

# Specialty hospitals: Myths vs. facts

**MYTH: Specialty hospitals harm general hospitals.**

**FACT: There is no evidence that specialty hospitals harm general hospitals.**

The most recent Government Accountability Office (GAO), Medicare Payment Advisory Commission (MedPAC), and Centers for Medicare and Medicaid Services (CMS) reports confirm earlier findings that general hospitals are largely unaffected by competition from specialty hospitals, and specialty hospitals stimulate a competitive environment in many markets, which can have positive effects on quality of care. Specifically, the GAO report found that there was little evidence to suggest that general hospitals made substantially more or fewer operational or service changes, or different types of changes, if some of their competition came from a specialty hospital. Similarly, MedPAC's updated evaluation of specialty hospitals found that specialty hospitals do not have a statistically significant effect on the total revenue or total margins of community hospitals in their markets. Finally, a 2006 CMS-funded study published in *Health Affairs* found that specialty hospitals actually stimulate a competitive environment, which can have very positive effects on quality of care.

**MYTH: Physician-owned specialty hospitals provide poor quality of care and are a drain on their communities.**

**FACT: Specialty hospitals provide clear quality and community advantages.**

A 2006 CMS-funded study published in *Health Affairs* found that risk-adjusted 30-day mortality rates were significantly lower for specialty hospitals than for community hospitals. The study also found that Medicare patients' satisfaction with specialty hospitals was very high and that specialty hospitals incurred a greater net community benefit than community hospitals when accounting for the value of uncompensated care provided by specialty hospitals and taxes paid by them. In addition, 33 specialty hospitals across the country received a five-star rating from HealthGrades, functioning in the top 15 percent of hospitals in the nation.

**MYTH: Certain policies regarding specialty hospital emergency responses and patient transfers violate Medicare's conditions of participation, as noted in a recent Office of Inspector General (OIG) report**

**FACT: Virtually all of the "facts" and conclusions in the report that relate to hospital compliance with federal staffing requirements and emergency policies are without merit.**

Specifically, 29 of the 37 hospitals the OIG claimed use 911 as a substitute for stabilizing patients have challenged the allegation and provided documentation that supports the falsity of the OIG's claim. In addition, all eight of the hospitals the OIG listed as supposedly violating Medicare conditions of participation due to improper staffing have produced documentation showing that they were, in fact, properly staffed based upon CMS guidelines during the times in question. Finally, the OIG negatively reported on the number of hospitals with emergency rooms and the size of those emergency rooms. However, the report neglected to mention that state law controls these issues and that all of the hospitals met their state law requirements. CMS and other independent accrediting bodies have deemed these hospitals acceptable. Many of them are five-star ranked by HealthGrades and/or listed by independent quality authorities as the No. 1 hospital in their specialty and state. The OIG Report does a disservice both to the medical professionals of these hospitals and, more critically, to the patients who are served by them.

**MYTH: Efforts by the general hospitals to enact legislation that would ban physician-owned hospitals, such as H.R. 1424, would not close these hospitals or reduce access to care.**

**FACT: Legislation that bans new physician-owned hospitals and imposes burdensome conditions on existing ones, including H.R. 1424, will effectively dismantle the entire physician-owned hospital sector.**

This legislation would eliminate the "whole hospital exception" to the Stark self-referral regulations, which permits physicians to refer Medicare or Medicaid patients

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to hospitals in which they have an ownership interest provided they meet certain conditions. Absent this exception, physicians would be prohibited from referring Medicare and Medicaid patients to hospitals in which they have an ownership interest, making it virtually impossible for a new physician-owned hospital to survive. In addition, H.R. 1424 would put onerous conditions on existing physician-owned hospitals. These conditions include significant restrictions on growth and reducing physician ownership in the aggregate to 40 percent and individually to two percent, forcing physicians to sell at fire-sale prices due to government intervention in a private market.

