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# EDITED TRANSCRIPT

HMA - Health Management Associates, Inc. to Discuss Impending 60 Minutes Segment Conference Call

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**OVERVIEW:**

HMA discussed about impending 60 Minutes segment.



## CORPORATE PARTICIPANTS

**John Merriwether** *Health Management Associates Inc - VP of Financial Relations*

**Alan Levine** *Health Management Associates Inc - SVP, Florida Group President*

**Eric Waller** *Health Management Associates Inc - SVP and Chief Marketing Officer*

## PRESENTATION

### Operator

Good morning. My name is Rob, and I will be your conference operator today. At this time, I would like to welcome everyone to the Health Management comments on impending 60 Minutes segment conference call. All lines have been placed on mute to prevent any background noise.

(Operator Instructions)

Thank you. Mr. John Merriwether, you may begin your conference.

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**John Merriwether** - *Health Management Associates Inc - VP of Financial Relations*

Thank you, Rob. Good morning everyone. We apologize for the technical difficulties and getting the call started a little late. I think we have everything ready to go. I'd like to welcome you to Health Management's conference call. We anticipate this call to be brief.

As you may recall, in July, we first called your attention to a local newspaper report on our Pennsylvania market saying that 60 Minutes was interviewing emergency physicians who formerly worked at some of our hospitals. At the time, we noted that a producer for 60 Minutes was soliciting contact from physicians through the American Academy of Emergency Medicines website. Yesterday, at approximately 5.30 PM Eastern Time, we received notification from the executive editor CBS's 60 Minutes that they intended to broadcast a story related to Health Management on Sunday, December 2.

Given that 60 Minutes has not released any indication on its website of the airing the story, we continue to have no certainty about the exact contents of the story, although we have been able to gather certain information about the themes of the story, based on our interactions with 60 Minutes. That said, we wanted to share some details with you about the operation of the Company's emergency departments. We appreciate everyone rearranging their schedule to be with us on such short notice.

Before we get started with the call, I'd like to read our disclosure statement. Statements made in this presentation are based on current estimates of future events and the Company has no obligation to update or correct these estimates. Listeners are cautioned that any such forward-looking statements are not guarantees of future performance and involve risks and uncertainties that our actual results may differ materially as a result of these various factors. Additional disclosure statements accompany the data charts that have been provided for the call this morning at 8.50 AM Eastern time.

Presenting with me on the call today are Alan Levine, Senior Vice President and Florida Group President, and Eric Waller, Senior Vice President and Chief Marketing Officer. Now, let me introduce Alan Levine. Prior to assuming his role with Health Management, Alan was Secretary of Health for both Florida and Louisiana. In those capacities, led efforts to fight Medicaid fraud. For the past few months, we've attempted to cooperate with 60 Minutes to provide information and answer their questions. Further, Health Management provided an on camera interview with Alan on October 8, 2012.

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**Alan Levine** - *Health Management Associates Inc - SVP, Florida Group President*

Thank you, John. Good morning.



First, I'd like to reiterate what John said in that at this point, we do not know for certain what specifically will be in the story, other than what we can surmise from the questions I was asked during my interview with 60 Minutes. That having been said, we do want to take some time this morning to share with you what we do know, and to discuss our emergency room operation.

At Health Management, it is our commitment to remain focused, first and foremost, on doing what is right for our patients. If we do this, and we do, we believe our hospitals and our company will thrive, as we have. This strategy is proving results, as evidenced by the fact of the joint commission named 41 of our then 65 hospitals as top performers in the United States for 2011, which is a rate four times the national norm. It is a recognition earned by only 18% of hospitals nationally.

Fortune magazine named Health Management one of the worlds most admired companies in health care, including ranking us number one in social responsibility, and number one in quality of product and service. Company wide, our hospitals compiled a score above 98 out of 100 for adherence to core measures, process of care measures that are tracked by the centers for Medicare and Medicaid services. Our scores are among the leading scorers in the industry. These results happen because we do measure what we do. We are focused on providing the best processes of care for our patients and the results do show.

We expect our physicians, more than 10,000 affiliated and contracted physicians throughout the United States, to consistently provide high-quality care for our patients by adhering to evidence-based practices in the exercising of their outstanding medical skills. Patients are admitted from emergency departments only, only by primary care doctors, hospitalists, or specialists exercising their independent medical judgment, and working in consultation with our ER doctors. Simply put, administrators cannot and do not admit patients.

In providing the highest quality care possible for our patients, we also strive every day to operate with the highest ethical standards and in compliance with the heavy, heavy regulatory requirements of our Business. We have a comprehensive compliance program that seeks to assure that the laws are clearly understood and followed. When any employee, doctor, patient, member of the community or anyone raises complaints or concerns about our Company or about our hospitals, we endeavor to fully investigate the concern and rectify any issues that are uncovered.

