



Innovations in the Business of Health Care

The Role of Specialty Hospitals

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by Sean Parnell

Texas Public Policy Foundation
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Foreword

Revealing a misunderstanding of economics, or perhaps a willful desire to reorder the universe, countless people from opinion leaders and policymakers to patients and providers often declare that “the free market cannot work in health care” and “health care is different.” Indeed, we may feel differently about health care and our health care decisions, but the laws of economics do not distinguish between any given health care service and any product bought and sold throughout the rest of the economy. What’s more, government intervention in the marketplace produces predictable results that restrict competition, set prices, and allocate resources and the like, regardless of the industry on which the government concentrates these efforts. In this case, health care is no different.

Today the U.S. health care system suffers the consequences—both intended and unintended—of heavy government regulations that have distorted the marketplace and left a tangled mess. Though there are dozens of examples, it is particularly instructive to look at the places where health care innovation attempts to break through.

Free market economics relies on willing buyers and sellers in voluntary exchange where each is free to maximize their satisfaction. For purposes of this paper and future Foundation publications on innovations in the business of health care, we look to these voluntary transactions as the ultimate goal as we advocate a more competitive health care marketplace built on free markets that provide health care freedom. Stated differently, our interest in pursuing a free market solution to improve the health care marketplace for all Texans requires us to consider how we might peel back layers of government regulation and interference that prevent this free exchange from taking place.



With this paper, we first turn our attention to the emergence of specialty facilities, which operate in an already heavily regulated corner of health care policy and have a long history of considerable regulation of their own. Criticisms abound: they serve only high-paying patients, they serve only comparatively healthy patients, they promote overutilization due to the physician-owners’ profit motives, they leave the not-for-profit hospitals with gaping holes due to lost revenue, they don’t face the same regulations that other hospitals face—the list goes on. To address these criticisms policymakers have both suggested and attempted a number of strategies, including a moratorium on the construction of specialty facilities, requirements on disclosure of a physician’s financial interests in such facilities, and even a return to onerous regulatory restrictions like “certificate of need laws” that put bureaucracies in charge of approving new facilities.

Our answers to these criticisms and to some policymakers’ interests in intervention and regulation are simple: allow competition to flourish and place the freedom of patients and providers as the paramount objective. Robust competition predictably brings consumers more choices, lower costs, and improved quality. Where competition is stifled, the opposite occurs.

In the case of specialty facilities and physician self-referral, we are told that consumers—and, perhaps more to the point, insurance companies—must be protected from unscrupulous profit-minded physicians who are responsible

Definitions of specialty hospitals vary, but generally they can be thought of as inpatient facilities that focus on only a few areas of medical care, such as cardiac care or orthopedics.

for overutilization that results in higher costs and more claims. While the evidence of overutilization and specialty facilities is at best mixed, it would be hard to suggest that overutilization of these specialty facilities is any more dramatic than the trend of overutilization seen throughout the health care system, largely due to third-party payment that insulates the patients from the cost of care. Indeed, whether an unnecessary visit to the doctor's office or a patient willing to receive care at a facility in which their physician has a financial stake, such criticisms might be better addressed by patients acting as consumers with some interest in the cost and quality of their care.

Furthermore, it is difficult to argue that the profit motive for physicians to self-refer is any stronger than the motivations for doctors to refer patients to a hospital setting in which they have privileges to practice. Regardless of the direct financial stake, doctors have an incentive to ensure that the hospitals where they practice are successful.

The only true way to control utilization is to allow patients to determine, in concert with their doctors, which treatments and services are best, as well as which facility to use. With respect to the free market, this

only happens as patients and providers engage in voluntary transactions where both come away satisfied with the deal they made.

The other frequently cited concern is that specialty facilities have an advantage over the competition because they do not cover the range of services that traditional hospitals offer—that they play by different rules. However, to the degree these are established in law, lawmakers would do better to address those laws that put traditional hospitals at a competitive disadvantage, rather than considering ways to simply put the competing specialty facilities out of business. Again, any move to limit competition has negative consequences for patients who wind up with less choice and no competitive pressures to influence price or quality.

Without dismissing many of the criticisms out-of-hand, it is important to recognize that many of the criticisms leveled at specialty facilities merely identify the symptoms of a health care system suffering from a lack of competition in general. More competition—not less—can best address these criticisms.

Specialty and physician-owned hospitals can play an important role in bringing more competition

to health care. If they deliver better quality care, as many people believe, the marketplace will reward these facilities. If the traditional hospitals do a better job at treating more complex cases, they will be rewarded likewise. In either case, the facilities will either compete to better serve the patients' demands, or they will seek legislative favors to insulate them from competition. Let's be clear that the latter provides no favors for anyone, least of all the patients looking for care or wishing for health care freedom.

No doubt a position in favor of unfettered competition will rankle some—particularly those with no interest in competing. But if lawmakers look first to untangling the regulatory morass and allowing providers (hospitals and doctors) to engage in serious competition, the consumer will be the better for it. Few would choose a world where policymakers have deferred to the lowest common denominator, choosing to prop up facilities to protect them from competition while at the same time effectively shutting down those facilities that patients would have chosen if given a choice.

Introduction

As health care spending spirals upward, governments and private health insurance companies look for ways to reduce costs amid a growing and seemingly insatiable appetite for more—and more expensive—medical care. Policymakers and health care providers alike are quick to point out that not all of the care received or paid for is equally necessary, noting that inappropriate utilization contributes to rising health care expenditures. In recent years, specialty hospitals, often owned by the physicians treating patients within the walls of these privately owned facilities, have made their way into the crosshairs.

Popular opinion suggests that these facilities bear some responsibility for inappropriate utilization due to a profit motive on the part of physician owners. This line of thinking, and the predictable charges of greed, comes as no surprise in an environment that has successfully assigned financial responsibility to third-party payers, along with an atmosphere that eschews profits in health care as being immoral. As a result, the effort to reduce inappropriate utilization often focuses on the symptom by limiting the supply of these services, rather than addressing the distortions in the marketplace that would impact consumer demand.

As home to more specialty facilities than any other state, these facilities have come under intense scrutiny in the Lone Star State. In addition, as innovations in the business of health care generate interest around the country, Congress has responded with similar efforts to limit the expansion and creation of these facilities. Over the years, a considerable body of literature has emerged evaluating specialty hospitals around the country, and their impact on the health care system overall.

The purpose of this report is to examine several key issues and the literature that public policy leaders in Texas will want to consider as specialty hospitals seek to continue their growth. The report has been organized to focus on three of the most significant questions:

1. Do the financial incentives associated with physician ownership of specialty hospitals lead to inappropriate utilization, where doctors make treatment decisions based not on the patient's best interest, but rather based on their own financial interest?
2. Is the quality of care at specialty hospitals generally inferior, equivalent, or superior to that provided by larger general hospitals?

