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**THE SPECIALTY HOSPITAL DEBATE:
THE DIFFICULTY OF PROMOTING
FAIR COMPETITION WITHOUT
STIFLING EFFICIENCY**

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I. INTRODUCTION

The United States' health care system attempts to balance the policy goals of access, quality, and cost of care.¹ Each of these goals is interrelated, and an attempt to affect one component often will come at the expense of another.² Our system is plagued by increasing numbers of uninsured patients,³ significant problems with quality,⁴ and ever increasing costs of care.⁵ The United States' current health care expenditures are about the size of France's entire economy and growing.⁶

While many factors contribute to rising health care costs, a significant portion is attributed to hospital services.⁷ Some have speculated as to why costs of hospital services continue to rise,⁸ but most

¹ U.S. GEN. ACCT. OFFICE, HEALTH CARE: UNSUSTAINABLE TRENDS NECESSITATE COMPREHENSIVE AND FUNDAMENTAL REFORMS TO CONTROL SPENDING AND IMPROVE VALUES 3 (2004), <http://www.gao.gov/new.items/d04793sp.pdf> (last visited Feb. 28, 2006) [hereinafter GAO UNSUSTAINABLE TRENDS].

² See, e.g. James E. Eggleston, *Patient Advocacy and Consumer Protection Through Union Activism: Protecting Health Care Consumers, Patients and Workers During an Unprecedented Restructuring of the Health Care Industry*, 41 ST. LOUIS U. L.J. 925, 926 (1997).

³ THE KAISER COMM'N ON MEDICAID AND THE UNINSURED, HEALTH INSURANCE COVERAGE IN AMERICA 7 (2004), <http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=46814> (last visited Feb. 28, 2006) (stating that 18% of individuals under age sixty-five in the United States do not have health insurance).

⁴ See LINDA T. KOHN, ET AL., TO ERR IS HUMAN: BUILDING A SAFER HEALTH CARE SYSTEM 1 (2002) (explaining that as many as 98,000 people die each year as the result of medical mistakes).

⁵ GAO UNSUSTAINABLE TRENDS, *supra* note 1, at 3 (explaining that health care spending represented 7% of Gross Domestic Product (GDP) during 1970 and is estimated to grow to 17% by 2010).

⁶ Analysis on file with author. Based on total United States GDP of approximately \$11 trillion, our current health care spending represents the entire GDP of France. Compare CENTRAL INTELLIGENCE AGENCY, THE WORLD FACTBOOK (2005), <http://cia.gov/cia/publications/factbook/geos/fr.html> (last visited Feb. 28, 2006) (highlighting statistical facts about France) with CENTRAL INTELLIGENCE AGENCY, THE WORLD FACTBOOK (2005), <http://cia.gov/cia/publications/factbook/geos/us.html> (last visited Feb. 28, 2006) (comparing similar statistics about the U.S.). Current estimates suggest health care spending in the United States represents approximately 15% of GDP.

⁷ PAULA SPURWAY, BLUE CROSS & BLUE SHIELD ASS'N, STRAIGHT TALK NEWS LETTER: HOSPITAL SERVICES AND THE RISING COST OF HEALTH CARE (Sept. 2003), <http://www.fepblue.org/toyourhealth/tyhhhospitalcosts.html> (last visited Feb. 28, 2006).

⁸ *Id.* (explaining that the reasons for the rising cost of hospital services include nursing shortages, the cost of outpatient services, hospital market consolidation, and new medical technologies).

