

MARKET WATCH

Specialty Versus Community Hospitals: What Role For The Law?

A paradox exists in the mixed market/regulatory posture of U.S. health care.

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ABSTRACT: U.S. health care has long featured a struggle between regulation and markets as vehicles of reform, and the community hospital is at the center of this struggle. The key to its financial viability is cross-subsidization, whereby revenues from insured patients subsidize the care of the uninsured and underinsured, and profits from well-compensated services support those operating at a loss. Cross-subsidization has been challenged by efforts to move highly compensated services and well-insured patients to ambulatory surgical centers and specialty hospitals. We review the ongoing battle between through a legal lens and offer conjectures about the outcome. Refined certificate-of-need regulation may be the preferable policy choice.

A CRITICAL BATTLEGROUND in the ongoing conflict between regulation and markets as vehicles of reform in U.S. health care is the community hospital. The key to these hospitals' financial viability is cross-subsidization. Patients with private insurance underwrite under- and uncompensated care for Medicaid patients and the indigent, and profits from well-compensated services, such as cardiac care and orthopedic surgery, support services operating at a loss, such as emergency rooms and substance abuse counseling. Without a single payer to redistribute resources across the system as a whole, the hospital performs this function in a microcosm.

For twenty-five years, efforts to remove highly compensated services and well-insured

patients from the hospital have challenged cross-subsidization.¹ The best example is the ambulatory surgical center (ASC), developed by for-profit chains in partnership with local surgeons. Efforts to remove services from hospitals have accelerated.² Nearly every profit center in the hospital other than surgeries with longer lengths-of-stay—high-reimbursement radiology, many orthopedic procedures, and all forms of endoscopy—can now be moved off site. The Federal Trade Commission (FTC) and the Department of Justice (DOJ) applaud these developments as market-driven responses to the high costs of hospital-based care.³ General hospitals warn that specialty hospitals threaten their financial viability and quality of care by reducing the volume of procedures performed in full-service settings.

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Hospitals have encouraged legal responses to inhibit the removal of services. There are four such sets of responses. First, since physicians working in specialty hospitals generate patient flows by referring their own patients, the federal Stark anti-self-referral law has been amended to impose an eighteen-month moratorium on reimbursement to physicians for self-referral of Medicare and Medicaid patients to specialty hospitals that were not in existence or under development in November 2003.⁴ Second, state self-referral laws could inhibit physician ownership of new centers. Third, state certificate-of-need (CON) laws may retard the development of freestanding specialty facilities. Fourth, hospitals may use “economic credentialing”: denying admitting privileges to physicians who compete for patients and profits by investing in specialty facilities.

We review this growing battle over specialty hospitals through a legal lens and offer some conjectures about the outcome. Although self-referral rules have been the principal means for regulating specialty hospitals, it is unclear whether self-referral is a major issue in specialty facilities. In addition, the legality of economic credentialing under federal law is questionable. The use of legal tools to address a problem for which they were not designed highlights the need to directly address community hospitals’ financial viability. As a result, refined CON regulation may be the preferable policy choice.

Moving Services From The General Hospital

■ **Economic forces.** The economic forces driving the rise of specialty facilities were identified more than thirty years ago by Jeffrey Harris, who described hospitals as “two firms.”⁵ Hospital administrators provided specialized inputs for medical care, such as operating rooms, inpatient beds, and diagnostic laboratories, while physicians determined the nature and level of patient care. This internal division reflected the physician’s fiduciary obligation to provide all appropriate care without regard to cost.

For Harris, this organizational structure created two problems. First, without formal pricing mechanisms for physicians to signal where hospital administrators should distribute resources, physicians instead used “loosely enforced standards, rules of thumb, side bargains, cajoling, negotiations, special contingency plans, and in some cases literally shouting and screaming.”⁶ Second, the limits of hospital capacity had to be set without being able to predict the exact demand for patient care. Hospital administrators had an incentive to minimize reserve capacity, while physicians did not. The stress on internal resources would increase as demand approached the limits of hospital capacity. In the worst-case scenario, these arrangements could unravel, converting the hospital into a series of fiefdoms of separate specialties.

