No. 11-40631

IN THE
UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

PHYSICIAN HOSPITALS OF AMERICA and
TEXAS SPINE & JOINT HOSPITAL,

Plaintiffs-Appellants,

v.

KATHLEEN SEBELIUS, Secretary of the
Department of Health and Human Services

***Defendant-Appellee*.**

On Appeal from the United States District Court
for the Eastern District of Texas, Tyler Division

Brief of Amici Curiae The Physicians Foundation, Inc. and
Texas Medical Association
in Support of Plaintiffs-Appellants

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Rule 26.1 Certification

In compliance with Fed. R. App. P. 26.1, *amicus* The Physicians Foundation, Inc. is a nonprofit corporation operating under the laws of the State of Florida. It has no parent corporation, and no publicly held company owns 10% or more of its stock.

Amicus the Texas Medical Association (TMA) is a nonprofit corporation operating under the laws of the State of Texas. It has no parent corporation, and no publicly held company owns 10% or more of its stock.

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INTEREST OF AMICI CURIAE

The Physicians Foundation, Inc. (the Foundation) is a Florida not-for-profit corporation. The Foundation seeks to advance the work of practicing physicians and to improve the quality of healthcare for all Americans. The Foundation is unique in its commitment to working with physicians nationwide to create a more efficient and equitable healthcare system. The Foundation pursues its mission through a variety of activities including grant-making and research. Since 2005, the Foundation has awarded more than $22 million in multi-year grants. The Foundation was founded in 2003 through settlement of a class-action lawsuit brought by physicians and medical associations against private third-party payers. The Foundation includes the following signatory medical societies which contribute board members to the Foundation: Alaska State Medical Association; California Medical Association; Connecticut State Medical Society; Denton County Medical Society; El Paso County Medical Society; Florida Medical Association; Hawaii Medical Association; Louisiana State Medical Society; Medical Association of Georgia; Medical Society of New Jersey; Medical Society of the State of New York; Nebraska Medical Association; New Hampshire Medical Society; North Carolina Medical Society; Northern Virginia Medical Societies; South Carolina Medical Association; Tennessee Medical Association;

Texas Medical Association; Vermont Medical Society; and Washington State Medical Association.

The Texas Medical Association (TMA) is a private, voluntary, nonprofit association of over 45,000 Texas physicians and medical students. TMA was founded in 1853 to serve the people of Texas in matters of medical care, prevention and cure of disease, and improvement of public health. Today, TMA's maxim continues in the same direction: "Physicians Caring for Texans." TMA's diverse physician members practice in all fields of medical specialization. TMA supports Texas physicians by providing distinctive solutions to the challenges they encounter in the care of patients.

Some of TMA's member physicians are investors in physician owned hospitals. Some of TMA's member physicians have privileges at physician owned hospitals in which they have no investment interest. Many of TMA's member physicians are providers under the Medicare and Medicaid programs. All of TMA's member physicians have an interest in the advancement of science and healthcare, in quality medical care, in patient well-being, and in the public health.

The Physicians Foundation, Inc. and The Texas Medical Association seek to file an amicus brief which will bring to this case another perspective that is not necessarily shared by the parties to this case.

Pursuant to Fed. R. App. P. 29(c)(4), the source of authority to file this brief is Fed. R. App. P. 29(a), as all parties to this appeal have consented to its filing. Pursuant to Fed. R. App. P. 29(c)(5), no party's counsel has authored this brief in whole or in part, no party or party's counsel has contributed money intended to fund preparing or submitting the brief, and no person—other than the amici curiae, its members, or its counsel—contributed money intended to fund preparing or submitting the brief.

Summary of Argument

Physician owned hospitals (POHs) have historically provided the finest in hospital care. Studies show that these hospitals have the highest quality and are ranked at the top by patients. Unlike not-for-profit hospitals, POHs pay state and federal income taxes, sales taxes, investment taxes, and property taxes. They employ thousands and pay billions in salaries. They provide uncompensated care, provide care that costs less than their competition, and serve poor communities.

Despite the exceptional benefits that POHs provide, their competition has been successful in lobbying Congress to implement section 6001 of the Patient Protection and Affordable Care Act (PPACA). Section 6001 has condemned these fine hospitals and paved the way for non-POHs to monopolize the health care industry. The arguments lodged against POHs, upon which Congress based its decision, are flawed and unreasonable. Section 6001 does not remedy alleged physicians' financial conflicts of interest in referring to hospitals in which they have a financial interest, but rather worsens such conflicts of interest. PPACA contains conflicting provisions. On the one hand PPACA creates financial incentives for the formation of Accountable Care Organizations (ACOs), in which physicians are encouraged to take leadership roles, to accept financial risk, and to refer to hospitals within the ACO network. On the other hand it creates section 6001 which restricts the ability of a physician to own a hospital, because, they

argue, physicians should not receive a financial incentive for referring to a hospital in which they have an interest. Not only does PPACA worsen alleged conflicts of interest and create new ones, section 6001 removes competition from the health care market with disastrous results. It also removes the incentive innovation, as competition ensures that hospitals venture to improve their care. It also threatens the ability of physicians to make medical decisions.

Non-POHs which have removed the competition have unclean hands, and have been guilty of antitrust violations and violating the Anti-kickback and False Claims Acts. Their bad behavior has been awarded to the detriment of patients, physicians, and society.

