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TRENDWATCH

Impact of Limited service Providers on Communities and Full-service Hospitals September 2004, Vol. 6, No. 2

Limited-service providers, often referred to as "niche" providers, are a growing presence in the health care field. These providers focus on specific conditions or procedures (e.g., heart, orthopedic, and surgical services) and include single-specialty and multi-specialty hospitals, ambulatory surgical centers (ASCs), and diagnostic testing facilities. They are more common in states without Certificate of Need (CON) regulations, and most are either partially or fully-owned by physicians.

The AHA estimates that there are well over 100 limited-service hospitals currently operating—nearly triple the number from 1997—and that approximately 30 more currently are under development.[1] In addition, 3,735 Medicare-certified ASCs currently are open, growing at a rate of 6 percent per year.[2]

The impact that these facilities have on patients and the broader health care delivery system is beginning to be better understood. Physicians' ability to refer to facilities in which they are owners has the potential to place the medical interests of the patient at odds with the financial interests of the physician. Past research in other practice settings indicates that the financial incentives created by physician ownership can lead to higher referral rates for services and potentially unnecessary utilization.[3]

The impact on broader access to care for the community is another concern. As owners of the facilities to which they refer, physicians have both the ability and the financial incentives to shift the well-reimbursed services and patients to their own facility. This practice can drain essential resources from full-service hospitals that rely on these patients to cross-subsidize money-losing, but essential community services (e.g., burn, emergency and trauma care) and care for low-income populations.

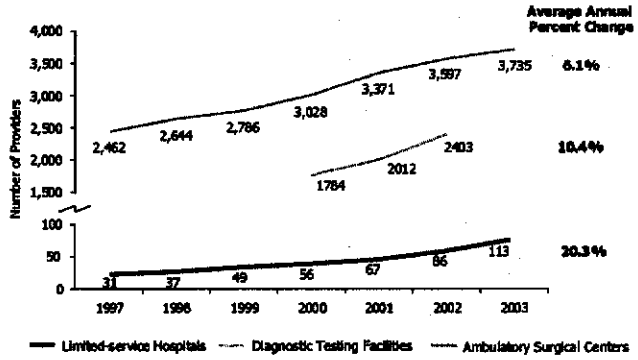
Last year, Congress recognized these concerns and placed an 18-month moratorium on physician self-referral of Medicare and Medicaid patients to new limited-service hospitals while the Centers for Medicare & Medicaid Services (CMS) and the Medicare Payment Advisory Commission (MedPAC) study the issue.

New medical technology and the associated shift of care to outpatient settings have contributed to the growth of limited-service providers. Widespread physician access to capital, the prospect of more operational control and productivity, and high profit margins have made limited-service providers attractive ventures for physicians.

This issue of TrendWatch highlights the trends and implications of the growth of limited-service providers.

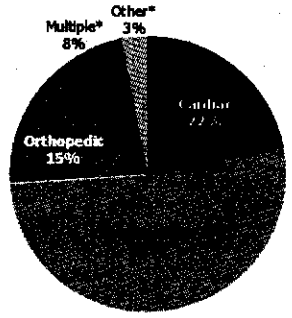
The number of limited-service providers is growing rapidly.

Chart 1: Number of Limited-service Hospitals, Ambulatory Surgical Centers, and Diagnostic Testing Facilities, 1997-2003



Newer limited-service hospitals are focusing on cardiac, orthopedic, and surgical care...

Chart 2: Percentage of Limited-service Hospitals by Specialty, 2004

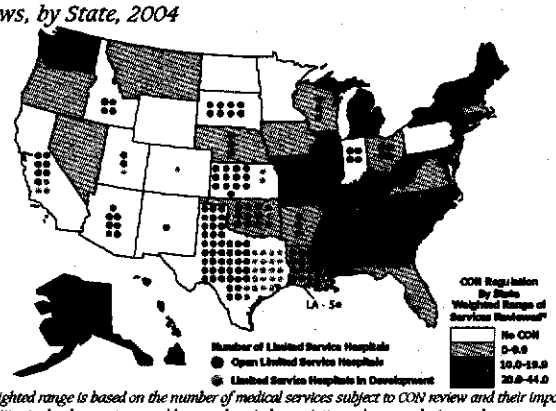


n = 170 Limited-service Hospitals open and in development

Note: Consistent with the Medicare Modernization Act, long-term acute care, cancer, psychiatric, children's, and rehabilitation hospitals are not included in the definition of limited-service hospitals.
**Multiple includes a combination of orthopedic, surgical and/or cardiac. Other includes limited-service hospitals that could not be identified with respect to specialty area.*

...with the greatest proliferation in states having no CON regulations.

