COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES
INSURANCE
COMMITTEE HEARING

RYAN OFFICE BUILDING
ROOM 205
HARRISBURG, PENNSYLVANIA

TUESDAY, JUNE 8, 2010
9:00 A.M.

PRESENTATION ON
HOUSE BILL 2521 & 2522

BEFORE:

HONORABLE ANTHONY M. DeLUCA, MAJORITY CHAIRMAN
HONORABLE DAN FRANKEL
HONORABLE BRYAN BARBIN
HONORABLE DOM COSTA
HONORABLE FLORINDO J. FABRIZIO
HONORABLE NICK KOTIK
HONORABLE KATHY MANDERINO
HONORABLE ANTHONY J. MELIO
HONORABLE JOSH SHAPIRO
HONORABLE MATTHEW SMITH
HONORABLE THOMAS KILLION, MINORITY VICE CHAIRMAN
HONORABLE BRAD ROAE
HONORABLE SCOTT W. BOYD
HONORABLE GARY DAY
HONORABLE ROBERT W. GODSHALL
HONORABLE GLEN R. GRELL
HONORABLE ADAM C. HARRIS
HONORABLE MARGUERITE QUINN
HONORABLE CURT SCHRODER

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ALSO PRESENT:

ART McNULTY
EXECUTIVE DIRECTOR

KATHY McCORMAC
EXECUTIVE DIRECTOR

KELSEY J. DUGO,
COURT REPORTER
NOTARY PUBLIC

I N D E X

TESTIFIERS

P R O C E E D I N G S

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CHAIRMAN DeLUCA: Good morning, ladies and gentlemen. It's about 9 o'clock. I call this meeting to order. And before we start, I would like to have the members introduce themselves from my right.

REP. FABRIZIO: Florindo Fabrizio; Erie County.

REP. COSTA: Dom Costa; Allegheny County.

CHAIRMAN DeLUCA: Chairman Tony DeLuca from Allegheny County.

EXECUTIVE DIRECTOR McNULTY: Art McNulty; Executive Director of the House Insurance Committee.

REP. KILLION: Tom Killion; Delaware and Chester Counties.

EXECUTIVE DIRECTOR McCORMAC: Kathy McCormac; Executive Director of the House Insurance.

REP. HARRIS: Adam Harrisburg; Juniata, Mifflin and Snyder.

CHAIRMAN DeLUCA: Okay. And again, I want to welcome everyone here on this public hearing on House Bill 2521 and 2522, which I recently introduced.

This two bill package can play an important part in lowering the insurance premiums that we all pay. House Bill 2521 has a genesis in the American Medical Associations ethical codes and enacts the anatomical pathology service disclosure

act.

The legislation requires a referring health care provider to provide certain disclosures in the bill for the services provided to a patient. The required disclosures include: First, the name and address of the physician or lavatory providing pathology service; secondly, the amount paid or to be paid for the service.

House Bill 2522 is sourced in the PA workers' compensation law, which prohibits self-referrals by health care providers that are prohibited by federal law. This legislation extends the workers' compensation prohibition to providing any medical services in the Commonwealth.

Now, before I turn this over to the presenters, a truly distinguished group, I would last to make one last comment. The members of this committee will recall at last weeks hearing on implementing the new federal health care in the state one of the major themes that came out of that hearing was the concern about cost containment provisions in the new law.

The bills we consider today are cost containment measures. That will address some of the concerns we have heard last week and we have been following the news on the new health care law. We understand that the major thing of the federal health care issue is cost containment. How do we save? And that is what this committee has been looking at, is ways to introduce legislation, bring it out on the floor, that will

help render some cost containment to try and get a handle on costs of health care in our Commonwealth.

Again, I want to thank everyone for attending. Let me recognize Representative Godshall who showed up and Representative Grell. Thank you very much.

The first person to testify is Pam Ertel, President and Monica Ziegler, Legislative Chair of the PA Ambulatory Surgery Association. Welcome.

PRESIDENT ERTEL: Good morning, Mr. Chairman and Members of the House Insurance Committee. Thank you for letting the PA Ambulatory Surgery Association for testifying today on House Bill 2522.

My name is Pam Ertel. I am the Director of the Reading Hospital SurgiCenter at Spring Ridge and I'm also the President of PASA. We represent 142 of 298 Ambulatory Surgery Centers in PA. Today I would like to discuss the issue of self-disclosure and transparency as it applies to Physician-Ownership in an ambulatory surgery center and also Patients' Right to Know.

Transparency: Most physicians and surgery centers agree that disclosing the physician's financial interest in an ambulatory surgery center, or other specialty medical office is necessary and it's ethical, especially when referring a patient for further treatment or procedures.

Medicare establishes requirements under the Conditions for Coverage, which all ASCs must meet in order to be certified

to participate with Medicare. Effective May 18, 2009 under section 416.50, Condition for Coverage in regards to disclosure of physician ownership: The ASC must also disclose where applicable, physician's financial interests or ownership in the ASC facility in accordance with the intent of Part 420 of this subchapter. Disclosure of information must be in writing and it must be furnished to the patient in advance of the date of the procedure.

ASCs in PA implemented this policy in varying ways and I have many samples of those ways in which they put the ownership on the consent form. They put the ownership in writing, they put the physician's names in writing that are owners of the facility. And this information is given to the patients prior to their surgery. So they're well aware when physicians -- if the physician doing the procedure is an owner or a nonowner of the facility.

If these initiatives aren't enough to ascertain physician ownership transparency, we propose placing signage in all ASC with listing each physician and what their ownership stake is.

But more important than this is the Patients' Right to Know. At a time when health care costs are skyrocketing and access to quality patient care is a national priority, the U.S. House Energy and Commerce Committee has penned three health care bills focusing on transparency. One of these is the

Patients' Right to Know. It is meant to give patients greater access to information concerning their care and I believe in the past this committee has written some things in regards to patient's cost and the patient's ability to know when the procedure is going to cost, the cost of Medicare in general. We can go to a restaurant, we know what we're going to pay for anything that we pick off that menu, but do the patients know what the procedure is going to cost prior to receiving their bill?

One component of this bill would require ASCs and HOPDs to report publicly their charges for services on typically performed procedures, what their reimbursement would be from Medicare and Medicaid for these services, factors used in reducing fees for those with financial need and quality care data. We believe this bill will empower patients with critical information in order to make more informed decisions on where to receive their care. A public record of the quality and cost data of ASCs will assist in education -- educating the public on the benefits of ASCs.

We believe that ASCs are meeting America's surgical needs and so much more. We provide high quality cost effective services, receiving only 62 percent of what hospitals received for the same service. Like other segments of the community, we find creative and numerous ways to give back to the community via Health Fairs and fundraisers for charitable events.

In closing, PASA does support disclosure of physician ownership and/or financial interest. We believe the Conditions of Coverage, as established by Medicare, have addressed the requirements necessary to ascertain ownership disclosure to patients and our compliance to these requirements have been implemented. We also support legislation in support of patient's right to know.

I thank you for giving me this opportunity to testify today and I welcome any of your questions.

CHAIRMAN DeLUCA: Thank you, Pam. Any questions? I want to recognize Rep. Quinn and Rep. Frankel. I'm sorry. Go ahead, Ms. Ziegler.

LEGISLATIVE CHAIR ZIEGLER: Good morning, Mr. Chairman and good morning Representatives. I echo Pam in saying thank you for allowing us this opportunity.

My name is Monica Ziegler. I am the Administrator of the Surgery Center of Lebanon, also doing business name as the Physicians Surgical Center. We are located in the heart of PA. I am also the Secretary of PASA and the Chairperson of the Legislative Committee. This is an opportunity for us to speak to you about the opportunities that Physician Owned Ambulatory Surgery Centers across the State of PA can offer towards solutions for health care.

Due to time constraints, my focus will be on how ASCs have demonstrated their contributions to the Health care of PA

and the U.S. in three very distinct areas.

Initially, I would like to do an introduction about ambulatory surgery centers. ASCs are health care facilities which offer patients the opportunity to have selected surgical or procedural services performed outside the hospital setting. Since their inception more than three decades ago, ASCs have demonstrated an exceptional ability to improve quality and customer service while simultaneously reducing costs. At a time when most developments in health care services and technology typically come with a higher price tag, ASCs stand out as an exception to the rule.

First area of focus is quality of care. ASCs have a focused business. We're providing surgery to patients that "walk in and walk out." We have learned from the lessons of Peter Drucker in his research on "Search for Excellence", quoted by Tom Peters in the book -- know your specialty and do it well, ask the input of the professionals involved; employ staff and afford them accountability for their actions.

We promote limited wait times for patients, minimal infections, provide flexible scheduling, have minimal complications and have mastered the art and science of outpatient anesthesia -- which is very specific -- anesthesiologists that specialize in outpatient surgery induction and recovery. We provide care with state of the art technology and equipment and are accredited by: Department of

Health, Medicare, AAAHC or JCAHA or AAAAHC, Department of Environmental Protection, DEA, and other local agencies.

Additionally, many insurance companies also accredit each individual facility prior to contracting with them. In many areas, ASCs are held to more stringent standards than traditional hospital settings.

Research demonstrates -- as evidence by an article that we'll hand at our completion here -- that ASCs consistently perform as well as, if not better than, HOPDs, or Hospital Outpatient Departments, when quality and safety is examined. A recent study included an examination of the rates of inpatient hospital admission and death in elderly patients following common outpatient surgical procedures in HOPDs and ASCs. Rates of inpatient hospital admission and death were lower in freestanding ASCs as compared to HOPDs. Even after controlling for factors with higher-risk patients, ASCs had low adverse outcome rates.

How do I know? In our first year of operation, we had no less than 13 inspections, passing all of them. Outcome reporting shows a less than .01 percent of infection rate, with only two known infections since the day we opened. This would be consistent with Rep. DeLuca's bill, I believe, where you promote, decrease, minimize infections. We support that. Nausea and vomiting, a complication of anesthesia, has been so low that we had nothing statistically significant to evaluate.

We tried to do CQY settings on it multiple times. Patient satisfaction scores consistently run near 90 percent monthly, with a 50 percent return rate. Nurses, specializing in OR and outpatient care provide care to our patients.

Second focus is cost efficiency. Not only are ASCs focused on ensuring patients have the best surgical experience possible, the care they provide is more affordable. We excel at providing efficacy and efficiency of care. We're doing the right thing in an cost efficient/timely manner. One of the reasons ASCs have become so successful is that they offer valuable surgical and procedural services at a lower cost when compared to the hospital charges for the same services. Beginning in 2007, Medicare payments to ASCs were lower than or equal to Medicare payments to HOPDs for the comparable services for 100 percent of procedures.

The fact is that as of 2008, Medicare paid ASCs only 63 percent of what they paid HOPDs receiving for providing the exact same services. For 2009, it was estimated that ASC were reimbursed only 59 percent of what HOPD reimbursement was for the same services.

Additionally, patients typically pay less coinsurance for procedures performed in an ASC than for comparable procedures in the hospital setting. We echo Rep. DeLuca's efforts for cost efficiency, targeting on keeping patients cost down. As an example, a Medicare beneficiary could pay as much

as $496 in coinsurance for a cataract extraction procedure performed in a HOPD, whereas that same beneficiary's copayment or coinsurance in the ASC would be only $195. By having surgery in the ASC, the patient may save as much as 61 percent or more than $300, compared to their out-of-pocket co-insurance for the same procedure in the hospital.

Administrators, physicians and staff will tell you that efficiency in delivery processes facilitate our ability to provide cost efficient care. We provide flexibility of scheduling and our room turnover averages is less than 5 minutes compared to hospital turnovers of 30-45 minutes. Suppliers are either necessary or eliminated; prices are negotiated constantly with suppliers. Facility sizes match need -- we manage overhead costs. What does this mean to you as legislators?

If hospitals generated $12 billion in revenue from outpatient services procedures on Medicare and medical assistant patients in PA, in one year, performing those same procedures in an ASC would save you $5 billion.

That brings us to the last point. Access to care for all patients, including the indigent patients. Despite the controversy "on the streets" -- because I know it's out there -- we, ASCs, do take care of Medicare and Medical Assistance patients, those with low paying insurance companies or those with capped insurances; we care for self-pay patients and offer

them a significantly reduced rate and we write off co-pays of those on the poverty scales. And at our center, we participate in a program called Mission Cataract, were we provide free cataract surgery to those in need in surrounding areas.

In this informational age, where patients are informed and given choices and are encouraged to participate in their care, ASCs are allowing patients to have procedures in a timely manner that are convenient and affordable with quality outcomes. The self-referral act, as written, has the opposite affect, it will deny patients access to the best in quality and efficiency, and affordability for outpatient services. I believe that PA should be a leader in promoting access to affordable, quality care for all.

We, as professional partners in this room, should join ranks with the rest of the country in promoting transparency of costs so that informed patients can make individual choices. We should also be leading the efforts to allow more procedures on the Medicare list to be approved for ASCs, recognizing the efficiency of lesser costs to payors and patients by expansion of approved list. Just as there are no other states in the U.S. that prohibit physician ownership or referral to ASCs in which they are invested, it is time for PA to promote opportunities for all, patients and providers.

It is the goal of every ASC to provide patients with excellent care at reasonable prices to create an environment

that allows for nearly 100 percent patient satisfaction each and every visit; to minimize wait times for patients and allow for equal access to care for all; and, to improve the quality of life of physicians, thus, supporting PA's retention and recruitment of quality physicians.

We believe that ASCs are one of the key solutions to health care reform, allowing persons access to quality, affordable health care.

Thank you for this opportunity to address your committee.

CHAIRMAN DeLUCA: Thank you, both of you, for testifying.

I would like to recognize Rep. Schroder and Rep. Roae, who have joined us today.

