THE CASE FOR SPECIALTY HOSPITALS:
Myth vs. Fact

Myth: "Studies have shown that niche providers like heart hospitals, cancer clinics, orthopedic hospitals, etc., "cherry pick" their patients by treating a lower percentage of severely ill patients, referring the sickest, most costly to the general hospital."

Fact: There is only one "study" that is cited in support of this "cherry picking" myth—an April 2003 GAO report on specialty hospitals. In this report, the GAO compared year 2000 discharge data at 25 specialty hospitals in six states with data at 396 general hospitals in the same urban areas. General hospitals saw, *at most* between 2% to 5% more severely ill patients than their specialty counterparts in cardiac, orthopedic, surgical and women's cases. *This is not a significant difference*, and certainly does not lend any credence to claims that specialty hospitals engage in "cherry picking." General hospitals and specialty hospitals are seeing the same types of patients.

Fact: One can't draw any conclusions regarding the GAO's comparative severity analysis between specialty hospitals and general hospitals, because the GAO specifically stated that it did not analyze or draw any clinical or economic conclusions from its analysis.

Fact: Physicians utilize specialty hospitals because these hospitals provide high quality care and because they can frequently provide their services more efficiently and conveniently to patients than at the local general hospital.

Fact: According to the GAO's April 2003 Report, in half of the specialty hospitals in which physicians had ownership interests, the average individual physician share was less than 2% of total shares owned in the specialty hospital. This share is so small that the there is *no incentive* for physicians to steer their patients to specialty hospitals.

Fact: This argument overlooks that fact that *the majority of physicians that practice in specialty hospitals have absolutely no financial ties to the hospital*. The GAO found that most, i.e., **73%**, of physicians with admitting privileges in limited service hospitals had **no ownership interest in that hospital**. Consequently, most physicians utilizing limited service hospitals do not engage in self-referral and their referral decisions are not swayed by financial considerations.

Fact: Most specialty hospitals strictly enforce a policy that prohibits discrimination against all types of patients. Steering less ill patients to specialty hospitals vis-à-vis

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[1] However, page 14 of the GAO reports also states "However, our results also show that some physicians own considerably larger shares of 15 percent or more. Furthermore, the combined share owned by physicians who are members of a single group practice represents the majority ownership in some hospitals."

general hospitals based solely on financial considerations would violate these anti-discrimination policies.

Myth: "Specialty hospitals drain essential resources from general hospitals –they undercut the ability of general hospitals to meet the needs of the broader community by drawing profitable services away from general hospitals, making it more difficult to support other critical, and unprofitable, services, such as trauma center, neonatal ICUs, and burn units. The community loses access to specific services or ultimately to all the hospitals services as the general hospital closes."

Fact: The Office of the Inspector General of the Department of Human Services has stated that from 1990 to 2000, 296 urban hospitals closed. The advent of specialty hospitals was not in any way responsible for these closures. They closed because they were not competitive and suffered insurmountable operating loses. The closure of these weakened facilities occurred before development of most limited service hospitals.

Fact: Opponents of specialty hospitals have not provided any evidence that limited service hospitals have caused a general hospital to close. They haven't even provided any evidence that an acute hospital has had to close a department because of entry of a limited service hospital into the health care market.

Fact: The California HealthCare Foundation recently completed a study which found that although the emergency department of a hospital may *itself* lose money per patient, the hospital as a whole makes a profit on emergency room patients because revenues that hospitals make on patients admitted through the emergency room exceed any loses incurred on patients not admitted. The study's authors concluded, "In the current economic environment, the ED is an essential department that few hospitals can do without. Today's ED is becoming the 'front door' for most hospitals. As such an essential component of the institution, it is therefore unlikely that hospitals will close their EDs."

Fact: Very few community acute hospitals operate burn units. Most of these units are run by tertiary medical centers. For most general hospitals, what affect a limited service hospital may have on the viability of a burn unit is not a relevant issue.