As I said, 60 Minutes' questions to me focused on admissions through our emergency rooms in the general time period of late 2008 through 2011. An analysis of our admissions data by a third-party expert shows that during that time period, the admissions rates through Health Management's emergency rooms remain consistent and completely in line with industry norms. We have seen no evidence of upward trends, spikes or jumps that can be attributed to anything going on in the emergency department. Given the hard data, we remain uncertain about what to expect from the 60 Minutes story.

Just to repeat, emergency room admissions data across our hospitals reflects no significant change, and are in line with industry norms. We will discuss the admission data points with you in a moment, and provide background on the analytics firm that conducted this review for us.

Based on the questions asked of me during my interview with 60 minutes, let me discuss some of the areas I expect that they may cover in their report. While I hope the story is an accurate reflection of the challenges faced by our industry covering topics like, number one, over utilization of observation status classification for patients who should be classified as inpatients. And two, the pressures created on our hospitals by the recovery audit contractor process. I understand that such topics do not make for sensational news. In fact, we could spend days discussing the policy nuances of hospital operation and how these policies are impacting hospitals throughout the United States.

Given that, I would relay to you that I did my best to educate 60 Minutes about the topics they raised. The reality is, as the American Hospital Association has clearly articulated in their lawsuit against CMS, and in the public comments issued by the American Hospital Association, and as the center for Medicare advocacy has stated in their class-action suit against CMS on behalf of senior citizens, Medicare beneficiaries are being severely impacted and hospitals struggle with how to manage these patients between observation and inpatient status under threat of serious financial consequences or even inappropriate allegations related to admission.

Again, I refer you to the AHA lawsuit for specific examples. I'd also refer you to the study recently conducted by Brown University, which is perhaps one of the best examples of how this shift is occurring. One of the hospitals cited, incidentally, in the American Hospital lawsuit is a neighboring hospital to Carlisle Regional and is not affiliated with Health Management.



All told, I was asked extensive questions about whether Health Management has excessive admissions from our emergency departments. We do not. Further, we provided 60 Minutes with hard data from the government to support it. I was also asked about hospital testing protocols. We follow recommendations made by the American College of Emergency Physicians related to triage-based testing. Our hospital medical staff's determine what testing is done, and we measure our process of care results everyday to make sure we see patients timely, provide an accurate diagnosis, and get care provided appropriately.

Since we take these matters so seriously, we have been conducting an extensive review and internal investigation since we first became aware of certain allegations, including those raised, we think, being raised by 60 minutes. We have retained some of the top experts in the United States to examine our practices, guide our internal investigation, and evaluate our data. We looked at the data on our admissions from both the ER and the number of tests ordered for emergency patients, both at the hospital and company levels. Health Management's review shows there is no basis for an allegation that admissions through our emergency departments increased or are not in line with the industry standards.

This morning we have posted the results of the relevant data analysis on our website and we would encourage you to review it. You can access this data by visiting the Company website at [hma.com](http://hma.com), where you will see a button entitled ER admissions data. This button also resides on the Investor Relations page.

While we do not know for sure, 60 Minutes did inquire about several former Health Management employees, including some with pending litigations against our Company. As always, we will not comment about pending litigation and those matters will be handled appropriately, not in the media but in the courts. Also, we sincerely hope that 60 Minutes has the journalistic integrity to thoroughly investigate any claims or statements to assure that inaccurate allegations are not aired inappropriately by CBS.

Once again, what our experts have determined was that the admissions data simply does not support any allegation that Health Management's emergency rooms were operated inappropriately. Our performance on these metrics is in line with national averages, and our individual hospitals are in line with local competitors. Eric Waller will have more to say about our data and other research in just a few minutes.

Our industry faces serious concerns related to our regulatory environment. We have discussed many of these topics in detail with 60 Minutes, and we hope they will address subjects like the proper classification of patients, including the lawsuit filed against CMS by the American Hospital Association and a class action filed against CMS by the Center for Medicare Advocacy. These very lawsuits evidence that hospitals throughout the nation and Medicare beneficiaries are faced with serious challenges related to the issue of observation and inpatient. Frankly, we don't understand how any story that discusses admission processes in the ER can be a fair story unless it also appropriately tells the story that the industry is facing with the proper management of patients in the ER related to inpatient and observation status.

These are the last three-points I want to emphasize. Number one, our focus has been and is now always on our patients. As long as we continue to do the right thing for our patients, which means providing the highest quality health care that we can, success will follow.

Number two, we are proud of the work our almost 45,000 employees and 10,000 affiliated staffed physicians do everyday to ensure the safety and well-being of our patients. Third, it is our goal to not only meet, but exceed regulatory requirements by doing the right thing and providing the best care possible for patients.

The joint commission is the agency that accredits hospitals on behalf of the Federal Government, and the federal governments own accreditation not agency has highlighted our hospitals as one of the top performing in the United States. The bottom line is if we do misstep, we are fully committed to remedying any errors and improving our processes to make sure it does not happen again. That's what you would expect from any responsible company.