Monica, I understand about the quality that the ambulatory presenters provide. I think they do a great job. But I also understand this is also a business -- health care is a business today. So I would like to know how -- even though you're providing quality service, how do we know that a lot of the services not being -- even though it's quality -- done for financial gain? And when I say that, I understand about individuals who own an ambulatory surgery center who don't refer anybody to any place else because people refer them to themselves -- I mean to the center. But I also understand when you have an interest in something, we're all human and

sometimes we tend to maybe -- and that we've been reading in the news media there's a lot of tests that they believe are unnecessary. So how do we insure that when somebody has a financial interest, not the individuals who are on the facility, but referring physicians to the facility are not doing it for personal gain?

LEGISLATIVE CHAIR ZIEGLER: That's perfect. I'm glad you asked that question. I was hoping you would. To me, it's kind of easy because the laws have already protected us from that. They're a medical necessity law. So everything that you do, you have to document and justify medical necessity.

The accrediting bodies, the regulatory agencies, the insurance companies, the Department of the Health, they are all looking to make sure that what we say we did, we did and that it was needed. Those same laws apply to in hospital settings and in ambulatory surgery settings.

So if our physicians do a procedure that wasn't medically necessary and wasn't justified, all of those utilization reviewers within the payer mix and within the regulatory agencies would say, you don't get any payment for that procedure, it really wasn't necessary. So to me it was a no-brainer because we're already doing that. We have to justify what we do.

PRESIDENT ERTEL: And I would like to add to that.

The Department of Health, for ambulatory surgery centers, I know there's rules and regulations. We need to have a quality committee and they need to identify members on the quality committee and they have to be physicians that are nonowners and they are doing their review of the charts. So a physician has no financial ownership is involved in the committee that reviews the patient's charts to look for those very things. Was this medically necessary?

CHAIRMAN DeLUCA: And I understand that. In a perfect world, probably, that is true. If I was a physician, just like an attorney who would be able to turn things around, I would certainly be able to make something, I think, medically necessary on how I would prescribe the procedure.

So I'm sure these individuals who are reviewing these bills and that here, who don't see the patient first, they are only looking at what the physician submits to them. And I'm sure that the physicians are able to -- and not that I want to say that they are not trying to do anything, but sometimes I'm sure they can make it medically necessary. I'm sure, to a physician, that's not a big trick.

I would imagine -- some of these charges that I see on some of these statements I get, I don't even recognize them and don't know them. So I don't know -- even though as a layperson, I don't know if that's true or not.

But if that was the case, why, under Medicare, did we

get Stark I and II of everything that is being scrutinized, not only medically necessary out there? And Stark I and II came because of the fact that we were using over-utilization of prescribing services. So you don't get that on the Medicare level, I mean, that's prohibited; am I correct?

PRESIDENT ERTEL: Yes.

CHAIRMAN DeLUCA: So something happened there. I just want to -- we're talking about cutting costs and I understand the value of the ambulatory centers. On the same token, I also understand that we're in a world that people have a financial -- when somebody has a financial interest, sometimes -- and I'm not saying everybody, don't get me wrong.

A lot of this legislation comes from individuals -- the minority of individuals who abuse the system and that's any legislation. But I just want to make sure that we're not -- we're providing -- I know we're providing quality service. I'm not questioning that. But the fact is that sometimes I'm worried about whether we are overutilizing some of these procedures for financial gain.

And evidently, as I read the news media, some of those tests, I would imagine, are being paid for, unless they're not getting paid for -- some of the tests that they are saying aren't necessary on their studies have shown that some of these physicians are prescribing more than they should prescribe, especially on some of the MRIs and some of the other stuff.

LEGISLATIVE CHAIR ZIEGLER: I guess we're probably not in the position to talk about the MRIs and --

CHAIRMAN DeLUCA: I understand that. I'm just eluding to that. That's the only thing I'm saying. That's my only concern. I understand about the cost factor, but you can eliminate the cost factor, what we're saving if we're overutilizing so that doesn't bring the cost -- do you have an answer to that?

LEGISLATIVE CHAIR ZIEGLER: At every facility, they are, what we compliance policies. And because ambulatory surgery centers are traditionally smaller than a hospital setting, my staff actually knows what their compliance policy means. So as a smaller facility, a smaller organization, a specialized organization, if someone were doing something intensionally wrong, there would be someone rising out of the group in a heartbeat, saying, that's wrong.

In a hospital -- and not that -- we need hospitals. But it's harder to police those kinds of things in a hospital. So abuses of the system can go on for far longer before you recognize them.

In a surgery center with 24 staff and 16 or 21 physicians, it comes right to the surface who's doing what, and we're monitoring everything. If I had Dr. DeLuca doing 20 tonsils in one week and prior to that he never did that, you would rise to the surface as an outlier and I would start

saying, hey, Dr. DeLuca, what are you doing?

CHAIRMAN DeLUCA: So in other words, what I hear you saying is that, if we're only paying for necessary services and this bill does no harm because the services have to be necessary, this bill would be a good bill; is that correct?

PRESIDENT ERTEL: Yes.

CHAIRMAN DeLUCA: So you have no problems with the bill then?

LEGISLATIVE CHAIR ZIEGLER: No. As far as --

CHAIRMAN DeLUCA: Well, you're saying that everything is necessary --

LEGISLATIVE CHAIR ZIEGLER: The self-referral bill?

CHAIRMAN DeLUCA: Yes.

LEGISLATIVE CHAIR ZIEGLER: The way that I'm reading the bill is that you're prohibiting physicians from referring to their ambulatory surgery centers or bringing their cases to the surgery center; is that incorrect?

CHAIRMAN DeLUCA: Only with the federal law -- pertaining to the federal law.

LEGISLATIVE CHAIR ZIEGLER: Okay. That's the part that I oppose. I oppose that physicians can't refer to their own surgery center, that Dr. DeLuca can't refer to Dr. Killon to do procedures at his surgery center, but you both own partnerships.

CHAIRMAN DeLUCA: You oppose that part of it, even though they are going to get paid because it's medically necessary?

LEGISLATIVE CHAIR ZIEGLER: I'm not sure. I don't know that I'm understanding you there. I'm reading it that -- I think we're saying different things.

CHAIRMAN DeLUCA: We're utilizing the workers' comp law. You can't do that under workers' comp law, so we're using the same guidelines as the workers' comp law.

LEGISLATIVE CHAIR ZIEGLER: I have heard that before.

CHAIRMAN DeLUCA: You've heard it before and I'm glad you're hearing it again.

LEGISLATIVE CHAIR ZIEGLER: I know, but the way that you implied it and the way that we implied it --

CHAIRMAN DeLUCA: We implied it as the same situation as the workers' comp law. We have no problems with the workers' comp law. So I don't understand why this would be a problem that you would endorse. Maybe you might want to go back and take a look at it and read it a little bit, just look at the workers' comp law and come back to us and let us know what your thoughts are on it.

LEGISLATIVE CHAIR ZIEGLER: If you can guarantee me that my physicians can do surgery at their surgery center under the bill, then I would support the bill.

CHAIRMAN DeLUCA: We're not going to guarantee anything. We're not guaranteeing, but we do appreciate your testimony. Any questions? Rep. Killon, did you have a question?

REP. KILLION: Yes. At the end of your testimony, you talked about retention and recruitment. We have some of the best medical schools in the country and in PA, particularly the Southeast where I live and we're seeing more and more of our doctors choosing a practice in other states.

And one of my concerns is -- my question is, if 2522 would pass, would that help us recruit retaining physicians or would it be a detriment to retaining and recruiting physicians?

LEGISLATIVE CHAIR ZIEGLER: Anything that stifles the ambulatory surgery center, development and growth will further limit retention and recruitment of physicians in PA. We already know that we're dealing with malpractice insurance and caps on insurance and these other outliers.

If we take away a surgery center practice that does improve their quality of life -- and when I say, improves their quality of life, they can come in in an afternoon and do a few cases and still have time to go back to see more patients. It doesn't take them from 12 o'clock until 9 o'clock at night because they have to wait for somebody to kind of come in. Not only that, but it helps to support their livelihood.

Physicians are not going to places, but they don't have

opportunities such as this. They want improved quality of life; they want time with their families; they want to be reimbursed for what they are doing. And if we don't allow that opportunity in PA, I think that we will lose a further population. They will do exactly what you are saying, they will leave the state.

PRESIDENT ERTEL: If I could interrupt. With my own personal experience in interviewing physicians for recruitment, almost 99 percent of the time they ask me if there's an ambulatory surgery center in the area, and for the same reason.

They're not asking to buy a share into it. They're asking me because of the cost efficiency for the patients, the efficiency for themselves so that they have time off with their families and they know by benchmarking that the quality of care in ambulatory surgery centers is superior to the hospital.

LEGISLATIVE CHAIR ZIEGLER: I would add one thing to that. In hospitals at the present, the trend is that hospitals are employing physicians again, which we used to see back in the early 80s.

When they employ those physicians, if they don't incentivize them with volumes and with workload measures, those physicians kind of come in and park. So even though we may think that ASCs, oh, they're incentivize because they own, if we force it all back into the hospital, they're do exactly the

same thing, but far worse. They are saying, we have to do all of this or we don't pay you this much.

REP. KILLION: Thank you.

CHAIRMAN DeLUCA: Rep. Godshall.

REPRESENTATIVE GODSHALL: I just want to mention that I've had a lot of use of hospitals over the last number of years and I really have no complaints, but at the same time, I've had on two occasions had to use the -- did use the facility for -- your facilities over the last -- in the last so far this year. And one of the things that really impressed me is the ease of getting in and out, the promptness of the appointment, the curtesy, and more than anything else was the follow-up.

But my last appointment at the one in Montgomery County 11:30 appointment. They asked me to be there about 15 minutes ahead of time. I was taken, instead of 11:30, I was taken in at 11:20 and I have a habit of sometimes leaving on my own rather than have a driver and them stop me at the door. But the follow-up, more than anything else, I really appreciate it.

It was not only a follow-up with a doctor, but also by the nurse that was on hand. And it was a lot easier way and attending than getting into a former hospital and I would just say that there's a lot of good work being done and I appreciate what you're doing. Thank you.

LEGISLATIVE CHAIR ZIEGLER: Thank you very much.

That was very nice.

CHAIRMAN DeLUCA: Thank you. I want to recognize Rep. Smith, Rep. Boyd has joined us. And just to follow-up on Rep. Killion's question about whether that would reduce the ranks of this. We're not closing the ambulatory centers.

Why would a physician not want to come into PA because of the fact that he doesn't -- he's not permitted to have an interest in an ambulatory center? You mean that's an incentive for somebody -- for us to get more physicians? I mean, if that's an incentive then I can understand that maybe we are over testing.

If that's going to be in the Senate, for somebody to come in and practice medicine in PA, because we're not because closing the ambulatory -- the bill doesn't say that we're going to close the ambulatory centers. I want to understand that why would a physician not want to come into PA because of the ambulatory centers? The only reason that I can figure out is that it's more lucrative for them if he gets an interest.

LEGISLATIVE CHAIR ZIEGLER: The biggest thing is quality of life. It is truly quality of life. I've had orthopedic surgeons -- and they're probably the best examples I can give because their need to do surgery is -- it just happens. You know, you fall and break your arm, you tear your shoulder or whatever. In the hospital, they are put into align in some cases and they have to wait. In ambulatory surgery

centers --

CHAIRMAN DeLUCA: I understand, but maybe you're missing my question here. I understand the benefits. I mean, I've gone to ambulatory centers. I understand. But I don't understand what would prohibit a doctor from coming into PA just because he couldn't have an interest in an ambulatory centers. I don't understand that part of it.

I understand the benefits. It's cost effected, it's quality, I understand all of that. But as far as Rep. Killon's question, reducing -- physicians would not come into PA because they are not allowed to self-referral. I'm not talking about the quality or anything else, the quality of life. Why would that prohibit a physician coming into PA if he was not allowed to self-referral? Do you understand my question now?

LEGISLATIVE CHAIR ZIEGLER: When you speak to -- go ahead.

REP. KILLION: It almost sounds as if it's wrong for a doctor to make money. Our doctors are struggling. I speak to many of the physicians in my area and I live seven miles from the Delaware border. A doctor can transfer down to a hospital in Delaware and get a $30,000, $40,000 pay rate because of the difference between the now premiums.

I think we need to have full open, disclosure transparency so patients know. But I think doctors are struggling to find ways to make ends meet. And ownership in

one of these facilities is a way to increase their income a little bit, given work they're faced with, low pay outs or Medicaid and Medicare and all of the other problems facing our doctors.

I don't think it is a bad thing, as long as it's disclosed and it's open. If I'm a young doctor and I'm looking for a place to practice, I want to go have a great quality of life, which these centers provide, but I also want to go to a place where I know I can pay off all of these loans that I have, as well as take care of my family.

So I think that's why it would be impediment for a young doctor to decide to practice in PA if they know they don't have these other opportunities available to them. And that's what I was looking for. Thank you.

PRESIDENT ERTEL: I also noticed with the ownership piece, they are more inclined to get involved. They are inclined to get involved with their reputation. The facility has to be the best because their name is attached to it. And I think that's really important.

It's the difference of owning a house or renting. You are more inclined to invest back into your house if you own it rather than renting an apartment.

CHAIRMAN DeLUCA: And I understand the question here. If that's the case, then if we want more doctors to come into PA because of the financial interest -- and we're not

saying all doctors -- then maybe we ought to look at repealing the workers' comp back, which is this bill is geared towards. And that would give the physicians more opportunity to make more financial income.

Maybe we can get more physicians to come into PA if we repeal workers' comp back. And I would like for you to take a look at the workers' comp. Thank you very much.

LEGISLATIVE CHAIR ZIEGLER: Thank you.

CHAIRMAN DeLUCA: The next individual to testify is James Goodyear. He is the President of the PA Medical Society. Dr. Goodyear.