ARGUMENT

Physician Owned Hospitals (POH) are excellent, innovative, high quality institutions that have been targeted by their competition for financial reasons. Large community hospitals have complained that POHs specializing in cardiac care, orthopedics, and surgery were taking away their most profitable patients.[1] They also argued that physician owners have a conflict of interest when they refer patients to their own hospitals. Yet, non POHs are buying physician practices and in some areas directly employing physicians—these physicians have a 100% interest in their non-POH employers/owners. Conversely, over 70% of physicians on staff at POHs are *not* owners or investors in the facility.[2] According to the October 2003 GAO Report, approximately 73% of physicians with admitting privileges to specialty hospitals had NO ownership interest in the specialty hospitals in which they practiced.[3] A majority of POH physicians that are owners have less than a 2% interest in the hospital. It is not physician ownership of hospitals that is the most troubling conflict of interest—rather, it is *hospital ownership of physicians*.

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[1] See Medpac Report to Congress, Physician-Owned Specialty Hospitals, March 2005.
[2] See, e.g., Physician Hospitals Economic Impact Analysis 2009-2010, Physician Hospitals of America (48,190 credentialed physicians to 11,147 physician investors); United States General Accounting Office, "Specialty Hospitals," October 2003, page 9.
[3] United States General Accounting Office, "Specialty Hospitals," October 2003, page 9.

Physician ownership of hospitals is a natural fit. Physicians are interested in the health and welfare of their patients, which includes innovations, equipment, treatment options, and patient satisfaction. In fact, our nation's first hospital and many of our best hospitals were founded by physicians. In 1751, a physician named Dr. Thomas Bond joined with Benjamin Franklin to build our nation's first hospital in Philadelphia, Pennsylvania.[4] Physicians started two of the world's most renowned healthcare facilities—the Mayo Clinic and the Cleveland Clinic.[5] In Texas, physicians started hospitals such as Scott & White over a century ago, and Texas Spine & Joint Hospital in 2002.[6] POHs have continued today to be the finest hospitals in this country, providing patients and the community with better outcomes, shorter hospital stays, fewer complications, and greater patient satisfaction than community hospitals.

I. Arguments Against POHs are Flawed

In light of studies showing the effectiveness, efficiency, quality, safety, and community benefit of POHs, one would expect physician hospitals to be commended; rather, they have been condemned. The arguments against POHs were not reasonable at the time Congress enacted section 6001 of the

[4] Pennsylvania Hospital, www.uphs.upenn.edu.
[5] See, e.g., Mayo Clinic, www.mayoclinic.org; Cleveland Clinic, my.clevelandclinic.org.
[6] See Scott & White, www.sw.org.

Patient Protection and Affordable Care Act (Section 6001), and they are not reasonable now. The legislative facts on which Section 6001 is apparently based could not reasonably be conceived to be true.[7] The risks that the POH opponents have complained of will only be worsened by section 6001, and new problems are emerging with disastrous effects on patients and society.

A. Sec. 6001 does not remedy alleged financial conflicts of interest, but rather worsens them

The Secretary has argued that financial conflicts of interests are such a tremendous risk that they outweigh all the established benefits of POHs.[8] Yet this new law has created even more financial conflicts of interests. Hospitals are buying up physician practices and in some areas are directly employing physicians. These directly employed physicians are encouraged to refer within the hospital system, and independent physicians are being squeezed out of the community.[9]

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[7] *Vance v. Bradley*, 440 U.S. 93, 111 (1979) (emphasis added).
[8] See, e.g. Defendant's Response to Amici Briefs of Retiresafe, Texas Medical Association, and Physicians Foundation, Inc., Civ. Act. No. 6:10-00277-MHS, In the United States District Court for the Eastern District of Texas, Tyler Division.
[9] See, e.g., Carreyrou, J., "Nonprofit Hospitals Flex Pricing Power in Roanoke, Va., Carilion's Fees Exceed Those of Competitors," The Wall Street Journal Online, August 28, 2008.

By removing high quality POHs out of the equation, non POHs have been able to aggressively dominate the healthcare market.[10] Furthermore, the majority of non-POHs are not-for-profit entities, thereby not paying state, federal, or local property, sales, or income taxes. They also receive grants and federal funding. These "not-for-profits" are able to retain their profits because they don't have investors or dividends to pay. The profits they retain allow them to pay excessive salaries to their executives and amass incredible treasure troves. The charity that they provide often does not equal the tax breaks they receive, and they aggressively file suit against, and place liens on the homes of, their patients.[11] These aggressive non-POHs have eliminated the competition, and the result will be greater financial conflicts of interest, higher health care costs, fewer choices for patients, and less innovation.

Furthermore, the legislative facts that Congress relied upon in enacting section 6001 are directly in conflict with other provisions of the Patient

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[10] See *The State of Texas v. Memorial Hermann Healthcare System*, Cause No. 2009-04609, In the District Court of Harris County, Texas, 281st Judicial District (Agreed Final Judgment Jan. 26, 2009); M. Perin, "Hospital Lawsuit Continues to Simmer in Court", Houston Business Journal, January 7, 2008; R. Fields, 20 Largest Not-for-profit Hospitals," Becker's Hospital Review, July 19, 2010.

[11] Carreyrou, J., Martinez, B., "Nonprofit Hospitals, Once For The Poor, Strike It Rich With Tax Breaks, They Outperform For-Profit Rivals," The Wall Street Journal Online, April 4, 2008; Carreyrou, J., "Nonprofit Hospitals Flex Pricing Power in Roanoke, Va., Carilion's Fees Exceed Those of Competitors," The Wall Street Journal Online, August 28, 2008; "From Charity and Tax Breaks to Healthy Profits," The Wall Street Journal Online, April 4, 2008.

