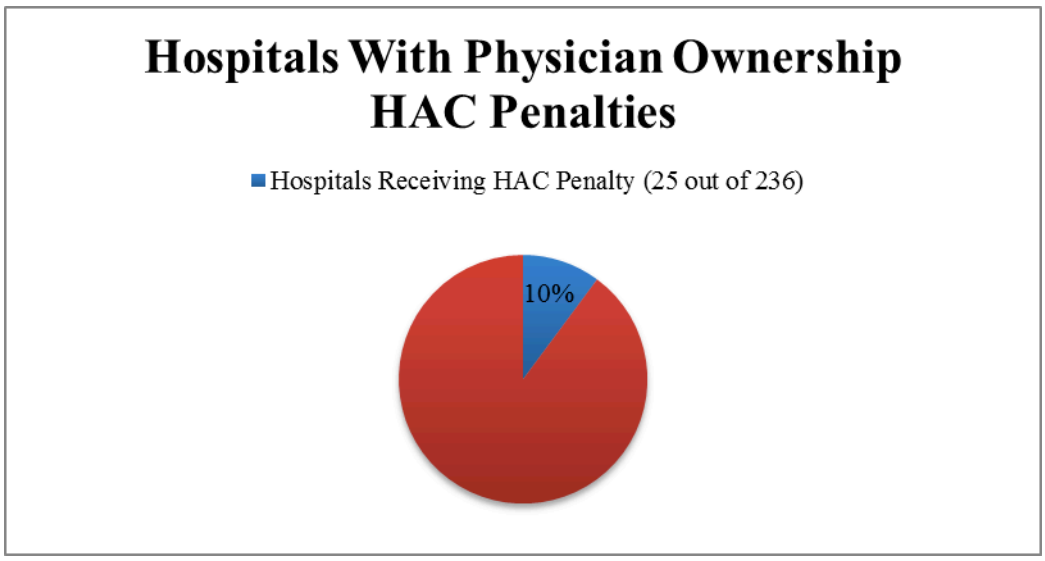


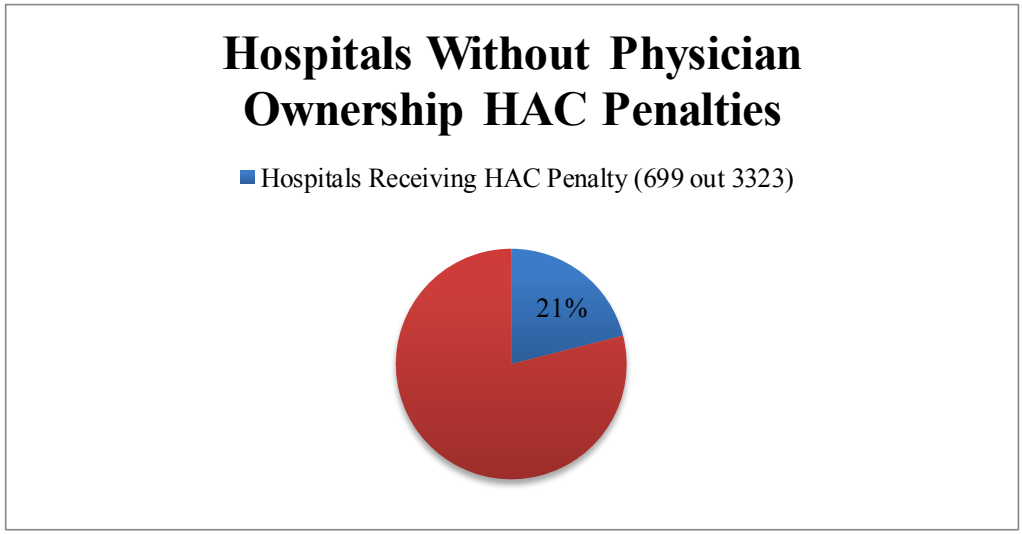
Value-Based Purchasing for Hospitals with Physician Ownership

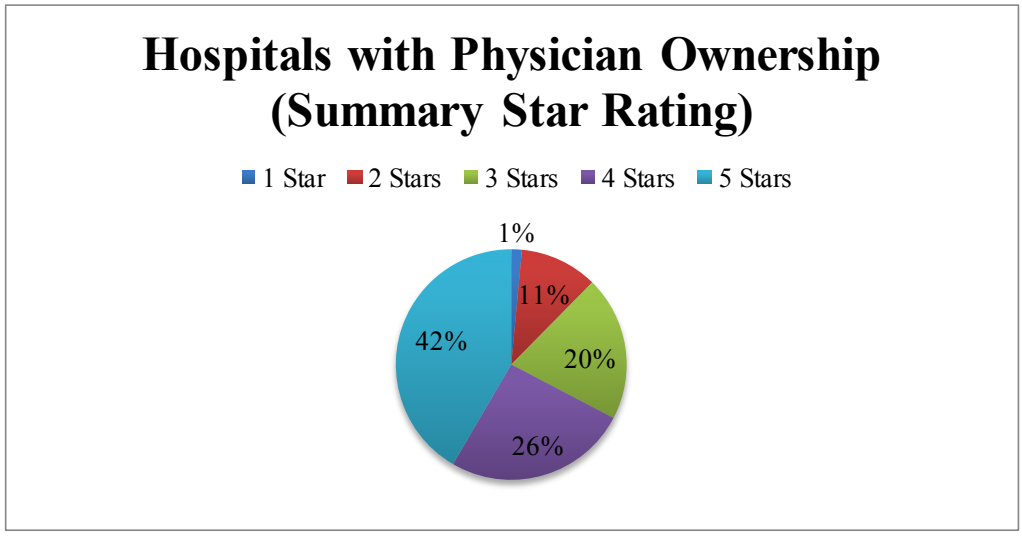


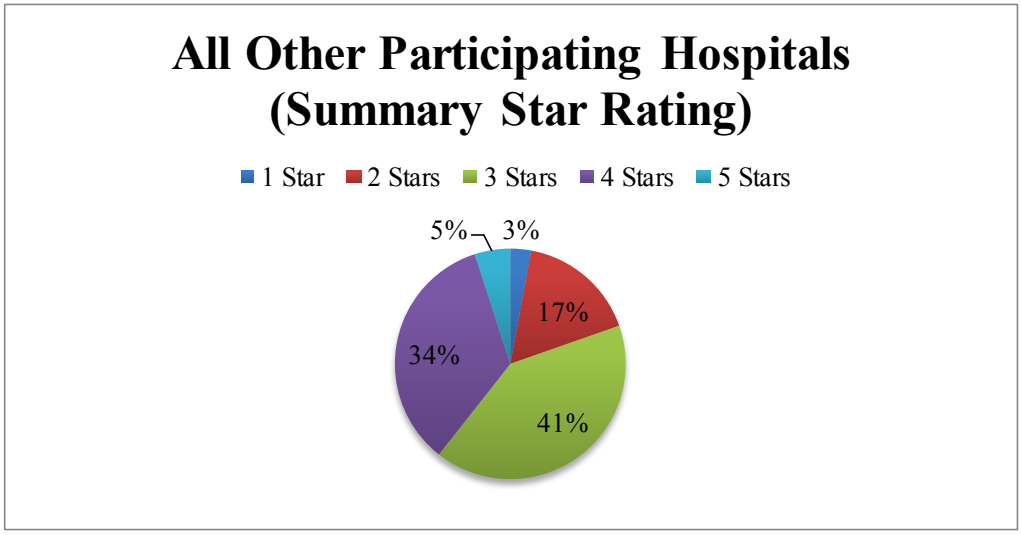
Value-Based Purchasing for All Other Participating Hospitals




Hospitals With Physician Ownership HAC Penalties
Hospitals Receiving HAC Penalty (25 out of 236)
10%


Hospitals Without Physician Ownership HAC Penalties
Hospitals Receiving HAC Penalty (699 out 3323)
21%


Hospitals with Physician Ownership (Summary Star Rating)
1 Star
2 Stars
3 Stars
4 Stars
5 Stars
1%
11%
20%
26%
42%



Physician Ownership Model

The governance model of POHs revolves around patients. It is the patients that have been forgotten by the opponents of POHs in this political debate. Many POHs were developed by physicians who were frustrated that they could not utilize the equipment they believed would lead to better outcomes or were forced to work with staff whose competence they questioned. In many cases, the frustration led them to invest in their own facilities where they have direct control over how the hospital runs. These physicians have the ability and motivation to design a hospital's layout and operations in a way that maximizes quality and efficiency. This leads to better outcomes at lower cost as they make needed investments at the bedside, without spending extravagantly if there isn't a correlation to patient outcomes.