True to our mission to enable America's best local healthcare. Our work often is what ensures our communities have a local hospital at all so patients can get the care they need close to home. Fulfilling that mission is the basis of all of our success clinically, operational, and financially. Now I will turn it back to John.



**John Merriwether** - *Health Management Associates Inc - VP of Financial Relations*

Thanks, Alan. I would now like to introduce Eric.

As you may recall, Eric have a presentation at our 2011 Investor Day on the analytics capabilities that we are developing. Our leading edge use of the massive amounts of data we collect at our 70 hospitals helps us recognize patterns in our Company's patient data to predict the clinical needs of our communities, potential for readmission rates, demand for services and staffing needs. Eric has led this and many other important initiatives for the Company since he joined us in 2009. He will now take us through the research the Company conducted, including the data that undercuts the assertions that we believe 60 Minutes plans to report on.

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**Eric Waller** - *Health Management Associates Inc - SVP and Chief Marketing Officer*

I will keep this brief. First of all, thank you all for coming. As Alan has communicated, we take this very, very seriously. What we did is we undertook an analytic, unemotional, unbiased effort to try to get at is there anything in the data that would indicate any of the allegations may be true. The conclusion here is we find no validity to any of these potential allegations in the data, that anything is outside of industry norms.

We hired a firm called Opera Solutions. Opera is actually headquartered here in New York. Opera was recently selected by CMS to provide advanced analytical services to their exchanges to actually look for fraud in the exchanges once they are developed. They are very, very reputable firm. We provided Opera our data and said, look at it. We looked at it on a national level, we looked at it on a local level, we looked at it by DRGs and some of the stated peppered approaches. We looked at it even down to the physician level, doing some very advanced analytic techniques.

The conclusion is that our ER rates, and then I walk you through four very brief slides or five slides, that summarize what I am saying. Our ER rates tracked the national ones. If you look at it over the period in question, we did the paired T-squared test, we find no significant difference between the national averages and us.

If you look at our hospitals and you normalize for service lines, different age, different parts of the country, we have an older population in Florida, we find they are is not statistically different than the averages. It is not there. If you look at samples -- statistics from sample hospitals, we find at local level, that we are in line with local averages, local state averages.

John, if John would walk through the slides here, they are hard to read. The first slide is probably the most telling. Our ER admission rate was 13.3% in the start of the period in '08, and we actually, in July, at 11, coincidentally at the exact same. The ups and downs in the chart are winter, flu, it's up in the winter, down in the summer. You guys are the industry experts so this is very familiar. The bottom line, is it has been flat over the period.

If you look at the Medicare rates, the Medicare rates actually decreased if you look at our internal data from 36.4% to 34.4%. Very flat decline. Again, these are in line with the national norms. No statistical significance.

We looked at it sort of by hospital system, and calculated our one-day stay rates. We availed ourselves so the med par data, the HCUP's data, as well as our internal data. Most of the data sources we would have access to. I know many of you have run these analyses yourself. We have seen them in reports. If you look at it by system, it is about -- our one day stay rate is about 10%, and the red bar on the chart up there, it is difficult to read, we are in the middle to the back of the pack. Matter of fact, we have the lowest as of the first couple of months through 2011.

Then we will shift gears for a second here, I will give you a macro level view. Since Carlisle came up in our recent -- a couple days before our last earnings call, there was a report in the Carlisle Sentinel that specifically mentioned Carlisle, and I know one of you, Boyd Witt, mentioned Carlisle this morning in your reports. We mentioned it on our July call as well. I want to give you a little bit of insight into Carlisle for that reason.

If you look at Carlisle's inpatient admission rate by year, it is actually below the national average. We use the other urban averages. There is the urban, other urban and rural. We fall squarely 87% of our hospital, 85% of our hospitals overall are in the other urban category. And all of the hospitals in Pennsylvania are in the other urban category. We are below the national average and we are at or below the Pennsylvania average. There is nothing there.



If you looked at the one-day stay rates in Carlisle, Pennsylvania compared to the national average and the Pennsylvania other urban average as well, we are below those averages. We did not see anything in Carlisle, Pennsylvania, that would indicate anything out of the norm.

With that, we have done exhaustive analysis. We even went to a physician level. I do not have the slide to speak to it, we looked at the number of combinations, emergency room physicians do not admit patients. They must consult with your primary care physician. They must call a specialist, a cardiologist or one of the attendings to admit. They have to partner, as they should, with other folks in the care, making the final admission determination.

We looked at representative hospitals and found 5,000 combinations of the multiple ER docs in the ER with multiple physicians, the primary care docs and others. 5,000 different combinations, so potentially 350,000 just in simple math combinations. It would be very, very difficult. There are a lot of people involved here. We went down to the physician level. I only bring that out to illustrate the level of effort we have gone to, through Opera, to look for anomalies in the data.