Protection and Affordable Care Act (PPACA). For example, section 3022 of PPACA promotes the creation of Accountable Care Organizations (ACOs). This section *encourages* the formation of collaboratives among health care providers. The purpose of these collaboratives is to maintain patient care *within* the collaborative *for a direct financial incentive* from the government. Thus, physicians, hospitals, and insurers, for example, will form a collaborative and patients will be *referred within this collaborative*. The incentive is financial, and the collaborative shares in the incentive. At the same time Congress was creating this ACO concept of collaboratives (with financial incentives for referral), it was creating the prohibition on POHs (because of the financial conflict of interest from referral). "The legislative facts on which [Section 6001] is apparently based could not reasonable be conceived to be true."[12]

B. Removal of Competition is Bad for Patients

Competition requires one to be innovative. Innovation is key to the success of health care in America. Would any individual prefer health care 100 or 50 years ago to that which is available today? Non POHs had the opportunity to show physicians and patients that they were better than their

[12] *Vance v. Bradley*, 440 U.S. 93, 111 (1979).

competition. Rather than focusing on innovation and improvement, these non POHs did everything they could to crush the competition.

Congress has taken the choice away from patients. The Secretary has argued that POHs "undermine" non-POHs.[13] Would government ever remove an auto maker from the market because that auto maker was so successful it was "undermining" the competition? Should Apple have been squeezed out of the market because it was "undermining" IBM? When competition is intense, patients benefit with better care, better prices, and better service. No matter how big or small the players are, competition is good for business and good for patients—without competition, where is the incentive to improve?

One Medicare Payment Advisory Commission study reported that competition with specialty hospitals has had positive effects on community hospitals' operations, akin to a "wake-up call."[14] The study reported that competition provides community hospitals with a stimulus to make constructive improvements.

Let competition work. A joint study between the Department of Justice and Federal Trade Commission found that the American free-market system

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[13] See, e.g. Defendant's Response to Amici Briefs of Retiresafe, Texas Medical Association, and Physicians Foundation, Inc., Civ. Act. No. 6:10-00277-MHS, In the United States District Court for the Easter District of Texas, Tyler Division.
[14] Report to Congress, Physician-Owned Specialty Hospitals, March 2005, Medicare Payment Advisory Commission (MedPAC), page 10.

is built on the premise that open competition and consumer choice maximize consumer welfare, even when complex products and services such as healthcare are involved.[15] "Healthy competition equals healthy consumers. Consumers want high-quality, affordable, accessible health care, and the challenge of providing it requires new strategies," said FTC Chairman Timothy J. Muris.

The Carilion Experience. A chilling example of what happens in the healthcare sector when competition is removed is in Roanoke, Virginia.[16] In the case of Carilion Health System (Carilion), the U.S. Department of Justice failed to prevent a merger between Carilion and the town's other hospital, thus creating a monopoly over medical care in the area. As a result, Roanoke Valley health insurance rates have gone from being the lowest in the state to the highest. Health care costs have soared in the area. For example, Carilion charges four to 10 times what a local endoscopy center charges for a colonoscopy. As a "not-for-profit" entity, Carilion benefits from untaxed investment gains, with annual profits exceeding $100 million. Its CEO receives over $2 million in compensation, and his predecessor received a pension of $7.4 million in 2003.

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[15] "Improving Healthcare: A Dose of Competition," A Report by the Federal Trade Commission and the Department of Justice, July 2004.

[16] See Carreyrou, J., "Nonprofit Hospitals Flex Pricing Power in Roanoke, Va., Carilion's Fees Exceed Those of Competitors," The Wall Street Journal Online (Aug. 28, 2008).

In 2006, Carilion began offering to buy private physician practices and pay their salaries. Physicians who chose to remain independent say their patient referrals from Carilion physicians plummeted within months. One such independent physician was informed by colleagues that the hospital system asked them *not to refer patients to doctors it didn't employ, calling such referrals "leakage."*

Does this profitable "not-for-profit" hospital system give back to the community? The Roanoke City General District Court devotes one morning per week to cases filed by Carilion against patients for past due bills. In 2007, Carilion sued 9,888 patients, garnished the wages of 5,478 patients, and placed liens on 3,920 patients' homes.

The experience of this one community is an example of what will happen across the country, with devastating results, when competition is removed. Removing competition from an industry increases costs and hurts communities.

C. Physicians Should Make the Medical Decisions

In its federally mandated report to Congress, MedPAC stated that the most common reason for physicians to establish surgical hospitals was

governance.[17] "Physicians wanted to control decisions made about the patient care areas of hospitals so they could improve the quality of care provided, improve their productivity, and make the hospital more convenient to them and their patients."[18] The battle regarding governance wages on, with physicians having little say in the operations of a hospital, such as the equipment that is purchased or the staffing of specialists. Concerned physicians who challenge a hospital administrator's decisions regarding patient safety are quickly silenced, or labeled as disruptive physicians who eventually lose their privileges at that hospital.[19]

In the past few years, increasing tension has developed between the organized hospital medical staff and hospital administration and boards. Many hospital medical staffs believe physicians have certain rights and duties, as defined in the hospital medical staff bylaws adopted by the medical staff and approved by the governing body, governing medical policy and practice. Hospitals, however, more often are usurping the medical staff function. In that regard, some hospital boards have unilaterally overridden a medical staff's appointment of its officers, forced the removal of physicians