PRESIDENT GOODYEAR: Good morning. I'm Dr. Goodyear, a general surgeon in Montgomery County and current President of the PA Medical Society. The general PA Medical Society represents physicians of every medical specialty throughout our commonwealth. And our mission is to protect the physician-patient relationship.

While the issue of self-referral is vital to those providing direct patient care, I frankly believe that it is of greater importance to our patients, whose ability to receive quality, timely, safe, and convenient health care services could be adversely affected if this bill becomes law.

Let me begin by thanking Chairman DeLuca and the members of this committee for the opportunity to share our strong opposition to House Bill 2522 and why we believe that it

is a solution looking for a problem. We welcome this opportunity as we all strive to provide the best care possible for Pennsylvanians.

I am not an expert on the complexities of self-referral law. There are attorneys and others who dedicate their entire careers to mastering this complex subject. I would like you and the members of this committee, specifically, to know that I do not have an ownership interest in any ancillary facility, imaging center, surgery center or laboratory service.

Beginning in 1989, and again in 1993, the federal government enacted Stark I and II. These laws were an effort to remove potential conflicts of interest when physicians refer Medicare patients to health care facilities in which they have a financial relationship. It took the federal government more than ten years to develop regulations to address the many unintended consequences of these laws. Twenty years later, regulators continue to develop new exceptions as they identify "good" self-referral practices that otherwise have been prohibited. Make no mistake, physician self-referral is extremely complex and this is the most heavily regulated area of medical practice today.

Some of you may view self-referral with a jaundiced eye, believing that having a financial relationship in a facility drives physicians to perform unnecessary procedures or order unnecessary tests. I believe physicians would not

violate their professional ethics or risk harm to their patients for a few extra dollars.

So what motivates physicians to create physician-owned ancillary surgical centers, known as ASCs? In many cases, physicians join together to establish these facilities out of frustration when hospital administrators inhibit their ability to practice. These centers often result in lower cost, better quality, and safer and more patient-friendly medical care.

In response to Rep. Godshall, that patient-friendly environment is the rule in these outpatient settings.

Let me highlight some examples that I believe these centers do.

My first example demonstrates how gastroenterologists stepped in to fill a void. In the early 1980s, hospital administrators often turned down requests for costly colonoscopy equipment in favor of more lucrative equipment procedures.

Then, as now, physicians are frequently frustrated by constraints imposed by hospital administrators, such as inadequate staffing for operating rooms or slow acquisition of new technologies. In the case of colonoscopies, gastroenterologists met their patients' need to access quality care by establishing endoscopy centers in their communities. As a result, these physicians revolutionized colorectal screening and continued to save countless lives through early

cancer detection.

Surgeons who join together to establish an ASC are more freely able to make management decisions that vastly improve quality of care, productivity, and patient satisfaction. The ASC can schedule procedures, maintain appropriate staffing levels, and purchase the needed supplies and equipment. These decisions are made in the best interest of both patients and physicians and are not influenced by the need to redirect financial resources to buy a new helicopter, remodel an emergency room or hospital atrium, or even build a new hospital.

Even though I don't have a financial relationship with my local surgery center, when it's appropriate for my patients' individual needs -- which parenthetically, it often is -- I prefer to do my cases there for those reasons. Many of my fellow surgeons feel the same. I also should mention that many physicians believe that patient safety is further improved in ancillary facilities given a patient's limited exposure to infections that we all know exist in hospitals.

My second example is a patient seen by an orthopedic surgeon for an ankle injury who needs an x-ray or other diagnostic image to make an accurate diagnosis. If the physician is able to provide the necessary imaging services in-office, the examination, diagnosis, and initiation of treatment can be accomplished in one patient encounter. The

alternative is to refer the patient to a diagnostic imaging center or hospital outpatient department. This delays diagnosis and treatment until the orthopedic surgeon receives a report back from the center and the patient is seen for a second time. This fragments safe and effective care in my opinion.

Providing ancillary services in physician offices speeds up the diagnosis and treatment of a patient's medical condition. When on-site ancillary services are not available, the patient needs to schedule a new appointment with a different physician at a different facility. Having these services readily available is especially important to the elderly and other patients with limited transportation options or mobility problems.

So far, I've giving you examples that show how provision ancillary services in a physicians' office improves access, quality, and safety of care. But cost concerns are an equally compelling reason why physicians oppose restrictive self-referral. "One-stop shopping" can be cost-effective because it can improve efficiency and lower overall costs by reducing the number of office visits required.

Hospitals are required to have certain personnel and equipment available at all times regardless of whether they are needed to provide a specific diagnostic imaging or other ancillary service. Those indirect hospital costs contribute to

the overall cost of patient care.

At a system-wide level, severe self-referral restrictions potentially pose a barrier to clinical integration. Clinical integration is a key component in new reimbursement models aimed at controlling costs and improving quality of care. The self-referral restrictions in House Bill 2522 create an unnecessary maze of barriers that physicians must overcome to clinically integrate with other physicians and health care providers.

Federal law gives the secretary of Health and Human Services the authority to waive federal self-referral restrictions that impede new reimbursement models being tested for Medicare and Medicaid patients. Clearly, the very body that enacted self-referral prohibitions recognized the inherent flaws and shortcomings caused by these prohibitions when it comes to an efficient health care delivery marketplace.

This is where self-referral gets very confusing and becomes a political football. Let me give you another example. The American Hospital Association is advocating for elimination of the federal self-referral restrictions for compensation relationships that physicians have with hospitals. This is fascinating since today you will likely hear from the Hospital and Health System Association of PA testify in favor of House Bill 2522 and perhaps even call for more limiting language. This is even more ironic because House Bill 2522, in our

opinion, will affect all self-referral, including self-referral that takes place in ancillary facilities jointly owned by physicians and hospitals. It could even affect self-referral within the hospital itself.

Don't get me wrong, we recognize the need to reduce over-utilization. However, additional self-referral restriction that cause physicians' administrative costs to escalate is not the solution. Defensive medicine is the driving force of over-utilization, particularly in highly litigious areas of our state, like Philadelphia, where liability costs are among the highest in the country. You won't be surprised to hear me say that medical liability reform is imperative to help reduce health care costs. I also would welcome the opportunity to come back and talk with you about how the state could facilitate other efforts to rein in health care costs, such as standardizing managed care contracts and physician credentialing procedures.

But without documented evidence that problems exist, we believe that enacting further self-referral restrictions, on top of the existing federal Stark law and anti-kickback statute, will only pile on additional penalties and further increase administrative costs for physicians.

We firmly believe that federal laws have effectively addressed abusive self-referral practices. All that House Bill 2522 really accomplishes, in our opinion, is adding draconian

state penalties and imposing a strict liability standard. In the end, physicians will have to hire attorneys to review any financial relationships to ensure compliance; more costs; more hassles; no perceived benefits, for both patients and physicians.

These are our over-arching concerns with House Bill 2522, but we also have concerns with ambiguities in the drafting that may have unintended consequences.

For example, te bill lists "designated health services," such as diagnostic radiology, but does not define them. Does diagnostic radiology include vascular diagnostic studies, ultrasounds, myocardial perfusion studies, echocardiography, or even mammography? Will the self-referral prohibition apply when one of the designated health services is reimbursed as part of a composite rate for a non-covered service? An example would be a clinical laboratory service that is part and parcel of an ambulatory surgery encounter.

Yes, you can fix each of these concerns one by one, but the Stark experience shows that new issues will inevitably arise. And, given the pace of the changing health care delivery system, the unintended consequences of enacting this bill could be to cripple an already handicapped system.

Another alarming aspect of this bill is that it would directly tie state self-referral law to federal Medicare rules. This means that self-referral restrictions could be increased

by changes at the federal level. But changes in Medicare are largely driven by federal budgetary woes or problems related to other states.

Rather than delineating exceptions for appropriate physician financial relationships, House Bill 2522 incorporates the exceptions under the Stark law and the safe harbors to the anti-kickback statute. The problem with this is that the federal government can change those rules at a whim. For example, the Stark in-office ancillary services exception is critical to allow physicians to provide imaging in their offices. If the federal government excludes echocardiograms from this exception, does that same restriction now apply in PA?

Yet another problem with the bill is that it gives hospitals an unfair competitive advantage. For just a moment, let's examine the playing field between hospitals and physicians since hospitals appear to be most threatened by the efficiency of physician-owned facilities.

Under the federal Stark law, which House Bill 2522 largely mimics, physicians cannot refer patients to independent diagnostic imaging centers that they own. Yet a hospital that owns a diagnostic imaging center can direct its employed physicians to refer only to that center, exclude physicians, potentially, from its medical staff who refer patients to a competing imaging center, or refuse to lease space in a

hospital-owned physician office to those physicians who provide competitive diagnostic imaging.

Adding insult to injury, physicians may provide in-office CT scans, but are required to provide patients with a list of CT scan providers in the area. We think that's okay, but hospitals funnel patients to their CT scanners without any requirement to advise patients of alternatives. If hospitals truly were concerned about conflicts of interests driving physician referrals, they would likewise oppose abusive practices that channel patients to their facilities.

PA is not the most attractive state in which to practice medicine given our liability system and poor reimbursements. Placing further restrictions on physician self-referral will further impede our ability to compete for quality physicians and attract new physicians here to this commonwealth. Physicians want to practice in facilities and with technology that offer high quality, cost-effective, and convenient care for their patients.

Rather than continuing to bog down a health care delivery system at the brink of collapse, I believe that the best approach to this dilemma is simple: Transparency.

Require all health care provider -- including both physicians and hospitals -- to fully disclose their financial relationship with an entity to which a patient is being referred. If the patient has concerns, let them decide where

to receive their care or diagnostic imaging. When I refer a patient for diagnostic imaging, or for that matter to another physician, one of the question that I always hear is, "Is that where you would go?"

Let's give patients the information that they deserve to make an informed decision and stop trying to legislate where they must go for treatment.

In the end, improved outcomes and clinical integration mean better care at a lower health care cost. If we disrupt these principles, we will create a delivery system that can't embrace or change or capitalize on technological advances and cost savings.

Thank you again for the opportunity to share with you my thoughts on House Bill 2522. To the best of my ability, I will be happy to answer any questions from the committee.

CHAIRMAN DeLUCA: Thank you, Doctor. Before I ask you a question, I want to recognize Rep. Melio, Rep. Barbin, Rep. Day and Rep. Shapiro, who have joined us today. Thank you very much.

Doctor, just to let you know that one of the things that you mentioned is self-referral practices. I think that was in your testimony and I agree with you. I don't know if you're aware, but we try to work with you -- not with you, with your organization every year to come up with a good self-referral piece of legislation that most of all of the

states have some type of self-referral law in the states.

So we have been trying to work with your organization for a year to get their input on how we can make a good self-referral law that would benefit everyone and reduce the cost. I don't want you to think that we haven't done that. We have done that. We have reached out to the Medical Association Society. They haven't come back to us.

Now, I understand up here in Harrisburg we want to sometimes leave the status quo and don't do anything. As chairman of this committee, I don't believe that's the way to go because we need to have a vision on how we do things. Too many years we were just satisfying one group or the other group and we haven't gotten a handle on the cost, which affects the Medical Society because, as you mentioned on some of your testimony about reimbursement and liability and everything else, it seems like when we had just one leg of the stool, that person or organization goes away and leaves the other two here so we don't get any satisfaction on trying to reduce cost. And they are driving the small business -- not permitting them to be able to help their employees.

Back in the west -- I don't know if you're familiar -- but the physicians back there and the self employed are getting killed. They just got their insurance rates, 70 percent increase, which they can't sustain, even though they are self employees. So, I mean, we need to do something.

I don't want you to think that we haven't tried to reach out and we want to reach out to you. We want to reach out and work with your organization. I can't force you to the table. I mean, if you guys don't want to come up with some type of opinion, how we can make a better bill out of this, I can't force you there. I have told them that we were going to run a bill and I have given them over a year to come up to -- I can't do any more than work with you. I'm willing to throw it out there to work with you.

And I understand the benefits of ambulatory centers. Don't get me wrong. I'm not trying to outlaw -- I don't want anybody to think that I'm trying to outlaw ambulatory centers on behalf of hospitals. I know the benefits of ambulatory centers.

All that I'm trying to do is to make sure that we have a bill that could possibly cut down the costs to make sure that we keep our doctors and we keep individuals because as more and more people become uninsured, our primary physicians are not going to be able to stay in business. They are only making $110,000 right now and if they don't have any patients, they're going to make less. That's all I'm trying to do with this legislation.

I don't want you to think that we're not trying to work with you. We are trying to work with you. As I said most of all the states have some type of self-referral. What I want to

come up with is a good self-referral bill and I would like to work with your organization. But, unfortunately, they haven't feed to the table. So I just want to throw that out to you.

PRESIDENT GOODYEAR: May I comment?

CHAIRMAN DeLUCA: Yes, you can.

PRESIDENT GOODYEAR: Thank you. I think that the PA Medical Society has attempted to work with the individuals here in Harrisburg, specifically asking that the referral bill be designed primarily around transparency and disclosure. We believe that that's the most fair and appropriate way to address this issue. We also do not believe that banning self-referral will have any significant affect on reducing cost. It's not going to reduce cost. We don't believe that there's any evidence that self-referral policies -- as currently exist -- create over-utilization. We believe that over-utilization comes primarily from a broken liability system and that has been shown to be the case time and time again.

Further, by limiting the number and access to ancillary and ambulatory facilities, with the increasing number of individuals now potentially flooding the cover market -- and we support that -- limiting access is going to make it worse, not better. We want to open access. We want to make patient access, patient choice, physician choice better to improve the environment and not restrict it, which we believe will harm the system, not provide it.

So we have tried to work with you and we will continue to try to work with you. And we think that transparency and disclosure from all stakeholders is the way to do it.

CHAIRMAN DeLUCA: As I talked to my executive director, he informed me that most of your comments from -- not from you, from the organization, was to criticize the bill, tell us what you didn't like, but didn't tell us what you wanted in there. Now, I understand about transparency.