This kind of balkanization renders hospitals unable to pool risk across patients or to redistribute resources from better-insured to under- and uninsured patients and from profitable to unprofitable categories of treatment. Moreover, the breakup of the hospital can occur not only within the hospital itself, but also through the exit of specialties and patients to separate facilities.

■ **Rise of specialty facilities.** The rise of specialty hospitals and ASCs illustrates these trends. Specialty facilities focusing on the health care needs of specific patient populations or a limited range of medical procedures are not new (for example, children’s and psychiatric hospitals). However, ASCs and specialty hospitals are different, because they draw patients and revenue directly away from community hospitals instead of complementing their services.

ASCs are outpatient facilities. Ophthalmologic procedures, such as cataract removal and lens insertion, and gastroenterology procedures, such as colonoscopy and upper gastrointestinal endoscopy, account for more than two-thirds of ASC services provided to Medicare beneficiaries. ASCs are less capital-intensive and much larger in number than specialty hospitals, and they are growing rapidly. The number of Medicare-certified ASCs increased

50 percent between 1997 and 2003, to 3,735. Over the same period, Medicare payments to ASCs doubled (to \$2.07 billion), as did the volume of ASC procedures provided to Medicare beneficiaries.⁷

The U.S. Government Accountability Office (GAO) has defined specialty hospitals as inpatient facilities in which two-thirds of patient claims are in one or two major diagnosis categories or diagnosis-related groups (DRGs). As of February 2003, 110 hospitals met these criteria. Ninety-two were cardiac, orthopedic, surgical, or women's hospitals, which accounted for 2 percent of short-term, acute care general hospitals across the United States. In 2001, less than 1 percent of Medicare spending on inpatient care was for treatment at specialty hospitals. However, specialty hospitals more than tripled in number between 1990 and 2003.⁸ New specialty hospitals tend to be located in fast-growing urban areas and are concentrated in states without CON legislation.⁹ Larry Casalino and colleagues also report that specialty hospitals are concentrated in areas with large single-specialty cardiology or orthopedic medical groups and are less likely to be created in markets with dominant hospitals.¹⁰

■ **Physician investment.** The rise of ASCs and specialty hospitals has been fueled by physician investment. Seventy percent of specialty hospitals (either existing or under development) that reported ownership data to the GAO had some physician ownership, and the average rate of physician ownership was just over 50 percent.¹¹ As of February 2004, physicians had ownership interests in 83 percent of ASCs, and they owned 43 percent outright.¹² Physicians invest in specialty facilities to increase their compensation without raising the volume of procedures or revenues, because they now access profits as well as professional fees. Not surprisingly, 74 percent of specialty hospitals are for-profit, compared with 20.1 percent of general hospitals.¹³ Hoangmai Pham and colleagues have linked physician investment in specialty facilities during the 1990s to declining physician incomes, which fell 5 percent between 1995 and 1999 because of man-

aged care cost containment efforts.¹⁴

Physician investment in specialty facilities may also be an attempt to assert greater control over the practice environment. Specialty facilities are customized for a limited set of procedures. The physicians who perform those procedures choose their surgical equipment and the scheduling of their procedures, and they may hire the specialty-trained nurses with whom they work. In community hospitals, many or all of these decisions would be made by hospital administrators, often slowly and without physician consultation, balancing the interests of many specialty groups.

■ **Role of industry groups.** The focus of recent debate has been on specialty hospitals; the debate has engaged leading health industry associations. The American Hospital Association (AHA), sometimes with the Federation of American Hospitals (FAH), has called for federal regulation to stem the rise of specialty hospitals.¹⁵ The AHA argues that specialty hospitals erode cross-subsidization by "cherry picking" relatively well-insured and healthy patients (where profit margins are higher) and by limiting or denying care outright to under-insured, indigent, and less healthy patients. Specialty hospitals can also focus on the most profitable procedures, such as cardiovascular surgery and orthopedic surgery. Patients and treatments excluded from specialty hospitals remain the responsibility of community hospitals. Because of the flight of profitable patients and services to specialty facilities, community hospitals may become less able to offer uncompensated care or to operate money-losing burn units, emergency departments, and trauma centers.