With that, I'll turn it back over to John.

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**John Merriwether** - Health Management Associates Inc - VP of Financial Relations

Thanks, Eric. I think Alan wanted to add a little something here before we conclude.

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**Alan Levine** - Health Management Associates Inc - SVP, Florida Group President

Eric did a great job laying out the slides. I want to add one thing. He mentioned HCUP's, which is the healthcare cost utilization project data. We -- Opera used the HCUP's data in the national emergency data set for looking at our data, primarily because that is the most nationally credible data that is available. It is claims data, it is tens of millions of claims. It is the real data.

There are multiple sources of data you can go to. Most of those other sources are voluntary surveys and other sources of the data. We went to the actual data source that researchers use, that CMS uses, and that the ARC uses. The HCUP's data is ARC data. We went to the government for the government source of the data, which is what is used throughout the industry and by analysts and by experts in analyzing trends in the industry.

That is why we chose that data set. That is why we chose Opera. Opera is a very well regarded nationally. As Eric mentioned, they were selected by CMS to do see CMS's own fraud and abuse detection. We went to the best sources in the industry to do our analysis.

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**John Merriwether** - Health Management Associates Inc - VP of Financial Relations

Thanks, Alan. To follow that up, we believe the data are very clear. They provide no basis to support allegations of emergency room admissions. Our confidence that these allegations would not be supported by the data, even before the analysis by the independent third-party, stems in part from our confidence in our very robust and comprehensive compliance program at Health Management.

Every Health Management associate receives compliance training upon being hired and at least annually thereafter. Including the annual review and signing of Health Management's code of business ethics -- code of business conduct and ethics. This commitment to our compliance program also extends to our vendors and physicians. We actively encourage our associates to report any questionable activities which might not be in compliance with our code of business conduct and ethics so that we may investigate and resolve the concern. See for yourself, I encourage you to review our code of business conduct and ethics, which can also be found on our website at [www.hma.com](http://www.hma.com).

In a moment, we will be happy to take some questions from those here in attendance and answer them as best we can given that we have not seen the story from 60 Minutes. After the story airs, we will discuss whether additional comment or information is necessary. That will conclude our formal remarks. We will take just a couple of seconds here and we will open it up to some questions. Just a few to keep it brief here in the room.



## QUESTIONS AND ANSWERS

**Unidentified Audience Member** -- *Analyst*

Thanks. Can you just talk about whether or not you employed the doc in the ER or -- and especially the ones who are doing (inaudible) or do you outsource the (inaudible) first? And then second, can you discuss sort of who is involved in the decision to admit a patient into (inaudible)?

**Alan Levine** - *Health Management Associates Inc - SVP, Florida Group President*

Thank you. First, two-part question. The first part is -- are physicians that are in the emergency department employed by us or are they outsourced? The second part of the question is -- what is the process for an admission?

To answer the first question, we do not employ emergency room physicians. They are independent providers, normally under contract. I should also mention, any contract physician is required to comply with our compliance policies as well. But the decision to hire or fire a physician in the emergency room is actually made by the independent group, not by us. We have no direct authority to employ or deal with independent physicians. That is handled through, A, their private group, or B, through the medical staff procedures that are deployed in the hospital through the medical staff processes.

The second part of the question, the decision to admit a patient is a very complex medical decision that is made by, and using the independent medical judgment of a physician. Those are the Medicare guidelines, and we follow those guidelines. It has become more complicated because of the interference in that decision by for-profit, RAC auditors who are paid a contingency fee to come in and substitute their judgment for the judgment of a medical physician who actually examined that patient and made the decision about what was best for that patient. That is the essence of the lawsuit that is going on right now between the AHA and the federal government.

What happens, an ER physician -- an ER patient comes into the hospital. They are evaluated by a triage nurse. The triage nurse takes all their symptoms. Our systems are deployed to do the proper testing, so that when the physician sees the patient, they have all the information they need to do a proper assessment of the patient. Remember, in the ER, timing is everything. If somebody comes in with a chest pain, somebody comes in with a neurological issue, you want to make sure that you diagnose as quickly as possible, so you can get treatment as quickly as possible.

The ER physician, if, in their judgment, they need additional testing, they order additional testing. We encourage the ER physician -- we presume most patients have a physician of their own. Many don't. We encourage the ER physician to contact the patient's private physician because these ER physicians, in most cases, have never seen that patient before. We want them to have as much medical history on that patient as they can.

That private physician consults with the emergency room physician, and the private physician makes the decision whether or not to admit that patient. Sometimes that private physician can be a specialist, for instance, it could be a cardiologist, it could be whatever doctor is on call for that patient's particular type of symptoms. Once the decision is made to admit, then all of those -- by the doctor, then all of the systems are deployed to get the patient as quickly as possible up to a patient room.