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[17] Report to Congress, Physician-Owned Specialty Hospitals, March 2005, Medicare Payment Advisory Commission (MedPAC).
[18] Report to Congress, Physician-Owned Specialty Hospitals, March 2005, Medicare Payment Advisory Commission (MedPAC), pgs. 7-8.
[19] See, e.g., Huntoon, L. R., M.D., Ph.D, "Abuse of the 'Disruptive Physician' Clause," Journal of American Physicians and Surgeons, Vol.9, No.3, Fall 2004 (editorial).

for reasons unrelated to quality of care, amended unilaterally hospital medical staff bylaws, and adopted conflict of interest policies and procedures that target physicians on the staff who participate in competing health care ventures.[20]

II. Physician Owned Hospitals Provide the Finest in Hospital Care

Studies have shown that POHs have better health care outcomes, shorter hospital stays, and much higher patient satisfaction ratings than non-POHs.[21] Specialty hospitals have all-registered nurse staff, low patient to nurse ratios, high procedure volumes, electronic physician ordering, single rooms, and the latest equipment.[22]

A. Studies Show Physician Owned Hospitals Have the Highest Quality

The University of Iowa conducted a retrospective cohort study of 51,788 Medicare beneficiaries who underwent total hip replacement and 99,765 who underwent total knee replacement in 38 specialty orthopedic

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[20] See *Medical Staff of Community Memorial Hospital of San Buenaventura v. Community Memorial Hospital of San Buenaventura* (Ventura County, California Sup. Ct., 2003, Case No. CIV 219107); Dasco, S., Bennett, R., "Is There a Case for an Independent Medical Staff?" DOCTalkOnline.com, January 2007.

[21] *See, e.g.*, Greenwald, Leslie & Cromwell, Jerry et al., *Specialty Versus Community Hospitals: Referrals, Quality And Community Benefits,* 25 Health Affairs 106, 112-116 (2006).

[22] *Id*.

hospitals and 517 general hospitals between 1999 and 2003.[23] This study of over 150,000 Medicare patients found that complication rates were 40 percent lower for hip and knee surgeries at facilities specializing in orthopedics than for community hospitals. Those are startling statistics.

The British Medical Journal has reported findings of fewer deaths, fewer post surgery infections, fewer blood clots and fewer heart problems at specialty hospitals than at more generalized hospitals.[24] The study analyzed over 1.27 million Medicare patients at 3,818 U.S. hospitals who underwent primary or revision hip or knee replacement. The study revealed that the rate of death for patients who had hip and knee replacements was twice as high at the least specialized hospitals compared to patients treated at the most specialized hospitals. Similarly, the rate of post-surgery infection decreased from 2.6 percent at the least specialized hospitals to 1.6 percent at the most specialized hospitals. The study's senior author, Peter Cram, M.D., noted that larger hospitals were categorized as less specialized because they do many other types of surgeries besides orthopedics.[25] The author

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[23] Cram, Peter, et. al., *A Comparison of Total Hip and Knee Replacement in Specialty and General Hospitals*, The Journal of Bone and Joint Surgery (American), 2007;89:1675-1684.

[24] Hagen, Typson P; Vaughan-Sarrazin, Mary S; Cram, Peter. *Relation between hospital orthopedic specialization and outcomes in patients aged 65 and older: retrospective analysis of US Medicare data*. BMJ(Clinical research ed.) 2010;340:c165 (11 February 2010).

[25] See University of Iowa Health Care Media Relations news release, *Medicare data reveals differences in orthopedic surgical outcomes* (15 Feb 2010).

suggested that taking ideas from more specialized hospitals to less specialized hospitals would result in better outcomes all around.[26]

Available studies suggest that risk adjusted outcomes may be 10% to 20% better at specialty hospitals.[27] There are endless examples of the quality of care POHs provide, such as those of Texas Spine & Joint Hospital and Heart Hospital, discussed below.

1. Heart Hospital of Austin

Physician-owned Heart Hospital of Austin ranked *first in the nation*--above the Mayo Clinic, Cleveland Clinic, and other world-famous U.S. hospitals--for the percentage of patients who survived a heart attack.[28] In its study, USA Today took Centers for Medicare and Medicaid services data from more than 4,400 hospitals to rank the best and worst on death rates, and examined a three year time span between 2005 and 2008.[29] In an interview with the *Austin American-Statesman*, the president and CEO of the Heart Hospital said he believes the hospital's size is an advantage as well as its

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[26] *Id*.

[27] Cram P, Rosenthal GE, Vaughan-Sarrazin MS. *Cardiac revascularization in specialty and general hospitals*. N Engl J Med 2005;352:1454-62; Barro JR, Huckman RS, Kessler DP. *The effects of cardiac specialty hospitals on the cost and quality of medical care*, J Health Econ 2006; 25:702-21; Greenwald L, Cromwell J, Adamache W. et. al. *Specialty versus community hospitals: referrals, quality, and community benefits*. Health Aff (Millwood) 2006;25:106-118; Am Heart J 2008;156:155-60.

[28] *In government comparison, Heart Hospital ranks first nationally in heart-attack survival*, Austin American-Statesman, September 8, 2009 (Based on USA Today study of CMS data). Heart Hospital was physician owned at the time of these rankings.