The AHA also suggests that the departure of specialists from community hospitals undermines their ability to provide specialist care in emergencies, because fewer specialists are willing to be on call. Moreover, the requirement in the Emergency Medical Treatment and Active Labor Act (EMTALA) for community hospitals to provide emergency care gives specialty facilities a competitive advantage, because the latter are free from EMTALA obligations as they operate on an ambulatory basis

or choose not to provide an emergency department.

Finally, the AHA has argued that specialty hospitals raise financial conflicts of interest. Physicians should make treatment decisions, including referrals, solely on the basis of patients' health needs. However, because physicians may refer patients to specialty hospitals in which they have an ownership interest, financial self-interest may overwhelm clinical judgment and lead to unnecessary referrals, threatening both cost and quality.

The case for specialty hospitals has been made by the American Surgical Hospital Association (ASHA).¹⁶ The ASHA argues that specialty hospitals improve patient satisfaction, because they provide patient-centered care by removing layers of bureaucracy; improve clinical outcomes, because they focus on a narrower range of procedures performed in higher volumes than in generalist community hospitals; and simultaneously lower costs and expand access through economic efficiencies.

Finally, organized medicine has entered the fray. The American Medical Association (AMA) Board of Trustees voted in December 2004 to oppose efforts to prohibit self-referral to specialty hospitals, to oppose the enactment of federal CON legislation and the expansion of state CON legislation, and to support the repeal of state CON legislation.¹⁷

The Stark Law

The main legal battleground for stemming the rise of specialty hospitals has been the Stark law. It was enacted in response to evidence that referral by primary care physicians to independent health facilities in which they had ownership interests increased referral volume and health care costs.¹⁸ The Stark law prohibits physicians from referring Medicare and Medicaid patients to entities with which they or members of their family have a financial relationship to receive a "designated health service."¹⁹

Since such services include inpatient and outpatient hospital services, the Stark law appears to prohibit specialists from referring patients to specialty hospitals in which they in-

vest. However, the law contains special rules governing referrals to hospitals. When it was enacted, it was thought that an individual physician's ownership interest in an entire hospital would be so diluted that it would have no effect on referral decisions but that an investment in a specialty department could distort clinical judgment. The Stark law therefore has a "whole hospital" exception, which permits self-referral where the physician has invested in an entire hospital but defines this exception to exclude particular specialty programs within a hospital.²⁰

Specialty hospitals fall under the "whole hospital" exception because they are free-standing facilities. The AHA has argued that this is a loophole in the Stark law, because specialty hospitals are functionally equivalent to inpatient specialty departments and may raise the same concerns regarding self-referral.²¹ In response to these concerns, the Stark law was amended by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. MMA prohibited self-referrals to specialty hospitals by amending the whole-hospital exception to exclude new specialty hospitals, but only for eighteen months, from 8 December 2003 to 8 June 2005.²²

The key to the scope of the moratorium is MMA's definition of *specialty hospitals* as those that "primarily or exclusively" care for patients undergoing procedures that are cardiac, orthopedic, or surgical or in another specialized category of services designated by the secretary of health and human services (HHS).²³ "Primarily" is not defined. Existing hospitals and those under development are grandfathered under certain conditions.²⁴ Finally, MMA required the Medicare Payment Advisory Commission (MedPAC) and HHS to study a variety of issues related to specialty hospitals, such as the costs of providing care relative to community hospitals, financial impact on community hospitals, self-referral, quality of care, and uncompensated care.

Although a ban on self-referral would prevent neither the creation of specialty hospitals nor physicians' investment in them, it may inhibit their spread by making investment less

attractive to physicians. Amendments to the Stark law were probably easier to obtain than a new, comprehensive regulatory regime for specialty hospitals that directly addresses the problem of cross-subsidization. However, relying on the Stark law as an indirect mechanism to address cross-subsidization raises the question of whether self-referral to specialty facilities is actually a problem. As we suggest below, the evidence is equivocal.