3. Have specialty hospitals harmed the ability of general hospitals to provide vital care to the community?

This paper attempts to address the issue from both a national and a Texas perspective. It should be noted that because Texas had nearly one-quarter of all specialty hospitals in the United States during the time period most research was conducted, information from national reports are strongly influenced by facilities in Texas.

The data in this report is drawn from sources believed to be reliable, and the author has extensively footnoted all sources. However, the conclusions drawn are entirely the author's, and should not be taken to represent the views of the authors or institutions cited in this work.

Ultimately, in examining the health care landscape today, this paper argues that more competition between insurers and providers alike can help drive down cost of care and improve its quality, while giving people real choice in the care they receive. Specialty hospitals reflect this type of health care innovation. The literature indicates no dramatic differences in utilization between specialty and general hospitals, and there is little evidence to suggest



The fact that the ratio of high-profit to low-profit procedures did not increase is evidence that the practice patterns of physician-owners are not influenced in an inappropriate way by the financial incentives that exist at specialty hospitals.

that physician self-referral bears responsibility for any increases in utilization. At the same time, most research has pointed to a high quality of care in specialty hospitals, perhaps attributable in part to a difference in patients, but also likely the result of smaller size, specialization, as well as an arguable focus on patient expectations and business efficiencies. The review of the literature suggests that these facilities do indeed fulfill an important role in health care delivery today and into the future.

The Emergence of Specialty Facilities

Physician-owned specialty hospitals represent an innovative way to deliver inpatient medical services, and over the past decade nearly 130 have opened their doors and more are currently in development. Along the way, they have become a flashpoint for critics concerned about their impact on general hospitals and the health care system as a whole.

Definitions of specialty hospitals vary, but generally they can be thought of as inpatient facilities that focus on only a few areas of medical care, such as cardiac care or orthopedics. The most contentious aspect of specialty hospitals

is either part- or full-ownership by physicians, who operate the facility as a for-profit institution.

Specialty hospitals trace their development to the creation of ambulatory surgical centers (ASCs), which started to appear more than 30 years ago. An ASC is typically a stand alone facility, not attached to or affiliated with a traditional, general hospital. Along with performing diagnostic and pain management services, these facilities also perform limited surgical procedures. Patients seeking care at ambulatory surgical centers are admitted, treated and discharged with in a single day, no overnight hospitalization is available or necessary for the services performed at these facilities.

ASCs developed slowly until 1982, when the federal government first approved them for reimbursement in the Medicare program. From that point, they grew rapidly, and by 2005, there were more than 4,100 ASCs in the United States.¹

Specialty hospitals grew out of ASCs after some of these facilities began to add inpatient procedures and capabilities. In Texas, hospitals are classified in two categories, specialty hospitals and general hospitals, because of this broad division, the term specialty hospital has grown to encompass a variety of acute care facilities.

Specialty hospitals are generally thought of as simply inpatient facilities that focus on only a few areas of medical care, such as cardiac care or orthopedics. However, specialty facilities are subject to a number of regulations, which vary depending upon the type of service the hospital or clinic provides, the facilities' location, hours of operation and clientele. Unlike ambulatory surgical centers, specialty facilities treating Medicare patients must provide emergency services that are in compliance with Medicare participation requirements. Additionally, all hospitals are required to have a registered nurse on duty at all times and must have a physician either on call or on duty around the clock. These regulations create a unique niche for each service facility and often create difficult barriers for smaller, more narrowly focused clinics. One of the most inhibiting policies restricting the development of specialty facilities has been certificate-of-need laws that prohibit building new health care facilities without approval from the state.

As a result, specialty hospital development has been focused in states without Certificate-of-Need requirements,² particularly in Arizona, California, Kansas, Louisiana, Oklahoma, South Dakota, and Texas.³

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A 2003 study by the Government Accountability Office (GAO) counted a total of 92 specialty hospitals in the United States, including 17 specializing in cardiac care, 36 in orthopedics, 22 in general surgery, and 17 in women's care.⁴ The GAO report highlighted the differences between general hospitals and specialty hospitals, noting in particular the differences in size. For instance, the report found that, on average, only 16 inpatient beds are in surgical specialty hospitals, 21 in orthopedic hospitals, 59 in cardiac facilities, and 61 in hospitals specializing in women's care, compared to an average of 170 beds in general hospitals.⁵

In 2003, the U.S. Congress passed an 18 month moratorium on the development of new specialty hospitals as part of the *Medicare Prescription Drug, Improvement and Modernization Act of 2003*. Although the moratorium was allowed to expire in June 2005, it was effectively extended when the Centers for Medicare & Medicaid Services (CMS) suspended approval of new Medicare provider numbers for specialty hospitals.⁶ This action was subsequently supported in the *Deficit Reduction Act of 2005* passed by Congress and signed by President Bush.

During these years, the criticism of specialty hospitals grew sharper.

Particular skepticism has been directed at a branch of specialty hospitals owned and operated by physicians. Critics argue that physician owners have a financial incentive to direct clientele to the facility where they have an ownership interest and have been accused of steering patients away from general hospitals in an attempt to generate more profits. General hospitals argued that they were losing money due to the specialty hospitals, while many insurers argued that the physician interest increased inappropriate utilization of these facilities.

In August 2006, the federal moratorium ended, yet the issue has remained in the crosshairs of many in Washington and resurfaced for a period in the federal legislation reauthorizing the State Children's Health Insurance Program in 2007.

As home to approximately one quarter of the specialty hospitals in business across the country, Texas has also grappled with policy issues surrounding specialty hospitals. In 2005, Texas lawmakers passed Senate Bill 872, increasing disclosure of physician interests in facilities to which they refer their patients, and directing the Texas Department of State Health Services to conduct an evaluation of certain aspects of these facilities. Legislation that would have imposed a moratorium

on the construction of specialty hospitals failed to make its way out of committee, though the underlying support for a prohibition on physician self-referral remains among many of the stakeholder groups.

In both Washington and Austin, policymakers hear the same criticisms and consider the same questions. Do specialty hospitals drive inappropriate utilization? Does a physician's financial interest influence their decisions? Do specialty facilities cherry pick the healthiest and paying patients? Do specialty hospitals provide a different quality of care than general hospitals? What financial impact do specialty hospitals have on general hospitals?

Utilization

Perhaps the most common criticism of specialty hospitals is due to physician ownership of these facilities. The criticism seems logical enough: because physician-owners benefit financially from procedures performed at facilities in which they have an ownership stake, they have an incentive to recommend and perform procedures that are unnecessary so as to generate additional income.