Chart 3: Number of Limited-service Hospitals Relative to CON Laws, by State, 2004



**Weighted range is based on the number of medical services subject to CON review and their importance; facilities in development reported by state hospital associations, data may be incomplete*

The Lewin Group

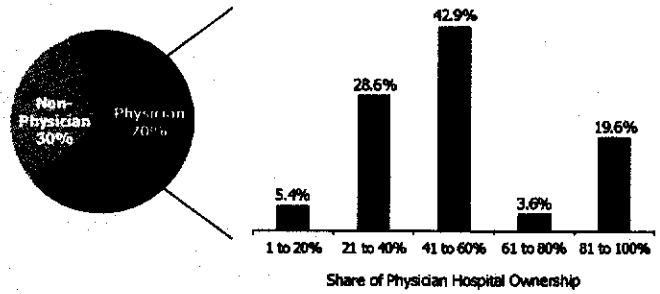
Physician ownership of limited-service providers raises concerns about self-referral...

Seventy percent of limited-service hospitals currently operating or under development have some level of physician ownership. The share of physician ownership averages just over 50 percent.[1] Physicians also have ownership stakes in approximately 83 percent of ASCs.[2]

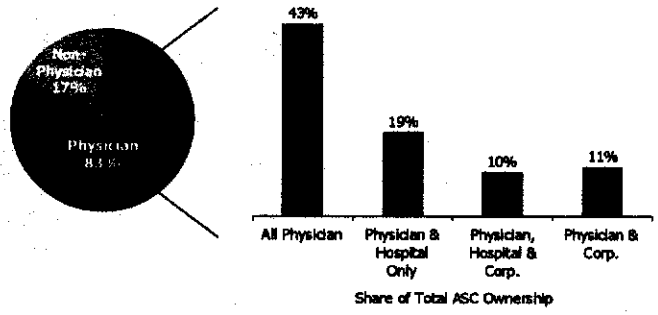
The ability of physicians to refer to facilities in which they have an ownership interest can create an inherent conflict between the clinical needs of the patient and the financial interests of the physician. The opportunity for financial gains beyond professional fees, including a share in facility profits and an equity interest, can create incentives to increase and direct patient referrals based on economic rather than clinical criteria.[3]

Physician ownership of limited-service providers is substantial...

Chart 4: Physician Ownership of Limited-service Hospitals, 2003



Physician Ownership of ASCs, 2004



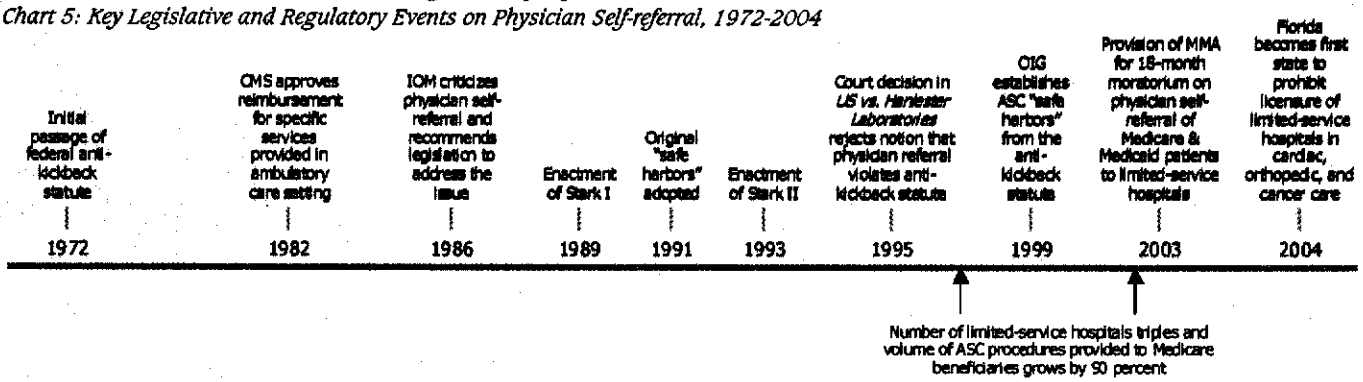
In 1972, Congress passed the federal anti-kickback statute to address the issue of improper financial inducements. The statute prohibits entities from offering or receiving remuneration tied to the referral of Medicare and Medicaid patients. In 1991 and 1999, the Office of Inspector General (OIG) promulgated exceptions to the federal anti-kickback statute, which, in addition to statutory exceptions, are collectively known as "safe harbors." These rules protect certain types of activities (e.g., investment in certain types of Medicare-certified ASCs, joint ventures, and group practices) from violation under the federal anti-kickback statute, subject to certain requirements. Various interpretations of these laws have facilitated physician investment in limited-service providers.[4]

In 1989, Congress enacted the Ethics in Patient Referrals Act to limit physician self-referral. Under the original statute (commonly referred to as Stark I), a physician cannot refer Medicare patients to a clinical laboratory in which the physician, or an immediate family member, has a financial interest, subject to certain exceptions. In 1993, the law was extended (Stark II) to cover referrals for additional "designated health services,"[5] including radiology and inpatient and outpatient hospital services, among others.[6]

The Stark law contains a number of exceptions. In particular, the "whole hospital" exception permits self-referrals by physicians when they have ownership in the whole hospital, as opposed to a subdivision of a hospital. The legislative intent of the exception was to allow for ownership in general hospitals that offer a full spectrum of health care services, where a single referral would produce little personal economic gain. Since limited-service hospitals are much smaller—often closer in size and the scope of services to a hospital department—the potential for personal financial gain to influence physician referral has raised concerns.[7] This exception allows physician self-referral to any inpatient or outpatient service offered by the "whole hospital" including diagnostic services, such as lab and imaging.