Fact: Opponents of specialty hospitals like to give the impression that there are a huge number of specialty hospitals threatening the viability of acute hospitals. They do this by confusing the differences between ambulatory surgical centers ("ASCs") and limited service hospitals. Limited service hospitals are not ASCs. There are currently over 3,300 ASCs performing between six and seven million procedures a year. But the first GAO report, issued in April 2003, identified *only* ***92*** specialized hospitals in operation.

Fact: Limited service hospitals simply do not have sufficient market share to pose any threat to acute hospitals. According to the GAO, limited service hospitals constitute ***only 2% of the total number of general hospitals and only about 1 percent of Medicare spending for inpatient services*.** By contrast, there are ***almost 5,000 general hospitals*** in the U.S. Further, limited service hospitals by nature tend to be small facilities focusing

on a few procedures and utilizing a highly trained and specialized health care and medical staff. These small facilities are a far cry from the massive general hospitals and hospital systems that exist in many communities.

Fact: In October 2003 Report, the GAO found that for-profit limited service hospitals ***did not perform as well as*** for-profit general hospitals. The GAO did find that specialty hospitals "tended to outperform" non-profit general hospitals." (About 85% of all general hospitals are not-for-profit hospitals ("NFPHs"), and about 90% of limited service hospitals are for-profit entities). This finding shows that acute hospitals can compete with, and even outperform, limited service hospitals. The GAO's finding does not demonstrate that limited service hospitals necessarily result in the curtailment of services or closure. What the finding does show is that NFPHs are not being operated with optimal efficiency. Rather than becoming more efficient, these general hospitals want state legislators to shield them from competition.

Fact: This myth completely ignores the many pro-competitive effects created when limited service hospitals enter a market. For example, communities that have one dominant general hospital often have some of the *highest health care costs* when compared to other communities in the state. Entry of an additional provider into the community injects needed competition, which creates lower costs for the insured and uninsured, as well as the community's employers. This cost reduction is crucial since the number of *working* uninsured grows each year, and health insurance premiums have been experiencing annual double-digit increases. As the U.S. Department of Justice has stated, competition among hospitals, health plans, and physicians is a "critical component of containing health care costs."

Fact: The hospital industry has used this type of myth before in prior efforts to insulate itself from legitimate competition from ambulatory surgical centers ("ASCs"). In the early 1970s, as ASCs evolved as a more efficient alternative to the hospital for a specific class of surgeries. Insurers came to recognize the advantages and value that ASCs provided vis-à-vis hospitals. For example, in 1977 a Blue Cross and Blue Shield study demonstrated that services performed in ASCs cost, on average, 47% less than when those services were performed in a hospital. Reimbursement by private and public payors naturally followed this recognition. In 1982 there were only 40 ASCs. There are now over 3,300, where between six and seven million procedures are performed annually. The hospital industry has failed to stop the development of ASCs because ASCs make economic sense. With their focus on a limited number of inpatient procedures, limited service hospitals are the natural and logical next step in the market-driven evolution of health care.

Fact: Rather than reducing access to services, the entry of limited service hospitals into a market actually increases access because they draw top-flight medical specialists and sub-specialists to communities. Because working at a specialty hospital alone is insufficient to support a physician practice, these specialists also must serve on staff at the local general hospital, which augments the services that it provides.

Fact: This myth completely ignores the potential for quality that limited service hospitals bring to the health care market. Hospitals that focus on just a few surgical specialties are often able to provide higher quality services at lower cost than hospitals that choose to provide a broad range of services. This is a matter of common sense—where focus is placed on just a few procedures that are performed with great frequency by highly trained staff using specifically designed and updated equipment, quality and cost reduction naturally follows. Due to their smaller size, limited service hospitals are much more flexible than general hospitals, enabling physicians and staff to respond more rapidly to patient care concerns.

Myth: Specialty hospitals don't have emergency rooms. Laws should be passed requiring all limited service hospitals to have emergency departments.

Fact: According to the GAO's October 2003 Report, almost half (45%) of specialty hospitals had emergency departments. This myth is just a smoke screen for the industry's real intention—to insulate itself from fair competition. The central aspect of the limited service hospital that increases the quality and efficiency of its services is the fact that it is a "focused factory." By mandating emergency departments, acute hospitals merely want to destroy both the benefits of surgical specialization and cost-effective innovation in the ever-evolving health care market.