Now, here is what also happens. When a patient is admitted to observation status, remember, observation, if you read Medicare's own guidelines, observation is intended to be a 24-hour period or less where the doctor can do additional testing and make their own decision about whether or not to admit the patient. Observation has never been intended to be a substitute for inpatient admission. What you have seen in the Brown University study from 2007 to 2009 is that not only have observations exploded, but the number of observations that have stayed two days or longer has also doubled.

What happens is, you have patients that could be put in observation status; those patients are sent to a floor just like an inpatient is. They are treated the exact same as an inpatient. They get testing, they get the same nursing care, they get the same everything. At the end of the day, the patient often doesn't even know whether they are in observation or in inpatient until they get discharged.



If they are on observation status, they get a bill because it is paid for by Medicare Part B, they have to pay a huge copayment, where they wouldn't have to pay that copayment had they been admitted. And more importantly, clinically, if a patient is put in an observation status that needed to be an inpatient, if that patient needs any post-acute rehab or nursing care, Medicare will not cover it, and the patient will often be asked to pay up to \$10,000 or more out of their pocket in order to access those services.

Here is what happens if they can't afford it. The patient ends up coming back to the ER because they could not get the post-acute services they needed. This is the continuum-of-care issue that I raised earlier, and it is the essence of the AHA lawsuit that has been filed. But the process for admitting is a physician in the ER consulting a private physician, and the private physician ultimately making the decision whether to admit that patient or not.

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**Unidentified Audience Member** - - *Analyst*

Thanks. I think earlier you mentioned that there was some adjustment for (inaudible). I'm curious what those adjustments are in the data that you used. Did you just look at the raw data (inaudible) 60 Minutes is not hiring anyone (inaudible). On an unadjusted basis, is there a difference in any of findings (inaudible)?

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**Alan Levine** - *Health Management Associates Inc - SVP, Florida Group President*

I'm going to repeat the question. The question is -- in Eric's remarks earlier related to the differences in each of the markets and how the data may be different in each markets and adjustments. Let me be clear, the only adjustments to the data are actually labeled in the slide, at the bottom of the slide. And what they are adjusted for is we wanted to make sure -- I don't have the slides in front of me, but at the bottom of the slides it references the patients that left without being seen, patients that were transferred to other hospitals, those patients were removed. There was no adjustment made related to different hospitals. The data is absolutely clean.

What Eric was referencing was that each hospital is going to have different admission percentages based on the dynamics in that market. For instance, a rural hospital is going to have a lower admission percentage. We have hospitals that are rural that have a 5% or 6% admissions percentage, whereas a high-volume, high-intensity, sophisticated hospital with all the sub-specialties is probably going to be upwards of -- well, I don't want to guess, but some could be as high as 20% to 30% depending on the type of market. What Eric was referencing is variations by market, and not in terms of adjustments to the data. Any data adjustment is at the bottom of the slide.

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**Unidentified Audience Member** - - *Analyst*

Two questions. Actually one relates to Carlisle specifically. I wonder if you can comment as to whether you made any significant changes in regards to staffing at Carlisle emergency room, and how you think that might have played into this particular story perhaps?

And then, secondly, stepping back and thinking about HMA's data on a consolidated basis, and what you've been reporting, clearly inpatient admissions have been under a significant pressure, and we have seen that trend (inaudible). Your numbers have been, certainly, a little bit worse. And presumably, there is a little bit of relationship to [staff] your rate of growth observation as it relates (inaudible). I would love to get your thoughts on whether you think there's been a specific corporate policy that has had an impact on that trend, whether you think there are more about the internal forces that you mentioned in terms of RACs and that. Would like to get your thoughts on how you think your trends are playing out in relation to the industry (inaudible).

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**Alan Levine** - *Health Management Associates Inc - SVP, Florida Group President*

Yes. Let me repeat. There is two parts to the question. First part was, Carlisle, related to staffing, and have we made changes to staffing at Carlisle. I will come back to that in a minute.



The second part is, and correct me if I misstate your question -- the trends in the industry related to observation and inpatient, and what are we seeing? Is that a correct summary?

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**Unidentified Audience Member** -- *Analyst*

Yes, (inaudible).

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**Alan Levine** - *Health Management Associates Inc - SVP, Florida Group President*

Okay. Let me answer the second one first. In terms of trends in the industry and HMA's metrics -- Health Management's metrics, I can't comment on anything going on currently in the quarter, obviously that will occur through our proper reporting mechanisms.

What I can say is what you have seen is similar to the rest of the industry. In fact, we are seeing, in terms of observations, we are seeing the same trends. We are seeing growth in observations that are over two days. We are seeing -- which is troublesome to us because of the impact on seniors, set aside all of the business metrics here. This is having a disgraceful impact on senior citizens.