...despite various efforts to regulate physician self-referral.

Chart 5: Key Legislative and Regulatory Events on Physician Self-referral, 1972-2004



...and utilization of health care services.

Case studies document a discernible shift in volume when referring physicians acquire a personal financial interest in a limited-service provider. For example, a study in Louisiana found that physician investors in an ASC reduced referrals to the full-service hospital by approximately 50 percent, while non-investor surgical volume remained relatively constant.[1] Similarly, a study in South Dakota found that the number of cases at the full-service hospital fell by 77 percent upon the opening of an ASC.[2]

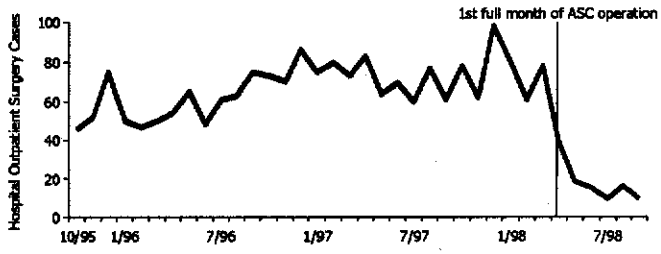
Physician self-referral also is linked to higher use of services. In 1989, the OIG found that patients of physician-owned clinical laboratories received 45 percent more laboratory services than Medicare patients in general.[3] Additionally, a 1994 GAO analysis of referral patterns of investor and non-investor physicians in Florida found physician owners ordered 54 percent more MRI scans, 27 percent more CT scans, 37 percent more nuclear medicine scans, 27 percent more echocardiograms, 22 percent more ultrasound services, and 22 percent more complex X-rays.[4]

Hospital and health plan leaders have expressed concern about the overall impact of physician-owned limited-service providers on access to care, utilization and costs. Financial incentives that promote greater service use may put patients at risk and drive up health care costs. Costs to the community may also increase due to the creation of duplicative capacity. The actions full-service hospitals must take in response to shifts in capacity and utilization may affect costs and access as well. These steps may include recruiting additional physicians to maintain emergency access to affected services, budget cuts and service reductions in other areas, or, when possible, negotiating higher rates with private payers for other services. In some cases, full-service hospitals may not be able to maintain services in affected areas, reducing access to care for the broader community.

Questions have been raised about the quality of care provided in certain limited-service settings. For example, in a recent report to Congress, MedPAC examined the growth of ASCs and the high rate of utilization of services at these facilities. Noting that regulation of ASCs is less stringent than that of hospital outpatient departments, the report called for "a better understanding of the quality of care provided in alternative settings, including safety, regulatory oversight, and clinical considerations."[5]

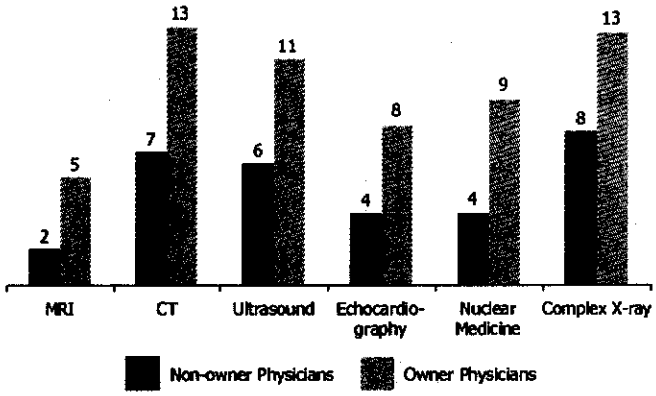
Physician ownership influences where physicians direct referrals...

Chart 6: Orthopedic Surgeries Performed by Physician Investors at a Full-service Hospital System Before and After ASC Opening, October 1995 – September 1998



...and the amount of care they provide.

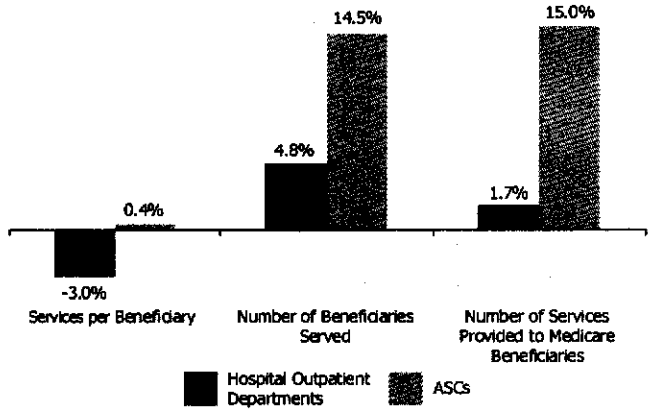
Chart 7: Number of Imaging Services Ordered per Physician, Owner vs Non-owner, 1990



NOTE: Information from Florida Health Care Cost Containment Board and Florida BCBS; analysis includes 16,157 physicians.