Myth: Limited service hospitals are not subject to the kinds of regulations and administrative costs incurred by general hospitals.

Fact: Limited service hospitals must meet the same state licensure, Medicare, and Medicaid requirements as general hospitals. Costs of compliance are every bit as onerous, and probably much more, on limited service hospitals than they are on the acute counterparts, since general hospitals can absorb more compliance costs due to their larger size. In the GAO's April 2003 study, surgical hospitals had a median of 16 beds, and women's hospitals had a median of 61 beds. General hospitals had approximately **170** beds. General hospitals also frequently benefit from even larger economies of scale because they are often affiliated with a wider, sometimes national, hospital system. This affiliation also helps them to absorb compliance costs in a manner unavailable to independent, physician-owned limited service hospitals.

Myth: Physicians are the only health care providers that can self refer.

Fact: Hospitals frequently exercise complete control over physicians' referral choices by threatening to deny or revoke staff privileges of those hospital-based physicians that refuse to steer their patients to the hospital.

- One way hospitals coerce physician referrals is through the employment relationship. In jurisdictions permitting hospital employment of physicians, many hospitals as a condition of employment require physicians to refer their patients only to the hospital. A hospital can dismiss any physician that fails to confine his/her referrals to the hospital. In many locations, the hospital is the only

facility where the physician can effectively practice his/her hospital-based specialty.

- Hospitals are also coercing physician referrals through a very disturbing practice known as "exclusive credentialing." Exclusive credentialing occurs when a hospital grants a physician staff privileges only if the physician agrees to restrict his/her referrals in a manner prescribed by the hospital. This type of credentialing has ***nothing to do*** with a physician's training or education, but is merely a way to ensure physicians' "loyalty." Exclusive credentialing can take one of three forms.

  First, the hospital may require the physician to refer all, or a certain percentage of, his/her referrals to the hospital.

  Second, the hospital may limit the number of referrals that the physician can make to competing facilities.

  Third, the hospital may severely confine physician referrals through insurance. The hospital, or the larger system of which the hospital is a part, may fund its own insurance products or plans. The hospital then conditions staff physicians' participation in the insurance products on the physicians' satisfying referral requirements. The physicians are then forced to refer their patients to the hospital because they cannot afford to lose the client base connected with the insurance products.

Fact: The facts show that though the employment relationship and "exclusive credentialing" not only do hospitals self-refer, but hospital self-referral poses much greater concern than physician self-referral.

- First, by telling physicians where and when they can refer, the hospital administrator and/or board of directors take medical decision-making away from physicians and give it to themselves. This runs counter to all patient expectations and violates the sacredness of the physician-patient relationship. Because of the relation of trust inherent in the physician-patient relationship, physicians are under strict legal and ethical obligations to act in the best interests of their patients, and patients have commensurate expectations. *Hospital administrators/board members have no ethical and legal obligations to the patient that even remotely approximate those of the practicing physician.*

- Second, hospital self-referral arrangements may have a detrimental effect on patient care because the patient's physician is forced to refer to the hospital or affiliated facility, even if an unrelated facility, not necessarily a limited service hospital, might be able to provide higher quality care more efficiently.

- Third, hospital self-referral drastically reduces patient choice. Patient choice is eliminated because the physician cannot offer the patient any option other than the hospital, even if other options might be more convenient or otherwise preferable

to the patient. The patient expects to have the final say as to where, when, and how he or she will receive treatment, *not a hospital administrator*.

- Fourth, hospital self-referral arrangements are created only one reason—to protect the hospital's market share by thwarting legitimate competition and to protect traditional sources of revenue irrespective of any broader societal concerns. Coercive hospital self-referral arrangements are, therefore, the very height of conduct constituting a conflict of interest. Any attempts to restrict physician referrals should also address the vastly more problematic issue of coercive hospital self-referral arrangements.