When you have a senior citizen with a broken spine that sits in observation for five days and can't get into post-acute rehab, that is a story that ran in an AARP Magazine. It didn't happen in one of our hospitals, but this is what's going on out there, and it is very harmful to seniors. That is really, fundamentally, ethically why we think this needs to be addressed.

But as to the trends, we are seeing the same trends as the rest of the industry. Admissions pressure is the same as what we are seeing in the industry. And Gary Newsome, on one of our previous calls, alluded to one of the challenges you see in our numbers is, truly, if you see the economic variations that are going on with joblessness, in the larger markets where people go for jobs, number one, you see migration towards markets where people go for jobs. And those larger markets are typically not our markets. We are in the secondary and smaller markets primarily. And then those markets are also, typically, the first to come back. And so, we think our metrics will follow; it's what you have been seeing in our quarterly reports.

As to the first question about Carlisle, I'm glad you raised it. I'm going to take a little liberty here; I'm glad Carlisle is coming up. Number one, to be clear, last year, Carlisle was one of the hospitals that was ranked by the joint commission as one of the top-performing hospitals in the United States of America. Based on the process-of-care measures, which are not subjective, they are objective measures. We are very proud of what our staff and our doctors in Carlisle are doing. From 2009 to 2011, Carlisle's staff recruited more than 40 new doctors into that community. They added several new programs there, including a major cancer program. We have seen very good success at Carlisle.

Now, let me tell you what happened to us about one year ago, August a year ago. Because of some of the success we have had with recruitment of physicians and attracting people to that hospital, we saw a sudden growth in our emergency room visits. And our staffing was not prepared for that. That all plays out with the state of Pennsylvania citing us, and all of that. Those issues were addressed. In fact, they were addressed even before the state cited us.

One of the reasons, I should mention, 60 Minutes kept asking me about why we track admission percentages. Any hospital CEO will tell you, one of the biggest challenges you have is staffing. You have to be reactive to your volumes. If you do not have good predictability in your admissions numbers, you are going to have a staffing catastrophe. You are going to either be under-staffed, which is very bad for patients, or you will be over-staffed, which is very bad financially. We track our admission percentages on a daily basis, so that we can project our staffing. That is primarily why we do it. In addition to making sure we're making the right clinical decisions for our patients.

At Carlisle, we got surprised about one year ago with our staffing shortage in the ER. It was addressed. Since then -- in fact, I've got to tell you, today in the newspaper, in one of the two Carlisle newspapers, there is a letter to the editor from a patient who was discharged about a week or so ago and said -- I've been reading all this stuff about Carlisle, I don't know what all you people are talking about, it was the best care I've ever had in a hospital. This was a letter to the editor that was in the paper today. We are pretty darn proud of what's going on at Carlisle, and we're proud of our employees there.



**Unidentified Audience Member** - - *Analyst*

Thanks, Eric and Alan for all the details. I'm just curious, you've had a bit, or a lot of time to work on this and respond and help us try to understand (inaudible). What level of interaction or engagement have with policy makers or regulators to help inform them of this (inaudible)?

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**Alan Levine** - *Health Management Associates Inc - SVP, Florida Group President*

Great question. The question is -- what interaction have we had with regulators and other policy makers? We have a -- personally, I have spoken with acting Administrator Tavenner to give her a heads-up about the story. We gave her a heads-up about a month or so ago, after I was interviewed. We have met extensively with staff on Capitol Hill to brief them on it.

One of the things that has continued to come up as we've talked to staff on Capitol Hill is, as soon as I talk about this issue, as soon as I mention observation and inpatient, everyone understands the issue. They understand this is a major challenge and it is a subject of major litigation now. We are -- all of our colleagues in the industry, I talk to them all the time, our competitors and other colleagues alike. We are all facing the same challenge. What are we supposed to do?

Here is the bottom line example. If you admit a patient -- if you don't admit a patient, and you place them in observation and they stay in observation for three days, and they receive all these services, and then they get a bill or they can't get post-acute services, we hear about it from the patient, their family, or maybe even their lawyers. We hear from the patient. And we are blamed for it. The hospital is blamed for it. If we admit the patient, or if we advocate for admitting the patient, then we are accused of improperly admitting patients.

Our bottom line is this -- irrespective of all of these other issues that are out there, the guidance that I personally give our doctors and our hospitals is -- do the best for your patients. Do what you think is medically appropriate for your patients. We will deal with all of the other issues later, but do not ever put us in a position of not providing what is best for your patients, strictly for administrative or financial reasons. That is the last thing that you should do.

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**Unidentified Audience Member** - - *Analyst*

Can you remind me when you bought Carlisle?

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**Alan Levine** - *Health Management Associates Inc - SVP, Florida Group President*

That was before I came into the Company.

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**Eric Waller** - *Health Management Associates Inc - SVP and Chief Marketing Officer*

I don't want to guess, but it has been at least 10 years, right?