A GAO report found the majority of physician owners have shares of only 2-4% of their hospital.[ii] The GAO also concluded the majority of physicians who refer patients to POHs have no ownership interest in the facilities, and thus, have no financial incentive to make such referrals. Approximately 74% of physicians with admitting privileges at POHs are not investors, suggesting the attractiveness of the model goes well beyond financial gain[iii]. Physicians' control every facet of how a POH is run – bureaucratic and administrative inefficiencies are greatly reduced compared to NPOHs. Operating rooms (ORs) run as a well-oiled machine – both the surgical/medical team and support staff. After a surgery the ORs are turned over in 15 minutes or less, while at NPOHs this often approaches an hour.[iv] This makes for unhappy patients and physicians.

The governance model also allows for rapid change. If there is a need identified that will improve patient care it does not have to run through committee after committee, it can be implemented immediately. All of this greatly contributes to high quality patient outcomes and satisfaction.

Community Support versus Profiteering

All hospitals, whether tax-exempt, for-profit, and physician-owned hospitals, need to be profitable to stay open. There are numerous examples of physicians purchasing tax-exempt and for-profit hospitals

that were closing due to bankruptcy. St. Joseph's in Houston, TX and Doctor's Hospital of Michigan in Pontiac, MI are just two examples of physicians purchasing hospitals that were closing so that care would be preserved for underserved populations. The opponents of POHs abandoned these communities and it was physicians who maintained access to care. Physicians could not do this today under current law.

Tax-exempt models perpetuate an inefficient model. By needing to "reinvest" or spend down their profits, often by expanding their physical plant or increasing administrative overhead, they add significant additional costs to the system, as Medicare bases a portion of reimbursements on facility cost reports. This creates inefficiencies that have little return for patients.

The for-profit model naturally creates investor pressures for high returns on investment. Almost 3 million shares of Hospital Corporation of America's (HCA) stock trade every day. These shareholders rarely have any tie to the community where there is an HCA hospital. Investors are seeking a profit through dividends and a higher stock price.

The POH model is based upon investments by individual physicians. These physicians are treating patients – often their neighbors – and devote their career to the community in which they live and practice. The majority of income is derived from providing physician services, not the hospital investment; however, the investment assures they can provide services on their own terms, not an administrator's.

The diversity of these models creates a competitive environment which is good. PHA believes patients benefit when they have more choice in who provides their healthcare. Public policy should encourage physicians who believe in their services enough to financially invest in where they treat patients. All the data demonstrates the real beneficiary is patients.

According to HRSA, nearly 30% of all POHs serve Medically Underserved Areas and/or Medically Underserved Populations.

Most importantly, in terms of community benefit, a CMS study found that POHs spend an average of 5.5% of their total revenue on community benefit, compared to only .87% for NPOHs. Community benefit includes taxes paid and charitable care.[v] As an example, in the case of the Indiana Orthopaedic Hospital, a portion of hospital ownership was placed in security trust for charitable purposes and over $2.1 million has been donated to the Central Indiana Community Foundation. Clearly POHs are not the greedy, profiteering enterprises for which they are accused of being by their opponents.

CBO Estimates

Over the past 10 years the CBO has scored anti-POH legislation as saving anywhere from$2.8 billion to most recently $300 million. Countering CBO's $500 million score during the ACA debate was CMS's Office of the Actuary that concluded there would be no budget impact. In fact, in 2014 CMS published Medicare payments to hospitals for the top 100 DRGs and top 30 APCs for the first time. CBO did not have access to this data prior to this time. The data also included the number of cases each hospital

performed. Using simple arithmetic, if all the cases that were performed at POHs were transferred to their competitors within the same hospital referral region, it would cost an additional $3.2 billion over 10 years to treat those patients.[vi] Simply put, POHs provide less costly care for patients than their competition.

Utilization

After a decade of debate, critics of POHs have not been able to construct a coherent, evidence-based case that POHs have higher utilization (i.e. "inappropriate" utilization) than their NPOHs. There has never been any evidence provided in any recognized study, government-produced or otherwise, that POHs result in inappropriate utilization.[vii]

POHs that provide focused services yield utilization of a very narrow procedure group. In doing so, they excel at providing the highest levels of quality and efficient care. The model creates what would be considered "centers of excellence" in any other industry. Providing efficient care means a hospital is able to perform more surgeries or procedures in the same time frame than NPOHs. In fact, many physicians will not treat Medicaid patients unless it is at a POH as they can do several Medicaid cases in the same amount of time it takes them to do one case at a NPOH. This efficiency of care allows the physician to continue to serve Medicaid patients. Without it, they would lose money and ultimately would have to greatly reduce such services.

One of the goals of the ACA is to improve access to healthcare services and POHs are able to better serve more patients than their counterparts.

Demand Matching is not Cherry Picking

The national associations that represent NPOHs continue to falsely accuse doctors at physician-owned facilities of "cherry-picking" patients. If one steps back and thinks about the issue, POHs not only do not cherry pick patients, but they are fighting for the ability to serve more Medicare and Medicaid patients. Section 6001 did not outlaw new POHs; it mandated that CMS would not provide reimbursement for treating those patients at new POHs and grandfathered POHs could not expand and continue to serve Medicare and Medicaid beneficiaries. POHS are fighting the current political battle so they can serve all patients.

In a working paper titled "Physician Investment in Hospitals: Specialization, Incentives, and the Quality of Cardiac Care," Dr. Ashley Swanson – a professor at the University of Pennsylvania's Wharton School of Business and a former associate of Jonathan Gruber, the principal architect of the ACA – asserts that "there is little evidence of physician-owner cherry picking" and that "the banning of further physician ownership as part of the ACA may have detrimental effects on patient health." She continues, "Treatment at a physician-owned facility can lead to substantial improvements in mortality risk for cardiac patients." She finds that not only do physician owners not cherry pick, they provide a higher quality of care for their patients compared to their competition.

Rather than cherry pick, physician owners of hospitals ensure their patients are treated at the facility that will best meet the patient's needs. An efficient healthcare system provides choice and different levels of care. As previously stated, not all patients need the same level of care and physician-owned

hospitals provide a valuable option for many patients, just as an ambulatory surgical center or a large general acute care facility does for others. The key is that physicians provide informed consent with patients and the patient decides where the healthcare services will take place. Most physician owners of hospitals are have privileges to practice at multiple NPOHs simultaneously, just as physicians without an ownership stake in a hospital are affiliated with multiple facilities, including POHs. Cherry picking does not occur at POHs; matching the patient to the facility that will provide the optimum outcome is the driver of referrals.

Ironically, in 2007, CMS eliminated any incentive that might lead to the so-called "cherry picking" of Medicare patients. CMS changed the inpatient hospital payment policy to base payments on actual costs rather than charges, better reflecting the severity of a patient's condition. The agency believed these changes would more accurately reflect the costs of caring for a patient and reduce incentives that might exist for any hospital to treat the healthier and more profitable patients. Physician Hospitals of America welcomed the transition to a severity-adjusted DRG system, whereas the new policy was opposed by the associations representing NPOHs**.**

Services Vary at Hospitals

Over 60% of POHs have emergency departments. It is true there are POHs that do not have an emergency department. This is also true for some non-physician-owned hospitals. Hospitals are licensed at the state level and some state laws require a hospital to offer certain services while others do not. This includes emergency services. As part of the Medicare Conditions of Participation, POHs, as well as any other hospital, are required to detail a plan for how emergencies and transfers are handled. POHs fully comply with this mandate.

Community needs are the key drivers to any service offered by hospitals. Government regulation also dictates how those services are to be delivered. Hospital emergency department services vary significantly in terms of the level of treatment provided. For instance, of the nearly 6,000 hospitals across the country, only 1,675 of them have a trauma center[viii]. It is not uncommon for patients with severe injuries or medical conditions to be transported from one hospital to one that is better equipped to provide a higher level of care. This is also true for burn victims. As of 2012, there are 123 self-designated burn care facilities in U.S. hospitals. When a severely burned patient is transported to a general community hospital, it is usually necessary for that patient to be transported to one that is equipped to treat these more complex cases. Another example of varied services within the hospital industry is Neonatal Intensive Care Units (NICU). There are varying degrees of care that NICU's offer and many hospitals do not have any level of this specialized care so newborn babies in need of neonatal care are routinely transferred to another hospital with a NICU because they have the experience, equipment, research and processes to assure the best care possible. All hospitals, no matter what type, transfer patients from time to time ensuring they receive treatment in the best possible environment.