[29] *Id*.

partial doctor ownership.[30] He said the doctors have a strong say in how the hospital is run, and a physician-governed institution has a different culture. A professor of medicine at Yale University who helped CMS develop the mortality measures agreed that the culture makes a difference. [31]

Thomson Reuters named Heart Hospital of Austin as a five-time winner of the Nation's 100 Top Hospitals for Cardiovascular Care in 2010.[32] Heart Hospital of Austin is one of only 10 hospitals in the nation to receive this award. The study found that the 100 Top Hospitals cardiovascular winners have: 1) 17% lower mortality rates for heart attack patients; 2) 10% lower mortality rates for heart failure patients; 3) 27% lower mortality for bypass surgery patients; 4) 22% lower mortality following PCI; 5) fewer post-operative complications, with 99% patients complication-free; 6) approximately 12% shorter average hospital stay; and 7) 12% lower cost per case.[33]

The Heart Hospital of Austin was also ranked number one in Texas for Overall Cardiology Services by HealthGrades in 2010, and ranked number one in Texas for overall cardiac services for six years in a row (2004-2009) by HealthGrades.

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[30] *Id*.
[31] *Id*.
[32] Heart Hospital of Austin press release, July 27, 2010.
[33] *Id*.

2. Texas Spine & Joint Hospital

Texas Spine & Joint Hospital, founded by physicians in 2003, was ranked number one in Texas for Spine Surgery in 2008.[34] According to the study, the outcomes for spine surgery at Texas Spine & Joint Hospital for 2005-2007 gave it a five-star rating and were the highest in the entire state of Texas. It was ranked in the top 5% in the nation for spine surgery for four years in a row, 2006-2009, by HealthGrades. It also received the Spine Surgery Excellence Award in 2010, ranking it in the top 5% for spine surgery in the nation.[35]

The awards given to these hospitals go on and on. Regardless, these hospitals have been condemned as have all other POHs in this country. Apparently patient care of exceptional quality is not the goal of Congress today. "Promoting the general welfare" of the people appears to be secondary to protecting the large "not-for-profit" hospitals.

B. Physician Owned Hospitals are Ranked Top Among Patients

Not only do POHs receive top marks in quality, they take top rankings for patient satisfaction as well. An August 2009 *Consumer Reports* study considering the views of *over one million* patients nationwide showed physician owned and operated hospitals as the very best in the country,

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[34] HealthGrades Hospital Quality in America Study, October 2008.
[35] HealthGrades Hospital Quality in America Study, October 2010.

among over 5,000 hospitals.[36] *These ratings were based on survey data collected by the Centers for Medicare and Medicaid Services (CMS)*. The June 2009 release of data, which was posted in August 2009, was based on the 12 month period ending September 2008. Patients were asked about their hospital experience, focusing on communication with nurses, communication with doctors, responsiveness of hospital staff, pain management, communication about medicines, discharge information, cleanliness of room and bathroom, quietness at night, and whether they would recommend the hospital to friends and family.

Overwhelmingly, physician owned hospitals ranked at the top. According to this study of over one million patients, physician owned hospitals were ranked *Number One* in 19 states, with many states having *multiple* physician owned top rated hospitals. This is particularly significant because approximately 20 states do not have physician owned hospitals.

Physician hospitals held the number one position in Arkansas, Arizona, California, Colorado, Idaho, Indiana, Kansas, Louisiana, Montana, Nebraska, New Mexico, Nevada, North Carolina, Ohio, Oklahoma, Texas, Utah, Washington, and Wisconsin. In several states, physician hospitals held numerous slots in the top ten rankings. For example, in Arkansas

[36] ConsumerReportsHealth.org August 2009; See Physician Hospitals of America, Patient Experience of Hospital Care, September 4, 2009.

physician hospitals ranked 1st, 2nd, and 6th. In Arizona, physician hospitals ranked 1st, 3rd, 4th, and 5th. In California, physician hospitals ranked 1st, 2nd, and 6th. Idaho's 1st, 2nd, and 4th rankings belong to physician owned hospitals. Indeed, in Kansas, physician hospitals held *all* top five rankings, 1st through 5th, as well as 7th, 10th, 11th, 12th, and 13th. All top nine hospitals in the state of Louisiana were physician hospitals. In Indiana, physician hospitals ranked 1st, 2nd, 4th, 5th, 10th and 11th. The top two hospitals in Nebraska and top three in Ohio were physician hospitals. In South Dakota, physician hospitals were ranked 2nd, 3rd, 4th, 5th, 6th, and 7th. Oklahoma physician hospitals ranked 1st, 3rd, 4th, 6th, 7th, 8th, and 9th. Physician hospitals in Montana held the 1st and 4th rankings, and in Ohio they held all top three slots. Patient satisfaction of physician hospitals in Texas is particularly significant. In all of Texas, with its highly renowned quality of hospitals, the following rankings were held by physician hospitals: 1st, 2nd, 3rd, 8th, 9th, 10th, 11th, 12th, 13th, 15th, 17th, 18th, 19th, 21st, 23rd, and 26th. Overwhelmingly, patients prefer the quality of care received at physician hospitals.

Patient Satisfaction Means Quality. The Centers for Medicare & Medicaid Services (CMS) uses Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) data "to enhance

accountability in health care by increasing transparency *of the quality of hospital care* provided in return for the public investment."[37]

Furthermore, since July 2007, hospitals subject to the Inpatient Payment System (IPPS) annual payment update provisions ("subsection (d) hospitals") must collect and submit HCAHPS data in order to receive their full IPPS annual payment update. Non-IPPS hospitals, such as Critical Access Hospitals, may voluntarily participate in HCAHPS. IPPS hospitals that fail to publicly report the HCAHPS survey data may receive an annual payment update that is reduced by 2.0 percentage points.