Let me ask you, Doctor, just as a layperson myself, I know that I go to my physician and the physician tells me that I need a test and I ask him where to go. I'm sure I won't go shopping for a center and say, well, you know what, I'm going to go to Tony Amelio's Center or something like that. I would take my physician's word if he sent me, if I'm not mistaken; is that correct? Or would they just go to any place even though you have transparency there and you say that you own some of it?

Would you not -- would they not take your word as their physician is to go -- because they trust you, and that's what I would do. I would trust my physician. I'm certainly not going to go out searching for some place just because of -- even with 20 percent or 10 percent, I'm still going to go there because it doesn't make any difference because my physician recommended me there and I'm going to take his word because I trust him; is that true?

PRESIDENT GOODYEAR: We would hope so. We think that a patient-physician relationship is a relationship that we will protect as the very pinnacle of our advocacy. And it is that trust and that shared decision making between the patient and the physician that we think needs to be protected at all times. And so if that relationship exists to the extent that we want it to, yes, we would expect that patient to follow our advice.

At the same time, I believe that the physicians of PA -- and I speak for the physicians of PA -- practice ethical medicine. So they are not inclined to just say, I want you to go to this center because I'm a part owner and not the other one, that we will always keep patients first. And I believe that to be ethically the case and I will stand on that belief.

CHAIRMAN DeLUCA: Doctor, nobody is trying to say anything different. We believe that the medical profession is ethical or we wouldn't be introducing these other types of legislation. That's not the case. We're looking to try and save cost. That's what we're talking about. And all 49 states have some type of self-referral legislation.

We're looking forward to working with you and I want to thank you. Any question? Rep. Barbin.

REP. BARBIN: Thank you, Doctor, for your testimony. Between the health care situation that we got ourselves in on the federal level and the immigration problem

that we have, both problems are not being addressed by the federal government and that's causing states to say, we need to do better.

Arizona passes an immigration law this morning that said you have to be legal to work. The same thing is true about health care. What the bill is trying to accomplish is to reduce some of the cost. It may not be a huge savings, but only a few self-referrals could be eliminated. There are appropriate ones. The cost for the overall system would go down, would let us cover all of those people that lost their jobs and lost their insurance.

My question for you is, I read the testimony of Pam Ertel and she says that her group has no objection to a financial statement that discloses what those problems may be. Legislators provide a financial disclosure statement that say what their interests are. What objection should the medical society or hospital or any provider have to at least identify what their sources of interest are so that if it was available on a government line or internet access, you would at least be able to check?

Do you have an objection to Ms. Ertel's suggestion? Is there a file that at least would disclose what your interests are?

PRESIDENT GOODYEAR: No. No objection. We agree with transparency and disclosure. If that's the way to go,

then we don't believe that restrictions on self-referral are going to significantly change and lower the health care costs at all. We don't believe that. There is self-referral that goes on within the hospitals.

REPRESENTATIVE BARBIN: But you just stated that the Commonwealth was taking the federal law and applying it to just physicians, that federal law does not apply to hospitals. And that to me says, you don't want this law to apply to the state level because it doesn't apply to hospitals. But if it applies to hospitals and to physicians, wouldn't that be fair and wouldn't that drive down costs because there is a federal law?

There is the anti-kickback law that applies. That's what the Stark sessions are about. They say that the federal government will come in and limit circumstances and try to undo the relationships that are too close. And you say you don't think it's fair to apply that federal law to physicians because it's not applied to hospitals. But we're in that position where we have to do something about self-referrals.

So why should we answer the disclosure and apply the rules to anybody? Anybody that's taken money from the government, Medicare, Medicaid, state subsidies, whatever, they have a duty to the taxpayers to provide services at the lowest cost. And if we can't know what those costs are because there is no disclosure method, why do you object to a rule that would

at least identify what the relationships are?

PRESIDENT GOODYEAR: I don't object to transparency and disclosure. I object to bands and restrictions on self-referral as defined in the laws.

REPRESENTATIVE BARBIN: But it's up to you to say what it is that's wrong with this that will apply to everybody as opposed to saying, we're not going to do this because you're not taking on another group as well.

Don't you have that responsibility as a group? You represent a group of people that makes their livelihood some part of which is coming from government subsidies. You can call it anything that you want, but the government is paying a large portion of health care and it's starting to get to the weight that's throwing whole system into a crash. And you can't sit back there when the system situation is crashing and we're just not going to participate because then the system crashes. You need to fix a bill like this because it's the only way to lower cost. That's all.

CHAIRMAN DeLUCA: Rep. Schroder.

REP. SCHRODER: Dr. Goodyear, good morning. I appreciate your testimony. I think it's ironic that for the past year or so you were just raped over the coals by a couple of members of this committee for not coming to the table or not participating or whatever else you want to call it. It seems to me that both physicians and perhaps people in the medical

society have a bit of a tendency, maybe even a little of a suspicion to engage members in the general assembly or individuals or committees. I've heard that from a rank of fellow doctors back in my area and they don't call.

It's been ten years or so that we've been trying to get a little better with the medical malpractice issues from time and time again to the legislature for relief only to hear you testify today that we still have the highest medical malpractice rates in the nation, or at least in this region.

After all, it was just last October that this legislatures raided or stole your M-Care funds that you had to go to court to get it back. In my mind, that is not a very conducive atmosphere to expecting or demanding the physician community to come before this committee for any bad idea or for anything at all. Would you like to comment on that?

PRESIDENT GOODYEAR: Yes, I would. I could not have said it better. Thank you.

CHAIRMAN DeLUCA: Just for the record, nobody has raped the doctor over the coals. Now, you might interpret that, Rep. Schroder, but certainly, nobody has raped him over the coals and I take offense to that statement, that I would rape him over the coals or Rep. Barbin has raped him over the coals. Our job is to ask questions. That's what this hearing is all about. It's not to pick sides, Rep. Schroder, it's to get answers.

And I did try to work with him. You don't know that. And if you would have came to me and said that, I would have told you. If you would have asked me when we were working, not with the doctor, with the organization. So I take offense to your statement that I've tried to rape him over the coals or Rep. Barbin tried to rape him over the coals.

Let me also say, you've talked about the no practice insurance, so let's be truthful, when you bring it up there, you were on this -- you were a representative when you have to control the House, you had control of the Senate, you had control of the governorship and I didn't see you do anything or your party do anything for --

REP. SCHRODER: That is nonsense, Mr. Chairman. Don't accuse me of not doing anything about medical malpractice. Everyone in this office knows that that is a lie. That is a lie.

CHAIRMAN DeLUCA: You started it and now I'm going to finish it. And I thought you were out of line. Rep. Shapiro.

REP. SHAPIRO: Let me ask a few questions. The fundamental apprentice it seems behind this legislation is that there is an unfair playing field, that it is unfair because physicians somehow have these side deals where they're able to make extra money in a way that's inappropriate. It seems that it's unfair to the patients some are suggesting because they,

at the end of the day, loose out or in terms of perhaps quality of care, but most importantly because the cost of the system goes up and ultimately hurts them. And there's obviously been rhetoric turned around on both sides. I think the justification for a bill like this is to certainly rein in costs and improve care.

I'm not convinced that this legislation is needed or does that and I was hoping that you could try and drive a little deeper into the notion of cost containment, which has obviously been the focus of what happened in Washington and what we can continue to try to do here in Harrisburg.

So you respectfully dismiss the motion that this bill is going to control cost or that there is a need to control cost. Let me ask you to dive a little bit deeper into that and explain that. The chairman, who, obviously, knows a great deal about these issues, suggests that this is the way to control costs. So address that with a little bit more depth, if you many.

PRESIDENT GOODYEAR: Let me start with, we do need to control costs. The current trend of -- in excessive of $2 trillion in the federal government, climbing at one and a half to two times the GDP every year is unsustainable. We cannot continue to do that.

PA Medical Society, the AAMA physicians across the country recognize we need to do something and that change in

the way that health care is delivered needs to change and there is a lot of components.

This bill -- and I'm going to go back and forth between the general concept of lowering health care curves in this bill -- assumes that there is over-utilization because physicians are benefitting, there's not over-utilization. These patients, as was testified before, there needs to be medical necessity justified at multiple levels, notwithstanding the justification between the physician and the patient that they need to have that treatment, which I will tell you is the highest level of justification for doing a procedure or providing a service to a patient.

In this age of informed consent, information sharing between physicians and patients, the patients are determining for themselves what's necessary and that's the highest level and then we have government regulations and state regulations, insurance industry looking at medical necessity. I don't believe there's over-utilization.

The efficiencies that are realized in ambulatory facilities and services that are provided, actually lower cost in my opinion. Care now -- and I think all of you will recognize -- is very, very fragmented. You go to your primary care physician's office, he wants you to see a specialists. You have to then get a name and a phone number. You have to call and you wait three or four weeks to get a consult. He

says, thank you for coming in and seeing me, but I'm not the specialist you need to see, you need to see this guy across town, who sends you to a hospital for a test and then to this laboratory for a study. This is fragmented care and it's inefficient. It's tremendously inefficient. And there's multiple drivers of our rising cost, but the fragmentation of our care is one of them.

We need to figure out how to better integrate and collaborate between all health care providers if we are going to effectively lower the health care curve. Another component obviously is medical liability reform.

This bill does not allow us to move in that direction in clinical integration. It moves us in the opposite direction. If we're not going to allow people to do imaging studies in the ancillary facilities in their own offices and continue to work together for a more collaborative of integrated system, we're not going to lower costs. I think this stands in the line.

REP. SHAPIRO: So let me follow-up on that. I hurt my knee, I go to my orthopod's office and he reviews and says, you need an MRI. Now, there's two options at that point. He can either, if he has an imaging center attached or near his office or in his office, send me down the hallway and get the MRI on my knee; or he can do what you just said in your fragmenting example, give me a slip and call the number and you

go over and maybe wait a little bit and you get your knee examined.

Are you seeing an increase in the number of, say, MRIs ordered -- and I don't mean to pick on orthopods, pick whatever example you want -- as a result of having these facilities attached inside of -- associated with that medical practitioner's office? Because it seems to me that that's where you get the added cost.

It's a benefit to the patients to walk down the hallway. They don't particularly care, as long as their insurance is covered. But I would agree with the chairman's premise, if all of a sudden you go from, instead of ordering 10 MRIs a day to 25 MRIs a day, because now the center is down the hall and you want to make a few extra bucks. Can you talk a little bit about maybe some data points that address that concern?

PRESIDENT GOODYEAR: I think we're seeing better care because we're seeing more studies. The federal government has an institute for clinical effectiveness. I think it's going to look at opportunity for evaluating medical necessity when treatments and imaging studies are appropriate or when they are not appropriate to provide information to physicians to use as tools to provide the best service to patients under a given circumstance. And I think that medical necessity and transparency, rather than obstructing that, is the right way to

go.

Have I seen increased MRIs? I've seen increased MRIs because we're learning more about how the use of MRIs and other studies can improve patient care. But I will tell you that it's not only on an outpatient basis, it's on an inpatient basis as well.

Every child that goes into an emergency room now with a bump on his head, gets an MRI study, that's not an outpatient study, that's also being driven at the inpatient arena as well.

So, yeah, we're seeing more, but I don't think -- I honestly don't believe that it's based on unethical, self-serving financial interest of patients, but rather on quality patient care, number one, and -- I'm sorry I have to bring it up -- I think it's based on medical liability issues and defensive medicine issues as well. And I think that's a very, very significant component, if not, the very major component for the concern of over-utilization.

REP. SHAPIRO: Thank you, Mr. Chairman.

CHAIRMAN DeLUCA: Thank you. Rep. Day.

REP. DAY: Thank you, Mr. Chairman.

I wanted to start out by saying -- you covered, what I believe, are the issues here between doctors and patients. There are federal Stark laws. I think that's important to note. But most importantly, transparency is the way to address this issue. I believe, bring the light of day, some sunshine

on this issue -- Rep. Shapiro gave an example, go into your doctor.

My son broke his collarbone; we go in; we need to get an x-ray and he gets referred to another facility. I get a sheet of paper and I get to choose from this. Coincidentally, everybody on that list is part of that health network also. So it was a self-referral within that health network. I think that the important part of that process is possibly regulations or legislation that would require in that case right there at that point to sunshine, not only your options within the network or owned by that physician, but also the other options that are available there.

Do things like this as employers or referring to doctors, there is precedent and systems already set up, it's pretty easy to do this? So I really think that this point really comes down to transparency.

I want to support the chairman, though. Although, as I read through and listened to your testimony, I felt like I could have jumped over there and pretty much been saying that a lot of key themes, not exactly. So I take many of the positions that you've taken today. Although I find myself in that position, I also want to support our chairman and his effort to attack costs by inviting the industry in to talk about this and I think it's important.

The days of one side supporting this group and one side

against it, have to be over. They absolutely -- I don't want to just look at you. I want to just talk to everybody. I don't mean to be pointing it at you. But it's important to note that although I'm right in that chair with you on this testimony on this bill, I'm also with the chairman and what he's trying to accomplish as far as attacking costs. We have to do it. Whether the Democrats are in charge of this committee, whether the Republicans are in charge of this committee, we must all work together.

And what I would like to do first is go to the people in the industry. Typically, what happens many times is the industry does exactly what the chairman said and says, we'll try the status quo, we'll go to the opposite party and we'll try to get some problems created between the two and just part it out that way. We need to be better.

I'm asking you to please be apart of the process because when you're not, this is the type of legislation that comes out of it. I need your help in order to forward that. Our colleague from Chester -- although, I'm sorry about the exchange that happened here today -- raises an important point that I want to make note of also.

If we're very serious about containing costs, I believe we need to listen to the health care industry, as I just stated. And that also addresses the issue of mandates and those types of regulations. As time goes by, we need to

revisit a lot of these. They can bring to us -- Mr. Chairman, I'm just asking you as an inquiry -- their top five, top six issues. And I would really like to see this committee take a look at those.