Concerns about such inappropriate utilization are predictable, and perhaps not entirely unfounded. Past

Margins at for-profit specialty hospitals average about 12.4 percent for Medicare patients and about 9.7 percent for all payers, which is not significantly out of line with margins at for-profit general hospitals, which average 14.6 percent for Medicare patients and 9.2 percent for all payers.

studies concerning physician referrals to facilities in which they had an ownership interest for diagnostic imaging, physical therapy, and lab facilities, did show patterns indicating possible inappropriate utilization of these services.⁷ It was concerns about physician ownership leading to inappropriate utilization that led to the so-called Stark I and Stark II laws, which place restrictions on the ability of physicians to refer patients to facilities in which they have an ownership interest.

Notably, the potential for this referral bias is not exclusive to physician ownership, a similar opportunity for inappropriate utilization resides in arrangements where physicians, employed by a particular hospital, benefits by referring patients to their employing facility. Suggesting that physicians will only over utilize services for their personal gain and not for the betterment of their employer, ignores a significant parallel between the two arrangements.

Still, a review of the literature both across the country and in Texas shows little evidence that the presence of a specialty hospital or physician self-referral drives up utilization at a more dramatic rate than increases in utilization in general. Charges of inappropriate utilization abound, despite studies across Texas that have found “no evidence

that overall utilization rates in communities with specialty hospitals rose more rapidly than utilization in other communities.”⁸

Many opponents of specialty hospitals have focused on the possibility that physician ownership may lead to an increase in the utilization of certain medical procedures. There is limited evidence suggesting that physician ownership is associated with an increase in utilization of some medical services. However, there is no evidence suggesting that the financial incentives of physician-owners have led to inappropriate utilization, and some evidence demonstrating that the profit motive has not influenced physicians’ clinical decisions.

According to a recent Medicare Payment Advisory Commission (MEDPAC) study, between 1996 and 2004 the rate of coronary artery bypass graft (CABG) procedures among Medicare recipients in markets with heart specialty hospitals grew by about 25 percent, compared to growth of 19 percent in markets without specialty hospitals.⁹ However, the MEDPAC report also notes that the rate of heart surgeries was increasing rapidly in these markets before the heart specialty hospital opened.¹⁰

MEDPAC found that CABG surgeries, which tend to be more profit-

able, did increase somewhat faster than typically less profitable angioplasty and defibrillator implantation procedures,¹¹ but there was no change in the ratio of procedures performed on less-severely ill and more-severely ill patients.¹² MEDPAC concludes that “the ratio of high-profit surgeries to low-profit surgeries was not significantly affected by the presence of specialty hospitals.”¹³

The fact that the ratio of high-profit to low-profit procedures did not increase is evidence that the practice patterns of physician-owners are not influenced in an inappropriate way by the financial incentives that exist at specialty hospitals.

It is also important to note that the MEDPAC study did not attempt to measure whether specialty hospitals themselves were the cause of increased, and possibly inappropriate, utilization. To the degree it is plausible that there is an inappropriate increase in utilization in markets with specialty hospitals due to physician-owners being influenced by financial considerations, it is also plausible that an inappropriate increase in utilization is due to the practice patterns at community hospitals.

This, in fact, may have been the case in at least one instance. Rapid City



Regional Hospital in Rapid City, South Dakota, faced the loss of neurological surgery business due to the opening of a for-profit specialty clinic, the Black Hills Surgery Center, in 1997. As reported in the press, "Since [Black Hills Surgery Center] opened in 1997, the rate of outpatient surgery in Rapid City has doubled. It now has one of the highest rates of back surgery in the country..."¹⁴

It is not apparent, however, that surgeons at the specialty hospital are responsible for the increased utilization, inappropriate or otherwise. According to a news account:

Competition between the two hospitals has been especially fierce in neurosurgery ... Regional performed 764 neurosurgery operations in 1996. By 2000, the number had dwindled to just 187. Regional began to fight back. In 2001 it recruited Steven Schwartz, who was fresh out of residency. Although not yet board-certified in the specialty, Dr. Schwartz quickly started doing as many as several procedures a day. That year, the number of neurosurgery cases at Regional rose to 336, and it continued climbing to 531 in 2002.

... Dr. Schwartz has since had many malpractice suits filed against him. At least 20 are still pending ... Many of the suits also name Regional. They allege that Dr. Schwartz performed

unnecessary surgery, operated on the wrong side of patients' spines and fused the wrong disks in patients' backs. The South Dakota State Board of Medical and Osteopathic Examiners later placed Dr. Schwartz on probation....

Some of the plaintiffs say Regional protected Dr. Schwartz because it was under competitive pressure. A suit brought by Miriam Conley, a Rapid City woman who alleges Dr. Schwartz operated on the wrong disk in her back, says Regional "intentionally concealed" his mistakes because his surgeries otherwise "would be performed in facilities competing with Rapid City Regional Hospital."¹⁵

The allegations regarding unnecessary surgery at Rapid City Regional Hospital, if true, are almost certainly not representative of typical behavior at full-service hospitals. However, it does serve to illustrate the point that increases in utilization in markets with specialty hospitals are not particularly compelling evidence of inappropriate procedure recommendations on the part of physician-owners seeking additional profits.

A 2005 study published in *The Journal of Bone & Joint Surgery* looked specifically at the practice patterns of 10 orthopedic surgeons in the Houston, Texas area over a 15 year period, including seven years before and eight

years after opening a specialty hospital in which they held a financial interest.

The study found that financial incentives associated with an ownership interest in a specialty hospital did not appear to influence the number or rate of surgeries they performed. Prior to the opening of the specialty hospital, each surgeon had, on average, increased the number of surgeries performed by 1.9 procedures per year.¹⁶ After the specialty hospital opened, the number of surgeries performed by each surgeon increased on average by .9 per year.¹⁷

The percentage of patients undergoing surgery by the group also did not increase noticeably. Prior to the opening of the specialty hospital, 27.5 percent of patients seen by the 10 doctors went on to have a surgical procedure, whereas after the specialty hospital opened 28.4 percent of their patients underwent surgery.¹⁸

The study concluded that "The surgical volume and surgical rate essentially did not change after the specialty hospital opened. The small fluctuations in surgical volume can be attributed to factors other than financial incentive, such as continued practice growth, increased operating room time, fewer deferred ("bumped") surgical procedures, and increased efficiency...."¹⁹

Comparing the surgeon's expected fee of \$3,622 to the potential profits from an ownership share of a specialty hospital, it is hard to imagine that an extra \$65 would be sufficient incentive for a doctor to recommend unneeded procedures.