Conclusion

Opposition to physician-owned hospitals did not come from patients, who flock to these facilities because of their positive outcomes and overall experience. The ban on physician-owned hospitals is not

and never has been organic. It has come from the Big Hospital lobby which views any disruptive innovator as a threat to their bottom line. It is this group that has requested that Congress ban POH expansion. Patients are certainly not a focus in the pursuit of this policy.

It is time to put sound policy before politics. Patients should always be the driving force behind providing hospital services. They should be able to seek treatment at hospitals that provide high quality outcomes and patient satisfaction at a low cost. Physicians want to ensure their patients receive the best care possible. The POH results speak for themselves.

Section 6001 has had a negative effect on patients as access to lower cost, high quality centers of excellence has been limited. We believe public policy should be implemented that align with high quality patient care and not the politics of David versus Goliath. We appreciate the Chairman for holding this hearing as the current policy simply stifles patient access to some of the best hospitals in the country. PHA asks Congress to repeal Section 6001 of the Affordable Care Act.

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[i] 2012 CMS Hospital Value Based Purchasing Data

[ii] Specialty Hospitals: Information on National Market Share, Physician Ownership and Patients Served. Washington, DC: Government Accountability Office; 2003

[iii] Specialty Hospitals: Geographic Location, Services Provided and Financial Performance. Washington, DC: Government Accountability Office; 2003

[iv] PHA Benchmarking Report

[v] CMS. Study of Physician-owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003: Centers for Medicare and Medicaid Services, Department of Health and Human Services;2005.

[vi] "Physician-Owned Hospitals Result in Lower Expenditures," Issue Brief, Avalon Heath Economics. 2013

[vii] "Do Physician-Owned Hospitals lead to Higher Utilization?" Issue Brief, Oxford Outcomes. 2012

[viii] TIEP: Public Reports – Trauma center Designation and verification by Level of Trauma Care

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

Dear Sirs:

I am the CEO of Salina Surgical Hospital in Salina, Kansas. I would like to thank you, Chairman Brady, Ranking Member McDermott, and other members of the subcommittee for the opportunity to submit comments in connection with the above-mentioned hearing.

My objective today is to help the House Ways and Means Health Subcommittee understand why ending discrimination in Federal Law against hospitals with physician ownership is necessary if we ever hope to make positive change that will positively affect both Medicare and Medicaid patients across the country. Patients should be the driving force behind providing hospital services. Patients should be able to seek treatment at hospitals that provide high quality outcomes and patient satisfaction at a lower cost. Section 6001 of the ACA both prohibits newly constructed physician owned hospitals (POH) from being able to treat Medicare and Medicaid patients and restricts the Medicare-licensed physician owned hospitals that were grandfathered under the law from growing to meet community needs. This anti-competitive policy is bad for our health care system, bad for Medicare and most important, bad for patients. I am strongly urging Congress to allow hospitals with physician ownership to compete on a level playing field with every other hospital in the country, particularly when it comes to growth. This can be accomplished by supporting the bi-partisan legislation, H.R. 976, to increase patient access to physician owned hospitals.

Salina Surgical Hospital (SSH)

About Us

Opening our doors in 1999, Salina Surgical Hospital was the concept of a group of local community involved physicians and investors with a commitment to patient satisfaction and care. Salina Surgical Hospital and Salina Regional Health Center (SRHC), our community hospital, formed a joint venture to develop a state of the art entity with the mission to provide the highest quality healthcare services at a reasonable cost using modern, state-of-the-art technology in a friendly and caring environment by highly-skilled, compassionate staff in an effort to serve the people of Salina and its surrounding communities. SSH is a multi-specialty hospital that provides both inpatient and outpatient services.

Salina Surgical Hospital is located in Salina, Kansas. We serve the city of Salina as well as north central Kansas. Our patient population is close to 50% Medicare and Medicaid. We are a multi-specialty hospital that offers specialized care for Orthopedics, General Surgery, Ophthalmology, Digestive Health Women's Health, Otolaryngology, Podiatry, Urology, and limited Neurosurgery.

Salina Surgical Hospital is proud to be a partially physician owned hospital. Physician ownership means that the physician owners play a major role in deciding how Salina Surgical Hospital is run and what equipment and supplies are purchased by the hospital. Physician ownership reinstates the physician

back into the decision-making role which allows our physicians to deliver the highest quality of dedicated service in the facility that they co-own.

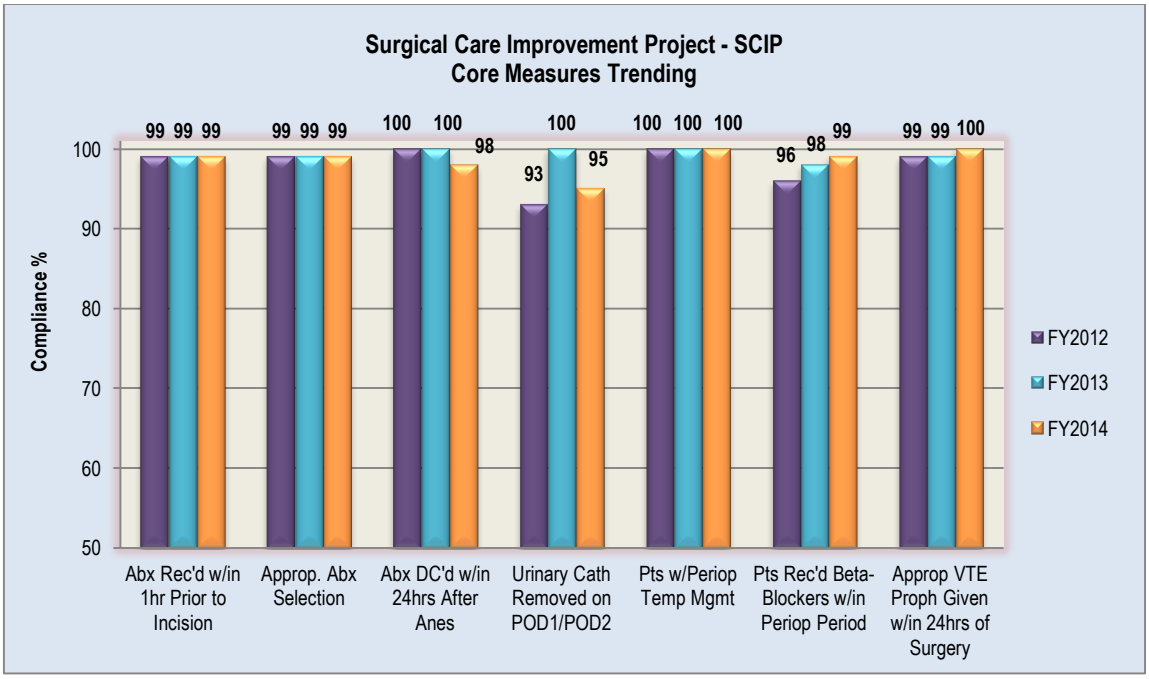
In addition, being partially physician owned sets us apart because our medical staff has a direct investment in the quality of care you receive. This ensures you are treated with respect, dignity, and the compassion you deserve. Our facility is comprised of four operating rooms, two endoscopy suites, and 16 staffed inpatient rooms (Licensed for 18 inpatient rooms).