Again, I thank you for your testimony today. I'm just going to make those statements and turn it back over to the chairman. Thank you, Mr. Chairman.

CHAIRMAN DeLUCA: Thank you, Rep. Day. Let me just say before we go to Rep. Killion, I apologize for my outbreak. Me and Rep. Schroder are friends. Sometimes we get a little hot, but I'm sure we certainly -- this is a bipartisan committee. We've done a lot of good things bipartisanly and I certainly apologize for my outbreak. So I just wanted to let you know that. That's not what usually happens. Rep. Killion.

REP. KILLION: Very briefly, just following up on the Chairman and Rep. Shapiro and Rep. Day. I would like to see if you could provide a committee with language on the -- what you think would work with transparency and also to make sure that things are medically necessary so we can all accomplish the goal of lowering costs. So if we could see some -- if you could help put some language together for us, maybe we won't need this house bill.

PRESIDENT GOODYEAR: We would welcome that opportunity. Thank you very much.

CHAIRMAN DeLUCA: Thank you. Rep. Frankel.

REP. FRANKEL: Thank you, Mr. Chairman, and thank you for your testimony this morning.

One of the areas that you touched on in my sense is that we haven't addressed and it is the issue of fragmentation, particularly with respect to the inability to electronically communicate much of the information, whether it's from imaging, methodology, whatever it is, just some replication.

I think we've all had the experiences. I have two elderly parents, I've got children in my own experiences. I'm not amazed with the amounts of duplication, whether it's getting blood work done, whether it's getting an x-ray or imaging that takes place, because there is just not any communication between hospitals, between physicians and so forth.

It seems to me that that's one area that we ought to be looking at. And what have you seen across this country and other places that we start to address that issue?

PRESIDENT GOODYEAR: Yes. The foundation for better communication and the system that needs to proceed affected, clinical collaboration and integration that ultimately will result in a lower health care cost and bending the health care curve is health information technology.

A lot of the duplication is because there is that lack of ability sometimes to communicate. Someone has a CT scan done yesterday, but ends up in a different facility tomorrow

night and they don't remember or they don't know or they're unaware of what they had done yesterday and there's no ability to communicate.

Health information technology will, in fact, be the platform for reduced fragmentation in my opinion; reduced fragmentation, better collaboration and better clinical integration.

At the same time, I think there needs to be a realignment and a shared vision between hospitals and physicians and all stakeholders. I think that that collaboration and communication will, in fact, be the most substantial benefit to lowering the health care curve going forward.

The problem is that, that's all going to take time. We need to do it right. Unfortunately, we can't do it fast. But we're doing it. There's people that are doing it. I think the right people are there and looking at that from our side, from the actual health care delivery industry side. The PA Medical Society is focusing on this issue of getting those kind of things on their way.

REP. FRANKEL: It's amazing to me because in other aspects of commerce across this country, we're doing those sorts of things and we haven't been able to get that kind of communication electronically. And the field of medicine is mind boggling in this day and age and is taking so long.

It just seems like there is almost some kind of conspiracy out there and that the folks that are making the computer systems that are utilized by medical practices and so forth are just not encouraging this sharing of information. We do it throughout the rest of our lives, personally, through business. But the field of medicine still hasn't been able to do it. And it's just incredible to me, the amount of duplication that results out of that failure.

So I'm encouraged that the Medical Society has focused on this, but I think that's clearly one of the areas to bring down, the cost of medicine today, and has got to be focussed. Thank you.

CHAIRMAN DeLUCA: Thank you. Rep. Quinn.

REP. QUINN: Thank you very much for being here today, Doctor. Thank you also for all that you do to try and communicate with us so that we can make the PA Medical Society a better climate for physician.

We're both from the Southeast where we wish we had more doctors coming in to practice. We still have decent access to care. What is your vision of this bill if it were signed into law tomorrow than in place in 60 days? What is the industry doing to mark our more rural areas where we don't have an access to facilities?

PRESIDENT GOODYEAR: I think that the ability to develop these type of systems would certainly be inhibited. I

think that an access -- a progressive access issue. The other thing -- and I think the question was raised by Rep. Killion -- about our ability to attract physicians to come and work in those rural areas.

I don't have a financial interest in any of these, but I know physicians who are looking for partners that if they weren't able to supplement their income with this type of program -- and, again, not because they're over-utilizing, but reimbursements are low in this -- would not be able to attract partners to go to these. I think it will be an -- have an adverse effect on access.

REP. QUINN: Thanks. And Rep. Shapiro mentioned that there is an underlined thought here that some physicians are making extra money in a way that's inappropriate. Now, many of us here recently have been alluded through the press that there are practices out there where we can be making money in a way that's inappropriate. And many of us, who are self-included, take great offense to the broad brush stroke look at the legislature. Is there a way -- we get printed in the papers if things are out of whack in the expenses -- that your industry can self-monitor, can say, hey, you're referring too much to yourself? How do you do that within your own policies?

PRESIDENT GOODYEAR: I think that the monitoring system is really about medical necessity. If patients go to a

physician and by necessity documented indications for tests, indications for procedures, is documented and it's necessary, that's the monitoring system that you really want to -- if physicians are profiting from a business venture, quite frankly, if they're not over-utilizing or inappropriately benefiting, I don't understand the problem with that. If we're providing safe, effective, necessary care to patients and that is allowing us physicians that have those financial interest to stay here in the Commonwealth. It's that little extra collar that permits them to stay here, is that a problem? If it's over-utilization, I would say it was a problem, I just don't see the evidence that there is. And nonmedical necessity, there's no evidence of that either. I'm not sure if that answers your question.

REP. QUINN: What I'm looking for is the mechanism by which we can take a scalpel approach into finding that physician if he or she is out doing this appropriately -- doing this in an appropriate way as opposed to just saying they don't.

PRESIDENT GOODYEAR: I suppose that's a discussion. I can't think of an answer to that right now. I think it's a discussion appropriate to have and we can certainly do that.

REP. QUINN: Thank you.

CHAIRMAN DeLUCA: Thank you. Any other questions?

Rep. Melio.

REP. MELIO: If a patient is in for a blood test, one requires fasting, one does not require fasting, they send you to two different facilities and it's put on a computer, and the computer doesn't always send that information back to the hospital that's supposed to get it. So what happens in a situation like that?

PRESIDENT GOODYEAR: Well, I think that if a physician sends certainly would be beneficial if a physicians could do it right in his own office because it would have the information right there, but if he's sending it out to an outside facility, and the information doesn't come back, then it's his obligation, at his own expense, administrative cost, to then search it out, call up the patient, what facility did you have it done and then call the facility, maybe they're open maybe they're not. Call them when they're open, get the information and faxed to me and do it all within the HIPAA requirements of confidentiality and privacy. These are the fragmentation of health care of which there are a million more than I could ever elucidate in this hearing that I think need to be addressed to lower health care costs.

REP. MELIO: But doesn't that drive up the cost of --

PRESIDENT GOODYEAR: It certainly does. It absolutely does drive up the cost.

REP. MELIO: Thank you, Mr. Chairman.

CHAIRMAN DeLUCA: Any other questions? I want to thank you very much for your testimony and I look forward to working with you.

PRESIDENT GOODYEAR: Thank you very much. I look forward to working with you also.

CHAIRMAN DeLUCA: Thank you.

The next individuals to testify would be Dr. David Levin, Professor and Chairman Emeritus of the Department of Radiology, Thomas Jefferson University Hospital and Jefferson Medical College. Welcome, Doctor. Dr. Richard Taxin, who is the President of the Southeast Radiology and Philadelphia Ray Society.

PROFESSOR AND CHAIRMAN EMERITUS LEVIN: Mr. Chairman and members, thank you very much. I appreciate the opportunity to testify in front of this committee today. My name is David Levin. I'm a retired radiologist. I was formally the chairman of the Department of Radiology at Thomas Jefferson University Hospital in Philadelphia.

Since I was in that position for 16 years, from '86 to '02, and since I have retired, I have done a lot of research and publishing on the matter of utilization patterns in imaging, including self-referral, the issue we're talking about this morning. I have spoken about this issue in 18 different states for various medical societies and I have also spoken to

MedPAC and CMS about self-referral problem.

My colleague sitting next to me is Dr. Richard Taxin, who is the past president of the PA Radiological Society and he is also the president of his large radiology group at the Crozer Chester Medical Center.

I'm speaking an behalf of the PA Radiological Society today. And our society supports efforts to limit the growth of high-tech imaging resulting from self-referral in the offices of non-radiologist physicians.

We appreciate your interest, Mr. Chairman, and the interest of the rest of the member of this committee in doing something about this problem. Today I have to testify in our position to House bill 2522, at least to some extent. I'll explain that in a few minutes.

Now, the title of this bill is "The Prohibition on Health Care Provider Self-Referral Act." And in its present form, this bill does not contain costs, as you eluded to correctly earlier, Mr. Chairman. This bill in its present form, again, does not contain the rising costs of specific high-tech imaging services like MRI, CT and PET scanning that are self-referred by a lot of physicians in their own private offices. The bill in its present form simply reaffirms the exceptions to the federal Stark laws. It does not specifically limit self-referral in high-tech imaging.

Now, when the Stark laws were first passed almost 20

years ago, the purpose was to prevent physicians from profiting by referring patients to facilities in which they, themselves, had an ownership interest. So it was trying to get at self-referral. The problem was that the bill contained a large loophole, which is called the in-office ancillary services exception. And the in-office ancillary services exception permitted self-referral if the referrals were made to equipment that located in the offices of those physicians. So in other words -- if I can paraphrase it -- what the bill said was, you, as a doctor, cannot refer a patient for imaging -- I'll use the imaging as an example because that's what I'm most concerned with -- the bill in essence says, you, as a doctor, cannot refer a patient for an imaging test to a facility down the block in which you have an ownership interest. But under the in-office ancillary services exception, it's okay if you self-refer that patient for an imaging test done on a piece of equipment located right in your office, that's the nub of the problem. That in-office ancillary services exception is the nub of the problem and this bill in its present form doesn't address that.

Now, the exception, when you think about it, you might ask the question, why did they do that? Why did they prohibit self-referral but then allow it to go on in a physician's office? And the answer to that is, 20 years ago when these bills were passed, the Stark laws, that exception actually made

some sense because in those days, doctors were not -- nobody was putting MRI or CT or PET scanners into their offices. It just wasn't being done.

In those days MRIs were still in its infancy and PET scanners weren't even available on the market. They couldn't be purchase. So none of this stuff was going on back in those days. 20 years ago, the only equipment that doctors were putting in their offices were x-ray machines -- plain x-ray machines, and to some extent, ultrasound machines as well.

Now, having an x-ray machine in your office in those days -- and it still does -- made some sense because they used those x-ray machines to perform services that were ancillary to the visit by the patient to the office that day. So let me give you an example, and Dr. Goodyear, I think, eluded to one of these examples.

A woman falls down, twists her ankle; she has pain and swelling and tenderness, so she comes to her doctor's office. And the question is, is this a sprain or is this a fracture? And that question can be very quickly answered by doing an x-ray or to use another example. A patient comes into his doctor's office with some shortness of breath and a fever and a cough. And the question is, is this pneumonia or is this not pneumonia? And here, again, you can answer that question very quickly with a plain x-ray.

In those days, having an x-ray machine in a doctor's

office, even though that doctor was not a radiologist, actually made some sense. The problem is that, in the 20 years since these Stark laws were passed, that exception has been subverted. The intent of that exception has been subverted. And now you have doctors putting high-tech imaging equipment into their offices, MRI machines, CT scanners and PET scanners. And those are the three areas that the PA Radiological Society is very concerned with.

We feel that physicians should not be able to self-refer for an MRI, CT or PET scanners that are in their offices. These scanners, if they are state of the art, they are very expensive. They can cost anywhere from $1.2 to $1.8 million. And once a doctor puts into his office, he's literally forced to heavily utilize that equipment. I mean, he's got a huge investment to pay off, he's got costs of operating the equipment. So he feels constant pressure to utilize that equipment as much as he possible can, and that leads to over-utilization, a lot of unnecessary utilization.

In all honesty, I can't look into the hearts and minds of these doctors and determine whether they're using this equipment to make money or whether they're using it because they truly, sincerely believe that it's in the best interest of their patients. But what I can tell you is that there has been an abundance of evidence published in the medical literature showing that self-referral invariably leads to higher

utilization of imaging. And I would like to show you a few slides to demonstrate that.

Now, this was a study that was published in 1992 in the journal of the American Medical Association. And what they did here -- and I'll try not to go into too much detail -- but what they did here was that the investigators looked at a series of common clinical conditions, they used a large database of a commercial insurance carrier. They looked at a series of clinical presentations, which you see here, chest pain, congestive heart failure, you can see the others here, URI means upper respiratory infection and UTI refers to a urinary tract infection.

They looked at the utilization of imaging among two groups of physicians. One had their own x-ray equipment in their offices and self-referred and the other group referred to either hospital radiology facilities or to radiology offices. They calculated the ratios of the use of imaging comparing them to self-referring doctors to those doctors who refer to radiologists, and these are the ratios. You can see that they go to a low of 1.7 to a high of 7.7. That means that the self-referring doctors were utilizing imaging between 1.7 and 7.7 times as frequently as those who referred to either hospital facilities or to radiology offices.

Now, these statistics are mind boggling if you think about it. So the statement that was made before, that

self-referral doesn't lead to over-utilization, that is not true. I would absolutely deny that or argue that point.

Now, there was another study that was done at the same time. This study was not done by physicians, it was actually done by the United States General Accounting Office, which is now called the Government Accountability Office. The GAO is certainly an unbiased party in something like this.