Medicare data reflects the impact of ASC growth on service use and setting of care.

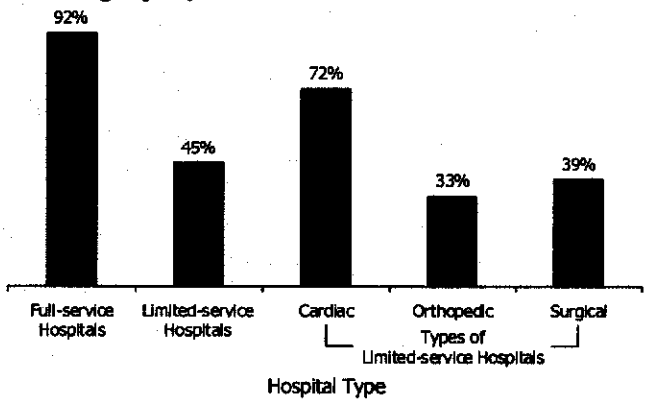
Chart 8: Average Annual Percent Change in Medicare Outpatient Surgical Volume, ASC vs. Hospital, 1998 – 2002



Limited-service hospitals appear to focus on the most profitable services and patients...

Limited-service hospitals typically do not have emergency departments...

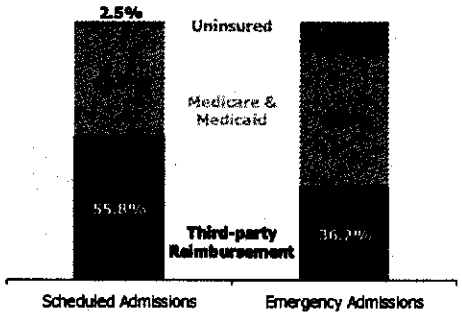
Chart 9: Percentage of Full-service and Limited-service Hospitals with Emergency Departments



Note: Data for general hospitals are from AHA's Annual Survey (2001). Specialty hospital data are from GAO's specialty hospital survey (2003), GAO's contacts with hospital administrators, and the CMS POS file (2003).

...affording them more control over their payer mix.

Chart 10: Percentage of Cases by Payer: Hospitals in Houston, TX, 2002



Physician owners have both the ability and financial incentives to direct patients to or away from the facilities in which they have an ownership interest. As such, limited-service hospitals tend to: 1) specialize in well-reimbursed services; 2) serve fewer high-acuity patients; and 3) serve fewer low-income and uninsured patients. Such practices can produce high returns for physician investors but place full-service hospitals at a disadvantage as they depend on a balance of services and patients to support the broader health needs of the community.

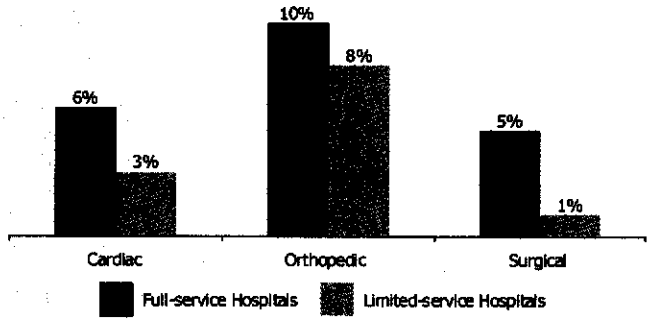
Payment relative to cost varies considerably depending on the type of service, the payer and the acuity level of patients. Heart, orthopedic and general surgical cases are among the most highly reimbursed relative to cost, and limited-service providers typically focus on these high volume, high margin services.[1]

Medicare and Medicaid pay less than private insurers for the same services, and providers receive little or no reimbursement for services to indigent patients. Medicare and many other payers reimburse a flat average rate for a specific case-type, regardless of patient acuity, with exceptions made for extremely high cost patients through outlier payments.[2]

Most limited-service hospitals do not have emergency departments (EDs),[3] affording them more control over their payer mix and patient acuity level. Unlike full-service hospitals, limited-service hospitals without EDs do not maintain costly standby capacity and do not have the obligation under the Emergency Medical Treatment and Labor Act (EMTALA) to screen and stabilize all patients, regardless of their ability to pay. Because emergency admissions are generally more acute and less stable than those that are elective, limited-service hospitals typically serve fewer high acuity patients relative to full-service hospitals.

These facilities deliver a lesser proportion of their care to low-income patients...