MedPAC and the Centers for Medicare and Medicaid Services (CMS) have recently reported back to Congress. Although MedPAC has called for an extension of the moratorium until 1 January 2007, the CMS opposes an extension of the moratorium.²⁵ But despite this difference, both MedPAC and the CMS propose to shift federal regulatory activity away from prohibiting self-referral and toward redesigning the hospital inpatient prospective payment system (PPS). Also, both suggest that specialty hospitals' competitive advantage may flow from inaccuracies in the Medicare payment system.

MedPAC, which reported in March 2005, suggests that the DRG system should be amended to better capture differences in severity of illness to reduce the incentive for specialty hospitals to cherry-pick healthy patients, that the relative weights of DRGs be based on the estimated costs of care rather than on charges to reduce the incentive to select more profitable DRGs, and that those weights be based on the national average of hospitals' relative values in each DRG. The CMS will follow up on these recommendations and plans to complete its review process by January 2006, without the need for additional legislation. It also proposes to eliminate differences in the outpatient PPS, which provides more favorable payment rates for hospitals than for ASCs. The CMS suggests that this difference could create an incentive to establish specialty orthopedic or surgical hospitals that effectively operate as outpatient facilities and are, therefore, functionally equivalent to ASCs. While this review process is under way, the CMS will not issue new specialty hospital provider agreements.²⁶

State Self-Referral Laws

■ **The status quo.** Many states have laws that regulate self-referral, prompted by the same concerns that gave rise to the federal Stark law. Pressure is growing for state self-referral legislation to be extended to cover such facilities, because the Stark law has important limitations. The eighteen-month moratorium expired in June 2005. Rules enacted by HHS under the Stark law define *referrals* to exclude designated health services performed personally by the referring physician, meaning that notwithstanding the moratorium, physicians could still refer patients to new specialty hospitals for inpatient care that they personally provide.²⁷

To serve as a substitute for the Stark law, a state law must govern referrals to hospitals, prohibit such referrals, and either contain no exception for whole hospitals or exempt specialty hospitals from such an exception. To be more comprehensive than the Stark law, a state law should contain no exception for services personally provided by referring physicians.

We reviewed state laws on self-referral with these criteria in mind.²⁸ Of the thirty-six states that regulate self-referral, twenty-nine regulate physicians' self-referrals to hospitals. Of these, sixteen require disclosure of the physician's investment interest to the patient, while the remaining thirteen prohibit self-referrals (as does the Stark law).

Of the states that regulate self-referral to hospitals, thirteen do so solely through rules of professional discipline, which generally includes penalties relating to medical licensure, including suspension, probation, or revocation. Two states use only civil penalties, six use a combination of professional discipline and civil penalties, and one employs criminal penalties.

Many of the state self-referral laws that govern referrals to hospitals contain important exceptions. Five states set a minimum investment threshold that physicians must cross to trigger self-referral regulations. This threshold varies greatly among states. Eight have a whole-hospital exception similar to that found in the Stark law. Like the Stark law, twelve

states exempt services provided by physicians personally from the scope of self-referral regulations. Indeed, some states are more lenient than the Stark law and also exempt services provided under the physician's direction.

In sum, while twenty-nine states have regulations governing hospital services self-referral, these regulations fall well short of prohibiting the self-referral of physicians to specialty hospitals in which they have an ownership interest. Only thirteen states prohibit self-referrals to hospitals; five of these have a whole-hospital exception that includes specialty hospitals. Laws in the eight remaining states could fill the gap that could be left if the federal moratorium on self-referral to specialty hospitals is not renewed. But six of these eight do not define services personally performed by the referring physician as self-referral. Thus, only two states (Nevada and New Jersey) go further than the Stark law and prohibit all physician self-referral to specialty hospitals.