Another report, this one by the Health Economics Consulting Group (HECG) in Iowa City, Iowa, addresses the most plausible reason why the financial incentive associated with physician ownership of specialty hospitals has not led to an increase in inappropriate utilization. Their report notes that "... it is likely that the magnitude of financial incentives is limited ... For half of the facilities with physician owners, the average individual physician ownership share was less than two percent ... Moreover, the entrepreneurial returns (i.e., the fraction of the facility fee considered operating margin) for any single case are likely to be substantially less than the professional fee charged by physicians. Given the order of magnitude difference between these two revenue streams, physician incentives are likely to be driven more by professional fees, which do not vary significantly by practice setting."²⁰

A quick review of the facts related to physician investment and reimbursement rates along with one hypothetical and one real-life example demonstrates why physician ownership is not likely to lead to an inappropriate increase in utilization.

Margins at for-profit specialty hospitals average about 12.4 percent for Medicare patients and about 9.7 percent for all payers, which is not

significantly out of line with margins at for-profit general hospitals, which average 14.6 percent for Medicare patients and 9.2 percent for all payers.²¹ At 70.4 percent of specialty hospitals, the largest share owned by a physician was 6 percent or less, and the median ownership share for a physician with an ownership interest was 2 percent.²²

Considering the relatively modest operating margins and limited physician ownership stakes typical of specialty hospitals, and factoring in the relative income potential from surgeon's fees vs. hospital profits, the financial incentive created by physician ownership of specialty hospitals seems far too small to lead to inappropriate utilization.

Consider the case of a relatively expensive surgical procedure: coronary bypass surgery. There are two primary DRGs for Medicare reimbursement of coronary bypass, 107 and 109. In 2005 the average reimbursement for DRG 107 was \$26,434 and represented approximately 64 percent of bypass surgeries performed in Medcath's cardiac specialty hospitals, and the average Medicare reimbursement for DRG 109 was \$23,499, representing the remaining 34 percent of procedures performed.²³ Surgeons performing these procedures received a physician's fee of \$3,622 for DRG 107s and

\$2,910 for procedures classified as DRG 109s.²⁴

By applying the information on operating margins and physician ownership of specialty hospitals to the data on physician fees, we can get an idea of what the potential increase in income would be for a surgeon who is recommending unneeded treatment. Performing an unnecessary DRG 107 coronary bypass, a for-profit specialty hospital could expect an operating profit of \$3,277.82 (12.4% avg. operating margin x \$26,434). If the surgeon performing the procedure owns 2 percent (the median ownership share), their gross share of pre-tax profits would be roughly \$65.

Comparing the surgeon's expected fee of \$3,622 to the potential profits from an ownership share of a specialty hospital, it is hard to imagine that an extra \$65 would be sufficient incentive for a doctor to recommend unneeded procedures.

A report by MEDPAC suggests that margins on cardiac surgery may be significantly higher than the \$3,277.82 used in the example above, between \$6,000 and \$12,000 per surgery.²⁵ Even with these higher profit levels, however, the incentive remains quite small compared to the surgeon's fee. On a surgery that earned the hospital \$12,000 in

A 2005 study of cardiac specialty hospitals by Dr. Cram and several other researchers found that, after adjusting for patient severity, patients in specialty hospitals had an 11 percent to 16 percent better chance of avoiding death than patients in general hospitals.

profits, a physician with a 2 percent ownership stake would only receive \$240 in pre-tax profits, still a fraction of the \$3,622 surgeon's fee.

The case of Richard Mathews, an executive at a benefits consulting company in South Carolina, is a real life example of how potential profits that could be realized by a physician-owner recommending unneeded care are likely too low to induce such behavior.²⁶

Mathews had reconstructive knee surgery in February of 2004 at the Beaufort Surgical Center, a specialty orthopedic hospital in Beaufort, South Carolina. His insurance company paid the entire bill, approximately \$1,227 for hospital charges and \$2,059 for the surgeon and anesthesiologist's fees plus other expenses.

Even if the surgeon operating on Mathews was one of the very few in the country who had an ownership interest of 15 percent or more in a specialty hospital,²⁷ the potential income gains are still too small to realistically think a doctor would recommend unnecessary treatment. Assuming a 9.7 percent margin on this procedure, a doctor with a 15 percent stake in the hospital would gain less than \$18 in income through that ownership, minuscule compared to their share of the

nearly \$2,000 in professional fees. A doctor with the average 2 percent ownership stake would stand to gain only \$2.38. Again, these potential gains are before taxes and other expenses.

The evidence clearly demonstrates that physician ownership of specialty hospitals does not lead to inappropriate increases in utilization, and is unlikely to do so in the future. Although fears about inappropriate utilization may have been well-founded initially, the research does not support continued concern. To the extent that physicians may perform unneeded procedures in order to increase their income, it is the physician's fee that is the most significant inducement, not potential profits from an ownership stake in a specialty hospital.

Quality of Care

The advantage of specialty hospitals is that by focusing their efforts on a relatively few areas of care, they should be able to improve both quality and efficiency. It is well understood that in most fields, specialization leads to gains that generally could not otherwise be realized. Professor Regina Herzlinger of the Harvard Business School observed that "Specialized health care facilities, partially owned by entrepreneurial physicians, present hope for

a higher-quality and higher-productivity health care system."²⁸

Herzlinger cited an example of the benefits of specialized health care facilities that was given by the CEO of an orthopedic surgery practice to *American Medical News*. "Orthopedists ... in a hospital ... work in the same operating room [as] general surgery and obstetrics. Orthopedics is nuts-and-bolts equipment intensive. It drives them crazy to have a staff that's not familiar with a tray of multisize screws and nuts and bolts."²⁹

Over the past several years multiple studies have examined the question, "Have specialty hospitals been able to achieve greater efficiency and quality through specialization?" Evidence strongly supports the view that specialty hospitals are delivering a higher level quality of care than general hospitals. Anecdotal evidence also suggests that greater efficiency has been achieved through specialization as well.

A study conducted and released in 2005 by the Centers for Medicare & Medicaid Services (CMS) documented the generally superior level of care found in specialty hospitals compared to competitor general hospitals. Among the key findings of the report was a comparison between specialty hospitals

Table 1: Cardiac Specialty Hospitals and Community Acute Care Hospital Competitors
AHRQ Inpatient Quality Indicators, Mortality Rates among Select Surgical
Procedures* For the Population of All Specialty Hospitals and Their Competitors

	Specialty	Competitor
AAA repair		
Number of deaths	16	101
Population at risk	206	948
Observed rate	77.67	106.54
Expected rate	99.91	141.82
Observed/expected ratio	0.78	0.75
CABG		
Number of deaths	152	484
Population at risk	4,036	10,922
Observed rate	37.66	44.31
Expected rate	47.87	51.50
Observed/expected ratio	0.79	0.86
PTCA		
Number of deaths	93	469
Population at risk	8,925	24,706
Observed rate	10.42	18.98
Expected rate	14.70	19.71
Observed/expected ratio	0.71	0.96
Carotid Endarterectomy		
Number of deaths	4	19
Population at risk	142	315
Observed rate	28.17	60.32
Expected rate	49.05	49.31
Observed/expected ratio	0.57	1.22

*NOTE: The data for observed and expected rates are per 1,000 discharges.