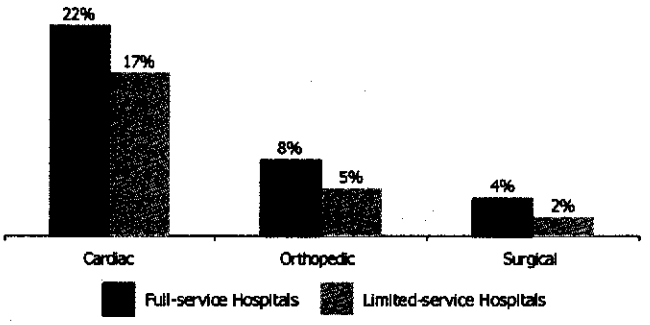
Chart 11: Medicaid Patients as a Percent of Total Patients, Full-service Hospitals vs. Limited-service Hospitals, 2000



Note: Analysis based on HCUP data from six states. Compared limited-service hospitals to full-service hospitals in the same market area.

...and serve a lower acuity patient population relative to full-service hospitals.

Chart 12: Severely Ill Patients as a Percent of Total Patients, Full-service Hospitals vs. Limited-service Hospitals, 2000



Note: Analysis based on HCUP data from six states. Compared limited-service hospitals to full-service hospitals in the same market area.

...limiting the ability of full-service hospitals to support the range of services essential to the community.

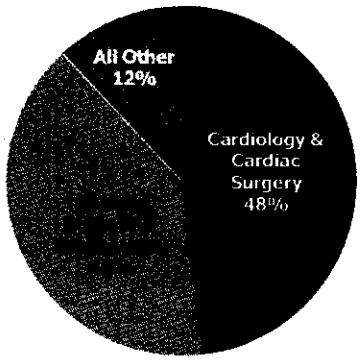
The rapid growth of limited-service providers raises concerns about their impact on care delivery in the community. As physicians move their practices to limited-service providers, they leave full-service hospitals less able to maintain the broad range of services vital to meeting community health needs.

The current payment system does not explicitly fund standby capacity for emergency, trauma and burn service categories, nor does it fully reimburse hospitals for care provided to Medicaid and uninsured patients. Full-service hospitals rely on cross-subsidies from some well-reimbursed services to be able to provide other under-reimbursed but essential community services.

These effects are illustrated in one midwest community after a physician-owned limited-service hospital opened in 1997. Three of four neurosurgeons—physician investors in the new facility—subsequently resigned from the full-service community hospital, significantly reducing neurosurgeon coverage in the community's only emergency department. To compensate for the gaps in emergency and trauma care, the hospital shifted to temporary staff coverage; however, this solution has proven difficult to maintain. In addition to the impact on the community at large, the hospital saw surgical volume drop across neurosurgery and other affected specialties (e.g. orthopedics). Operating room efficiency declined when elective cases were lost, but capacity for emergency cases had to be maintained.[1]

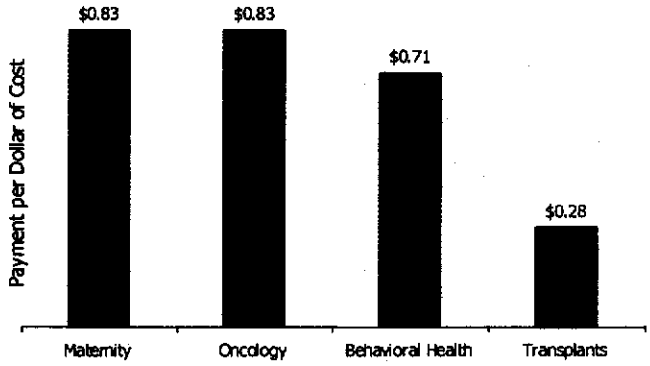
When physician-owners focus on well-paying services...

Chart 13: Percent of Net Income by Service in a Community Hospital System in the Southwest Region, 2003



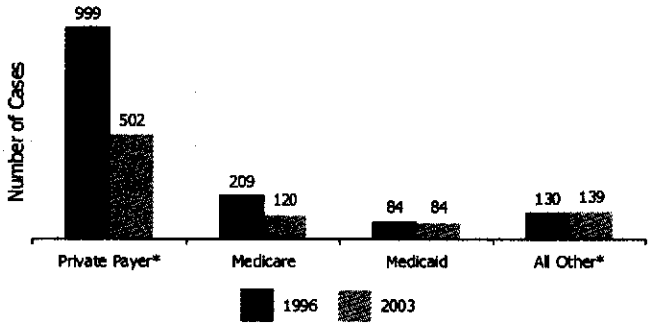
...full-service hospitals are less able to support essential, but money-losing care...

Chart 14: Payment per Dollar of Cost for Essential Services, a Community Hospital System in Southwest Region, 2003



...as they lose higher paying patients to limited-service hospitals.

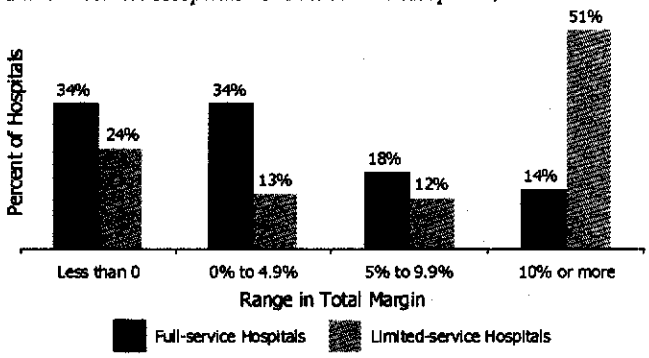
Chart 15: Changes in Orthopedic Cases, a Midwest Community Hospital After Surgical Hospital Opened in 1997, 1996-2003



"Private payer" includes BCBS, workers compensation, commercial insurance, managed contract care, and other insurance. "All other" includes CHAMPUS, self-pay and public health insurance.