■ **Proposed legislation.** Several proposed bills provide good examples of how state laws could be structured to address the rise of specialty hospitals. A Louisiana bill (S.B. 702, 2003) would prohibit self-referral by physicians to specialty hospitals, in the manner of the Stark law. Another (S.B. 430, 2003) would require only that physicians disclose their financial interest in specialty facilities to patients and inform patients of alternative providers. But such proposed legislation has enjoyed little success. A Colorado bill (S.B. 163, 2004) to prohibit referral by physicians to specialty hospitals in cases of financial conflict of interest has been stalled indefinitely. A similar bill died in Ohio (H.B. 71, 2003). However, if the federal moratorium expires, we can expect to see further activity by state legislatures. The question remains whether self-referral laws are the appropriate vehicle to use in regulating specialty hospitals.

State Certificate-Of-Need Laws

Another legal tool to address the rise of specialty hospitals are CON laws, which states have long attempted to use to regulate and rationalize the provision of health care services.

The impetus for their enactment was the realization that physician control of supply and demand could lead to the oversupply of medical services. By the late 1960s a number of states had enacted CON laws, which required hospitals wishing to add new beds, or entities proposing to build new facilities, to demonstrate that there was an unmet health care need.²⁹

Interest in state CON regulation surged in the mid-1970s because of the National Health Planning and Resource Development Act (NHPDA) of 1974. The NHPDA provided that states lacking a CON program by 1978 would face a decrease in federal Medicaid funding. It also clarified that the whole range of health care services, not just acute care hospital beds, should be within the scope of CON review.

The election of President Ronald Reagan in 1980 ushered in a decade of emphasis on market solutions for health care. Within two years, the CON-encouraging aspects of the NHPDA were repealed, and some states backed away from the programs they had established. But CON programs have been relatively hardy regulatory survivors. Thirty-eight states today retain some sort of CON oversight.

■ **Key elements.** The key elements determining the scope of CON laws are the services covered and the threshold at which a certificate-of-need is needed. The range of potential services is very broad, including, in various statutes, acute care beds, ASCs, burn care, cardiac catheterization and cardiac surgery, computed tomography (CT) and magnetic resonance imaging (MRI) scanners, lithotripsy, home health, obstetrics, radiation therapy, and subacute and long-term care. States interested in greater oversight set lower capital thresholds at which a certificate-of-need is needed and regulate a greater number of services.

The American Health Planning Association (the collaborating group of CON regulators) recently summarized the breadth of state regulation.³⁰ States such as Connecticut, Vermont, and Maine still maintain thoroughgoing oversight of the development of health care fa-

cilities. Interestingly, the pattern of distribution is not clearly related to the overall political leaning of the state. Reliably Republican states such as South Carolina and Georgia still have very broad controls in place, whereas in Massachusetts CON covers relatively few services and is subject to a high capital threshold, and some CON licenses may be bought and sold on the market.

Since their inception, CON laws have been used to block the balkanization of hospitals. In the late 1980s the Supreme Court of Oregon faced a dispute over the interpretation of CON legislation in a case involving ophthalmologists' efforts to build their own ASC.³¹ Their application was opposed by the community hospital where the physicians practiced and was denied by the Oregon State Health Planning and Development Agency. The court's decision in *Oregon Eye Associates v. State Health Planning and Development Agency* demonstrated its understanding that cross-subsidization was key to maintaining a reasonable array of services in the community hospital and was a legitimate reason to deny the CON application.

■ **CON and specialty facilities.** CON laws now appear to be the principal legal determinant of the growth of specialty hospitals. According to the GAO, states without CON laws account for half of the U.S. population and 55 percent of U.S. general hospitals but 83 percent of all specialty hospitals, 96 percent of specialty hospitals opened between 1990 and June 2003, and 100 percent of specialty hospitals under development as of June 2003.³²

The strong association between the absence of CON laws and the presence of specialty hospitals is supported by specific examples. In states where CON legislation is still enforced, hospitals have been able to resist the development of ASCs. For example, in Albany, Georgia, surgeons have sought to build their own ASC, but it was clear that the CON authority would deny their application, since the Phoebe Putnam Memorial Hospital had suffi-

cient resources to provide ambulatory surgical services. The surgical practice sought a single-specialty exemption and unsuccessfully challenged the constitutionality of the Department of Health's CON program.³³

