



## Arizona Hospital and Healthcare Association

### The “Boutique” Hospital Boom

Even as Arizona’s healthcare community works with policymakers to resolve our nursing shortage, our state faces a looming public health crisis resulting from an insufficient number of physicians, particularly specialists who are willing to serve on the on-call rosters of hospital emergency departments.

The recent emergence of so-called “boutique” hospitals—hospitals that limit their scope of service to profitable specialties like orthopedic surgery and cardiac care—has exacerbated Arizona’s shortage of on-call specialty physicians, as orthopedic surgeons and other specialists have migrated to limited-service providers. These hospitals primarily serve a commercially insured and Medicare population, and tend not to treat Medicaid or uninsured patients. Focusing on scheduled elective procedures, boutique hospitals typically do not provide a full range of emergency services.

#### **Congressional Response: Moratorium on New Limited-Service Hospitals**

Concerns about the impact these limited-service providers will have on community hospitals—and physicians’ ability to refer patients to facilities in which they have an ownership interest—led Congress to enact a moratorium on the growth of these providers as part of the Medicare Modernization Act (MMA) of 2003 and, in the Deficit Reduction Act of 2005, to extend the moratorium until August 8, 2006.

On January 12, 2005, the Medicare Payment Advisory Commission (MedPAC) adopted a recommendation to extend the MMA’s moratorium until January 1, 2007. The commission also voted in favor of changes to Medicare’s hospital inpatient payment system to curb financial incentives that Medicare creates for physician-owned specialty hospitals to specialize in more profitable services and select healthier patients. MedPAC also recommended that hospitals be allowed to offer incentives to physicians to encourage physician and hospital cooperation to lower costs and improve care. According to the recommendation, these so-called “gainsharing” arrangements, which are currently prohibited under federal law, could foster improved hospital-physician relationships.

Now that the moratorium has expired, the policy issue facing Congress is the fact that current laws governing hospital-physician business relationships—and the consequential growth of limited-service hospitals—have resulted in a distortion of the healthcare marketplace that threatens the financial viability of community hospitals and raises serious implications for patient safety. In short, **current laws allow limited-service hospitals to enter into precisely the same business arrangements with physicians that are illegal for general acute care hospitals.** Taking advantage of the

“whole hospital” exemption in the Stark laws governing physician self-referral, the typical business model for these facilities relies heavily upon financing from physician investors who comprise their medical staffs.

### **Implications for Arizona’s Patients and Community Hospitals**

The delivery of healthcare in Arizona—and across the nation—is changing rapidly in response to myriad forces, not the least of which is innovation. An ongoing concern is the growing imbalance between those healthcare providers who share in the social and community obligation of providing care to all and those who do not.

The last decade has been marked by a dramatic proliferation of these providers across America, and there is strong evidence to suggest that potential investors continue to see Arizona as an attractive target marketplace. In its April 2003 report to Congress, *Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served*, the Government Accountability Office (GAO) reported that certain types of specialty hospitals have tripled since 1990. In this study and an earlier one, the GAO defined a specialty hospital as a facility in which the diagnoses of two-thirds of its Medicare patients fell into no more than two major diagnosis-related-groups (DRGs) (e.g., diseases of the circulatory system), or those in which at least two-thirds of its Medicare patients were classified into surgical DRGs. According to the GAO, hospitals that meet these criteria fall into five types of specialty hospitals: cardiac, orthopedic, surgical, women’s, and other.

In its October 2003 report, the GAO cited 100 specialty hospitals in 28 states and another 26 facilities under development. Nearly two-thirds of the hospitals operating or under development are concentrated in seven states: Arizona, California, Kansas, Louisiana, Oklahoma, South Dakota, and Texas. Eighty-five percent of them are in rapidly growing urban areas, and nearly all (96 percent of those built since 1990) are in states—like Arizona—that do not have laws requiring developers to obtain a “certificate of need.”

**In Arizona, with our explosive population growth, large uninsured population, and critical shortage of physicians, the specter of an unfettered proliferation of limited-service providers would be disastrous to community hospitals and the patients they serve.**

*Potential Threats to Patient Safety.* The GAO found that more than 90 percent of the specialty hospitals that have opened since 1990 are for-profit and only 45 percent of them have emergency departments and treat Medicaid and uninsured patients. If they do provide emergency services, these services tend to be extremely limited. In Arizona, limited-service providers—even those that are licensed as acute care hospitals with emergency departments—generally refer emergency patients with conditions beyond their capability to nearby full-service hospitals. And given the fact that most limited-service providers focus on surgical services, there could be serious implications for patients who have an unanticipated event during surgery (e.g., cardiac arrest, pulmonary embolism), and who would need to be transported to a general

hospital. Indeed, the recent death of a patient in a Texas specialty surgical hospital underscores these patient safety concerns.