- Fifth, any concerns about physicians engaging in a conflict of interest because of self-referral are *absolutely dwarfed* by the conflicts inherent in coercive hospital self-referral arrangements. In most cases, the physician level of investment in the limited service hospital is so low (half of the physicians investing in limited service hospitals own shares of less than 2%) that any claim that that investment influences referral patterns cannot be reasonably entertained. In fact, the GAO found that most, i.e., **73%**, of physicians with admitting privileges in limited service hospitals had **no ownership interest in that hospital**. Physicians refer to limited specialty hospitals for reasons that have nothing to do with financial considerations/conflict of interest: better equipment and staff, convenience for patients, and because they have more say in the hospital clinical operations.

Myth: Many specialty hospitals do not participate in Medicare and/or Medicaid or limit their participation when they do, and many provide little uncompensated care.

Fact: All limited service hospitals participate in the Medicare and Medicaid programs. They also serve indigent patients. Most specialty hospitals strictly enforce a policy that prohibits discrimination against all types of patients, and they do not refuse to provide services to patients just because they are unable to pay for services."

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

Fact: Entry of limited service hospitals into a market brings additional resources to serve the needs of the community, e.g., by providing additional charity care. Local general hospitals by themselves cannot furnish all of the charity care required by community, since the total percentage of charity care that most hospitals provide is less than two percent of their total revenues. The amount of charity care provided by some physician-owned limited specialty hospitals actually exceeds what the local general hospital furnishes.

Myth: Allowing physicians to continue to refer to facilities in which they have an ownership interest will skew professional judgment and result in referrals for unnecessary services and/or referrals to those facilities when other treatments/other facilities would be more appropriate.

Fact: Of those physicians who have an ownership interest in a limited service hospital, the percentage of ownership is generally very small. Therefore, any referrals would not have a measurable impact on their financial interest in the hospital. According to the GAO, 70% of doctors who own a share in a limited service hospital own 6% or less of the hospital. 47% of the 70% own less than 2%. This low percentages should make it clear that profit is not a motivation for physician referral to limited service hospitals.

Fact: This argument ignores the real reasons why physicians utilize limited service hospitals; including:

- Technological advances in endoscopic surgical techniques, physician need for efficient surgical facilities and specialized staff, patient demand for a non-institutional and convenient setting, and payer demand for cost efficiencies.

- Physicians have greater input regarding how medicine is practiced in limited service hospitals than they do in larger general hospitals, where bureaucratic red-tape can make ordering important equipment and scheduling surgeries an ordeal.

- Many factors dictate physician referral patterns, such as managed care contracts, the patients themselves, the ambulances that take patients to emergency rooms. These, and other influences, may require physicians to refer to a limited service hospital regardless of any ownership interest.

Fact: The GAO report provided no evidence to support the myth above. As the GAO report stated "Data were not available on the identity of physician owners and therefore we could not determine if there was a relationship between physician ownership and referral behavior."

Fact: According to the October 2003 GAO Report "the majority of physicians who worked in limited service hospitals held no ownership interest in the facilities. Overall, approximately 73 percent of physicians with admitting privileges to specialty hospitals had *no* ownership interest in the specialty hospitals in which they practiced." In fact, most of the physicians working at limited services hospitals do not even invest in the hospital

Myth: The development of limited specialty hospitals is purely driven by physicians who want to increase their incomes.

Fact: Many specialty hospitals are owned and operated by general hospitals and/or hospital systems. According to the October 2003 GAO Report, one-third of all specialty hospitals, which varied widely in specialty, were owned or operated by local general

hospitals. **Over one-half of these limited service hospitals had *no* physician ownership.**

Myth: Physicians should not be permitted to refer to specialty hospitals in which they invest because this self-referral gives limited service hospitals an unfair competitive advantage vis-à-vis acute hospitals. Physician self-referral needs to be stopped in order to create a "level playing field" between nonprofit and specialty hospitals.