By contrast, in Kansas, where there are no CON laws, Wichita now has two heart hospitals, a spine hospital, a surgical center, and two acute care hospitals. The impact on community hospitals there has been dramatic. The non-profit Via Christi system performed 1,400 bypass surgeries in 1998 but only 650 in 2003.³⁴

Recent changes in Florida law illustrate how CON laws have become an important arena of conflict in the debate over specialty hospitals. In July 2004 the Florida legislature passed a law that prohibited the development of any specialty hospitals focused on cardiac, cancer, or orthopedic care.³⁵ Interestingly, Florida's strict CON laws had already had the effect of keeping most specialty hospitals out of Florida. The specialty hospital ban has been challenged as a constitutional violation by Tenet Healthcare, which operates several hospitals in Florida.

Similar developments are under way in other states but often without success. Massachusetts saw a legislative effort in 2003 (S.B. 641 and H.B. 1860) to reintroduce CON requirements for new hospitals in the state. Both bills have been at the committee stage since March 2004. In Indiana there were unsuccessful attempts (S.B. 359, S.B. 462, and H.B. 1346, 2004) to impose a moratorium on the construction of all hospitals, ASCs, and health facilities (including specialty hospitals) until 30 June 2006. A Mississippi bill (H.B. 1024, and S.B. 2782, 2004) to impose a moratorium on the construction of new specialty hospitals failed as well. A Missouri bill (S.B. 316) that would have imposed a moratorium until 28 August 2005 has been in committee since May 2005. However, Montana (S.B. 440, 2005) and Washington (S.B. 5178, 2005) have recently passed moratoriums on the construction of

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specialty hospitals until 1 July 2006 and 1 July 2007, respectively.

These measures should be contrasted with other state initiatives to regulate specialty hospitals by removing their competitive advantages. In New Jersey a new law (NJ Stat. Ann. 26:2H-18.57 and 2H-18.58) imposes an annual tax of 3.5 percent of gross revenues (to a maximum of \$200,000) on ASCs that are not owned by hospitals. These monies are deposited in a Health Care Subsidy Fund to fund hospital uncompensated care. Oklahoma legislation (63 OK Stat. Ann., Sec. 1-702b) requires all new specialty hospitals and ASCs to ensure that 30 percent of their net revenues derive from Medicare or Medicaid patients or to pay a fee to the state equal to the difference between 30 percent of annual revenues and care for Medicare and Medicaid patients into a similar fund. A Florida court ruled unconstitutional a similar attempt to tax ASCs to benefit community hospitals.³⁶ California has taken a different approach: A bill there (S.B. 828, 2003) would have prohibited any boutique hospitals from opening unless they operated emergency rooms that were open to all patients.

Economic Credentialing As A Weapon

Hospitals may use a hybrid form of economic credentialing to halt the export of services to for-profit ambulatory settings. Originally, economic credentialing meant that hospitals would assess the insurance coverage of a physician's panel of patients before granting admitting privileges, to limit privileges to physicians caring predominantly for well-insured patients.³⁷ This regressive policy was rarely used and so faced little litigation; however, the withholding of privileges from physicians or surgeons who are involved in competing ventures has become controversial.³⁸

The case of *Mahan v. Avera* is illustrative.³⁹ In *Mahan* an orthopedic group had established an ASC. When it attempted to get hospital admitting privileges for a new surgeon, the hospital credentials committee denied the application, offering little in the way of quality-based justification. The group and the surgeon

sued the hospital. The South Dakota Supreme Court eventually ruled that the hospital could base the credentialing decision on business reasons, not just quality of care. The case is significant in that it fits squarely within the traditional legal approach to credentialing decisions. Similar cases are under way in other states.

But federal law may soon assert itself in this area, even though it has until recently been considered a state matter. The federal Anti-Kickback Act (AKA) of 1986 prohibits any remuneration for physicians that is intended to bring about referrals. Arguably, the denial of privileges to physicians unwilling to refer patients for surgical care at the hospital is a violation of the AKA. In response to the AMA's concerns that physicians were being treated unfairly and perhaps illegally by hospital credentialing decisions, the HHS Office of Solicitor General issued a "Solicitation of Public Guidance on Certain Credentialing Practices" in December 2002.⁴⁰ The AHA has made it clear to the HHS Office of Inspector General that it believes that the AKA does not apply in this circumstance. Meanwhile, the federal government is still considering its course of action.