Source: CY 2003 Medicare IPPS claims. Observed/Expected ratios less than 1 indicate better than expected performance or fewer than expected deaths.

A 2005 study of cardiac specialty hospitals by Dr. Cram and several other researchers found that, after adjusting for patient severity, patients in specialty hospitals had an 11 percent to 16 percent better chance of avoiding death than patients in general hospitals.

and general hospitals of expected mortality rates for common cardiac procedures. For all four procedures compared, specialty hospitals had a lower than expected mortality rate, with the ratio of observed/expected mortalities varying between .57 and .79, where a ratio of 1.0 would indicate that the specialty hospitals did no better and no worse than expected.³⁰ Specialty hospitals performed better than general hospitals when compared on three of the four measures.³¹

The better results achieved by specialty hospitals focused on cardiac care translate into 87 patients that lived that would likely have otherwise died had specialty hospitals

only been able to achieve ‘average’ outcomes.³²

The CMS study also examined mortality rates for orthopedic and surgical specialty hospitals broken down by patient severity, and found that they also outperformed general hospitals. In orthopedic specialty hospitals, only 2 out of 6,018 patients (0.033%) died as inpatients across all levels of severity, while in general hospitals 1,101 out of 88,226 patients (1.248%) died.³³ (**See Table 2**)

One of the primary criticisms of specialty hospitals is that they “cherry pick” only the best patients, distorting the outcomes between specialty hospitals and general hospitals.

As such, critics contend that the general hospitals treat the poorest and sickest patients making comparisons impossible. In order to adjust for the different case mixes and get a more accurate perspective on the differing mortality rates between specialty and general hospitals, the table below calculates what patient mortality in orthopedic specialty hospitals would have been if they had identical mortality rates by patient severity to general hospitals. The analysis shows that had specialty hospitals achieved similar patient mortality results by severity level as general hospitals, an additional 25 patients would have died.

Table 2: Mortality Rates in Specialty and General Hospitals

	Number of Specialty Hospital Patient Deaths	Number of Specialty Hospital Patients	Specialty Hospital Mortality Rate	General Hospital Mortality Rate	Specialty Hospital Patient Deaths at General Hospital Mortality Rates
Moderate Severity, Major Ortho	0	3,954	0.00%	0.31%	12
Moderate Severity, Minor Ortho	0	1,614	0.00%	0.04%	1
Moderate Severity, Medical	0	79	0.00%	0.70%	1
Severe Severity, Major Ortho	2	346	0.58%	3.71%	13
Severe Severity, Minor Ortho	0	24	0.00%	3.38%	1
Severe Severity, Medical	0	1	0.00%	7.03%	0
TOTAL	2	6,018			27

Source: Study of Physician-Owned Specialty Hospitals, Centers for Medicare & Medicaid Services (2005) 43, table 5.4. Calculations by author.

Table 3: Deaths at Specialty and General Hospitals

	General Hospital Patient Deaths	General Hospital Patients	General Hospital Mortality Rate	Specialty Hospital Mortality Rate	General Hospital Patient Deaths at Specialty Hospital Mortality Rates	Potential Lives Saved
Moderate Severity, Major Ortho	124	40,192	0.31%	0.00%	0	
Moderate Severity, Minor Ortho	6	13,960	0.04%	0.00%	0	
Moderate Severity, Medical	102	14,583	0.70%	0.00%	0	
Severe Severity, Major Ortho	526	14,178	3.71%	0.58%	82	
Severe Severity, Minor Ortho	28	829	3.38%	0.00%	0	
Severe Severity, Medical	315	4,484	7.03%	0.00%	0	
TOTAL	1101				82	1019

Sources: Study of Physician-Owned Specialty Hospitals, Centers for Medicare & Medicaid Services (2005) 43, table 5.4. Calculations by author.

Table 3 shows what would have been the impact on inpatient mortality had the general hospitals achieved the mortality rates (again adjusted by severity) demonstrated by specialty hospitals. According to this analysis, 1,019 of 1,101 inpatient deaths would not have occurred in general hospitals if their patient mortality rates were equal to those of their specialty hospital competitors.

One researcher who has studied quality of care issues at specialty hospitals is Dr. Peter Cram at the University of Iowa School of Medicine. A 2005 study of cardiac specialty hospitals by Dr. Cram and several other researchers found that, after adjusting for patient severity, patients in specialty hospitals had an 11 percent to 16 percent better chance of avoiding death than patients in gen-

eral hospitals.³⁴ They concluded that the lower mortality rate was largely linked to the increased volume of surgeries performed at specialty hospitals³⁵ explaining that greater surgical volumes by both doctors and hospitals are closely linked to improved patient outcomes and reduced risk of mortality.³⁶

More recent research by Dr. Cram and his colleagues comparing patient outcomes at orthopedic specialty hospitals and general hospitals found significantly better patient outcomes at specialty hospitals. After adjusting for patient severity, their research found that patients at specialty hospitals were nearly 40 percent less likely than similar patients in general hospitals to experience adverse events including post-op hemorrhage, wound infection, and death, and after adjusting

for procedural volume as well, patients at specialty hospitals were 35 percent less likely to experience adverse events than patients in general hospitals.³⁷

As a result of this most recent study, Dr. Cram and his colleagues concluded that “There may be real, tangible benefits to hospital specialization”³⁸ and the “premature dismissal of the specialty hospital concept may deprive patients of an important innovation in health care delivery.”³⁹

Patient complications, particularly those considered preventable, are another key measure of the quality of care delivered at hospitals. The table on the following page summarizes the results of a September 2005 report prepared by outside researchers for CMS, com-

Table 4: Patient Complications at Specialty and General Hospitals

	Cardiac Specialty	General Cardiac	Orthopedic Specialty	General Orthopedic
Complications of Anesthesia	0.11	0.07	0.40	0.38
Death in Low-Mortality DRG	0.90	1.22	0.00	1.56
Decubitus Ulcer	0.64	0.91	0.47	1.10
Failure to Rescue	0.57	0.86	0.29	0.73
Foreign Body Left During Procedure	0.88	0.99	0.00	1.08
Latrogenic Pneumothorax	1.83	2.38	0.00	0.59
Selected infections due to medical care	0.56	1.33	0.00	1.35
Post-Op Hip Fracture	0.57	1.37	--	--
Post-Op Hemorrhage or Hematoma	0.35	0.68	1.71	1.57
Post-Op Physiologic and Metabolic Derangements	1.32	2.49	0.00	0.19
Post-Op Pulmonary Embolism or DVT	0.53	0.93	0.52	1.24
Post-Op Sepsis	0.67	1.03	0.09	0.66
Post-Op Wound Dehiscence	0.00	1.47	--	--
Accidental Puncture or Laceration	1.27	1.32	1.65	1.77
Post-Op Respiratory Failure	--	--	0.21	1.40
Transfusion Reaction	--	--	0.00	0.00

Source: Data from Specialty Hospital Evaluation-Final Report, International Health, Social, and Economic Research (Sept. 2005) 94-97, tables 5.5 and 5.6, RTI.

paring patient complications in cardiac and orthopedic specialty hospitals against competitor general hospitals.