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**Unidentified Audience Member** - - *Analyst*

If I look at slide 6, the one thing that does provide (inaudible) over the years was below (inaudible). From 2008 to 2010 (inaudible).

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**Alan Levine** - Health Management Associates Inc - SVP, Florida Group President

Yes. Thank you for asking. That is exactly a point that I was raising. Let me repeat the question. Looking at the slide from 2007 to 2009 or '10, the overall admission percentage increased. You have to look at this slide side by side with the one-day stays, with the one-day admissions. Let me tell you why.

As I mentioned, in 2008, beginning of 2008, we began doing aggressive physician recruitment into the community, as the community was growing. We recruited more than 40 new doctors into the community from -- it began in 2008, all the way through 2011. We've added several new programs in that hospital, including a cancer program. These are high-acuity programs. Among the doctors recruited were neurosurgeons, general surgeons, oncologists. These are high-acuity doctors. Previously, those patients would be sent somewhere else to be cared for.

Because they can be cared for now at Carlisle, what you will see is your higher-acuity admissions will go up. You have to look at the one-day admissions. The one-day admissions is what CMS looks at. That's where you have potential liability for patients that could have been in observation; those are the ones CMS looks at. The [pepper] data, all that stuff, and they look at your short-stay admissions.

If you look at the one-day admissions, not only are we below the average each of those years, but we were declining in each of those years. If we were doing something inappropriately -- if we were inappropriately admitting low-acuity patients that did not belong in the hospital, you would have seen the one-day admission percentages go up. You would not see them go down. That data is absolutely conclusive.

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**Unidentified Audience Member** - - Analyst

Great. Thanks. Can you talk about how (inaudible)?

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**Alan Levine** - Health Management Associates Inc - SVP, Florida Group President

The question is about ProMED, and how we use it in the ER, and questions about why we stopped using it. First, let me tell you a little bit about what ProMED is. If you Google emergency department IT systems, you'll find probably 10 or 11 different companies that do what ProMED does. A PulseCheck, which incidentally is a system that is used by our competing hospital -- from Carlisle; it is used down the street at one of the other hospitals. PulseCheck does all the same things ProMED does. T-Systems -- there is multiple IT systems that do this.

The American College of Emergency Physicians in 2004 put out a white paper where they talked about the need, effectively, for -- actually, let me back up a minute. There is two big groups that represent ER physicians. The American College of Emergency Physicians, which represents more than 30,000 emergency room physicians throughout the country. And there is the American Academy of Emergency Physicians, which represents I think around 2,000 ER doctors.

The American College of Emergency Physicians is the recognized authority on ER care. We follow their white papers and their guidance very closely. We read what they put out, and we try to follow what they put out. The ACEP recommended, in 2004, a couple of things. Number one, they recommend a triage-based order sets. Basically permitting triage nurses to order tests that are predetermined, based on patient symptoms, so that the test can be done rapidly, so that you can improve throughput through the ER. ProMED does that.

What happens is, a patient comes into the ER and they give us their symptoms. They give the triage nurse their symptoms. You have the triage nurse put the symptoms into the computer, the computer has predetermined test maps, and the process for those test maps to be predetermined is very important. Those test maps are determined by board-certified ER doctors, they are approved by the medical director of the ER in each hospital, and the medical executive committee, the elected medical executive committee of each hospital, which acts independently of the hospital, has to approve all standing orders. These are all covered.

And Joint Commission reviews these as well, as part of the accreditation process. So, all of our hospitals, obviously, are compliant with Joint Commission, and 65% of them are top performers. We follow all of those guidelines to make sure.



The primary issue with ProMED is to, number one, make sure that when a patient comes into the ER, we capture the symptoms appropriately, and we get the proper testing done. Another important feature of ProMED is that the ER doctor can cancel tests that they don't want. And there is what we call true tests and false tests. Meaning, a true test is a much smaller sample of tests where the triage nurse basically hits send and those tests are ordered. There is false tests where the ER doctor has to approve the tests before they are ordered. We believe that ProMED complies with all of the standards in the industry.

When you Google the other systems, the other PulseCheck, T-Systems, and you read the highlights of what those systems do, and you read their case studies, they talk about improving throughput through automated order sets, and evidence-based order sets. That's exactly what ProMED does.

Number two, ProMED also uses what is called -- it uses InterQual criteria, what's called QualCheck. If a patient meets inpatient criteria based on the InterQual criteria, we let the physician -- the system lets the physician know that. The physician then makes the decision whether they want to admit the patient or not. They do not have to admit the patient. They can send the patient home.

Let me tell you what happens. If the patient meets inpatient criteria, we have what is called flash meetings every morning in our ERs. The American College of Emergency Physicians, in one of their white papers, recommended that there be routine communication between administration, nursing, and the ER physicians. We have those meetings every single morning. We talk about patients that left without being seen, patients that were transferred to other hospitals. We talk about patients that met criteria for admission, but weren't admitted. We also talk about patients that were admitted to inpatient that may not have needed to be admitted. We do these realtime audits to make sure that the patient is in the right setting.