Fact: Contrary to misrepresentations made by the hospital industry, not-for-profit hospitals ("NFPHs") already enjoy a significant competitive advantage over for-profit limited service hospitals. (Ninety percent (90%) of limited service hospitals are for-profit entities, and about 85% of acute hospitals are NFPHs). NFPHs are exempt from all state and federal income taxes. They are also exempt from sales, use, franchise, and property taxes. NFPHs also have the enormous advantage of being able to raise financial capital from selling tax-exempt bonds at below-market rates, and receiving financial donations that are tax-deductible to the donors. NFPHs are granted these extraordinary exemptions on the theory that NFPs have assumed the burden of providing community benefits like indigent care. There are two crucial points here in connection with these benefits and the "level playing field" argument.

- First, NFPHs enjoy these benefits *regardless* of where they are located. NFPHs in suburban areas have the same advantages as those in the inner city, even though the suburban NFPHs provide significantly less indigent care than their inner city counterparts. This disparity is exactly the reason why some states are re-examining whether conferring property tax exemptions for NFPHs is appropriate. So the suburban general hospitals against which many limited-service hospitals compete have the best of both worlds: they are granted all of the benefits of an NFP that shoulders the obligation to care for the financially burdened inner-city, yet do not share the burdens. For some of these NFPHs with lighter indigent care loads the total value of their exemptions can exceed the costs of their indigent care. Limited service hospitals provide indigent care just as suburban NFPHs do, without benefiting from the myriad advantages that the NFPH have. In suburban areas, this creates an unfair playing field, *tipped in favor of the NFPH*.

- Second, *it is not at all clear that NFPHs provide more indigent or charity care than comparably located for-profit hospitals.* At least two studies have concluded that when "for profits and not-for-profits are located in the same area, they serve an equal number of uninsured patients." Again, this evidence suggests that, with their manifold advantages, the "playing field" is not tilted against NFPHs. If anything, it is tilted in their favor.

- Third, ***some for-profit limited service hospitals provide more charity/indigent care than the local general hospital***. For example, according to National Surgical Hospitals, a corporation with over 15 limited service hospitals across the

U.S., some of its hospitals provide more charity care than the large general hospital in the community.

- Even for NFPHs that provide a significant amount of indigent care, the disproportionate share program provides NFPHs with a financial "safety net" to compensate the NFPH and keep it operational. In spite of this governmental safety net, NFPHs still want legislators to insulate them from healthy competition.

- Finally, because most limited service hospitals are for-profit entities, they, unlike NFPHs, provide financial support to their communities by paying federal and state income taxes, and property, franchise, sales, and use taxes.

Fact: This myth completely ignores the tremendous *market* advantage that many NFPHs have over limited-service hospitals: size. Limited service hospitals are, by nature, small facilities. Due to their diminutive size, they cannot exert anything close to the market power of NFPHs. NFPHs alone have an average size of 170 beds. But this is not the full picture, since many NFPHs are parts of national health care/hospital systems, which have vastly more capital and resources than limited service hospitals that are wholly owned by physicians. NFPHs use this market power to insist on exclusive contracts with HMOs and other payers, thereby locking limited specialty hospitals out of the market.

Fact: The size of NFPHs also enables them to undercut the prices charged by limited specialty hospitals. The large NFPHs sell the only service that the limited service hospital provides—surgical services, at a loss. Unlike limited service hospitals, these large NFPHs can make up this cost difference through the array of services that they provide to non-surgical patients. This certainly is not a "level playing field" were limited service hospitals are concerned.

Myth: Limited service hospitals threaten access to care because they result in specialists refusing to take call at the local general hospital.

Fact: The difficulty that hospitals have had in having adequate call coverage is hardly due to the emergence of limited service hospitals. General hospitals have been grappling with this challenge for years. In many communities, some specialties will not take call unless they are assured that they will receive a stipend or receive other compensation. Other physicians are reluctant to take call because of scheduling problems. Still others do not want to take call because of extensive liability exposure and the exorbitant insurance premiums that they have to pay for malpractice insurance to cover that exposure.

Fact: Finally, physicians are not resigning their staff privileges because of limited service hospitals. Few, if any, physicians could maintain a viable medical practice continuing to provide services at the local general hospital.