Similar to the data for inpatient mortality, specialty hospitals appear to be providing a superior level of care as measured by complication rates when compared to general hospitals. Cardiac specialty hospitals do better in 13 of 14 areas measured, in many areas by a significant margin. For example, infections due to medical care at specialty hospitals occurred in 1.37 cases of every 1,000 admissions, only 56 percent of the expected rate of 2.42 infections per 1,000 admissions. Competitor general hospitals, on the other hand, had infections with 3.91 cases of every

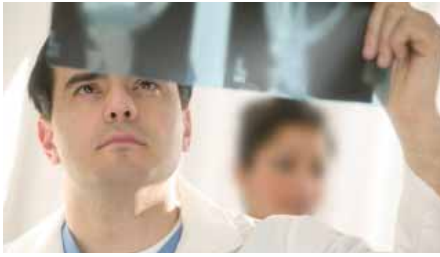
1,000 admissions, 133 percent of the 2.94 expected rate of infections.⁴⁰

Orthopedic specialty hospitals also performed better than competitor general hospitals, topping them in 11 of 14 areas measured and tying in one area as well. In several areas orthopedic specialty hospitals reported no incidences of complications, including objects left in a body during surgery, infections due to medical care, and death in low-mortality DRGs.⁴¹

One notable measurement where general hospitals do better is in the area of re-admissions for cardiac patients. Re-admissions can indicate “a problem associated with the quality of care during the [initial] admission”

according to one report.⁴² Cardiac specialty hospitals had a re-admission rate of 8.91 percent, compared to 7.73 percent for competitor general hospitals.⁴³ The higher re-admission rate in cardiac hospitals is more pronounced for patients with more severe illnesses, leading one report to suggest that “with respect to the most severely ill patients ... quality may be inadequate.”⁴⁴

Specialty hospitals that do not focus on cardiac care do not seem to have similar problems with re-admissions. Orthopedic specialty hospitals outperformed competing general hospitals in regard to re-admissions, with only 1.73 percent of their patients being readmitted compared to 3.53 percent at general hospitals.⁴⁵



While more difficult to quantify, patient satisfaction is an element of quality of care. Studies have generally reported an extremely high level of patient satisfaction in specialty hospitals compared to general hospitals. For example, stays in specialty hospitals of all types tend to be shorter than in competitor general hospitals⁴⁶ and patients are more likely to be discharged directly to their own homes rather than a rehabilitation or nursing facility.⁴⁷

Patient amenities are frequently better at specialty hospitals compared to competitor general hospitals. Discussing patient amenities, one report found that

“... beneficiaries receiving care at specialty hospitals had very positive experiences and expressed appreciation for the “extras” provided. Beneficiaries commented on the private rooms, more space, lower noise levels, and treatment of family members ... Several beneficiaries [noted] how the environment seemed to make recovery easier ... In contrast, many beneficiaries discharged from [general] hospitals expected the inconvenience associated with a shared room, a higher level of noise, limited family member accommodations, less plush waiting areas, and occasionally nettlesome teaching rounds and residents and interns.”⁴⁸

Several other factors also contribute to a higher level of patient satisfaction at specialty hospitals compared to general hospitals, particularly in the area of nurses. Patient-to-nurse ratios tend to be lower in specialty hospitals and nurse turnover is extremely low.⁴⁹ According to one report prepared by CMS, nurse staffing levels at specialty hospitals was “no more than three or four patients to a nurse and this staffing level was believed to enable nurses to spend more time with patients and their families.”⁵⁰ The report also noted that in competing general hospitals, 10 or 12 patients per nurse is not uncommon.⁵¹

Nursing care at specialty hospitals was typically delivered directly by RNs rather than nurse assistants or other less-trained personnel.⁵² In focus-group meetings with researchers, patients thought the “nurses were more attentive and knowledgeable at specialty hospitals”⁵³ than at general hospitals. Patients at general hospitals reported communication problems and language barriers with nurses, while there were no reports of such problems at specialty hospitals.⁵⁴

Patient amenities like private rooms, a more relaxing environment, efforts to accommodate family members, as well as a low nurse-to-patient ratio and more knowl-

edgeable nursing staff, have all contributed to higher levels of patient satisfaction than might be expected in a general hospital. It also seems reasonable to believe that these factors may contribute to better overall outcomes for patients in areas like reduced complications and quicker recovery time.

On balance, the evidence overwhelmingly demonstrates that specialty hospitals provide a consistently better level of care compared to general hospitals, with fewer complications and faster recoveries even after differences in patient severities are accounted for, and significantly higher levels of patient satisfaction. Specialization in hospital services appears to provide the same benefits to patients that specialization in other areas provides to consumers: better quality and greater satisfaction.

Financial Impact

Many critics argue that specialty hospitals take paying patients from general hospitals. Because of the way health care financing is structured in the U.S., some hospital services are reimbursed above cost, other reimbursement rates barely cover costs, and a number of services are reimbursed well below cost. The resulting cross-subsidization

Another consideration regarding the financial impact of specialty hospitals is the amount of charity care provided by both specialty and general hospitals, as well as the tax contributions of specialty hospitals compared to their non-profit counterparts.

allows a hospital's profit centers to support those that sustain losses.

To make this arrangement possible, hospitals must rely on a certain patient mix. Beyond whether a patient's care is paid by private insurance, public programs, or chalked up to uncompensated care, some patients are healthier than others and therefore less costly to treat. Until recently, hospitals were paid the same for both high- and low-severity patients, creating an incentive for physician-owners to only treat less severely ill patients in their own facilities while referring more severely ill patients to general hospitals in order to maximize their own revenues.

While some have argued that specialty hospitals built a practice around treating relatively healthy patients needing highly profitable treatments, and referring less profitable patients to general hospitals, most studies have not found that general hospitals suffer financially due to the creation of specialty hospitals. Furthermore, although there are some legitimate concerns about patient selection, they seem to be largely influenced by factors other than physician-owners' financial incentives.