**MYTH: Physicians who invest in specialty hospitals to which they refer patients create a conflict with the best interests of their patients.**

**FACT: Physician investment in—and referral to—a specialty hospital does not conflict with the best interests of patients.**

- MedPAC and CMS have found no evidence that physicians who have an ownership interest in a specialty hospital inappropriately refer patients to that hospital or have increased utilization.
- Data shows there is no difference in referral patterns between physician-investors and non-investors, proving that ownership and profit are not the driving factors in referring to specialty hospitals
- MedPAC found no evidence that overall utilization rates in communities with specialty hospitals rose more rapidly than utilization rates in other communities.
- The majority of physicians who admit patients to specialty hospitals have no ownership interest and thus receive no financial incentives to refer patients to them. In fact, approximately 73 percent of physicians with admitting privileges at specialty hospitals are not investors.
- A 2006 CMS-funded study published in *Health Affairs* found that most physicians refer patients to specialty hospitals for reasons totally unrelated to profits.

**MYTH: Physicians who invest in specialty hospitals “channel” patients to these hospitals.**

**FACT: It is general hospitals—not specialty hospitals—that “channel” patients.**

- General hospitals adopt policies that force hospital staff physicians to refer patients only to their facilities.
- General hospitals purchase physician practices and direct the physicians to refer to the hospital.
- General hospitals operate health plans with network referral requirements.

When hospitals dictate where physicians may refer patients, the hospital takes medical decision-making away from physicians and patients. This limits patient choice and can conflict with their specific health care needs.

**MYTH: Physicians who invest in specialty hospitals will not serve “on-call” in the general hospital’s emergency department.**

**FACT: Physician ownership of specialty hospitals is not the reason that hospitals are facing on-call coverage problems.**

On-call coverage problems result from numerous issues such as medical liability concerns, shortages of certain specialty physicians, unequal payment rates for on-call services, and the generally increasing demands on medical staff. Some general hospitals have actually exacerbated on-call coverage problems by adopting policies that alienate physicians—such as forcing physicians off their medical staff if they invest in a specialty hospital. Thus, problems that hospitals are experiencing with on-call services to their emergency departments began long before general hospitals became concerned about specialty hospitals.

**MYTH: General hospitals offer a full range of services that communities depend on in times of need—such as trauma care and burn units.**

**FACT: Though a number of general hospitals do offer such services, the majority do not.**

According to the American Burn Association, there are only 128 hospitals with specialized burn centers in the U.S. In addition, as of October 2006, there were only 189 Level I trauma centers, (the highest level trauma centers), and only 261 Level II trauma centers (secondary trauma centers that work in collaboration with and supplement Level I centers).

**MYTH: Specialty hospitals exist because of a loophole in the Stark self-referral laws, known as the “whole hospital exception.”**

**FACT: Specialty hospitals do not exist because of a so-called legal “loophole.”**

The “whole hospital exception” to the Stark laws permits physicians to invest in, and refer patients to a hospital if they treat the patients at the hospital and the referral is to that “hospital itself” and not merely a distinct part or department of the hospital, such as the laboratory. *Specialty hospitals are ENTIRE hospitals, not subdivisions of hospitals.* They provide

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a wide range of services for patients from “beginning-to-end” of a course of treatment, including specialty and sub-specialty physician services, and a full range of ancillary services. Many specialty hospitals also provide primary care services and have intensive care units and emergency departments.

**MYTH: CBO found that enactment of a ban on physician-owned hospitals would result in significant savings to the Medicare program and that improper physician self-referral increased utilization of health care services.**

**FACT: CBO’s cost estimates were not based upon physician over utilization. CBO’s cost estimates were, however, based upon an improper assumption—that a significant share of the service volume remaining after the destruction of the physician-owned hospital sector will migrate to ambulatory surgery centers (ASCs).**

CBO’s analysis assumes that services currently provided by physician-owned hospitals would migrate to ASCs, which are reimbursed at a lower rate than specialty and general hospitals. This assumption ignores the fact that 74 percent of the dollar-volume of ASC services is gastroenterology and ophthalmology services, which are not provided in great volume at hospitals. ASCs are fundamentally different facilities than hospitals and are simply not going to be able to absorb services that CBO claims would migrate to ASCs. Migration of services from physician-owned hospitals is much more likely to occur to other hospitals, which are paid the identical rates for treating patients as physician-owned hospitals.