In addition, given the current shortage of specialty physicians who are willing to remain on the call rosters of general hospitals, the potential for specialty hospitals to monopolize specialists further undermines hospitals' ability to meet critical community needs. A number of general hospitals in Arizona have experienced this phenomenon firsthand. Orthopedic surgeons, hand surgeons, neurosurgeons and other specialists are increasingly unwilling to take emergency call, citing lifestyle, payment and liability concerns. In recent years, when limited-service providers have opened, community hospitals in the same service area have seen specialists resign from their medical staffs en masse and affiliate with the limited-service provider, where surgeries are scheduled during business hours, patients have insurance and, because they have a relationship with their physician, are less likely to sue. This leaves community hospitals struggling to staff their emergency departments for certain specialties and provide inpatient care for patients who cannot afford care at the special hospital or who have complex medical needs that involve multiple specialties.

*Stark Exception Distorts Marketplace and Creates Uneven Playing Field.* Another concern centers on the ability of physicians to refer patients to specialty hospitals in which they have a financial interest. Supporters of specialty hospitals argue that in a free market, competition is healthy. But under the Stark laws, limited-service hospitals can do with impunity what community hospitals cannot do. Indeed, Stark carries grave penalties, including substantial civil money penalties and exclusion from federal programs. It also may be the basis for related claims under federal fraud and false claims laws, which can result in criminal penalties. As a result, the chief executive officer of a general acute care hospital can go to prison for entering into certain ventures with a physician that are perfectly legal for physicians to enter into with specialty hospitals.

Under the Ethics in Patient Referrals act of 1989 (commonly referred to as Stark I) and a subsequent law passed in 1993 (Stark II), Congress sought to limit physician self-referral by prohibiting federal reimbursement for many arrangements, including physician investments in hospital departments to which they refer. However, the Stark law contains several exceptions, notably, the “whole hospital” exception, which permits physicians to self-refer when they have ownership in the whole hospital, as opposed to a single department. The exception was intended to allow for ownership in general hospitals that provide a full array of healthcare services, where self-referral would produce little personal economic gain. But, as the GAO noted in its 2003 study, because specialty hospitals are typically much smaller in size than general hospitals—and closer in size to hospital departments—the whole hospital exception to Stark could allow physician owners to influence their hospitals', and therefore their own, financial gain through practice patterns and referrals.

*Financial Impact on Arizona Community Hospitals.* Limited-service providers focus on the most profitable services in healthcare today—cardiac care, orthopedic surgery,

obstetrics, etc.—and recruit the specialty physicians who provide this type of care as admitters and investors. This trend, combined with the fact that these hospitals typically do not provide emergency services, and are therefore not required to comply with the federal Emergency Medical Treatment and Labor Act’s mandate to treat all patients without regard to their ability to pay, positions them to siphon off the revenue community hospitals need to subsidize the uncompensated care they provide in their emergency departments.

Arizona’s community hospitals often provide services that are vital to a community but are financially risky. Trauma centers, burn centers and emergency department services provided to those without health insurance are often underwritten with revenue generated from other hospital departments. If this ability to cross-subsidize is eliminated, so will be the services provided to the community that result from that cross-subsidization.

Arizona’s healthcare market has long been a model of healthy competition. But even in a competitive environment, caring for sick people transcends the simple buyer/seller relationship. Some basic principles must endure: 1) patients must be able to trust that decisions about their care will be made based on what is in their best interest, not that of their provider; and 2) being a healthcare provider has always carried social and community obligations and must continue to do so.

The Arizona Hospital and Healthcare Association (AzHHA) strongly supports competition in the healthcare marketplace. But the current whole hospital exception to the Stark law threatens patient safety, distorts fair competition, and fosters conflicts of interest. Communities must rely on all healthcare providers to share in solutions for treating the poor and uninsured, and for ensuring access to essential services in the communities they serve. And patients must rely on policymakers to ensure that the incentives and business imperatives of a competitive market do not eclipse the public good.

### **Enact Legislation to Ban Medicare Payment to New Facilities, Eliminate the Whole Hospital Exemption or Reinstate Moratorium**

Because these issues are so critical, it is vital that Congress act on them this year. **AzHHA supports legislation that would:**

- **Permanently ban Medicare payment to new physician-owned special surgical hospitals, with a grandfather provision for existing physician-owned hospitals.**
- **Eliminate the whole hospital exception to the Stark laws.**
- **Reinstate the moratorium on Medicare payment to new physician-owned special surgical hospitals.**

**We urge Arizona’s congressional delegation to support H.R. 1424, the Paul Wellstone Mental Health and Addiction Equity Act of 2007, which includes a**

**provision to prospectively ban physicians from referring patients to hospitals in which they have a financial interest.**