These practices contribute to limited-service hospitals' higher profitability.

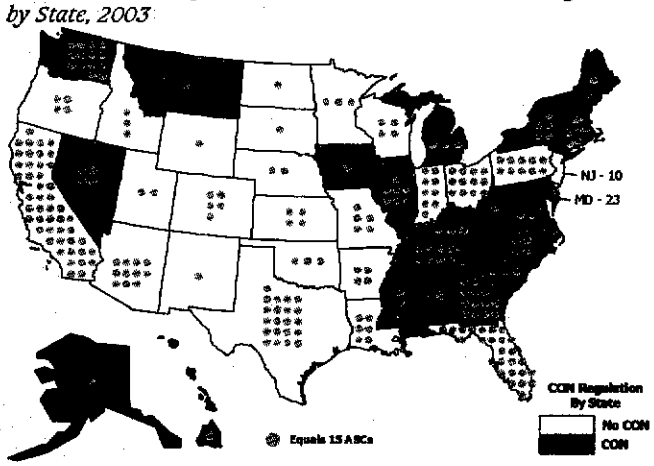
Chart 16: Percent of Hospitals by Range in Total Margin, Limited-service Hospitals vs. Full-service Hospitals, 2002



Federal and state governments are attempting to address concerns with limited-service provider growth and referral.

ASCs are primarily located in states with minimal or no CON regulation.

Chart 17: Number of ASCs Relative to CON Laws Governing ASCs, by State, 2003



States are grappling with the challenge of further regulating limited-service providers.

Chart 18: Examples of State Legislative Activity, 2003

Types of Rules	State Examples
Emergency Services	**AZ, CA & LA:** *Proposed legislation* to establish standards for emergency services at limited-service hospitals and ASCs (e.g., immediate availability of emergency physician, transfer agreements) or prohibited licensure unless hospitals maintain an ED. **WA & NE:** *Vetoed legislation* to require limited-service hospitals to provide 24/7 ED services. **IL:** *Enacted Hospital Licensing Act* to require all hospitals to have emergency department in order to receive licensure.
Certificate of Need Regulations	**AL:** *Enacted legislation* to increase thresholds for certain CON exemptions. **IL:** Legislation extended CON sunset to July 1, 2008. **MA:** *Enacted legislation* to require all facilities to apply for state review to add new services or make capital improvements.
Types of Procedures	**CA:** *Vetoed legislation* to prohibit licensure for hospitals with limited inpatient services (e.g., surgical procedures). **FL:** *Enacted legislation* to prohibit licensure of limited-service hospitals and facilities with 65 percent of discharges in cardiac, orthopedic, and cancer care. **NJ:** *Enacted legislation* to levy 3.5 percent tax on certain physician-owned ASCs. **GA:** *Proposed legislation* to impose 6 percent provider fee on ASC, laboratory, or diagnostic or imaging services.
Safety Net	**NM:** *Proposed legislation* to provide emergency services to non-paying patients and low-income reimbursed patients in the same proportion as patients treated in acute-care general hospitals. **OK:** *Enacted legislation* to impose fee on limited-service hospitals who have not earned at least 30 percent of annual revenue from Medicare, Medicaid and uncompensated care.
Physician Ownership (Stark-like)	**CA, CO, IN, LA, MA, OH & KY:** *Proposed legislation* to prohibit physicians with ownership interest in limited-service provider facilities from making patient referrals to those facilities. **MI:** *Enacted law* that included federal anti-referral law (Stark) under unprofessional conduct for health professions. **SC:** *Implemented regulation* to extend the federal prohibition on self-referral to all patients. **WA & MO:** *Proposed* or *enacted* temporary ban on physician self-referral to new limited-service hospitals.

Various types of laws have been enacted to address issues of physician self-referral, capacity control and adequacy of health care delivery. Some of these endeavors, however, have been unsuccessful. Loopholes in some statutes, such as the "whole hospital" exception, have undermined many of the original goals.