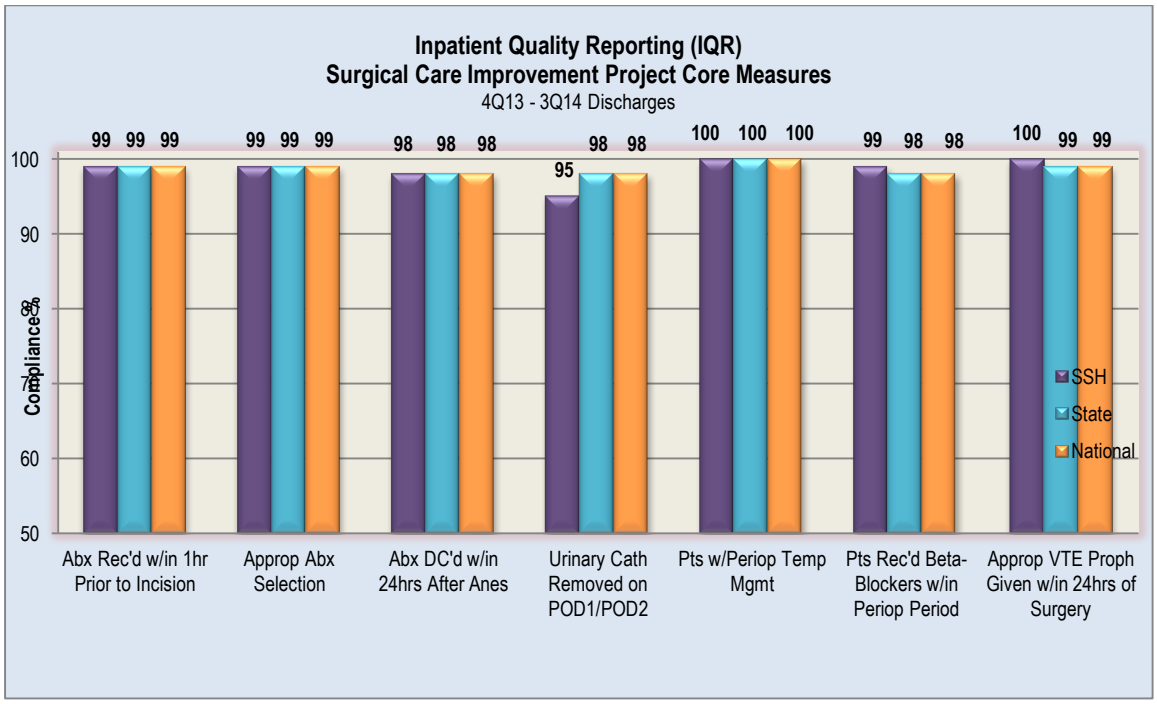
What also sets our facility apart is the partnership with our not-for-profit community hospital. Not only does our community hospital reap 50% of the revenue our facility creates, but we contract many services from our community hospital. An example of services contracted from our community hospital is physical therapy, occupational therapy, social services, pharmacist-in-charge services, and blood bank services. By contracting these services from our community hospital, we are helping to keep health care dollars in our direct community.

Quality at SSH

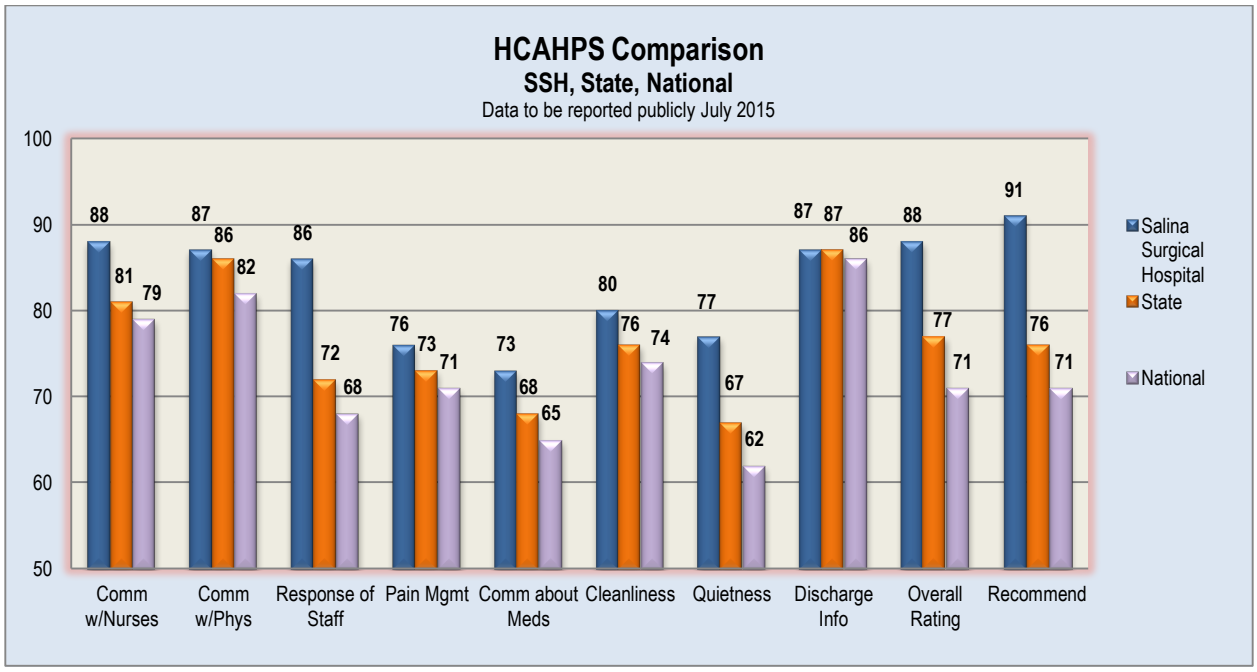
Quality care is what Salina Surgical Hospital (SSH) is about. SSH strives to provide the best quality care to every patient, every day, in the most efficient way. Because there are so many things that can impact quality of care, the hospital, its staff, and PHYSICIANS are continually looking for ways to improve the care they provide. Our high CMS quality measure scores, patient satisfaction, low infection rates, zero sentinel/never events, and achievements in the VBP program are a reflection of our hard work and commitment to excellence. The following charts showcase SSH achievements.

CMS Quality Measure Scores

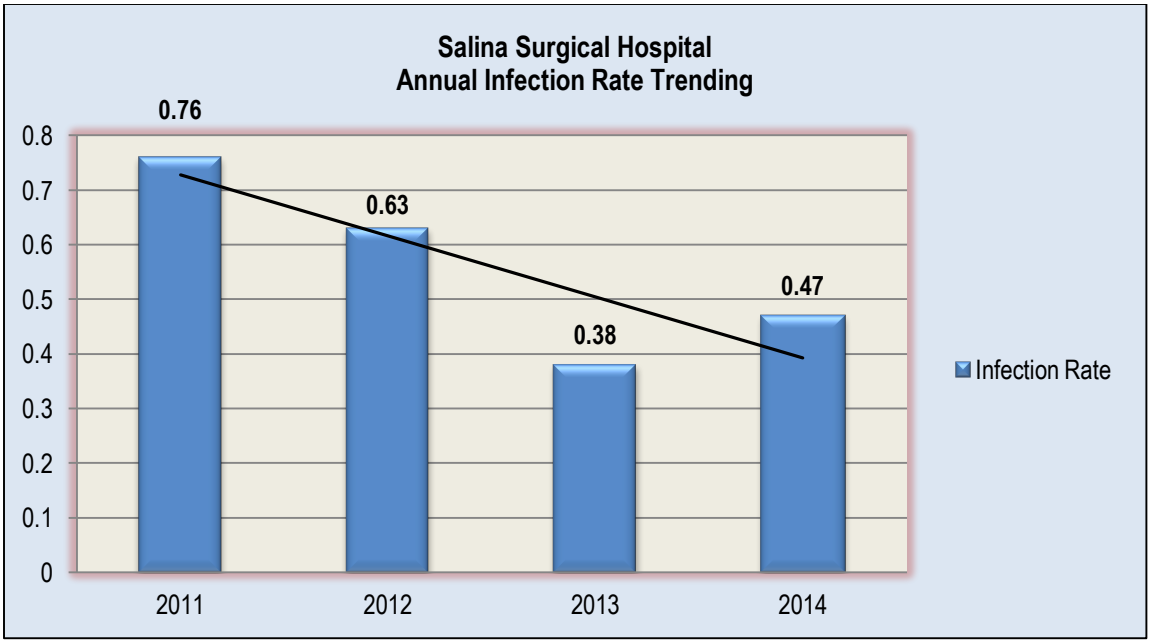




Patient Satisfaction



Infection Prevention



Value Based Purchasing

	FY2013	FY2014	FY2015	FY2016	FY2017 and Subsequent Years
Initial Base Operating DRG Payment Reduction	1.0	1.25	1.5	1.75	2.0
Clinical Process of Care	70%	45%	20%	10%	To be determined
Patient Experience of Care	30%	30%	30%	25%	
Outcomes	N/A	25%	30%	40%	
Efficiency	N/A	N/A	20%	25%	
# of Domains Required to Meet to Participate	2 Domains	3 Domains	2 Domains	2 Domains	
Value-Based Incentive Payment Percentage Earned by Salina Surgical Hospital	**1.3057** (0.3057 additional)	**Not Eligible** - Participation in 2 domains only	**3.1016** (1.6016 additional)	Pending	

Emergency Services

Salina Surgical Hospital is a POH that does not have an emergency department. It is the operating agreement between SSH and our community hospital partner that prohibits our hospital from

providing emergency services. Salina Surgical Hospital's scope of care, per our operating agreement, is limited to a surgical/procedural specialty hospital. Physicians are available on-call 24 hours a day, 7 days a week, but may not be on the premises. The nursing staff is trained in basic and advanced cardiac life support, as well as in the use of the full complement of available emergency equipment in the event an emergency should occur at SSH. Our patients understand that if they should need services not available at SSH, we have a transfer agreement and other affiliations with SRHC to provide these services. Transportation to and from SRHC will be arranged by SSH based on the level of care required. What enhances our ability to safely handle emergency situations are our staffing levels. SSH does not dilute our clinical staff with nurse extender positions. Our Inpatient unit is staffed predominantly with registered nurses and our patient to nurse ratio is 4:1 or less.