The Patient Protection and Affordable Care Act of 2010 also values patients' perspectives of hospital care. PPACA includes HCAHPS among the measures to be used to calculate value-based incentive payments in the Hospital Value-Based Purchasing program, beginning with discharges in October 2012.

III. Physician Owned Hospitals Provide a Significant Community Benefit

Not only do physician owned hospitals provide exceptional quality of care and consumer satisfaction, they also provide other benefits to the

[37] U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, https://www.cms.gov, (HCAHPS Patients' Perspectives of Care Survey).

communities that they serve. Whether through paying taxes and employing thousands, providing hospital access in poor areas, or providing charity care, physician owned hospitals provide a contribution to society which is unmatched.

A. POHs Provide a Significant Community Benefit

Physician hospitals employ thousands and pay billions in salaries. POHs pay property, payroll, and profit taxes. According to an eight state impact analysis study, the economic value generated by POHs is $3.9 billion in the eight states combined, ranging from $118 million in Pennsylvania to $2.3 billion in Texas.[38]

In Texas alone, Physician owned hospitals employed 22,740 individuals, and paid $1,121,570,000 in salaries in 2009.[39] Nationally, physician-owned hospitals employed 72,585 individuals, and paid $3,388,632,000 in salaries in 2009.[40]

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[38] Schneider, J.E., PhD, Decker, C.S., PhD, "The Economic Impact of Physician-Owned Hospitals in Eight States," Health Economics Consulting Group (January 12, 2009)
[39] Schneider, J.E., PhD, Decker, C.S., PhD, "The Economic Impact of Physician-Owned Hospitals in Eight States," Health Economics Consulting Group (January 12, 2009); Physician Hospitals Economic Impact Analysis 2009-2010 (study conducted by Physician Hospitals of America and available on the PHA website).
[40] Physician Hospitals Economic Impact Analysis 2009-2010 (study conducted by Physician Hospitals of America and available on the PHA website).

POHs pay a significant amount of tax, including property, payroll, and income taxes. Across the eight states studies, POHs were estimated to pay $207.4 billion in taxes in 2009.[41]

Contrast this community benefit with not-for-profit hospitals, which do not pay federal or state income, property, or sales tax. In fact, not-for-profit hospitals received an estimated $6-$8 billion in tax exemptions per year (1995 dollars), an average of $1.6 million per hospital.[42] According to one study, not-for-profit hospitals account for as much as 85% of the hospitals nationwide.[43]

A not-for-profit hospital does not have to distribute profits to shareholders or owners--any money earned must be channeled back into the organization in some way, and many non-profit hospitals reward their executives with large pay packages and pay for new facilities and equipment. When physicians are concerned about how the money is being spent, or concerned that the hospital is not spending its money in the best interest of the patient, these "public" hospitals hide their financial information from the public despite laws requiring them to disclose. [44]

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[41] *Id.*
[42] Cram, Peter, et. al. "Uncompensated care provided by for-profit, not-for-profit, and government owned hospitals." BMC Health Services Research 2010, 10:90.
[43] *Id.*
[44] See, e.g., *Knapp Medical Center, Inc. v. Jeffrey C. Grass*, Cause No. C-820-11-J, In the District Court of Hidalgo County, Texas, 430th Judicial District. In that case Physicians

In 2004, attorneys filed federal class-action lawsuits against numerous not-for-profit hospital systems, alleging the hospitals were not providing sufficient charity care to justify their tax breaks; these hospitals were also being investigated by the IRS for excessive executive and officer salaries.[45]

To make matters worse, CEOs at not-for-profit hospitals are paid on average $490,000 annually, while CEOs at a subset of 20 not-for-profit hospitals receive average compensation of $1.4 million.[46] For example, Northwestern Memorial, a Chicago not-for-profit hospital, paid its CEO $16.4 million in 2006.[47] The Center for Tax and Budget Accountability in Chicago estimates the value of Northwestern Memorial's property tax exemption to be $37.5 million. Northwestern Memorial is also exempt from $12.5 million in sales tax. According to the Center for Tax and Budget Accountability, the hospital's tax benefit is more than two times greater than

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on staff hired an attorney to seek financial records of this not-for-profit hospital to see whether the changes being made and money being spent was in the best interests of the patients. Pursuant to Tex. Bus. Org. Code section 22.352 and 22.353, a nonprofit corporation is required to maintain and make available for public inspection such financial records. The hospital responded by filing suit against that attorney, arguing that it is not required to disclose the financial records. Knapp Medical Center had created Knapp Medical Center Foundation to solicit public funds, and has asserted that it is exempt from these required disclosures, by making its solicitations through a foundation it established for that purpose. Tex. Bus. Org. Code section 22.355.

[45] See, e.g., USA Today, Scales Tipping Against Tax Exempt Hospitals, 8/24/2004.

[46] "IRS Study Finds Wide Variation in Amount, Type of Charity Care Not-for-profit Hospitals Provide," Kaiser Daily Health Policy Report, Feb. 2009.

[47] Carreyrou, J., Martinez, B., "Nonprofit Hospitals, Once For the Poor, Strike It Rick with Tax Breaks, They Outperform For-Profit Rivals," The Wall Street Journal Online, April 4, 2008.

the charity care it provides. Northwestern Memorial sues patients who don't pay their bills.

Indeed, community hospitals are not providing sufficient charity care, are paying their executives excessive compensation, and are receiving tax exempt status and other benefits. These overpaid executives have targeted physician owned hospitals and found friends in government to help them protect their pocketbooks.