There, again, the title of this report, which was presented to the congress in 1994 was referrals to physician-owned imaging facilities weren't HCFA's scrutiny. And there, again, without going into too much detail, what they did was, they also calculated ratios of use of imaging. They didn't use episodes of care, they used the actual different kinds of imaging equipment. And here were the ratios that they came up.

They found that the self-referring physicians used imaging between a low of 1.95 times, that's for CT, and 5.13 times for ultrasound as often as physicians who referred to hospitals or to radiology offices. So there, again, in this GAO study, it was shown very clearly and definitively that self-referring physicians use imaging a lot more frequently than those refer to hospitals or radiologists.

Now, this is a study that my colleagues and I at Jefferson did a couple of years ago. Here we looked at the use of, what are called, Nuclear Myocardial Perfusion scans. These

are the heart scans that are very commonly done both by radiologists and by cardiologists. So it's a good laboratory model to look at because its' a high-cost, high-tech procedure.

On the vertical axis here it shows that in the Medicare population, the number of exams per thousand Medicare beneficiaries. Back in 1998, which you see here in this column there, there are about equal numbers of studies done by radiologists and cardiologists. The cardiologists have the opportunity to self-refer. And, again, Mr. Chairman, you and Rep. Shapiro eluded to this, you go where your doctor tells you to go. If your doctor says, I have a scanner down the hall in my office and I suggest you go there, you're going to do that because you respect and trust your doctor.

Beginning in 1998, cardiologists began acquiring these nuclear scanners and putting them in their offices and you can see what happened to utilization. Here's the utilization among radiologists practicing in hospitals or in their own offices and here's the utilization curve among cardiologists who are able self-refer. And you can see among the cardiologists self-referral lead to a sky rocketing in utilization.

Now, here is an article -- and I've asked that you all read the text -- this was an article that appeared on the front page of The Washington Post last July, July of '09. The title of the article -- the headline of the article is "Doctors Reap Benefits By Doing Own Tests." And here's what the article

says: In August of '05, doctors at Urological Associates, a medical practice on the Iowa-Illinois border, ordered nine CT scans for patients covered by Wellmark Blue Cross and Blue Shield insurance. In September of that year -- that is the next month -- they ordered eight. So in other words, this urinology practice, a large practice, were ordering about eight or nine CT scans a months on patients insured by Wellmark.

But then the numbers rose deeply. The urologists ordered 35 scans in October, 41 in November and 55 in December. Now, think about those numbers. It's a huge difference. It goes on to say that within seven months, they were ordering scans at a rate that had climbed more than 700 percent.

The article goes on to say that the increase came in the months after the urologists bought their own CT scanner, according to documents obtained by The Washington Post. Instead of referring patients to radiologists, the doctors started conducting their own imaging and drawing insurance reimbursements for each of those patients.

Now, if there ever was a demonstration of what self-referral can lead to, this is an example of it. Again, this is a story by The Washington Post of last year. Now, if you're wondering how many CT scans are done in this country by non-radiologist physicians who have these units in their own offices, here are some numbers. You can see the curve. By the way, this was just in Medicare population. Starting 2001, you

can see that there has been a rapid escalation of the number of CT scans done on units that are owned by non-radiologist physicians in their offices.

So by 2008, Medicare was over one million scans. And bear in mind that the owners of these CT scanners were never trained. They are not radiologists. They were never trained in how to properly operate a CT scanner.

Now, Medicare is only about one-third of the total utilization of imaging and other services in this country. So if you want to estimate how much this is going on nationwide among all payers and all patients, you can multiply this by three. So roughly three million -- in 2008, roughly three million CT scans were done by physicians in their offices who were never trained as radiologists and never received training and how to properly operate those units.

Here are the same numbers for MRI scans. Again, Medicare, starting in 2000, going to about 100,000, all the way up to about a half a million. Multiply that by three. In the offices of non-radiologist physicians, now, you have over a million and a half MRIs being done on a self-referral basis.

MedPAC, the Medicare Payment Advisory Commission, made a report to the congress exactly a year ago. This was the cover of that report. The cover of that report was, "Improving Incentives in the Medicare Program." And one of the chapters in that report -- it was several hundred pages long. I have a

copy of it here if anybody wants to see it. One of the chapters was titled, "Impact of Physician Self-Referral on Use of Imaging Services Within an Episode." And what they did was, they studied 493 episodes of care, they categorized into about 22 different categories, depending on the clinical condition and the type of imaging study that was used to investigate the problem.

So they studied all of these episodes of care and they compared the use of imaging among doctors who are self-referred, on the one hand, but those who are instead referred to radiologists or radiology facilities. Well, not surprisingly, they found some of the same things that I've been telling you about. They showed that in all 22 categories of clinical episodes, there was higher imaging use with self-referral. And those patients who were being taken care of by self-referring doctors, used imaging -- I'm sorry, were up to 2.3 times as likely to receive at least one imaging study during the episode of care.

They also found that the episode with self-referring physicians have anywhere between 5 and 104 percent higher imaging spending than those where there was no self-referral involved. They gave one example. And the example was that 14 percent of all migraine episodes -- one of these episodes that I mentioned before was migraine headaches -- they found that 14 percent of all migraine episodes that involved self-referring

physicians, involved the patient getting an MRI scan, whereas only eight percent of those patients got scans when there was no self-referral involved. And, again, you can see what self-referral does.

Now, this is getting a little bit off the subject, to something that I'm going to talk about a little bit later. This is a quality audit that was conducted in the state of Utah about ten years ago. And what they did this was -- this was done by one of the major health care insurance carriers in the state of Utah -- they did a quality audit of all imaging facilities in that state and they graded them, basically, as to whether they met the quality standards or failed quality standards.

These are the number of sites in Utah that were actually inspected and these were the failure rates. And you can see that the filature rates were very high for the non-radiology facilities. You can just see the numbers here, 48 percent, 45 percent. And I'm going down the list here. We're trying to get to the Ob-gyns who were using ultrasound equipment in their offices. There was a seven percent failure rate. Among radiologists, the failure rate was only one percent.

I don't show these numbers to try to denigrate other physicians. It's just that physicians who are not radiologist are never trained in how to properly use imaging equipment.

And so the result is going to be quality failures, like you see here, and it's unavoidable. Again, I just say this not to try and denigrate or insult my non-radiology colleagues, but the fact of the matter is, if you're not trained to do something, you're not going to be able to do it right.

So that will be the end of the slide presentation. And I want to emphasize that I just showed you a few slides. There are many, many other studies that have been published in the medical literature, again, showing the same thing, self-referral inevitably leads to over-utilization.

Now, the proponents of self-referral in imaging will tell you that we do it because it's a convenience to the patient. The patient comes in to see me today, I decide the patient needs an MRI or CT scan, I can send the patient right down the hall to my MRI scanner in my office here.

So it's a convenience factor. That statement is basically untrue. That's a myth. And I'll tell you exactly why that is. The reason is because most of these high-tech scans require precertification or preauthorization by the patient's insurance company. And preauthorization or precertification takes time. It doesn't happen instantaneously. It can take you a matter of hours or even a couple of days before the precertification comes through from the insurance company and therefore the patient can't get the study done the same day anyway. That's one reason why it's a

myth.

Number two, it isn't likely that the scanner in that doctor's office is just going to be sitting there empty. More than likely, they have scheduled other patients and the scanner is already full. So the patient is not going to be able to fit into the schedule that same day anyway.

Number three, large specialty groups typically have multiple offices. And it's likely that if they have one of these high-tech scanners, the scanner is only going to be located at one office. So patients who are being seen at all of the other offices are going to have to go somewhere else and they also will not be able to get the scanners done the same day. So the convenience factor again is a myth.

I want to also say a few words about ambulatory surgery centers, which we've had some discussions about before, earlier this morning. There's been some concern express that if the in-office ancillary services exception was tightened up, the surgeons would no longer be able to own and perform surgery in ambulatory surgery centers.

The viewpoint of the PA Radiological Society is, we have no quarrel with the idea of surgeons being able to do surgery in ambulatory surgery centers, which they own. The reason that we feel that that's appropriate is because when they do that -- when a surgeon does surgery in an ambulatory surgery center that he owns, he is practicing within the scope

of his practice. He is doing what he was trained to do. And that, to me, is perfectly legitimate.

A doctor should be able to do what he has been properly trained to do in almost any setting that he wants to do it in. I have no quarrel with that. But what I think is not appropriate is if a doctor goes outside the scope of his practice and starts to do something that he's never been trained to do, like run an MRI scan or a CT scan or a PET scan. Doctors who are not a radiologists don't get any training in how to operate those machines.

Radiologists all train for fives years and that's what they learn. But non-radiologist physicians in any other field that you talk about don't get trained on how to run MRIs or CTs or PET scanners.

That sort of leads me into one or two last issues, one of them being the quality and safety issue. Now, I'm a radiologist. You for sure would not want me to do brain surgery on a member of your family and you wouldn't want me to deliver daughter's baby. I'm sure that you wouldn't want that to happen. So why would you want a non-radiologist physician who never trained to use an MRI scanner or a CT scanner or a PET scanner to be able to go ahead and use it in his offices? I think if you think about it, you realize that that shouldn't be allowed to take place.

These machines are very complexed. Any physician who

is supervising the operation of an MRI, CT or PET scanner needs to know the physics behind it; needs to know the technology behind it; needs to know what imaging sequences need to be done to properly make the diagnosis; needs to be able to supervise the technologist performing that scan; needs to know when the scan is appropriate or whether perhaps another imaging study would be more appropriate. There are all sorts of things that the supervising physician needs to know that they don't learn unless they have trained as a radiologist. So that is a real issue.

Now, one final point that I would like to make and then I'll finish, and that is, I believe that most physicians in PA should support the position that I'm espousing here today. Most physicians, including most members of the PA Medical Society, should agree that doctors who are not radiologists should not be allowed to do MRIs or CTs or PET scans in their offices. The reason that I say that is because most doctors in PA don't own these scanners. The vast majority of the PA Medical Society don't own MRIs or CTs or PET scanners in their offices, it's a small minority that do.

So if the -- if you think about it, payment for physician services is a zero-sum game. If costs go up in one area, then reimbursements are going to go down in another area. So if the small minority of physicians in PA who own these scanners, over-utilize and drive up the costs of imaging, then,

inevitably, the payments for other services that the majority of physicians provide, like evaluation and management services and surgery and things like that, inevitably, their services are going to go down.

So my belief is that the vast majority of physicians in PA should also agree with the physician that self-referral for MRI, CT and PET scanning by non-radiologists should not be allowed in the state of PA.

In conclusion, the PA Radiological Society opposes to some extent -- and I guess we should really say that we like the spirit of the law, but some of the wording of it, we don't think that's the bill. We are opposed to it in its present form because it affirms the in-office ancillary services exception of the Stark laws, which allow physicians to self-refer for these high-tech scans in their own offices.

We believe that the bill should be amended to exclude MRI, CT and PET scans from the protection that is often by the in-office ancillary services exception.

So, again, Mr. Chairman, thank you very much for the opportunity to testify. And I'll ask Dr. Taxin, who may have some additional remarks.

PRESIDENT TAXIN: I just wanted to introduce myself again. I'm Richard Taxin. I've been involved at the local level. I'm currently president of the Philadelphia Roentgen Ray Society. I'm a past president of the PA

Radiological Society. And, currently, I'm a member of the Council Steering Committee and vice chairman of the manage care division of the American College of Radiology. So I have knowledge on the local, state and national level.

Dr. Levin, here to my left, is being very modest. He is considered by one and all to be the world's leading expert on self-referral from the work that he has done. And he has won -- been awarded the gold medal of the American College of Radiology on the basis of his endeavors, trying to help contain costs, seeing that the right examination is done at the right time, at the right place and to care about the safety of the patients.

Dr. Levin and I were totalling up this morning -- and we're sorry to say -- almost 90 years of involvement together in diagnostic radiology. We've been around the block. He, on the academic side, me, on the private practice side. I've been in practice since 1974 in Delaware County. I've been president and chairman of our 26-radiology-member practice since 1993. And what I care about is quality of radiology, quality of diagnostic imaging and the safety of the patients.

We have embarked on campaigns for the safety of pediatric patients throughout the country and in the state of PA, talking about the Image Gently campaign, in which we've very successful with seeing those radiation for children has been reduced.

As part of the American College of Radiology, we are embarking on a new campaign called the Image Wisely campaign. And with that, we are trying to reduce the dose to all patients throughout the country for all imaging procedures, especially on Ct.

As part of the PA Radiological Society, Dr. Levin and myself have in deep and engaged in this process, as you, Mr. Chairman, know. And trying to be of help and value of this committee so we can come out with a bill that the PA Radiology Society and the members of this committee can be proud of.

Your goals, as I understand it are for cost containment and for the safety of the patient. These are noble goals and we are here to try to help you in this respect. However, I think this bill can be improved in certain ways.

The American College of Radiology is the foremost accrediting body of imaging centers and imaging throughout the United States. For example, once accreditation began for mammography services was necessitated by the law, approximately 25 percent of mammography centers were knocked out because they were not up to the quality. One of the things that you can do is see that accreditation comes in across the board for imaging centers. That would immediately enhance the quality and get rid of those who shouldn't be in practice.

We are advocating now, what's called computer-based ordering systems, so the physicians know the right study to

order. They don't necessarily always know whether it's better to do a CT or an MRI when somebody has a headache, for example. So we can go ahead and we can try to assist and emphasize that practise throughout. But what we can really do here today is ban self-referral for the high imaging studies of CT, MR and PET -- the high-cost imaging studies that these represent.

Unfortunately, I don't believe that's what -- this may be your intention in this bill, but I don't think that's what the bill says. And I think that it can be improved by including language that makes an exception to the exceptions in the Stark law. When Congressman Stark put through these laws, what physicians put in their office were $20,000, $30,000 x-ray machines to help assist them in diagnosing pneumonia or fractures and things like that. They never dreamed that people would be putting one and two and three million dollar machines in what they consider their "office". And that's where the problem has come in and that's where Dr. Levin has demonstrated the vast increase in the Medicare population, which, as you know, is a low reimbursing payer.

