

Dear Chairman and members of the Senate Public Health, Welfare and Safety Committee, for 2-16-05
 the record, my name is Dr. Nick Wolter, Chief Executive Officer of Deaconess Billings Clinic SB 440

DBC is a charitable, tax-exempt medical foundation, employing approximately 2,800 people to operate a 272-bed tertiary hospital, a 200 multi-specialty physician group practice, a 90-bed nursing home, and a research division. DBC also has six regional branch clinic sites in Montana ranging from Bozeman to Miles City as well as two branch sites in Wyoming. We also have affiliate agreements to provide management services to eight rural hospitals and every year, 52 physicians in 18 specialties provide outreach specialty clinics for residents of rural Montana, Wyoming, and North Dakota.

Specialty hospitals have been part of the U.S. health care system for many decades. Hospitals that specialize in care for children, women, eyes, and other medical areas have always been part of the modern medical landscape. What has raised questions and concerns in recent years has been the rapid growth of small, physician-owned hospitals specializing in surgery, cardiac care, and orthopedics; areas known to be highly profitable by hospital administrators. Advances in medical technology, pressure on physician's incomes, and distortions in the payment system have been cited as contributing to these developments.

The Congress, in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), responded to the specialty hospital phenomenon and its implications by imposing an 18 month moratorium that effectively halted the development of new physician-owned specialty hospitals. That act also directed MedPAC, an advisory body to Congress, and the Secretary of Health Human Services to report to the Congress on certain issues concerning physician-owned cardiac, orthopedic, and surgical specialty hospitals.

As Deaconess Billings Clinic's chief executive officer, I serve as a MedPAC commissioner.

The MedPAC report back to Congress found that:

- Physician-owned specialty hospitals do not have lower costs for Medicare patients than community hospitals.
- They concentrate on particular diagnosis related groups (DRGs) some of which are relatively more profitable than the average, and treat patient who are generally less severe cases.
- They tend to have a lower share of Medicaid patients.

- The financial impact on community hospitals in the markets where physician-owned specialty hospitals are located has been limited, thus far. (Their analysis used 2002 cost and claims data.) Those hospitals have managed to compensate for any losses of patients and revenues and demonstrate financial performance comparable to other community hospitals.
- Some of the incentives for patient selection can be reduced by improving Medicare's acute hospital inpatient payment system.

Physicians may establish physician-owned specialty hospitals to gain greater control over how the hospital is run, to increase their productivity and to provide greater satisfaction for them and their patients. They may also be motivated by the financial rewards; some of which may derive from inaccuracies in the Medicare payment system. Their recommendations concentrate on remedying those inaccuracies, which result in the system paying too much for some DRGs relative to others, and too much for patients with relatively less severe conditions. Improving the payment system would help make competition more equitable between community hospitals and physician-owned specialty hospitals, whose physician owners can influence which patients go to which hospital.

MedPAC recommended that CMS should improve the accuracy of Medicare's inpatient acute hospital prospective payment system by:

- Refining the current DRGs to more fully capture differences in severity of illness among patients.
- Basing the DRG relative weights on the estimated cost of providing care rather than on charges.
- Basing the weights on the national average of hospitals' relative values in each DRG.

They also recommended that Congress should extend the current moratorium on specialty hospitals for one year, in order to craft the legislation necessary to address these payment inaccuracies. There will continue to be Federal attention on the issue of physician self-referral for health care services where they have a financial interest. Because this legislation is consistent with these Federal policy recommendations, DBC supports SB 440.

Thank you.

Nicholas W. W. W.