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Boutique Hospitals: Competition or Exploitation?

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These new medical centers are for-profit ventures that specialize in specific high-revenue procedures including cardiac, cancer, and orthopedic surgery. The federal government estimates that about 100 specialty hospitals are in operation nationwide.

Relative to general hospitals, specialty hospitals, as a group, are much less likely to have emergency departments, treat smaller percentages of Medicaid patients, and derive a smaller share of their revenues from inpatient services. For example, 45% of specialty hospitals, but 92% of general hospitals, have emergency departments. (GAO)

The General Accounting Office (GAO) completed two studies of specialty hospitals for Congress last year. The first, released in May, found that specialty hospitals generally treat less-acute patients. It reported that the median percentage of severely ill patients treated in community hospitals is 29 percent higher than the median percentage of ill patients treated in cardiac boutique hospitals, 60 percent higher than at orthopedic boutique hospitals, and 100 percent higher than at surgical boutique hospitals.

The second, released in October, found that growth in specialty hospitals tends to be in areas with large group practices and no certificate of need (CON) requirements for new construction. About two-thirds of the 100 specialty hospitals GAO identified were located in only seven states. Most of the specialty hospitals in development are also in those same states, each of which had 5 to 20 specialty hospitals. The states are Arizona, California, Kansas, Louisiana, Oklahoma, South Dakota, and Texas.

Medicare/Medicaid Moratorium

As part of the Medicare reform legislation passed in November, Congress ordered a temporary ban on physician

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billing of Medicare or Medicaid for patients treated at any new specialty hospital in which the doctor has a financial interest. These two programs fund up to 70% of the revenues of specialty hospitals. The moratorium was aimed at giving federal officials time to study whether specialty hospitals are having a negative impact on community hospitals. The legislation directed the Medicare Payment Advisory Commission (MedPAC), the General Accounting Office (GAO), and the Department of Health and Human Services (HHS) to study the issue and report to Congress before the ban expires. After 18 months, Congress will have to decide whether further action is warranted. Without additional legislation, the moratorium will expire in May 2005.

Two separate studies are to be completed within 15 months of the effective date. MedPAC is to determine differences in costs of services between physician owned and full-service community hospitals; the extent to which both types treat certain patients; the financial impact of physician owned specialty hospitals on full service community hospitals; the proportions of payments by payer in both types of hospitals; and how the DRG system should be updated to better reflect the costs of hospital care. HHS is to determine the percentage of patients admitted to physician owned hospitals who are referred by physician owners; the referral patterns of physician owners to their own hospitals and to full-service community hospitals; the comparison of quality of care in both settings; and assessment of differences in compensated care in both settings, including the value of tax exemptions available.

The legislation effectively bans the development of new physician-owned specialty hospitals and limits the expansion of existing facilities for 18 months. That would allow congressionally ordered studies to explore whether these hospitals are cherry-picking healthier patients and those who require surgery for which the government-run Medicare program provides generous reimbursement. Community and general hospitals argue that it is a conflict of interest for physicians to refer patients to facilities in which the doctors are investors. While federal law generally prohibits such self-referrals, there is an exception for hospitals.

Competition or Exploitation?

Boutique hospitals like to claim that their success is a result of their ability to compete effectively for patients with community hospitals which they claim are no longer attractive to the physicians practicing in them nor to the patients served by them. The reality is that there is no true competition for patients between hospitals because the market is driven by physician referrals, and the driving force behind the success of boutique hospitals is the ability of their physician investors to self-refer patients. By referring their most desirable patients, those who are well insured and healthier than the uninsured, and those requiring the best reimbursed services, they are able to assure the financial viability of their specialty hospitals. In this way, they are able to exploit the Medicare program because it pays a fixed sum for the treatment of a particular diagnosis, regardless of the cost of the services required by a particular patient. The first GAO study confirms that boutique hospitals tend to treat those patients that are less sick, and therefore more profitable.

Opening a boutique hospital in a rural community could cause the local community hospital to reduce charity care and community benefits, reduce services to the uninsured, and reduce quality-improving capital investments in medical technology and information systems. The entry of a specialty hospital in a rural area would require the community hospital to forfeit its sole community provider status under federal regulations. The entry of the specialty hospital would threaten the loss of millions dollars of sole-provider funds, half of which comes from the county and half from the federal government. To qualify for the federal funds, a hospital must be the only provider within a 30-mile radius.

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Modeling the system, Medicare and Medicaid included, is nothing new in health care delivery. But this phenomenon is part of a much larger process of the polarization of service delivery, where financial considerations have replaced community values. If they can afford to do so, individual patients, physicians, and hospitals can serve themselves without concern for meeting community needs. Thus are communities divided economically. Those communities are left with harder-to-meet needs and less in the way of financial and other resources to meet them. It is left to legislators to decide whether they will legislate for regulation in order to seek greater equity in bearing the burdens of underserved populations and uncompensated services, thereby preserving the greater public interest.

Communities Divided

Community hospital administrators are hard pressed to meet the growing demands of patients and medical staffs alike for greater amenities and better outcomes while serving the entire cross section of their communities. Specialty hospitals in general offer more favorable staffing ratios than larger hospitals, with increased job satisfaction for nurses and the ability to offer personalized care to a smaller number of patients. Nurses typically care for only one or two patients on any given shift, and 4-to-1 during the evenings. Most boutique hospitals allow patients to remain in one room throughout their hospital stay and to see the same nurses daily. As a result, the hospital stay for the already healthier patients at a specialty hospital is often shorter than that of a standard hospital.

States with certificate of need (CON) programs in place covering the establishment of hospitals and ambulatory surgery centers have a public process for planning and review that can address their community issues in the public interest. Realizing this, legislators in states without CON are reconsidering its potential role in seeking equitable solutions that best serve all parties. In the absence of CON, the issues are being aired in the press while local officials are powerless to intervene and state legislators are torn between constituencies. For example, Pennsylvania's CON program sunsetted at the end of 1996. In Butler, a community of about 15,000 in Western Pennsylvania, Butler Memorial Hospital has plans to build a separate for-profit specialty outpatient surgery center. Its own nurses argue that the new facility could affect the existing hospital's finances, patient safety and nursing jobs. They have raised the issue that if the facility is constructed on a separate site, patients could be placed at greater risk if an emergency occurred during a surgical procedure.

Answers to the issues raised here must be sought in the larger society that decides how to fund health care, for whom, and with how much equity. Ultimately, it is a question of how we perceive health, and how we perceive ourselves in relation to everyone else.

For additional information, see the following:

U.S. General Accounting Office. Specialty hospitals: Information on national market share, physician ownership and patients served. April 18, 2003.
Available from <*http://www.gao.gov*>.

U.S. General Accounting Office. Specialty hospitals: Geographic location, services provided, and financial performance. October 2003.
Available from <*http://www.gao.gov*>.

Casalino LP, Devers KJ, Brewster LR. Focused factories? Physician-owned specialty facilities. Hospitals must decide whether to cooperate or compete with their specialists who own specialty facilities; either choice is fraught with dangers. *Health Affairs*. 2003;22:56-67.
Available from <*http://www.healthaffairs.org*>.

Devers KJ, Brewster LR, Ginsburg PB. Center for Studying Health System Change. Specialty hospitals: Focused factories or cream skimmers? Issue Brief. No.62. April 2003.
Available from <*http://www/hschange.com*>.