Critical Issues For Evaluation

Proponents of ASCs and specialty hospitals argue that they provide higher-quality, more efficient care. Detractors maintain that they provide care to only the healthiest and best-insured patients, inflate overall health care costs, and, in some cases, provide technically unnecessary services. Although limited data exist to answer these assertions, several bodies of evidence offer insight.

A recently published study by Peter Cram and colleagues directly compared the quality of care provided by specialized facilities and general hospitals to Medicare beneficiaries undergoing percutaneous coronary intervention or coronary artery bypass surgery.⁴¹ They found lower unadjusted mortality rates in specialty hospitals. However, patients in specialty hospitals also had illnesses of lower acuity, and specialty hospitals performed more proce-

dures. When the analyses were adjusted for these factors, they found no difference in mortality rates between the two types of hospitals.

This study's findings support an extensive literature demonstrating that institutions that perform a high volume of a given procedure provide higher-quality care.⁴² If the only quality benefit offered by ASCs and specialty hospitals is through volume, the advantages of high-volume care in specialized institutions may be lost as numbers of ASCs and specialty hospitals grow, as fewer procedures are performed by any given institution.

The assertion that ASCs and specialty hospitals provide more-efficient care is less well substantiated. Casalino and colleagues surveyed leaders from large medical groups, hospitals, and health plans about their opinions of the impact of specialty hospitals on health care provision.⁴³ Physician and health plan respondents believed that specialized facilities provide care at a lower unit cost than community hospitals. Hospital respondents were less likely to hold this opinion. And although specialty hospitals are more profitable than general hospitals, one cannot infer that this necessarily results from increases in efficiency.⁴⁴ In fact, the recently published MedPAC report found that physician-owned specialty hospitals do not have lower costs for Medicare patients than community hospitals, despite shorter lengths-of-stay.⁴⁵

The treatment of patients of lower acuity ("cherry picking") by ASCs and specialty hospitals, as observed by Cram and colleagues, could certainly explain differences in profitability and does appear to be taking place.⁴⁶ Since Medicare payments are based on typical costs associated with treating a particular DRG, the Medicare system itself creates financial incentives for specialized facilities to select patients with lower-than-average costs. In strong support for this hypothesis, Ariel Winter found that Medicare patients treated in

ASCs had lower risk scores (a reflection of a patient's expected costliness based on age, sex, and diagnoses) than patients treated in hospital outpatient departments for all ten procedure categories that accounted for the highest share of Medicare payments to ASCs in 1999.⁴⁷ Similarly, a recent GAO report found that specialty hospitals treated a lower proportion of severely ill patients in the same diagnostic categories treated at general hospitals.⁴⁸ The recent MedPAC and CMS reports also confirm these results.⁴⁹

Cherry picking is facilitated by the relative lack of emergency departments in specialty hospitals and, therefore, the ability to avoid admissions for more acute, higher-cost, and poorly insured patients. Since no financial incentive exists for the care of Medicaid patients, it is not surprising that specialty hospitals treat proportionately fewer Medicaid in-

patients, when type of condition is controlled for.⁵⁰ Although cherry picking implies that general hospitals are left caring for high-cost patients, no direct data exist on the actual impact of ASCs and specialty hospitals on the financial viability of general hospitals.

Finally, and most interestingly, whether physician ownership of ASCs and specialty hospitals leads to the provision of unnecessary care or influences its quality is unclear. The peer-reviewed literature on self-referral suggests that physician ownership may lead to higher use rates. For example, Bruce Hillman and colleagues compared the use of radiological tests by physicians who had imaging equipment in their offices (self-referring physicians) with that of physicians who always referred their patients to radiologists for testing (radiologist-referring physicians). They found that self-referring physicians were 4–4.5 times more likely than radiologist-referring physicians to obtain radiological investigations, and they charged much more for tests of the same complexity.⁵¹ Similar results have been ob-