Several forms of regulatory oversight focus on the supply of health care. For example, Certificate of Need (CON) regulations require that a permit be issued by a state agency before a health care facility may construct or expand, offer a new service or purchase equipment exceeding a certain cost. The purpose of CON laws was to prevent duplication of resources and limit excess bed capacity and services in communities. Congress required all states to enact CON laws in 1974, but later repealed that requirement and passed the responsibility onto states. Currently, 36 states and the District of Columbia have CON requirements, and most limited-service providers are located in states with no CON requirements, such as California and Texas.[1]

Federal and state governments have been proactive in addressing concerns around the growth and oversight of limited-service providers. When Congress passed the Medicare Modernization Act (MMA) in 2003, they placed an 18-month moratorium on physician self-referral under Medicare for new limited-service hospitals while MedPAC and the Department of Health and Human Services (HHS) study the issue. The law specifically covers cardiac, orthopedic and surgical hospitals but can be expanded at the discretion of HHS. Hospitals already in operation or under development as of November 18, 2003 are exempt. A bipartisan group of House members currently is pushing for further legislative action on limited-service providers, while a few states, including Washington and Missouri, have enacted or plan to enact a regulation banning physician self-referral to new limited-service hospitals, similar to the federal moratorium.[2]

At the state level, South Carolina has enacted more stringent Stark-like legislation by extending the federal prohibition on self-referral to all patients. Additionally, Illinois recently enacted legislation to require that all hospitals include a full-service ED, thereby making them subject to EMTALA, and Arizona proposed legislation to establish transfer agreements between full-service hospitals and limited-service providers.[3]

Limited-service providers raise broader issues about the health care system.

Limited-service providers have potentially significant effects on the health care system and on communities served. Subjects of greatest concern include the appropriateness of physician self-referrals, the role of competition in health care, and regulatory approaches that create unintended competitive advantages or disadvantages.

Proponents of physician-owned limited-service providers argue that competition from such facilities will lead to improved quality, service and efficiency. Others cite data suggesting that physician-owners and other investors can profit from such tactics as:

- Not taking on the commonly accepted roles and associated costs of a full-service hospital;
- Selecting a narrow range of service offerings; and,
- Using the physician-owners' ability to direct referrals to steer patients either to the facility in which they have a financial interest (self-referral) or to a full-service competitor.

Full-service hospitals are concerned that they will become unable to perform safety-net roles essential to their communities as limited-service facilities compete for patients. These safety-net roles include:

- Serving as a key access point for care for the nearly 45 million Americans without health care coverage, an expectation guaranteed by federal EMTALA requirements for hospitals having emergency departments.
- Providing standby capacity for routine emergencies, disaster readiness, trauma, burn units, and/or other essential community services.
- Delivering a wide array of services to a broad range of payers and patients of varying acuity levels.

This issue adds to the broader public policy debate about how best to provide affordable and accessible health care for all Americans.

Quotes from the Field

"Central to keeping the balance of services and community access is the issue of cross-subsidization. Full-service hospitals must rely on the ability to use revenues from the more highly reimbursed services to subsidize and sustain low- or no- profit services that are critically needed."

William Petasnick, President and Chief Executive Officer of Froedtert Hospital and Community Health System, Milwaukee, WI

"There are a lot of issues raised about the impact niche hospitals have on big hospitals — which are our health care safety net. There are also some questions about what type of disclosure a doctor needs to give a patient if that doctor owns part of the hospital." — Amanda Engler, spokeswoman for the Texas Hospital Association

"How can a doctor who is part owner of a for-profit [specialty provider] be expected to fulfill his or her duties towards his or her co-workers and in the same instance fulfill the duties towards the principal who is a not for profit hospital? This does not imply ill-will on the part of the doctor, it simply faces fundamental medical issues such as at which institution does the doctor place his or her patients....? We have often stated that an agent cannot serve two masters. This rule applies to medical professionals as well." — South Dakota Supreme Court ruling on an antitrust case involving Avera Health System and the Orthopedic Surgery Specialists

Endnotes:

Page 1: [1] The Lewin Group analysis of AHA state survey data, 2004
[2] CMS Office of the Actuary, 2004
[3] Hillman, BJ, Joseph, CA, Mabry, MR, Sunshine, JH, Noether, M., "Frequency and costs of diagnostic imaging in office practice—a comparison of self-referring and radiologist-referring physicians," *New England Journal of Medicine*, vol. 323, 1990; Mitchell, JM, Scott, E., "Physician ownership of physical therapy services: effects on charges, utilization, profits, and service characteristics," *JAMA*, vol. 268, 1992

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[2] American Association of Ambulatory Surgery Centers (AAASC) ASC Ownership Survey, February 2004
[3] Unland, James J, "Can Community Hospitals Survive Without Large Scale Health Reform?," *Journal of Health Care Finance*, Spring 2004
[4] Saner, RJ, Spindel, MP, and Fitzgerald, M, *New and Clarified Anti-Kickback Safe Harbors Issued*, Powers Pyles Sutter & Verville P.C., http://www.ppsv.com/issues/kickback.htm
[5] Designated health care services include: clinical laboratory; radiology; durable medical equipment; physical therapy; occupational therapy; radiation therapy services & supplies; parenteral & enteral nutrients, equipment & supplies; outpatient prescription drugs; prosthetics; home health services; and inpatient & outpatient hospital services
[6] Satiani, B, "Specialty Hospitals and the Stark Act," *Bulletin of the American College of Surgeons*, vol. 88, no. 11, 2003
[7] United States Government Accountability Office, *Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance*, GAO-04-167, October 2003