B. POHs Provide Uncompensated Care

According to the October 2003 GAO Report, relative to general hospitals, cardiac specialty hospitals tended to have larger shares of Medicare cardiac patients.[48] Medicare patients constituted similar shares of surgical patients at surgical specialty and area general hospitals and of gynecological patients at women's specialty and area general hospitals.

In many cases, physician hospitals provide *more* charity care than not-for-profit hospitals. Nationally, physician-owned hospitals provide, on average, approximately 6.2% charity care.[49] Texas physician hospitals

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[48] United States General Accounting Office, "Specialty Hospitals," October 2003, page 4-5).

[49] Physician Hospitals Economic Impact Analysis 2009-2010 (study conducted by Physician Hospitals of America and available on the PHA website).

provide approximately 5.2% charity care.[50] On the other hand, 58% of not-for-profit hospitals spent 5% or less of their total revenues on charity care.[51] Slightly more than one-fifth of not-for-profit hospitals spent less than 2% of their total revenues on community benefits.[52] A recent article concluded that not-for-profit hospitals provide a similar level of uncompensated care as for-profit hospitals, and therefore concerns about the minimal amount of uncompensated care provided by not-for-profit hospitals is warranted.[53]

C. Costs of Providing Care in POHs is Less Than Costs of Providing Care in Non-POHs

A recent study has found that that the costs of providing care in POHs is *less* than the costs of providing care in non-POHs.[54] The study finds that a patient treated in a POH will cost the Medicare program on average $734 (4.6%) less than a similar patient receiving the same treatment in a non-POH. The study also finds that for a subset of high volume cardiac and orthopedic procedures performed at POHs and non-POHs in the same

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[50] *Id*.
[51] Martinez/Carreyrou, Wall Street Journal, 2/13 (citing IRS Study); See also Kaiser Daily Health Policy Report, Feb. 2009.
[52] *Id*.
[53] Cram, Peter, et. al. "Uncompensated care provided by for-profit, not-for-profit, and government owned hospitals." BMC Health Services Research 2010, 10:90.
[54] J.E. Schneider et al., "Restrictions on Physician-Owned Hospital Growth: Comparing Medicare Expenditures on POHs and Non-POHs," Oxford Outcomes Issue Brief (December 15, 2009).

community, allowed Medicare charges for POHs were 6% less than allowed charges for non-POHs.

This statistical study concluded that current policies based on an assumption that POHs are associated with significant increases in total expenditures need to be reassessed.

D. Physician Hospitals Provide Service To Poor Communities and Save Imperiled Hospitals

America needs physician owned hospitals to provide excellent care to millions of seniors and poor in communities that are often disregarded by community hospitals. Physician hospitals have met that need, and have scored exceptionally high in patient satisfaction and quality of care in these underserved areas. For example, Doctors Hospital at Renaissance (DHR) in Edinburg, Texas, was recently named one of Thomson Reuters' 100 Top Hospitals for the third year in a row.[55] Thomson Reuters evaluated the performance of 2,926 hospitals in areas such as mortality, medical complications, patient safety, and average length of stay.[56] This hospital is located in one of the nation's poorest regions.

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[55] Thomson Reuters 100 Top Hospitals: National Benchmarks study, March 29, 2010.
[56] *Id*.

DHR was formed by a group of eight physicians in 1997 and has grown to 500 plus beds, providing state-of-the-art services. "Founded, built and operated by South Texans for South Texans, DHR works to ensure that medical marvels from around the world are available and attainable for everyone in our community," said the hospital's chief operating officer in a news release announcing the Thomson Reuters top hospitals designation.[57] The hospital is about 80% physician owned, and has additional investors from the local business community.[58]

The great majority of patients that DHR serves are impoverished and underserved. This is evidenced by the fact that 80 percent of the patients are covered by Medicare or Medicaid.[59] The hospital does not have many major commercial insurers in its market.[60]

In addition to serving poor communities, physician hospitals often save hospitals from impending closure. For example, St. Joseph Medical Center, the oldest hospital in Houston, likely would not exist today if not for physician ownership.

Physicians purchased St. Joseph Hospital when Christus Health Group, a not-for-profit hospital system, decided to sell it amidst financial

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[57] See Becker's Hospital Review, "Physician-Owned Doctors Hospital in Texas Attributes Success to Community Focus," April 20, 2010.
[58] *Id*.
[59] *Id*.
[60] *Id*.

losses.[61] The hospital's medical staff put together an investment group, and made the hospital and its patients thrive in the heart of downtown Houston.[62] The physician hospital provided $13 million in uncompensated care, and paid $3 million in taxes in 2007.[63]

Physicians took a struggling hospital which might have closed under a large hospital system's care, and expanded the services it provides. Stories of physicians coming together and saving hospitals exist throughout this country. The ban on new physician-owned facilities will prevent future success stories such as these.