This doesn't even begin to explore what's happening on the private side of reimbursements, and it's an ethical problem. In fact, The New York Times had in their "Ask the Ethicist" column about two months ago about physicians self-referring to themselves in their office. And the conclusion by the ethicist was that this represents a virtually

impossible conflict of interest for physicians.

When you have a debt of one or two million dollars, it puts that physician in a difficult position as to how to refer the patient for the proper study. It creates a tremendous conflict of interest on a physician's part and I think it's unnecessary. And you can go a long way to help out in this respect, that you have your own ethics laws in this August body.

So what we are recommending is that this bill be improved so you can put in simple language. And I believe it's part D under exceptions, so that, in some way, CT, MR, PET and can be excluded from this exception because that's where the costs lie as it's presently constituted. I'm really afraid that you're not containing any costs at all and I think that's really your goal.

CHAIRMAN DeLUCA: Thank you very much. I thought it was very informative. You certainly shed a lot of light on self-referrals. Let me just ask one of the questions that Rep. Killion asked before, do you see -- if we would initiate what you are saying, that it would keep physicians out of PA?

PRESIDENT TAXIN: Not in the slightest.

PROFESSOR AND CHAIRMAN EMERITUS LEVIN: I want to agree with that. By the way, I want to apologize. I noticed that before there were about 15 or 18 members of the commission. I must have bored them to death.

CHAIRMAN DeLUCA: I wish they were here to hear your testimony. The members really have other commitments. So I apologize on their behalf because there are other meetings going on. And it's not because that they -- sometimes they are on three or four committees and it's not that they just don't want to stay, it's just that they have other committee assignments.

PROFESSOR AND CHAIRMAN EMERITUS LEVIN: Thank you for making me feel better.

CHAIRMAN DeLUCA: No, I apologize. That happens a lot at meetings because of conflicts and that there.

I would like to say that this bill is not cast in stone. I would like to get you, if you would be willing to participate in a meeting along with a few representatives from the other side on this committee, the democrats and republicans, with the medical profession and the ambulatory center there and sit down and let's draft the best piece of legislation we can on self-referrals that not only reduces cost, but also benefits the patient's quality. I would hope that you would be willing to do that.

PROFESSOR AND CHAIRMAN EMERITUS LEVIN: Absolutely.

CHAIRMAN DeLUCA: Rep. Killion.

REP. KILLION: Real quick. First off, good to see, Richard. He's a constituent of mine, so I thought it

would be nice to say hi to him. Thank you for your testimony and we look forward to working with you.

Just a follow-up on the Chairman's question, when you said that -- in your testimony, you said that there's a small number of offices that actually have these equipments. That's why you think the PA Medical Society would probably not be opposed to it. When you said it --

PRESIDENT TAXIN: Excuse me. We didn't say the PA Medical Society, we said physicians.

REP. KILLION: Okay. Going back to the surgery centers. Your comments about physicians recruitment and retention on your amendment that you would like to see, is that also -- are you saying that you don't see the part of the bill that affects surgery centers or, in fact, recruitment and retention?

PRESIDENT TAXIN: No, I disagree with that. I think it would affect recruitment with surgeons. The problem in the state of PA is -- as I see it and I suspect you would agree with me -- the low reimbursements, and it's as simple as that.

A good friend of mine, the past president of the PA Radiological Society, moved from PA to Virginia. And he informed me that his lowest payment -- his lowest reimbursement in Virginia is higher than his highest reimbursement in PA.

REP. KILLION: Thank you. I just wanted to clear

up that point. Thank you.

PRESIDENT TAXIN: That's really the issue. But for ambulatory care, we have nothing to say against that.

PROFESSOR AND CHAIRMAN EMERITUS LEVIN: If I heard your question correctly -- I think you were asking if we restricted imaging self-referral, like we were talking about, would that deter physicians from coming to practice in PA. I don't think so because, as I said before, I think it's only a relatively small minority of physicians who own this high-tech equipment.

But if you remember the curves that I showed, it's a rapidly growing phenomenon, that's the problem. And I think, what I would hope you would do, is nip that in the bud. I think that's what you're trying to accomplish or what you would like to accomplish.

CHAIRMAN DeLUCA: Rep. Day.

REP. DAY: Thank you, Mr. Chairman. Thank you for your testimony today, I really appreciate it. You make very compelling arguments.

You offered an outstanding example of an existing practice, having a ratio, becoming an owner and the ratio changing. That's outstanding. I was actually trying to get out in the web a little bit and look at that practice and try to gather more information on that. I would be a little more interested in further facts -- and you might know them already

-- whether they were expanding at that time, just continue to close the door on that example, but I wanted to make sure that they weren't expanding. I see that they have three medical centers, kidney stone centers, a neurology practice or whatever.

But I just want to commend you. I was sitting here saying, we're getting an existing physician in their ratio and have a new one and then right as I was thinking it, you were presented it, so I appreciate that.

We have a highly specialized medical profession. How would you address the issue of whether a radiologist should be trained in reading all imagines as opposed to a specialized physician become trained -- in that case they're a neurologist -- in reading imagines of that section of the body, whether they are focused on their training in specialties?

PROFESSOR AND CHAIRMAN EMERITUS LEVIN: We have an opportunity here --

PRESIDENT TAXIN: I think I can answer that. In actual fact, most of these physicians where they make the money on the self-referral would not be called on the professional side, the interpretation side. Most of the higher radiologists or paid radiologists did that interpretation. The profits are on the technical side, not on the professional side.

So, in fact, it's very rare to find practices where the official readings are done by the referring specialty. Usually

they would hire a radiologist to do that.

REP. DAY: Thank you very much. And one other question, would you find -- if we had medical service areas where people who provide these services could list -- I'm a provider of this service -- on that medical, whatever that medical authority would be, the state or someone else, and we are in this medical service providing area and we list that -- we end up with, in larger areas there might be seven different providers of that.

If we would require that when you get to that point and you're referring and there's a sheet of paper that's given, would everybody list themselves as within a 50-mile radius up to eight of the closest providers? Do you understand where I'm going with this?

If that would be our regulation, just sunshine it and say here are the choices. The doctor could still say, I think you ought to go here. So we could still have self-referral, but it's mandated that they get to see everywhere else. So that person can decide, I live way over here, this one is half way in between, I'm going to that one because it's better for me. Would that alleviate the self-referral issue enough?

PROFESSOR AND CHAIRMAN EMERITUS LEVIN: I don't think so. And Chairman DeLuca eluded to this himself a little while ago. Patients tend to trust their doctors. They respect them, they trust them. And if you go to your doctor and you

complain about some pain in your neck or something like that and he says, you know, I think we need to get an MRI of your cervical spine. By the way, we have an MRI scanner right here in the office and you can just get the test done tomorrow. The likelihood is, you'll follow your doctor's advice because you don't want to challenge your doctor.

You don't want your doctor to say to himself, gee, this patient is challenging my honesty, my integrity and so forth. So the likelihood is, you'll just go and follow his advice, which is to go to his own scanner.

So I don't think that that idea of publishing a list of providers in the area, I don't think that's going to solve the problem.

PRESIDENT TAXIN: There is an old study that says -- when they did a survey of the population at large, if you want to make your own decision regarding your own medical care, 95 percent said yes. And then they did a survey of patients who have been recently diagnosed with cancer and they said, do you want to do your own medical decision-making or do you want your doctor to do it? 95 percent said that they want their doctor to do it.

REP. DAY: Thank you, Mr. Chairman.

CHAIRMAN DeLUCA: Thank you, Rep. We look forward to working with you. I will be putting a committee together to use your expertise and Rep. Day will do it bipartisanly.

And let me rest assure to this audience and to that TV out there, that I intend to move a self-referral bill and I want everybody to the table. And if they think the status quo is just going to continue, then they are going to have to put their votes up or down. But we want to come up with the best bill that will reduce cost and benefit -- we're not trying to hurt any profession, we're just trying to get something done that is quality care and reduces costs.

I wish the rest of the committee could have seen your presentation here because it certainly would have opened there eyes up to what we're talking about. So I look forward to working with you. And we will be a bipartisan committee.

PRESIDENT TAXIN: Thank you.

PROFESSOR AND CHAIRMAN EMERITUS LEVIN: Thank you.

CHAIRMAN DeLUCA: The next individual to testify would be Richard Lieberman. Dr. Lieberman is the urologist at the Urologist Specialists at Lehigh Valley. Welcome, Doctor.

UROLOGIST LIEBERMAN: Thank you. I think it's interesting listening to all the points of view and I think that there was nobody, not one speaker here today, that didn't excellent point. You have, I think, a very tough job to come up with something that fits our patients and the practice of medicine for Pennsylvanians. It's not easy to do.

CHAIRMAN DeLUCA: That's why we're asking your opinion and your expertise.

UROLOGIST LIEBERMAN: Chairman DeLuca and Members of the House Insurance Committee, than you for the opportunity to present testimony on the issue of physician self-referral and specifically House Bills 2521 and 2522.

My name is Dr. Richard Lieberman and I am a private practice urologist with Urology Specialists of the Lehigh Valley in Allentown, PA. In addition, I am a member of the Urologists for Patient Access to Care, otherwise known as UPAC, a group of Urology Group Practices who formed to ensure patient access is preserved through all legislative decisions in PA. I have personally practiced urology in the Lehigh Valley for 25 years -- most of which was a solid practitioner -- and currently serve as the Associate Chief of Urology at the Lehigh Valley Hospital as well as Co-Chairman of the Urologic Cancer Disease Management Committee at the Morgan Cancer Center at that same institution. I am also a Clinical Associate Professor of Surgery at Penn State Milton S. Hershey College of Medicine.

I am speaking today on behalf of UPAC to share our concerns about the preservation of all patients to access care that is beneficial for their needs. Patients in America have the ability to select a health care provider and decide which course of action they wish to take after a visit with that provider of their choice. It is true that this selection can often be limited by one's ability to afford the provider of

choice or be guided, often with selection, by an insurer, but basically, we all have the option to select a provider and make decisions about our own health and well-being.

With the said, it is vital that we protect the patient's right to make those choices and decisions. The bond of trust between patient and physicians is considered sacred as patients depend on the ability to select the providers, the location and the treatment option best suited for their specific cases. We offer hope, guidance, and comfort to our patients in a comprehensive fashion, a complete fashion, and a fashion with continuity of care as they receive care. We hold ourselves to the highest standards not only academically, but on an interpersonal level, making patients feel comfortable with our counsel before, during and after the delivery of services. Patient feedback is extremely favorable; satisfied, secure patients are more likely to access and complete appropriate treatment. Outcomes are therefore maximized.

The member physicians of UPAC are focused on serving our patients, offering preventive care as well as treatment for illness in an accessible, compassionate and professional manner. It is our hope and vision to preserve the patient's ability to connect with their care, their treatment and the providers that represent the best fit for that patient. We hope that any legislation affecting physicians issues, including self-referral, would take the patients' concerns into

account and ensure that the decisions being made are the best for those we all are serving.

It is understandable that government regulation is needed over businesses and the practice of medicine to some degree. Often times, like with any profession, there are a few bad apples that ruin the bunch and we appreciate the need to control and standardize some of the practices tat take place. It becomes concerning, however, if the government begins to practice medicine or interfere with a medical professional's judgement regarding the treatment of his or her patient inside of their own medical office.

Currently, physicians are regulated by federal Stark self-referral laws. These laws balance the need to defer to physicians judgement in establishing proper treatment while preserving patient choice and access to care against the concern that there are physicians who would put financial self-interest above the interests of the patient. In the medical field, the Stark laws are taken very seriously and govern much of our conduct. Concerns of over-prescribing or self-referring for purposeful over-utilization is a matter governed by the Stark laws at the federal level and applies to all Medicare beneficiaries. As something physicians already comply with, language which restates that this requirement is unnecessary, but not harmful to the current practice of medicine.

House Bill 2522, as I understand, expands language relating to self-referral and that is an expansion upon the federal Stark laws to include all payors at the state level. In making this change within state law, the patients' access to care is not harmed and the physicians can expand their current required practice for patients receiving Medicare benefits to all patients they serve. House Bill 2521 requires additional disclosure to patients, insurers or third-party payors to list additional information on billings in certain circumstances.

UPAC believes that the current requirements in relation to self-referral are sufficient and strongly address those within our profession who over-prescribing or self-refer for purposeful over-utilization. The requirements within these bills would not infringe upon a patient's right to select their provider and receive their treatments. It would not infringe upon a doctor's oath to deliver the highest quality of medical care. It is for the reasons previously stated that should there be a need to pursue additional governance to ensure patients and their rights are protected, UPAC believes that House Bill 2521 and 2522 would be a good place to begin.

Again, I would like to thank the House Insurance Committee for this opportunity to speak before you today and share my support to ensure patients have proper access to care. I would certainly be happy to answer any questions the Committee may have.

CHAIRMAN DeLUCA: Thank you, Doctor. And rest assure that anything we do up here will have the patients -- person in mind, regardless of any special interest group. The patient will be number one.

You've seen the statistics on that screen over there. Would you have any comments on them?

UROLOGIST LIEBERMAN: I think they're disturbing. I think that if one is going to embark upon multiple services within the umbrella of one's own practice, I believe -- and I certainly I practice this way and my colleagues do -- that these things need to be measured, these things need to be monitored. I'm not so sure that they need to be informally outlawed. I think it's a question of anything else that we do in medicine. I think you have to be trained to do testing, I think you have to be trained to read testing.