Conclusion

The BOTTOM LINE: ***It's all about CARING!*** Despite the fast pace and variety of cases that we perform, we consistently achieve high outcomes. From preadmission to discharge and beyond, our approach to the continuum of patient care is characterized by attention to detail, prevention rather than reaction and applying the best practices, all while being flexible and innovative. I would venture to say that this is the trademark for all physician owned hospitals.

Opposition to physician-owned hospitals did not come from patients. Patients flock to these facilities because of their positive outcomes and overall experience. The ban on physician-owned hospitals is not and never has been organic. It has come from the *Big Hospital* lobby which views any disruptive innovator as a threat to their bottom line. It is this group that has requested that Congress ban POH expansion. Patients are certainly not a focus in the pursuit of this policy.

It is time put sound policy before politics. Patients should always be the driving force behind providing hospital services. They should be able to seek treatment at hospitals that provide high quality outcomes and patient satisfaction at a low cost. Physicians want to ensure their patients receive the best possible care. The POH results speak for themselves.

Healthcare is changing. Every day, in every way. It requires true collaboration to solve the toughest issues-from revenue and cost pressures to compliance and technology hurdles. At Salina Surgical Hospital we strive to transform our top challenges into opportunities. There is no endpoint on our journey to continually maintain and improve our reputation of excellence and provide patients with quality service and the best outcomes.

Section 6001 has had a negative effect on patients as access to lower cost, high quality centers of excellence had been limited. I believe public policy should be implemented that align with quality patient care and the politics of David versus Goliath. I appreciate the Chairman for holding this hearing as the current policy simply stifles patient access to some of the best hospitals in the country. Salina Surgical Hospital asks Congress to repeal Section 6001 of the Affordable Care Act.

The Heart Hospital
Baylor Plano

Joint ownership with physicians

Now part of Baylor Scott & White Health

June 1, 2015

The Honorable Kevin Brady
Chairman
House Committee on Ways and Means
Subcommittee on Health
United States House of Representatives
Washington, D.C. 20515

Dear Chairman Brady:

The Heart Hospital Baylor Plano would like to submit the following written comments for the record for the hearing titled *"Improving Competition in Medicare: Removing Moratoria and Expanding Access"* that your committee held on May 19, 2015. The Heart Hospital Baylor Plano strongly believes that Congress can improve competition and expand access by passing the *Patient Access to Higher Quality Health Care Act of 2015* (H.R. 976) to eliminate Section 6001 of the Affordable Care Act ("ACA"), which prohibits (i) new physician-owned hospitals from treating Medicare and Medicaid patients, and (ii) the expansion of physician-owned hospitals that presently exist. This would not only improve competition and expand access, it would also improve the quality of health care and increase overall patient satisfaction.

The Heart Hospital Baylor Plano

The Heart Hospital Baylor Plano is a 116 bed specialty hospital located in Plano, Texas that is dedicated to providing the highest quality cardiovascular care. Although focused on cardiovascular care, The Heart Hospital Baylor Plano has a full functioning emergency department with the ability to care for and stabilize emergent patients. We are the ninth largest cardiac surgery center in the United States and rank first out of approximately 23 cardiovascular specialty hospitals nation-wide as measured by patient volume. In April of this year, The Heart Hospital Baylor Plano was one of only 13 North Texas hospitals to be awarded a five-star rating by the Centers for Medicare and Medicaid Services ("CMS"). We were also rated as one of the top 15 heart surgery programs in the United States last year by *Consumer Reports*. Locally, The Heart Hospital Baylor Plano, as noted by the Dallas-Fort Worth Hospital Council, is the largest heart surgery center out of 39 similar programs in the Dallas-Fort Worth Metroplex.

1100 Allied Drive, Plano,TX 75093-5348
469-81HEART (469.814.3278) • 877.814.4488 • 469.814.3521 Fax
TheHeartHospitalBaylor.com

Our commitment to patient service has also been repeatedly recognized. *Becker's Hospital Review* named The Heart Hospital Baylor Plano to its list of "54 Best Overall Patient-Rated Hospitals," "Top 55 Hospitals Patients Would Definitely Recommend," and "100 Hospitals and Health Systems with Great Heart Programs." The Heart Hospital Baylor Plano was also named a 2014 "Beacon of Excellence Award" and "Guardian of Excellence Award" winner by Press Ganey Associates. In 2012, for the fourth consecutive year, we earned an "Outstanding Patient Experience Award" as determined by the HealthGrades Quality Study, which places us in the top 5% in the nation for the Outstanding Patient Experience.[1]

CMS Data Shows Physician-Owned Hospitals Provide Higher-Quality Care

Although The Heart Hospital Baylor Plano has earned numerous awards for the high quality care we provide to our patients, we are not the only physician-owned hospital that has been recognized as a center of excellence within the American health care system. Seven of the top 10 hospitals awarded bonus payments for higher quality of care through the Hospital Value-Based Purchasing program in FY 2015 were physician-owned, as were 43 of the top 100. This is even more impressive when you consider that less than 5% of program participants were physician-owned hospitals. In 2005, CMS issued a report that found physician-owned hospitals also performed better than general hospitals in complication rates. When CMS compared 14 areas, including complications of anesthesia and infections due to medical care, physician-owned hospitals led in 13 of the 14 areas, in some cases by wide margins.

Section 6001 Prevents Competition

Despite an outstanding and established record of performance, Section 6001 of the ACA prohibits physician-owned hospitals from building new facilities that would treat Medicare and Medicaid beneficiaries. It also includes overly burdensome requirements that prevent existing physician-owned hospitals from adding any additional inpatient beds, operating rooms, or procedure rooms, even when the community in which they are located has an ongoing need for expanded services. When the federal government's own data shows that physician-owned hospitals can deliver care that is higher in quality than care provided by general hospitals, it makes no sense to leave a prohibition in place that prevents physician-owned hospitals from competing in the health care marketplace.

We are a good example of the current law's adverse impact on a community. Recent market data indicates that the Dallas-Fort Worth Metroplex is growing by approximately 100,000 residents per year. Given our community's exponential growth, the demand for heart and vascular care will continue to increase. However, The Heart Hospital Baylor Plano constantly operates at full capacity today and the prohibition against expansion will limit our ability to grow in the future to meet the increased need for care in our community.

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[1] A list of quality and service accomplishments for The Heart Hospital Baylor Plano can be found at Exhibit A.

Competition Leads to Innovation

Competition leads to innovation and The Heart Hospital Baylor Plano has been a leader in innovation. In 2011, we opened The Center of Innovation, a 10,000-square-foot facility that consists of an advanced training facility with a bioskills lab. The integrated services offered at the Center include medical education, staff development, student educational experiences, health care preceptorships and hands-on training events for medical professionals across the health care industry. The Center is not merely a resource for The Heart Hospital Baylor Plano's staff and invited guests, but an important center of learning that focuses on a variety of specialties, beyond just cardiovascular care. We would welcome the entry of new competitors in the market because we believe the additional competition would only help us to provide even better quality to our patients.

Again, thank you for the opportunity to provide comment on how to improve competition in the Medicare program. The Heart Hospital Baylor Plano strongly supports adoption of H.R. 976 to end the prohibition against the development of new physician-owned hospitals and the expansion of existing physician-owned hospitals. This law would spur competition in the Dallas-Fort Worth market and provide patients with greater access to high-quality health care. We would like to extend an invitation to you, and any of your colleagues to visit our facility and engage in a dialogue as to why we believe physician-owned facilities will continue to increase the efficiency and quality of care to all patients. We look forward to working closely with you to see that this important legislation becomes law.