IV. Non Physician Owned Hospitals Have Unclean Hands

Non physician owned hospitals have utilized numerous tactics to squeeze out the competition of physician owned hospitals, in order to preserve their bottom line. Tactics have ranged from preventing insurers from contracting with physician owned hospitals, to paying illegal compensation to doctors in order to induce them to refer patients to their hospitals. Community hospitals have also attempted to bully physicians

[61] Texas Medicine, April 2008; See also Hospital Partners of America, press release, August 19, 2006.
[62] Texas Medicine, April 2008.
[63] *Id.*; See also St. Joseph Medical Center, www.sjmctx.com.

who have an ownership interest in a hospital, by denying or revoking their staff privileges.[64]

A. Antitrust Violations by Non-Physician-Owned Hospitals

On January 26, 2010, Memorial Hermann Healthcare System (Memorial Hermann), Houston's largest hospital system, settled allegations by Texas Attorney General Greg Abbot that the hospital systematically discouraged health insurers from doing business with a competing physician owned hospital Town and Country Hospital.[65] Memorial Hermann paid the state $700,000 to settle the state antitrust claim.[66]

In its 2009 lawsuit, the State of Texas alleged that Memorial Hermann discouraged health insurers from contracting with Town and Country Hospital. The petition alleged that, upon learning that CIGNA had contracted with Town and Country, Memorial Hermann notified CIGNA of its intention to terminate its CIGNA contract as to all Memorial Hermann

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[64] See, e.g., *Platte River Insurance Company v. Baptist Health,* 2009 WL 2015102, at *2 (E.D. Ark. April 17, 2009) citing *Baptist Health v. Murphy,* 226 S.W.3d 800 (Ark. Sup. Ct. 2006) (Cardiologists with ownership interests in another hospital were denied staff privileges.) and *Janet Cathey, M.D. v. Baptist Health*, Cir. Ct., Pulaski Cty., Ark., CV-2 005-5701 (Physician terminated from staff membership because physician's husband held an interest in competing hospital.); *Roger Wolcott, M.D. v. Covenant Health System, No. 2008-544,773*, 99th Judicial Dist. Ct., Lubbock County, Texas (2008)(Physician filed claim for revoking his staff privileges after discovering his ownership interest in a competing hospital).

[65] *The State of Texas v. Memorial Hermann Healthcare System*, No. 2009-04609, Harris County, 281st Judicial District 2009.

[66] *Id*.

facilities.[67] Memorial Hermann notified the other health insurers in Houston of its termination with CIGNA as an example of what would happen to any other health insurer that contracted with Town and Country.[68] After learning that Aetna was considering a contract with Town and Country, Memorial Hermann notified Aetna that entry into such a contract would result in Memorial Hermann imposing a 25% rate increase on Aetna.[69] Aetna subsequently did not enter into a contract with Town and Country.[70] After being unable to obtain contracts with any insurer in the Houston market, other than CIGNA, Town and Country went out of business. Memorial Hermann subsequently purchased Town and Country's assets from its creditors.

The $700,000 Memorial Hermann paid to settle the Attorney General's cause of action was merely a slap on the wrist of the hospital giant. Memorial Hermann had, after all, been successful in protecting its turf.

B. Corporate Hospital Chains Violate Anti-Kickback and False Claims Acts

[67] According to the petition, "Memorial Hermann subsequently re-negotiated its contract with CIGNA, resulting in substantial rate concessions from CIGNA, far in excess of any reasonably foreseeable economic impact on Memorial Hermann from CIGNA's inclusion of Town and Country within its network." Original Petition, ¶, 6.7.
[68] *State of Texas v. Memorial Hermann Healthcare System*, Original Petition, ¶, 6.8.
[69] *State of Texas v. Memorial Hermann Healthcare System*, Original Petition, ¶, 6.9.
[70] *State of Texas v. Memorial Hermann Healthcare System*, Original Petition, ¶, 6.10.

The Department of Justice reached a $27.5 million settlement with Universal Health Services for violations of the anti-kickback and false claims laws at its hospitals in McAllen, Texas.[71] In that case, the DOJ prosecuted the chain for violating the False Claims Act, the Anti-Kickback Statute, and the Stark Law between 1999 and 2006, by paying illegal compensation to doctors in order to induce them to refer patients to hospitals within the group.[72] According to the DOJ, the chain induced several doctors to refer patients to its hospitals, disguising the payments with sham contracts.[73]

V. Conclusion

Physician owned hospitals provide a significant contribution to this country and its communities. Studies have shown their exceptional quality, and that patients rank these hospitals at the top for patient satisfaction. Economically, these hospitals pay billions in salaries, hundreds of millions in taxes, provide charity care, and provide services in underserved or abandoned areas. The facts Congress used to enact section 6001 are

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[71] See United States Department of Justice, Office of Public Affairs, October 30, 2009; *United States ex rel. Moilan v. McAllen Hospitals, L.P.*, et al., Case No. M-05-CV-263 (S.D. Tex.); See also, Commins, John, "Doc-owned Hospitals: DOJ Settlement Shows Problems with Corporate Hospital Chains," HealthLeaders Media, November 3, 2009.
[72] *Id*.
[73] *Id*.

unfounded and unreasonable. Amici The Physicians Foundation, Inc. and Texas Medical Association and respectfully request this honorable court to vacate the district court's ruling on summary judgment and remand for further proceedings.

Dated: August 11, 2011

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CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(a)(7)(C), I certify that this brief was produced in Times New Roman 14 point typeface using Microsoft Word 2003 and contains 6,980 words. I further certify that all required Privacy redactions have been made as required by 5th Cir. R. 25.2.13; that the electronic submission is an exact copy of the paper document as required by 5th Cir. R. 25.2.1; and the document has been scanned for viruses with the most recent version of a commercial virus scanning program and is free of viruses.

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PROOF OF SERVICE

I hereby certify that on the 11th day of August 2011, a copy of the foregoing Brief of *Amici Curiae* The Physicians Foundation, Inc. and Texas Medical Association in Support of Plaintiffs-Appellants was served on all counsel of record by electronically filing it with the Clerk of the Court for the United States Court of Appeals for the Fifth Circuit by using the Appellate ECM/ECF system, which automatically provides electronic notification to the following persons:

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