I'll give you a perfect example, and I was listening to Dr. Levin closely and Dr. Taxin as well. And I think that in our practice -- after 21 years of solo practice in the state of PA -- and to be quite frank with you, being very busy and very active in terms of numbers of patients and surgery and in-hospital and private practice concerns, I have to tell you that I found it quite difficult to keep that solo practice going. That attitude was shared by my other urologic colleagues in the Lehigh Valley and in other parts of the state and we came together and merged and formed a larger group.

This has been done in medicine for many, many years.

Some of these groups ultimately evolved into multispecialty groups. For instance, the Summit Medical Group in Summit, New Jersey has basically all specialties of medicine and kind of operates out an outpatient hospital almost in terms of radiology service, methodologic services, urologic services, orthopedic services, surgery centers. So we came together primarily so that we could continue to use the type of care, the good care, that we have been giving years prior. We are all university trained. I trained in the Philadelphia Medical School system and residency systems and I'm very proud of that.

We also work very closely with our hospital colleagues. There is nothing that we do, there is not one service that we provide that we prohibit our patients from going elsewhere to pertain. We have a CAT scanner, yet, we have put strong restrictions on the use of that CAT scanner. We do not do intravenous contrast studies. We do studies that allow us to improve the patient access to care, primarily kidney stone studies. When a patient comes into our office and has a kidney stone, no doubt that stone needs to be imaged.

Years past, we sent most of those patients to a variety of inpatient, outpatient units in the Lehigh Valley. Some private, some privately owned by radiologists only, which we had excellent relationships and continue to do. We still send our patients there. However, we have a CAT scanner in house

and we use it for that limited approach. We do not send patients downstairs to our CAT scanner for very complicated studies and we do have the oversight of radiologists involved. Interesting enough, and I really don't like antidotal information, but I think that the more people that look at these studies, the better.

I, myself -- I guess I don't think as myself as a cancer survivor, but I am. Approximately four years ago, admitted to the hospital, had a GI bleed, was kind of not feeling so hot for a couple of days and went through a multitude of tests, including CAT scanning. Doctors came by, everything was fine, they said you're much better, go home.

About three or four years later, I was sitting going over CAT scans that I had order for my own patients, which, incidentally, I personally review. And I looked at my CAT scan, which was supposedly normal, and I saw something on a kidney and I'm a kidney specialist. And I said, gee whiz, that's something that I need to look. I didn't think it was anything bad, but it gave me some concern.

A year later, I said to one of my associates, I need a CAT scan. He got the CAT scan, incidentally at the hospital as well, not in my own office. And the CAT scan showed something that was a little bit larger, which incidentally led me to have surgery, which turned out to confirm the fact that it was a kidney concern. I'm fine now and hopefully I'll be fine

forever, but it's an example of, in my mind, collegiality. I'm not angry at anyone for not mentioning anything, but I think that it proves to me that not only should I look at the reading that the radiologist gives me, which I do all of the time and read every word they say. And our radiologists are excellent in the Lehigh Valley. I think they are fist class. But I also check the studies. And we all miss things and we all make mistakes, because, let's face it, these studies, these higher-tech studies, have a multitude of diagnoses, a multitude of problems that can be notice that really don't necessarily relate to what we're looking at. So I rely on my radiologic counterparts to look over studies that are done.

Now, is there a money issue or reimbursement issue, sure there is. Where does the money go? Where does the reimbursement go? Does it go in one physician's pocket? Does it go into a hospital's pocket? I'm not really here to answer what is appropriate other than the fact that I think that proper conduct for a patient's benefit is the proper answer.

Now, I would again go back to Dr. Levin's slide and say, I don't like that. I think that that should be looked at. I do not think that we should practice over-utilization. And I would say that I would be very interested in my own practice to compare my rates of ordering, let's say, CAT scans or even kidney stones, before we have a CAT scanner in the office versus my rate of ordering that afterwards.

There are other radiologic items or tools that we use that are part of urology, ultrasound of the prostate. I could not possibly evaluate the numbers of patients that I need to evaluate for prostate cancer if I relied upon the availability of the ultrasound units in our hospitals in Allentown and I'm not just talking about the hospital that I primarily work in. In order to do a proper ultrasound of the prostate, I need to make sure that the patient, the doctor and the radiologist all converge at one time. That's an immense difficult situation.

So I went out and got the proper training and our younger partners have the proper training in their residencies, which, incidentally, are at institutions where radiology and urology go hand-in-hand. We had a meeting at Temple University Hospital every Monday afternoon for three hours. Every single Monday afternoon for my entire residency, there were radiologists from three or four hospitals there at all times in addition to radiologists. When he made a mistake reading an x-ray, they didn't come down on the resident just from his own specialty, but also from the radiologist.

So I think that those are a given take and they're there are overlaps in different specialties. I do certain surgeries that pediatric or general surgeons do. We both do them very well and that is overlap and that's been since day one of medicine. So, again, I think that who does the study is not as important as how they do the study. I think that we

should be monitored for utilization.

Let's face it, medicine is higher-tech now than it was before. And some things that I say to patients -- I don't slap a patient on the back and say, gee, you'll be fine, don't worry about it. As a specialist in particular -- but I feel that any doctor feels this way -- I feel that I owe that patient not just my hunch, but my hunch proven and my hunch -- and proof being, looking at what was the situation before I intervened and what is the situation after I intervened. And sometimes that requires -- a lot of time requires high-tech medicine.

We need to use that. It's there because it provides us with better medicine now than we ever did. If I didn't have a CAT scan, we wouldn't know that I had kidney cancer and I would be sitting here talking to you right now because of that. And if I was allergic to intravenous contrast or what the common man calls die, which I was taught to never use that word -- if we didn't have those tests, then why would be getting an MRI, which is a lot more money than a CAT scan?

There are reasons for ordering these things. And we are all taught and all evolved out rhythms of care. Yes, they are different from person to person, but if you step back and look at the broad view, they really are consistent. That's why a doctor can move from PA to Virginia for better reimbursement because he can walk right in and practice the same brand of medicine anywhere in the United States. I'm all for that.

So, again, I'm not necessarily in favor of every move that I make being checked off by someone in government who is not an informed medical person. But I am in favor of oversight and I am against over-utilization. And I think we have to look at that very closely. But broad brushes, we need to use them one in a while, but we don't have to use them in every situation.

CHAIRMAN DeLUCA: And, Doctor, just one more. You made a good point. You said that you went for training out there. Is that requirement to own a high-tech imaging or any other high-tech equipment in an office? Did you have to go for training or could you just higher somebody in your office?

UROLOGIST LIEBERMAN: We have technicians who are trained and certified by their --

CHAIRMAN DeLUCA: But you personally went and had training, so you wouldn't have to do that, right?

UROLOGIST LIEBERMAN: No, sir. I don't operate a CAT scanner. We have a CAT scanner in our office --

CHAIRMAN DeLUCA: I mean you went to train to read it and that there.

UROLOGIST LIEBERMAN: It's part of urologic training to read CAT scans. As a matter of fact, part of my board certification, the second part of the boards, was a separate dedicated practical examination on radiology. We were responsible to be able to read MRI, CAT scan, plain radiographs

and a variety other x-ray studies that are interval to urologists.

As a matter of fact, there are a number of studies that we perform, that I will personally go to the radiology suite in the hospital and help the technician perform that procedure. Only after those films -- those radiology films are imagined and going to our computerized pack system, as we call it, do we get a radiologist reading. In some cases, I'm already walking out with the answer. In the operating room -- and this is just an educated guess -- probably 30 or 40 percent of the operating room procedures that a urologist does involve some radiographic, some radiology procedure in the operating room. I don't have a radiologist there.

In years past, all of those films would then be sent over to the radiologist and they would generate a reading. Usually, we would get that reading a day or two later just by virtue of their volume. We stopped doing that. We use fluoroscopy now, which does not put films into the system for those specific studies simply because of financial issues, that once we did a study and acted on it and then waited for a reading to come from our radiology colleagues, the patient would not be impacted at that point and an entire separate bill would have been generated by radiology.

Now, please, I feel free to walk over to radiology or call a radiologist on the phone or talk to our radiologists who

deal with our office all of the time. They are my colleagues, I depend on them and certainly, I have missed things that they have picked up. That is what medicine is all about, a team approach.

CHAIRMAN DeLUCA: Thank you very much, Doctor. Any questions? Rep. Day.

REP. DAY: Thank you, Mr. Chairman. And I thank you for coming to testify and providing your testimony. Is it correct that your practice is associated with the Lehigh Valley Health Network?

UROLOGIST LIEBERMAN: We are not financially associated. Our 13 physicians, 12 of whom are partners, one employee essentially, who are all on staff at the Lehigh Valley Hospital. Many of the current staff are at St. Luke's Hospital as well, Sacred Heart Hospital, myself, all three. I'm not employed by Lehigh Valley Hospital.

Everything that I do for Lehigh Valley Hospital is pro bono. I use their facilities, I operate there, I see emergency room patients, I deal with the internal and medical, political climate at Lehigh Valley. That's how we relate to that. We are not employed by Lehigh Valley, though.

REP. DAY: In the case that we're talking about a referral, a urology practice uses these imaging procedures, like you said, we find things that 20 years ago, we might not have been about to diagnose as quickly, just integral parts of

your practice; is that correct?

UROLOGIST LIEBERMAN: Well, absolutely. I think, in regardless who owns a CAT scanner, there is a large body of information in the literature that talks about incidentalomas. And what an incidentaloma is something that's found on a CAT scan or some other study that you didn't expect to find and that's what happened.

The literature strongly, strongly supports that the curates for these things that are found preemptively is much, much higher. If I have a patient that comes into my office that says, gee, Doc, for the last year I've had a couple of episodes of having blood in my urine. I say, gee, you need a CAT scan. And I order a CAT scan and incidentally, that CAT scan doesn't get down in my office, it goes to the hospital, because that's where in my estimation should be done. And if that patient is down to have a kidney tumor, his chance of cure in a long-term survival -- which is really more of the medical term -- is much, much higher.

If he never had blood in his urine and we got the CAT scan for another reason and we found a tumor that way, once that blood in the urine shows up, his chance of survival goes down. It doesn't go down to zero, but it does go down significantly. Just by virtue of our high-tech nature or high-tech society, yes, we're saving lives.

We can argue issues of prostate cancer, whether we

should treat it, what age we should stop treating it, whether we should be aggressive, whether we should be conservative. You can interview Canadians, who don't do very much and that's their approach and there's an economic basis to that; and you can interview urologists, who want to be very aggressive; and you can interview radiation oncologists, who want to pick kind of other ways of treating these things. They all work, but it's that piece of judgment, that best fit that I eluded to that in my presentation, that really, really makes the difference. And I hate to use this.

I took a couple of -- I would like to call CEO courses, you know, MBA type courses for the doctor. And they kind of made fun of the word quality. They said, oh, you guys talk about quality care. Everybody gets quality care. Well, that's not really true and I think that particularly some of these facts that we've talked, we talk about quality.

Quality and trust is really one-on-one or one-on-two type of situation. When I talk to my patients, I'm not responsible for what the other neurologist said, I'm responsible for what I say. And I think most doctors will say that to you. And I think most doctors are prepared that way.

REP. DAY: I appreciate your answer. Thank you, Mr. Chairman for your time.

CHAIRMAN DeLUCA: Thank you, Doctor. We look forward to working with you.

UROLOGIST LIEBERMAN: Thank you.

CHAIRMAN DeLUCA: The next individual to testify is Dr. Chiadis. He's an Anatomic and Clinical Pathologist with the Valley Pathology Association.

ANATOMIC & CLINICAL PATHOLOGIST CHIADIS: Thank you, Chairman DeLuca, and thank you, members of the committee, for the opportunity to testify here. My name is James Chiadis. I'm the pathologist in the Lehigh Valley.

Our group covers two private hospitals, a private physician owned hospital, two small public hospitals, a number of anoscopy centers, ambulatory surgery centers and one physician owned lab and an anatomical pathology lab.

I'm not here to discuss House Bill 2522. I haven't read it and our society has not dissected it or has no comment on it. I'm only here to discuss House Bill 2521. And this addresses a practice -- which occurs to some extent in PA, I'm not sure exactly how much -- whereby, a physician will take a biopsy or collect a cytology specimen, such as a Pap smear, and send that specimen to a laboratory that they don't own or have no association with, they have no private interest in it. Typically, that laboratory would bill that insurance company for the service and be reimbursed in that manner.

The practice that this addresses -- that this bill addresses is when the laboratory instead is asked by the physician to bill them, typically at a discount rate and then

the physician will in turn bill the insurance company at the higher marked-up rate and get the full reimbursement. At the present time, it is now required for this to be disclosed to the patient in PA. This particular bill would require that the physician would disclose which laboratory did the test and what the cost was for that test.

If this bill were to be enacted, it would be in compliance with the AMA code of ethics. In addition, our society feels that this would be transparent and results in disclosure for the patient enhance patient care because it would give the patient an opportunity to either object or comment on that issue.

This is a practice which is legislated in at least 14 other states. There are a number of other states who go just beyond this -- beyond just the disclosure law. But at least 14 states have a disclosure law. And we have looked at the legislation and the PA Association of Pathologists endorses it and that's why I'm here.

That's the end of my comment. If there's any questions, I'll take them.

CHAIRMAN DeLUCA: Short and sweet, right?

ANATOMIC & CLINICAL PATHOLOGIST CHIADIS: Right. Saved the shortest for last.

CHAIRMAN DeLUCA: Thank you. I want to thank all of the individuals who sat through the testimony here today

their time to come here. I just want to remind, the Committee will make a floor of the House, that there will be a committee meeting -- a board committee meeting at the of call and it'll be here in the Ryan Building 205. And one of the bills that will be considered is House Bill 2105. Again, thank you and I want to thank everyone for attending. This meeting is adjourned.

(The hearing concluded at 11:51 a.m.)

I hereby certify that the proceedings and evidence are contained fully and accurately in the notes taken by me on the within proceedings and that this is a correct transcript of the same.

Kelsey J. Dugo
Notary Public