Sincerely,

Mark A. Valentine
President
The Heart Hospital Baylor Plano

The Heart Hospital
Baylor Plano

Joint ownership with physicians

Now part of Baylor Scott & White Health

EXHIBIT A

THE HERAT HOSPITAL BAYLOR PLANO
QUALITY AND SERVICE ACCOMPLISHMENTS

QUALITY

- The **American Heart Association** recognizes The Heart Hospital Baylor Plano for achieving 85% or higher compliance with all Get With The Guidelines®-Heart Failure Achievement Measures and 75% or higher compliance with four or more Get With The Guidelines®-Heart Failure Quality Measures for consecutive 12 month intervals to improve quality of patient care and outcomes. Recognition valid from 2014 to 2015.

- December 18, 2014 Baylor Scott & White Health announced an **alliance with Cleveland Clinic's Sydell and Arnold Miller Family Heart & Vascular Institute.** The alliance creates a collaboration involving the academic, clinical and research components of Cleveland Clinic and three Baylor Scott & White Health hospitals:
    - Baylor Jack and Jane Hamilton Heart and Vascular Hospital
    - Baylor University Medical Center at Dallas
    - The Heart Hospital Baylor Plano

- The Heart Hospital Baylor Plano: Recognized as a **"Top 10 Cardiovascular Specialty Hospital in the Country"** based on volume as reported by TRG Health Care Solutions.

- **The Society of Thoracic Surgeons (STS)** star ratings received for calendar year 2014 in Adult Cardiac Procedures: The Heart Hospital Baylor Plano received 3 stars, the highest rating an organization can receive, in Isolated Aortic Valve Replacement (ranks in the top 7.89% of facilities receiving 3 stars for AVR) and Aortic Valve Replacement + Coronary Artery Bypass Graft (ranks in the top 7.53% of facilities receiving 3 stars for AVR+CABG).

- **The Society of Thoracic Surgeons (STS)** star ratings place The Heart Hospital Baylor Plano in the top 2.8% of the nation for facilities receiving 3 stars in AVR and AVR + CABG. The 3 star ratings consist of absence of Mortality and absence of Morbidity. Morbidity includes, but is not limited to, reoperations, post-op strokes, renal failure and prolonged intubation.

- April 16, 2015 The Heart Hospital Baylor Plano was one of only 13 North Texas hospitals to be **awarded a five-star rating, the highest rating possible, by the Centers for Medicare and**

Medicaid Services (CMS). Additionally, The Heart Hospital was one of only 251 hospitals out of more than 3,500 U.S. hospitals to receive the five-star rating.

- June 27, 2014 ***Consumer Reports*** **rated The Heart Hospital Baylor Plano as one of the top 15 heart surgery programs in the United States**. The organization rated hundreds of heart surgery programs on two common types of heart surgery: surgical aortic valve surgery and coronary artery bypass graft surgery as well as on patient outcomes, including survival and complication rates.

- **Poster presentations at the national NCDR conference** in San Diego (March 2015): Subjects included "Code STEMI: Taking a Team Approach to Expedite Reperfusion Therapy"

- Participate in **submitting our quality outcomes in more than 25 databases, registries and governing bodies** that include, but are not limited to the following: Centers for Medicare and Medicaid Services (CMS), The Joint Commission, NCDR (National Cardiovascular Data Registry), The Society of Thoracic Surgeons, and VQI (Vascular Quality Initiative)

- **Pathway to Excellence®** designation 2010

- **Magnet® designation** – February 2011

- The **Joint Commission Accreditation** recertification 2013 zero deficiencies

- The Joint Commission **Advanced Heart Failure Certification** – April 2011

- The Joint Commission **Ventricular Assist Device (VAD) Certification** – June 2011 recertification, 2013

- Inter-societal Accreditation Commission Vascular Laboratories **(ICAVL) Vascular Ultrasound; Venous** and **Carotid Imaging** accreditation at the CACC and THE HEART HOSPITAL Baylor Plano

- Inter-societal Accreditation Commission Echocardiography Laboratories **(ICAEL) Cardiac ECHO** accreditation at the Center for Advanced Cardiovascular Care

- The Society of Cardiovascular Patient Care (SCPC) **Chest Pain Accreditation** Cycle IV +PCI – May 2014

- Designated as an **Institute of Quality (IOQ)** for **Cardiovascular Surgery and Cardiac Medical Intervention** May 1, 2013. Designated IOQ facilities demonstrate excellence in care, a commitment to continuous improvement and represent an exceptional value to Aetna's members. IOQ facilities are recognized in Aetna's DocFind® online provider directory to assist members with choosing facilities providing consistently high quality and high value care.

- Ranked **#1** out of 121 programs in Texas by **CARECHEX** in their Hospital Quality Ratings 2013, Cardiac Surgery (Major) Category. CARECHEX is one of the nation's largest privately-held healthcare information services companies.

- The Joint Commission **Top Performers on Key Quality Measures™** for 2012.

- The Joint Commission published this recognition in its "Improving America's Hospitals" annual report: "**As a Top Performer on Key Quality Measures, your hospital is among 620 hospitals, the top 18%.**" September 19, 2012

- American Heart Association Heart Failure **Gold Plus Quality Achievement Award**

- American Heart Association Mission Lifeline (STEMI) **Bronze Award** 2011

- American Heart Association Mission: Lifeline® Receiving Center – **SILVER Level Recognition Award 2012**. This award is based upon our Mission: Lifeline achievements through the ACTION Registry GWTG™ 2012 calendar year.

- Action (STEMI/NSTEMI) Registry **Platinum Award** 2013

- **#1 heart surgery program in the Dallas/Ft. Worth Metroplex**, performing one of every four heart surgeries last year. Nearest competitor performed approximately half as many as The Heart Hospital Baylor Plano.

- **First in the World** to merge two high-tech systems for atrial fibrillation therapy. The procedure combined multi-electrode mapping (MEM) software with the Epoch™ platform, an advanced computer-controlled technology that allows physicians to navigate within the patient's heart with robotic precision.

- **First in the World** to merge three high-tech systems for atrial fibrillation therapy. The procedure combined multi-electrode mapping (MEM) software with GE ultrasound and BioSense Webster Carto® 3D mapping for advanced computer mapping

- Developed **Plano Campus Thoracic Program** encompassing clinics, oncology and thoracic surgery in 2013

SERVICE

- Becker's Hospital Review has named The Heart Hospital Baylor Plano as one of the organizations on its 2014-15 edition list: **"100 Hospitals and Health Systems with Great Heart Programs."** The hospitals on this list lead the nation in cardiovascular and thoracic healthcare.

- June 24, 2014 Becker's Hospital Review named The Heart Hospital Baylor Plano as **one of the "Top 55 Hospitals Patients Would Definitely Recommend."**

- On December 10, 2014 The Heart Hospital Baylor Plano was named a **2014 Beacon of Excellence Award℠ and Guardian of Excellence Award℠ winner by Press Ganey Associates, Inc.** The Beacon of Excellence Award is presented annually to organizations representing the nation's three top-performing health care facilities by category that have achieved and consistently maintained high levels of excellence in the patient experience. The Guardian of Excellence Award is presented annually and honors Press Ganey clients who consistently sustained performance in the top five percent of all Press Ganey clients for each reporting period

during the course of one year. Press Ganey is the nation's leading health care performance improvement company and partners with more than 11,000 health care facilities, including more than half of all U.S. hospitals, to improve the patient experience.

- The Heart Hospital Baylor Plano was named **one of the "54 Best Overall Patient-Rated Hospitals" by Becker's Hospital Review**. Data was pulled from the Hospital Compare website and is based on data from January through December of 2013, the most recent information available.

- Becker's Hospital Review named The Heart Hospital Baylor Plano as **one of the "150 Great Places to Work in Healthcare"** in the United States.