“Federal and state laws against self-referral were intended to control the distortion of clinical judgment by financial incentives and not to block innovation.”

served for physician ownership of physical therapy and rehabilitation facilities and radiation therapy clinics.⁵²

Although these data are widely cited in the debate over the regulation of specialty hospitals, their relevance is not entirely clear. First, although the average rate of overall physician ownership of specialty hospitals is just over 50 percent, the majority of physicians working in these institutions do not have an ownership interest in the facilities, and the average share owned by individual physicians who do have an ownership stake is small.⁵³ The potential impact of self-referral as a driver of volume and quality may be limited. Second, the peer-reviewed literature about self-referrals deals with independent health care facilities, which provide services such as physiotherapy, diagnostic imaging, and radiation therapy. These services are qualitatively different than those provided directly by self-referring physicians in ASCs and specialty hospitals.

Other data collected under the auspices of the Florida Health Care Cost Containment Board, which do not appear in the peer-reviewed literature, found no increases in referral volume where care was personally administered by self-referring physicians. For example, physicians with an ownership interest in ASCs were as likely as physicians without an ownership interest were to perform surgery on their patients.⁵⁴ The validity of these findings is unclear, and no similar data exist for specialty hospitals.

Conclusion

Framing appropriate legal and policy responses to the rise of specialty hospitals illustrates the central dilemma in U.S. health care policy today. Market-driven reform strategy would encourage the growth of specialty hospitals and ASCs, because they are likely to be more efficient and more creative in the way they care for patients than community hospitals. But the growth of these facilities raises the specter of poor quality of care for patients with inadequate insurance. These patients will likely not have access to the specialty hospitals and ASCs, which will strategically max-

imize the insurance status of patients. Moreover, access within community hospitals will suffer, because of the erosion of cross-subsidization. Finally, because of the clear relationship between clinical volume and quality, decreasing patient volumes at general hospitals will lead to lower quality for patients left to receive care at these facilities.

Although it embraces the increased use of markets, the FTC-DOJ report acknowledges access concerns by arguing that governments should directly subsidize care to the under- and uninsured, while not interfering with the operation of markets.⁵⁵ Unfortunately, direct subsidies are not politically viable. Market-based reform in reality therefore means an unregulated system of ASCs and specialty hospitals without a broader system for cross-subsidization across patients and programs, as occurs in single-payer systems. This will lead to unacceptable efficiency and financial losses for general hospitals, making the regulation of markets a necessity. The CMS's efforts to fine-tune payment mechanisms through Medicare so as to decrease the competitive advantage of specialty hospitals and ASCs could help. But it demonstrates the paradox of the mixed market/regulatory posture of U.S. health care: The central government payer adjusts payment to reduce competitive advantages found in the existing payment structure.

Regulation must take place in a less haphazard and chaotic fashion than how it is occurring today. Federal and state laws against self-referral were intended to control the distortion of clinical judgment by financial incentives and not to block innovation. Moreover, self-referral laws may be unnecessary. We do not think that hospitals' efforts to control export of profitable procedures through credentialing will succeed in the long term. A critical mass of health care business for many specialties will soon be done on an outpatient basis, and the threat of the loss of credentials will be hollow.

WHAT SHOULD BE DONE? There are two clear options. Either Americans should endorse the market and accept inequality in health care in return for efficiency, or they should guarantee access through regulation. But in the interim, health policy must ensure the financial viability of the hospital as a business unit. We are more concerned about the impoverishment of cross-subsidies than about the drag on innovation that would result from regulation. Among the possible regulatory schemes for holding the hospital together, we favor the use of CON laws. These laws were meant to control health care costs, although advocates of ASCs would argue that they are now being used to prevent new low-cost approaches to health care. However, CON could be modified to incorporate the explicit analysis of the financial viability of local hospitals as part of the certification process. This would give policymakers the flexibility to address the access and quality problems that might arise from the proliferation of specialty hospitals.

Although it will please neither market or access advocates, any regulatory approach is merely a bridge to a point at which we make more profound decisions about how to provide high-quality, affordable health care for an aging population.

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NOTES

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