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[3] Report to Congress, Office of Inspector General, *DHHS: Financial Arrangements Between Physicians and Health Care Businesses*, pages 18 and 21, May 1989
[4] United States Government Accountability Office, *Medicare Referrals to Physician Owned Imaging Facilities Warrant HCFA's Scrutiny*, GAO/HEHS-95-2, Oct. 1994
[5] MedPAC, *Assessing adequacy and updating payments for ambulatory surgical center services*, March 2003

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[2] "The Medicare Program Focuses on Outlier Payments to Hospitals," *BNA's Health Care Fraud Report*, vol. 6, no. 24, December 11, 2002; BNA's Medicare Report, vol. 13, no. 47, December 13, 2002
[3] United States Government Accountability Office, *Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance*, GAO-04-167 Specialty Hospitals, October 2003

Page 5: [1] McManis Consulting, *Impacts of Niche Providers on Health Care Delivery*, Presentation to South Dakota Association of Healthcare Organizations Board, July 29, 2004; Note: In August 2004, the facility successfully recruited and employed a neurosurgeon.

Page 6: [1] American Health Planning Association, *National Directory of Health Planning, Policy and Regulatory Agencies*, Fifteenth Edition: February 2004
[2,3] State Niche Provider Legislation Overview, American Hospital Association, 2003

Sources:

Chart 1: The Lewin Group analysis of American Hospital Association state survey data, 2004; MedPAC analysis of Provider of Services file, 5% Standard Analytic File of ASC claims from CMS and MedPAC analysis of 5% Standard Analytic File of independent diagnostic testing facility claims from CMS as reported in MedPAC, *Ambulatory Care*, July 2004 (Data not available for all hospitals)

Chart 2: The Lewin Group analysis of American Hospital Association state survey data, 2004

Chart 3: The Lewin Group analysis of American Hospital Association state survey data, 2004; state hospital associations; American Health Planning Association, *National Directory of Health Planning, Policy and Regulatory Agencies*, Fifteenth Edition: February 2004

Chart 4: United States Government Accountability Office, *Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served*, GAO-03-683R Specialty Hospitals, April 2003; American Association of Ambulatory Surgery Centers ASC Ownership Survey, February 2004

Chart 5: Sec 1877 42USC & 1395nm; Public Law 108-173; 42USC & 1320-a7(b); Saner, RJ, Spindel, MP, and Fitzgerald, M, *New and Clarified Anti-Kickback Safe Harbors Issued*, Powers Pyles Sutter & Verville P.C., http://www.ppsv.com/issues/kickback.htm; Physician Self-Referral Education Resource Web Guide, *Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships*, http://www.cms.hhs.gov/medlearn/refphys.asp; Vaughan-Sarrazin, MS, Hannan, EL, Gormley, CJ, Rosenthal, GE, "Mortality in Medicare Beneficiaries Following Coronary Artery Bypass Surgery in States with and without Certificate of Need Regulation," *JAMA*, vol. 288 no. 15, 2002

Chart 6: Lynk, William J and Longley, Carina S, "The Effect of Physician-Owned Surgicenters on Hospital Outpatient Surgery," *Health Affairs*, vol. 21 no. 4, July/August, 2002

Chart 7: United States Government Accountability Office, *Medicare Referrals to Physician Owned Imaging Facilities Warrant HCFA's Scrutiny*, GAO/HEHS-95-2, Oct. 1994

Chart 8: MedPAC analysis of the 5% Standard Analytic files of ASC and hospital outpatient department claims from CMS as reported in MedPAC, *Ambulatory Surgical Center Services*, March 2004

Chart 9: United States Government Accountability Office, *Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance*, GAO-04-167, October 2003

Chart 10: HCA analysis of Houston market data, 2004

Chart 11: United States Government Accountability Office, *Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance*, GAO-04-167 Specialty Hospitals, October 2003

Chart 12: United States Government Accountability Office, *Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served*, GAO-03-683R Specialty Hospitals, April 2003

Charts 13 & 14: Data provided by a hospital system in the southwest United States. Relative gains and losses will vary by community based on demographics and payer environment. Net income represents earnings before interest, taxes, depreciation, and amortization at the service level.

Chart 15: The Lewin Group analysis of data from Rapid City Regional Hospital, Rapid City, SD

Chart 16: The Lewin Group analysis of HCRIS data, 2002. Includes 69 limited service providers who had been in operation for at least 2 years (at least one subsequent cost report filed). Community hospitals includes all other PPS hospitals.

Chart 17: The Lewin Group analysis of CMS Provider of Service File, 1Q04 release; American Health Planning Association, *National Directory of Health Planning, Policy and Regulatory Agencies*, Fifteenth Edition: February 2004

Chart 18: 2003 State Niche Provider Legislation Overview; SC Provider Self-Referral Act, 44-113; American Hospital Association; WA State Hospital Association; Medical Association of GA

TrendWatch is a series of reports produced by the American Hospital Association and The Lewin Group highlighting important and emerging trends in the hospital and health care field.

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