- Press Ganey 2013 **Beacon of Excellence Award** winner (Inpatient & Emergency Department) for maintaining consistently high levels of excellence in patient satisfaction May 2010 – April 2013. Awarded to the top three performers in the United States: Inpatient category of 100 – 199 bed and the top three performers in Emergency Department

- Press Ganey **Inpatient Summit Award:** 2009, 2010, 2011, 2012

- Press Ganey **Emergency Department Summit Award:** 2010, 2011, 2102

- Press Ganey **Guardian of Excellence Award.** Emergency Department, Inpatient and HCAHPS categories 2013

- **Becker's Hospital Review** (August 20, 2013) listed The Heart Hospital Baylor Plano as one of the "Top 51 Hospitals Patients Would Definitely Recommend"

- **Outstanding Patient Experience Award™** as determined by the 2012 HealthGrades Quality Study for the **fourth consecutive year** which places The Heart Hospital Baylor Plano in the **top 5% in the nation** for the Outstanding Patient Experience.

Statement for the Record

House Ways and Means Health Subcommittee

Chairman Kevin Brady (R-TX) and Ranking Member Jim McDermott (D-WA)

Improving Competition in Medicare: Removing Moratoria and Expanding Access

May 19, 2015

I am Richard Bruch, M.D., an orthopedic surgeon and serve as Board Chair of North Carolina Specialty Hospital (NCSH), a hospital with physician ownership which is unable to expand due to the limitations imposed by Section 6001 of the Affordable Care Act. I am a 1.31 % owner of NCSH.

Chairman Brady, Ranking Member McDermott and members of the House Ways and Means Health Subcommittee, thank you for accepting testimony regarding the issue of physician ownership of hospitals. As a general rule, physician owned hospitals provide great medical care with great patient satisfaction and provide this care at less expense than our competitors. H.R. 976 begins the process of allowing hospitals with physician ownership to provide additional great care at substantial savings to our patients.

NCSH located in Durham, North Carolina is licensed as a general acute hospital, the same licensure as all other North Carolina hospitals. NCSH has 18 licensed inpatient rooms and 4 licensed operating rooms. This represents 1.4% of Durham's licensed inpatient rooms and 5.3% of Durham's licensed operating rooms.

McPherson Hospital, the forerunner of North Carolina Specialty Hospital, opened in 1926. McPherson was a physician owned eye and ear hospital. As eye and ear surgeries became outpatient procedures the hospital inpatient census dwindled and the hospital was losing money. In 1998 Triangle Orthopaedic Associates, P.A. rescued McPherson Hospital which was then renamed North Carolina Specialty Hospital. Currently the majority of patients treated, both inpatient and outpatient, at NCSH are orthopedic and eye and ear patients. But NCSH also provides general surgery, bariatric surgery, plastic surgery, oral surgery, podiatry surgery, wound care, anesthesiology and pain management care.

NCSH treats the public. Current payer mix comprises 50% governmental funded patients including Medicare, Medicaid and Tricare. NCSH also treats indigent patients, providing free care via Project Access Durham County. Lincoln Community Health Center (LCHC) located in Durham is a federally qualified health center serving the uninsured and underinsured population. NCSH accepts the financial screen that LCHC assigns and Lincoln patients treated at NCSH need not go through any additional financial screening to determine their billing status.

NCSH provides superb care as documented by the ratings of CMS and other entities. Currently NCSH ranks 10th in the nation under the CMS combined ratings for Value-Based Purchasing Program and the Hospital-Acquired Conditions Program. The CMS 30 day Readmission rating is released quarterly and NCSH always ranks #1-#4 in the state. NCSH is one of only 251 hospitals in the nation to hold a 5 star CMS Patient Satisfaction rating. Consumer Reports Health assigned NCSH its highest rating for safest hospitals to have surgery, one of only two North Carolina hospitals to earn this designation.

How is this quality achieved? NCSH has a patient to nurse ratio of 4:1. All nurses must achieve ACLS and PALS certification within 6 months of employment. NCSH has an employee turnover rate of 7% annually; this rate is 1/3 the rate in the Triangle North Carolina region. Hospitalist physicians, who are Internists, are on site 24 hours per day, 7 days per week and they see every inpatient twice daily and record chart entries for these visits. A physician Anesthesiologist is present for every surgery performed. Medication reconciliation is performed on every inpatient by a licensed pharmacist. This is unique in the hospital industry and helps to make certain that every patient receives their medications correctly. As a result of this quality care, patient transfers to another hospital are low. During the past year, the patient transfer rate was 0.14%, 14 patient transfers with 10,056 patients treated.

NCSH has 160 credentialed physicians: of these, only 33 (21%) are active physician owners; 127 physicians are not owners. The majority of physicians practicing at the hospital have no financial incentive to do so; they choose to practice at NCSH because of the quality and efficiency of care and the cost savings to their patients.

NCSH provides lower cost care than other hospitals in the Raleigh-Durham-Cary-Chapel Hill area. For the same procedure, inpatient CMS reimbursement is more than 18% less than at the "non-profit" hospitals. For example, DRG Code 470 includes total knee replacement surgery. The Raleigh-Durham-Cary-Chapel Hill region has 8 hospitals performing these surgeries. NCSH Medicare payment for these surgeries is $10,102. The average Medicare payment for the remaining 7 hospitals in the region is $12,448. NCSH performs the same surgery at a lower cost and provides higher patient satisfaction and outcomes than our competition.

NCSH is proudly a for profit hospital. The hospital pays property taxes and the hospital's owners pay state and federal income taxes on the hospital's profits. This results in an approximately 7 % net community benefit using HHS's criteria.

Routinely NCSH is full, causing patient surgeries to be delayed or cancelled. NCSH has 6 observation rooms that have been constructed to full hospital inpatient room standards. Minimal expenditure would be required to convert these observation rooms, increasing NCSH inpatient capability from 18 to 24 beds. Additionally according to the North Carolina State Medical Facilities Plan, NCSH current surgery volume requires 6.31 operating rooms. NCSH has 4 licensed operating rooms and has a clear need for additional licensed operating rooms.

Durham County is dominated by the Duke University Health System which controls 98.6% of licensed hospital rooms and 94.7% of licensed operating rooms. NCSH serves as the sole competition in Durham County to Duke University Health System but lacks the ability to expand to serve the public. Without NCSH, 100% of hospital medical and surgical care in Durham County would be controlled by one entity.

Our nation is seeking better patient medical care at a lower cost point. Hospitals with physician ownership meet this need. Additionally the CMMS Innovations Center is piloting programs which align incentives for physicians to provide great medical care at a lower cost point. NCSH already accomplishes this goal.

Please release the shackles and allow higher quality and lower cost hospitals like North Carolina Specialty Hospital to expand their medical and surgical capabilities. Currently Section 6001 constraints cause discrimination against Medicare and Medicaid patients who cannot choose the highest ranking

hospitals because these hospitals lack the capacity to treat them. In Durham these patients are discriminated against by the predominance of one health system and the inability of NCSH to expand. Please repeal or amend Affordable Care Act Section 6001 so that existing hospitals with physician ownership may provide needed quality care to Medicare, Medicaid and Tricare patients. Please allow new hospitals with physician ownership to treat Medicare, Medicaid and Tricare patients. The ability of patients to choose their doctors and their hospitals is uniquely American. The present restraints on patients are un-American!

Thank you.

Richard F. Bruch, M.D., Consultant to Triangle Orthopaedic Associates, P.A.

Board Chair, North Carolina Specialty Hospital, 3916 Ben Franklin Blvd., Durham, NC 27704

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rbruch@triangleortho.com or rich.bruch@gmail.com

The Honorable Kevin Brady, Chairman,
Health Subcommittee
United States House of Representatives
Committee on Ways & Means

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

May 18, 2015

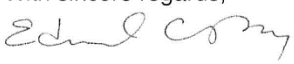
Dear Mr. Brady,

I would like to take this opportunity to provide my written testimony as a surgeon and non-owner that operates at a physician-owned surgical facility, namely, **North Carolina Specialty Hospital** in Durham, NC. I am a Plastic and Reconstructive Surgeon, caring for breast and skin cancer patients, as well as those with a wide range of burns, wounds and deformities requiring reconstruction. For the last six years, I have performed the vast majority of my surgical procedures at this facility, despite having staff privileges at two other nearby facilities, including a University-managed community hospital and its separate surgical center. When asked to choose a facility for their surgery, my patients have, with virtually no exception, favored the physician-owned facility due to its efficiency, cleanliness, friendly atmosphere and close attention to their needs. Patients tell me that they see the larger facility (even when under the care of the same doctor) as treating them as a "number," with less attention to quality standards, noisier patient floors, and a perceived lack of empathy. I have been a patient at this hospital, as well, and have never felt so well cared for at any other facility.