A March 2005 study from the Medicare Payment Advisory Commis-

sion reported that general hospitals facing competition from a heart specialty hospital saw their margins decline from 6.4 percent in 1997 to 3.4 percent by 2002, while those facing competition from an orthopedic specialty hospital saw margins fall from 6.6 percent to 5.6 percent.⁵⁵ However, these declines were actually less than the declines experienced by general hospitals in markets without competition from specialty hospitals, who saw their margins decline between 1997 and 2002 from 6.4 percent to 2.7 percent.⁵⁶

The report suggests that general hospitals competing with specialty hospitals "were able to "make up" lost revenue from other sources or reduce their costs."⁵⁷ On site visits, researchers found that general hospitals had "lowered their expenses by cutting staff ... [instituted] aggressive pricing strategies to raise revenue from private payers ... [and expanded] into areas they view as profitable, such as imaging, rehabilitation, pain management, and neurosurgery."⁵⁸

The Kansas Health Institute (KHI) also found that the 11 specialty hospitals in Kansas did not appear to be harming the operating margins of general hospitals, or at least that any such harm was relatively minor. In a December 2006 report,

KHI found that the average operating margin among general hospitals was -.7 percent in 1998 before any specialty hospitals opened and well below the average in 1998 for all U.S. non-profit hospitals of about 4.3 percent.⁵⁹ By 2003 the average operating margin for Kansas general hospitals had declined to approximately -1.6 percent, while across the U.S. it had risen slightly to about 5.1 percent for non-profit hospitals.⁶⁰

The study's author noted that "... the entry of specialty hospitals into the marketplace has not ... clearly impacted overall general hospital revenue and margins."⁶¹

Regarding patient selection for severity of illness, studies have generally found that specialty hospitals treat a somewhat healthier mix of patients. However, there appear to be reasons not related to financial incentives for at least some, if not most, of the differences in severity classifications for patients treated at specialty and general hospitals.

The September 2005 report to CMS describes the differences in patient severity among Medicare patients admitted to specialty hospitals and general hospitals. At the 18 heart specialty hospitals examined, 23.3 percent of all patients were in the "major" or "extreme" classification,

In Oklahoma City non-owners had 27 percent of their patients discharged from general hospitals classified as “major” or “extreme” compared to 20.4 percent of their specialty-hospital discharges.

while at the 98 competing general hospitals 29.5 percent of their patients were classified as either “major” or “extreme” severity.⁶²

A more recent study by The Lewin Group, commissioned by the cardiac specialty hospital chain MedCath, found that the patients in MedCath’s 12 hospitals that were open in 2005 actually had a higher level of severity on average than those of ‘peer hospitals.’⁶³ One of the main findings of the study was that “...MedCath heart hospitals have a 23.7 percent higher case mix severity for cardiac patients than the peer community hospitals.”⁶⁴

For orthopedic patients in the CMS study, the difference was more significant. While 22.9 percent of orthopedic patients at general hospitals were classified as either “major” or “extreme,” only 6.3 percent of specialty hospital orthopedic patients were in these higher severity classes.⁶⁵ For surgical specialty hospitals, 8.1 percent of patients were “major” or “extreme” compared to 18.1 percent at competing general hospitals.⁶⁶

On the surface, the differences may appear to support the claim that physician-owners are steering the least-ill patients to their own facilities for greater profits, while avoiding costlier patients by pushing

more severely ill patients into general hospitals. However, comparing the patient characteristics of non-owner physicians with admitting privileges at specialty hospitals to those of physician-owners seems to cast doubt on this claim.

Again looking at Medicare patients, the CMS report compared the discharges of physician-owners to physicians who had admitting privileges at specialty hospitals but did not have an ownership interest. Without a financial stake or profit motive, non-owners could reasonably be expected to recommend patients for treatment at the most appropriate facility without regard to how it would impact the profitability of a facility.⁶⁷

Examining six specialty hospital markets, researchers generally found that the severity levels of patients treated by non-owners at specialty hospitals was similar to those of patients treated by owners. In some cases physician-owners actually treated a greater share of more severely ill patients at their own hospitals than non-owners.

The four markets for cardiac care provide the greatest number of discharges to examine. The CMS researchers found that in the Dayton market, 29.9 percent of discharges from general hospitals by both non-

owner physicians and physician-owners were for patients classified as “major” or “extreme,” while 41.9 percent of non-owner discharges from specialty hospitals and 37.8 percent of physician-owner discharges were “major” or “extreme” in levels of severity.⁶⁸

In the other cardiac markets studied, both physician-owners and non-owners treated fewer of the most severely ill patients in specialty hospitals and more of them in general hospitals, although the differences were generally not large. For example, in Oklahoma City non-owners had 27 percent of their patients discharged from general hospitals classified as “major” or “extreme” compared to 20.4 percent of their specialty-hospital discharges.⁶⁹

In markets with orthopedic and surgical specialty hospitals, a similar pattern exists between owners and non-owners, although the differences in patient severity between specialty hospitals and general hospitals is much larger. In Oklahoma City, 20.3 percent of non-owner and 25.4 percent of physician-owner orthopedic discharges from general hospitals were classified as “major” or “extreme,” compared to only 4.5 percent of non-owner and 2.1 percent of physician-owner discharges from specialty hospitals.⁷⁰



Because physicians without ownership interests in specialty hospitals appear to have referral patterns similar to physician-owners regarding patient severity, something other than financial considerations is likely to be the explanation for why specialty hospitals generally treat fewer patients classified as ‘major’ or ‘extreme.’

The most likely explanation for the difference in patient severity levels treated by specialty and general hospitals is that both physician-owners and non-owners are in fact simply recommending their patients to the facility that is most appropriate for treatment, implying that general hospitals are more likely to provide the needed level of care for more complex cases. Texas-specific studies report the same: both physician owners and non-owners direct more complex and severely ill patients to general hospitals, for the primary reason that general hospitals are better equipped to handle the complications that often accompany these cases.⁷¹

Another consideration regarding the financial impact of specialty hospitals is the amount of charity care provided by both specialty and general hospitals, as well as the tax contributions of specialty hospitals compared to their non-profit counterparts. Although not a perfect comparison, it is useful to keep in mind that specialty hospitals pay

property and sales taxes, and pay income taxes on profits. These are payments to the community that would not be made if the specialty hospital did not exist and all procedures were performed in non-profit community hospitals.

The September 2005 report to CMS attempted to calculate the “net community benefits” of both specialty and non-profit hospitals. The benefits, such as tax payments and charity care, were given as a percentage of total operating revenues. Generally, the study found that specialty hospitals provide a total “net community benefit” of 5.52 percent of total operating revenues, compared to 2.48 percent for non-profit hospitals.⁷² An important caveat, however, is that the difference between what it costs to treat Medicaid patients and what Medicaid actually pays was not included.

Another frequent criticism is that investment in new medical facilities and equipment by specialty hospitals—as well as new non-profit and for-profit general hospitals— inherently leads to an increase in overall health care expenditures. Along these lines, critics argue that such investments result in duplication of services and equipment, as well as over-utilization of services, requiring more government coordination to ensure efficiency.