The reason we do this is, if a patient meets criteria for admission but is sent home, that patient may be exposed to unnecessary risk. We talk about it to make sure that we have not exposed a patient to risk. Similarly, a doctor might have a patient in the hospital -- they might admit a patient that does not meet InterQual criteria. If that occurs -- and we usually find that out through our audit process. If that occurs, we go to the doctor and we say -- this patient does not meet InterQual criteria, what do you want to do? The doctor has the option of saying -- notwithstanding the fact that it does not meet criteria, I want to keep that patient in the hospital. And we ask the doctor to document the reason for keeping the patient in the hospital. If the patient -- or the doctor can then convert the patient to observation status. That is one of the rubs right now because that patient can be converted to observation and the patient not even know. They think they were admitted, but then they were converted.

The bottom line is that what ProMED does is it basically, if you have read the Checklist Manifesto that Atul Gawande wrote, ProMED and all of these IT systems are nothing more than a checklist for doctors, so that they make sure that they do not miss anything, so that they do not expose a patient to unnecessary risk. No matter what we do in the ER, no matter what happens after the ER, there are multiple audit systems in place, either through our own Company or through the RAC audit process. It is really important for us to get it right. That's why we use these metrics.

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**Eric Waller** - Health Management Associates Inc - SVP and Chief Marketing Officer

The only thing I'll add on the lingering ProMED question, because it tends to come up, and we made available on our website the ProMED timeline. I know the issues with Tenet and the ProMED -- the CHS, excuse me, and the ProMED. We make available a timeline when we made the decision to go from ProMED to MEDHOST. There are links to internal documents where we set up a committee to look at the software. These pre-date any sort of public problem or issue with ProMED.

To sort of give you the business outline, I think we've got three or four different internal memos and a timeline, ultimately, we'd like to sort of put the decision to switch from ProMED to MEDHOST to rest. It was purely a business decision. It had nothing to do with any problems with ProMED, and that is available on the website as well.



**Unidentified Audience Member** - - *Analyst*

Thanks. Maybe just a few follow ups and clarifications. First, it seems like it's all Carlisle is the focus [to your extent]. To be clear, was there any other hospitals or any other companies or anything that we should be thinking about that could be part of the story as far as your sense?

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**Alan Levine** - *Health Management Associates Inc - SVP, Florida Group President*

The question is whether there is any other hospitals other than Carlisle. At this point, we do not know.

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**Unidentified Audience Member** - - *Analyst*

And then (inaudible), the data that you showed today, did you give that to CBS? Are they aware of that data or --

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**Alan Levine** - *Health Management Associates Inc - SVP, Florida Group President*

The question is whether we gave this data to 60 Minutes, and the answer is yes.

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**Unidentified Audience Member** - - *Analyst*

You mentioned also, just to be clear, were patients that were in these settings, was the analysis that you had done, we didn't see any of that data. Just wanted to make sure you had the chance to follow up and describe your findings on that note.

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**Alan Levine** - *Health Management Associates Inc - SVP, Florida Group President*

The question is tests per patient in the ER. I will tell you, we are very comfortable, based on the data that we have seen, that our test per patient has not changed. Pre ProMED -- excuse me, in the last -- what was the date that we looked at --?

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**Eric Waller** - *Health Management Associates Inc - SVP and Chief Marketing Officer*

Same sort of time period, we look at the average test by Medicare patient and average test ordered by all patients, and we found no changes.

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**Unidentified Audience Member** - - *Analyst*

Great.

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**Alan Levine** - *Health Management Associates Inc - SVP, Florida Group President*

One more?

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**Unidentified Audience Member** - - *Analyst*

I just want to follow up on -- you talked about the ability of physicians to override the ProMED system to their discretion (inaudible). Given these stats, do you know what percentages of docs actually go against what ProMED says? Is it a high percentage, a low percentage?

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**Alan Levine** - Health Management Associates Inc - SVP, Florida Group President

The question is what percentage of the docs override ProMED -- we don't really know that. I should also add, each hospital's test maps can be different based on the local medical staff's preferences. We wouldn't have any way of centrally measuring that. But what we would expect is that if an ER doctor was routinely overriding or saying -- I don't want a certain test, we would presume that the ER doctor would talk to the ER medical director, and they would eventually change that order set to better reflect what the local physician wants. At the end of the day, the physician is ultimately the one that has to do the orders.

**John Merriwether** - Health Management Associates Inc - VP of Financial Relations

Great. Thanks, everybody. That's going to wrap up the call. We appreciate your attention. Have a great day.

**Alan Levine** - Health Management Associates Inc - SVP, Florida Group President

Thank you.

**Operator**

Ladies and gentlemen, this concludes today's conference call. You may now disconnect.

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