While hospitals vary widely in their qualities and attributes, physician-owned facilities are uniquely motivated to maintain a positive patient experience since they present an *option* to the public. They succeed because they take this role very seriously. America has always embraced competition as a healthy market force to maintain quality and reduce cost in almost every branch of our economy. Because Healthcare represents one of the largest segments of our economy, it would stand to reason that allowing hospitals to compete with one another, rather than limiting their ability to do so, would be in the best interest of patients and payors alike.

I stand in favor of allowing physician-owned hospitals, and surgical facilities in particular, to provide an option to patients in communities where large health-system facilities sacrifice patient care for a "check-box" healthcare mentality, investing in their bureaucracy rather than improving the patient experience. Congress should allow patients a choice, and thus drive down the cost of healthcare delivery by breaking the monopoly. Thank you.

With sincere regards,



Edward C. Ray, MD, FACS

To Whom It May Concern,

I have worked at North Carolina Specialty Hospital for 22 years, so I believe I can offer some qualified observations about the facility. When I came to work for our hospital back in 1993, it was still located on West Main Street, in a facility built in 1926. Having come from a previous position in acute care (a 500-bed hospital in Florida) I was pleasantly surprised to find a work setting that still had the small-town atmosphere of "Mayberry". And I mean this in a good sense. The staff really cared for patients, as if they were family and nurse to patient ratios were quite low so the staff could take time with each patient. I was impressed to learn how many patients had come to our hospital on previous occasions through the years, as had their parents and their children.

In May 2005, we moved into our new facility; a truly state-of-the-art, 18 bed hospital with 4 O.R.'s; a Same Day Surgery department as well as many other bells and whistles. I wondered if we would retain our "small town" culture and sense of "family". I am pleased to report that this has, in fact, been the case! We still have a closely-knit, well-qualified staff; many have worked in larger facilities and can appreciate the fact that here at NCSH, they can take time to give the care that they were trained to give. Our administrative staff is very attuned to the needs of those of us who are on the front lines and they back us up with resources and equipment whenever we ask. Our outcomes are great, our complication rates are among the lowest in the state and we have received outstanding rankings by groups that evaluate hospitals and issue grades.

Our patients are happy; we know this because they constantly compliment the facility, the care they receive, and yes--they are still coming back when they require a new procedure! Word of mouth has spread; I have had folks tell me how wonderful their loved one or friend's experience was when I am standing in line at the grocery store, or movie theater.

I could go on, but I think you get the point: when people are given the time, resources and opportunity to provide excellent care, they do what is really the most satisfying for them: they give excellent care.

Sincerely,
Sheree E. Barak

DukeMedicine

Kernodle Clinic Mebane
101 Medical Park Drive
Mebane NC 27302-7639
Phone: 336-506-1214
Fax: 336-538-2396

To whom it May concern:

This letter is being written in support of North CarolinaSpecialty Hospital. I have been performing robotic assisted partial knee replacements at North Carolina Specialty Hospital for about 2-1/2 years. I chose the hospital because of the of the availability of the Mako robotic knee and hip system. The hospital had the vision to order this equipment about 5-6 years ago. There are only about 10 of these robotic systems in the state of North Carolina. I also chose this hospital because of its excellent reputation in regard to patient care.

I have been very pleased with the care my patients have received at North Carolina Specialty Hospital. My patients have repeatedly voiced their extreme satisfaction with the quality of care they have personally received at North Carolina Specialty Hospital.

The hospital staff is very professional and courteous. My patients and I have been treated as customers in a way that should be exemplified by all hospitals.

I look forward to continuing my relationship with North Carolina Specialty Hospital.

Harold Kernodle, Jr.

Harold Kernodle,Jr. M.D.

Triangle Orthopaedic Associates, P.A.

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May 19, 2015

Karen F. May
Chief Operating Officer
120 William Penn Plaza
Durham, NC 27704

Dear Ways and Means Committee:

My name is Karen F. May, Chief Operating Office at Triangle Orthopaedics, Associates, P.A. (TOA). I am writing today to commend the care provided by North Carolina Specialty Hospital (NCSH). Triangle Orthopaedics proactively tracks all patient satisfaction through the continuum of each patient's episode of care. The trend, through historical data consistently conveyed by TOA's patient population, is that the hospital staff and services provided by the medical staff at NCSH exceeds all expectations. Recently as an outpatient at NCSH, I experienced first-hand the care and calming affect the nurses, anesthesia providers and physicians delivered prior to my surgery and during my post-operative care. The facilities are immaculate and in general provide an environment that exudes professionalism and superior medical care. As a patient, I will certainly consider no other facility in the future other than NCSH.

Sincerely,

Karen F. May

Karen F. May,
Chief Operating Officer and Recent Patient for an Outpatient Procedure

May 18, 2015

To whom it may concern:

I am writing this letter in support of North Carolina Specialty Hospital. I have had three surgeries here in the past five years, and each one has had an outcome with no complications. When I compare surgical stories and other hospital experiences with friends or family, it is clear that NCSH towers above the rest. The care is exceptional, and as a patient you can tell that they really take pride in what they do for the community. My family members have seen several of the physicians who have ownership in North Carolina Specialty Hospital, and they have been very pleased.

I am also proud to say that I have been an employee at North Carolina Specialty Hospital for 12 years. I have been in charge of patient satisfaction survey administration and can attest to the fact that our patients LOVE our facility. We are consistently receiving comments that they will never go anywhere else for their care, and that NCSH needs to train other local area hospitals how to treat their patients. That in itself speaks great volumes about the outstanding care that is provided at NCSH.

The world needs more facilities like North Carolina Specialty Hospital. If every hospital ran as well and had the same quality scores and patient satisfaction ratings NCSH does, healthcare would be a lot better off.

Sincerely,

Candy Johnston

Candy Johnston

To Whom It May Concern

I was asked to provide a personal testimony regarding the services rendered at the physician owned North Carolina Specialty Hospital. As a former assistant professor in an academic university hospital setting I have unique perspective in seeing two opposite ends of the spectrum of patient services. In no way do I intend to question the level of medicine rendered at a large university hospital setting, however, I can unequivocally attest to the equally, if not higher, level of care with a higher level of efficiency, rendered by NCSH. Whereas in my former life as an assistant professor or orthopaedic surgery, my days in the OR were at best challenging and at worse extremely frustrating in that the system prevented me from delivering the type of care that I was accustomed to providing to my patients. Conversely, working at NCSH is as stress free an environment as surgery can be, and is always an enjoyable environment. The patients are extremely satisfied with the level of care. The staff is unparalleled in their commitment to providing high level care in a compassionate manner, all of which makes my life easier. Given the efficiency, I am able to see and treat more patient's, which ultimately pleases the patients in clinic who have easier and quicker access to care. Barely a day in clinic goes by that a patient does not comment to me about the wonderful experience at the hospital, which needless to say these days is an uncommon occurrence in most hospital settings. Furthermore, such accolades from patients are accompanied by their disbelief in the tremendous cost savings versus the same procedure done at a larger hospital setting.

I could go on and on about the personal testimonies that I hear from patients, but suffice it to say, that I am unaware of any hospital in our state of NC that functions more efficiently and at a higher level while maintaining an unparalleled work –friendly environment than what we have at NCSH.

Sincerely

J. Mack Aldridge, MD

To: The Health Subcommittee

From: Kim Lyon, RT(R)

As a health care worker, I have had two wonderful opportunities to work at Duke University Medical Center and at North Carolina Specialty Hospital over the span of 36 years. 28 of those have been at Specialty. Both of these facilities provide excellent care for their patients. Both earn prestigious awards. Both are a valuable asset to Durham and the surrounding area. Both are needed in the community.

What sets Specialty apart is the small and intimate atmosphere that this type of facility can offer. There is a huge sense of pride from Environmental Services to the physicians, because we strive to do our best because in a sense, we all are owners. We hire the best, set high standards of care and work as a team to insure all of our patients receive exceptional care.

We strive to treat all patients with the best possible experience for them that we can give. From the time they are greeted at the front door, to the time they are discharged, we provide for all of their needs. Not everyone likes the hassle of a big facility. Some like the personal and unhurried attention that we can give because of our size.

I cannot imagine not having a choice in the City of Medicine for healthcare. There is room for a physician owned place. There is a need for a physician owned place and I am proud to serve the community in a physician owned place!

Sincerely,

Kim Lyon, Radiology Manager