As a result, some critics have quietly suggested a negotiated stance—one that would allow the continued operation and construction of specialty hospitals, but only if coupled with the return of Certificate-of-Need (CON) regulations that give the government the ability to approve and deny applications for these facilities. Although the significant body of literature addressing the problems with CON is beyond the scope of this discussion, a few points bear recognition in considering whether reinstating CON laws would be beneficial for any purpose. Most notable is that although every state by 1980 had enacted CON laws, it soon became clear that the regulations had not succeeded in reducing health care costs. This prompted the federal government to repeal its CON requirement. Several states followed the federal government’s lead in abolishing CON laws, including Texas. Several scholars with Duke University’s Center for Health Policy, Law, and Management found that “CON laws had no effect on overall health care spending. While they found a modest reduction in hospital costs, this decline was offset by an increase in physician costs”⁷³ and “result(ed) in a slight (2 percent) reduction in bed supply but higher costs per-day and per admission, along with higher hospital profits.”⁷⁴



Specialization in hospital services appears to provide the same benefits to patients that specialization in other areas provides to consumers: better quality and greater satisfaction.

A later study by the same authors found that repeal of CON laws does not “lead to a ‘surge’ in either acquisition of new facilities or medical expenditures.”⁷⁵ They also found evidence to suggest that CON results in an increase in costs, contrary to the goal of these laws.⁷⁶ Even more persuasive may be the joint report from The Federal Trade Commission and the U.S. Department of Justice that concluded in a 2004 study that there is “considerable evidence that [CON laws] can actually drive up prices by fostering anti-competitive barriers to entry.”⁷⁷

Whatever may be the financial impact of specialty hospitals on general hospitals, it is unlikely that the additional capacity they introduce to the health care marketplace contribute in any way to climbing total health care expenditures.

Conclusion & Recommendations

The introduction of for-profit specialty hospitals in Texas and around the country has raised concerns among policymakers about the quality of care delivered by specialty hospitals, the financial incentives faced by physician-owners, and the impact on the ability of general hospitals to continue providing needed care to the community.

Based on the available research and information on specialty hospitals, the following conclusions can be made:

1. The literature on both clinical evidence as well as patient satisfaction surveys support the contention that the quality of care delivered in specialty hospitals is generally superior to that delivered in general hospitals.
2. Although there is evidence to support the claim that markets with specialty hospitals experience increases in utilization greater than markets without specialty hospitals, there is no clear evidence that the increase is inappropriate, nor is there any evidence that increased utilization is being driven by physician-owners pursuing profits at the expense of their patients.
3. There is substantial evidence to support the claim that specialty hospitals generally treat patients that are not, on average, as ill as patients treated in general hospitals. However, there is not evidence to suggest on any systematic effort by physician-owners to exclude or limit the treatment of less-profitable patients who are more severely ill, or otherwise adopt inappropri-

ate referral patterns in the pursuit of profits.

4. To date, the financial health of general hospitals does not appear to have been significantly impacted in a negative way by competition from specialty hospitals. Instead, general hospitals appear to have been able to deal with competition by cutting costs, expanding into profitable lines of business, and increasing revenues from private payers.

Accordingly, Texas lawmakers should reject efforts that limit competition and restrict the operation of specialty hospitals. Instead, lawmakers concerned about self-referral and the impact to general hospitals should consider loosening regulations on general hospitals, including employment arrangements for hospital-based physicians, in an effort to allow general hospitals to compete more freely with specialty facilities.

Specifically, the state should maintain a legal and regulatory environment that promotes competition among medical facilities, including for-profit, non-profit, and government-owned full-service hospitals, specialty hospitals, and ambulatory surgical centers. Barriers to competition should be limited to those that

ensure that facilities are capable of appropriately treating the patients they admit, rather than attempting to dictate certain medical services or patient severity mix or limit physician involvement in the ownership of facilities.

Additionally, to the extent that specialty hospitals may in the future harm the financial health of general hospitals, examine government policies that may impose undue burdens on general hospitals and adopt policies that lessen or even eliminate such burdens.

Finally, the state must continue to encourage health insurance structures that put individuals in control of these decisions. In reality, consumers pay for only 20 percent of their health care services and the remainder is paid for by a third party. As long as this arrangement continues, and consumers are responsible for such a small portion of their health care, we will continue to see over-utilization of health care services. The only way to combat this is to increase consumer sensitivity to the cost of health care services, giving patients a stake in their health care decisions and ex-

pecting consumers to ask the important questions: is this necessary? Are there less expensive alternatives? Is the facility to which you are referring me the *best* facility to treat me? In the absence of consumer involvement, policymakers around the country will be forced to control expenditures by limiting and controlling patient choice, potentially eliminating specialty hospitals and their specialized, quality care in the interest of the bottom line.

The most significant policy issue regarding specialty hospitals has already been addressed at the federal level, by adjusting hospital payments to reflect differences in patient severity. The above recommendations should satisfy most other concerns and lead to the development of a better understanding of the quality of care delivered by specialty hospitals, as well as the extent to which any problems exist related to patient severity case mix and increased utilization.

By permitting the continued development of specialty hospitals while taking measures to relieve any burdens imposed on general hospitals by government, Texas

policymakers can ensure that patients in the future will be able to benefit from high-quality care, delivered in the most appropriate setting, recommended by physicians working in the best interests of their patients.

The alternative, restricting or even eliminating innovative health care delivery facilities in order to protect established entities from competition, would result in a reduction in the quality of care available for the citizens of Texas, and should therefore not be considered. With the expiration of both the explicit and the de facto federal moratoriums on specialty hospitals, Texas should continue to be an example of innovations in the delivery of health care by allowing these facilities to flourish in a market-driven environment.

Competition drives innovation, efficiency, and quality improvements in all areas of our economy, and Texas has in many ways taken the lead in allowing a flourishing and vibrant marketplace for hospital services. Good public policy would continue to allow the development of this competitive marketplace. ★

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About the Author

Sean Parnell is currently president of the Center for Competitive Politics, a non-partisan and non-profit organization that promotes the First Amendment political rights of speech, assembly, and petition. He is also a Policy Advisor and the former vice president of external affairs at The Heartland Institute, a national non-profit research and education organization whose mission is to discover, develop, and promote free-market solutions to social and economic problems.

Parnell has written and spoken frequently on the issue of health care, with a particular focus on innovation in the delivery and financing of health care services. In addition to being a regular contributor to Health Care News on these and other topics, Parnell has also submitted testimony to Congress and spoken before other gatherings of public officials and health care professionals. He has also written on budget and tax issues, education reform, telecommunications policy, and legal reform.

Parnell received a bachelor's in economics from Drake University in 1996, and resides in Alexandria, VA with his wife Anne.

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