critics fail to address solutions to the causes of the problems.⁹ Most modern proposals suggest our health care system needs more free-market principles to help promote competition and reduce the cost of hospital services.¹⁰ A recent editorial in the Wall Street Journal depicted the growth of physician-owned specialty hospitals as an example of a free-market success story.¹¹ While specialty hospitals may be more financially profitable,¹² it is debatable whether their success is the result of shifting costs to competitors or if they truly are more efficient health care providers.¹³ As some truth likely exists in both arguments, policy makers must consider both issues. The overall goal needs to avoid restrictions on specialty hospital efficiency gains while promoting fair hospital market competition. This comment considers some effects of proposals aimed at regulating physician-owned specialty hospitals. The comment will: (1) provide background on what is a specialty hospital and how they differ from traditional hospitals; (2) explore the events leading up to the recent moratorium on specialty hospitals; (3) explore the application of self-referral laws to specialty hospitals; (4) consider the role of government reimbursement for hospital services; (5) examine the role of state and local governments in addressing problems caused by specialty hospitals; (6) explain how certificate of need laws have been used in the past to regulate hospital competition; (7) consider community benefits requirements for hospital markets; (8) consider possible taxes on specialty hospital services; and finally (9) consider the future of specialty hospitals.

II. BACKGROUND

A. The Advent of the Specialty Hospital

A specialty hospital is generally defined as a type of hospital that restricts its admissions to a particular group of persons or class

⁹ Most efforts to control costs do not provide global solutions. *See id.* (suggesting one solution for consumers is to use insurance plans that contract with preferred hospitals).

¹⁰ *See id.*

¹¹ *See Review and Outlook in the (Specialty) Hospital*, WALL ST. J., Jan. 3, 2005, at A8.

¹² U.S. GEN. ACCT. OFFICE, SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, SERVICES PROVIDED, AND FINANCIAL PERFORMANCE 5 (2003), <http://www.gao.gov/new.items/d04167.pdf> (last visited Feb. 28, 2006) [hereinafter GAO SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION].

¹³ *See generally* KELLY J. DEVERS ET AL., CTR. FOR STUDYING HEALTH SYS. CHANGE, SPECIALTY HOSPITALS: FOCUSED FACTORIES OR CREAM SKIMMERS (2003), <http://www.hschange.com/CONTENT/552/552.pdf> (last visited Feb. 28, 2006).

of services.¹⁴ Under this definition, a wide range of hospitals may be considered specialty hospitals, including children's¹⁵ and women's hospitals. The controversy over specialty hospitals has been related to more recent development in specialty hospitals.¹⁶ The General Accounting Office (GAO) identifies this "new" type of specialty hospital as a narrower group of hospitals that focuses on specific treatments such as cardiac, orthopedic, surgical, and women's services.¹⁷ For purposes of this comment, the author's discussion of specialty hospitals is based on the GAO definition. While these specialty hospitals represent a small fraction of the total hospital industry in the United States,¹⁸ the issues presented represent some core issues of the modern health care policy debate.

Recently, specialty hospitals have expanded rapidly, pushing this new form of specialty hospital to the forefront.¹⁹ One of the more controversial aspects of this new breed of hospital is that the majority of specialty hospitals involve some degree of physician ownership.²⁰ According to the GAO, physicians own approximately 70% of existing specialty hospitals.²¹ In response to concerns over the growth of specialty hospitals, Congress placed a temporary ban on future growth of physician-owned specialty hospitals.²² Although the moratorium is no longer in place, public policymakers

¹⁴ See U.S. GEN. ACCT. OFFICE, SPECIALTY HOSPITALS: INFORMATION ON NATIONAL MARKET SHARE, PHYSICIAN OWNERSHIP, AND PATIENTS SERVED 1 (Apr. 2003), <http://www.gao.gov/new.items/d03683r.pdf#search='gao%20and%20specialty%20hospital> (last visited Feb. 28, 2006) [hereinafter GAO SPECIALTY HOSPITAL NATIONAL MARKET SHARE].

¹⁵ *Id.*

¹⁶ *Id.* at 1–2.

¹⁷ GAO Specialty Hospital National Market Share, *supra* note 14, at 2–3.

¹⁸ *Id.* at 3. The GAO definition is a more limited classification of specialty hospitals based on analysis of past Medicare hospital reimbursement. *Id.* The GAO defines specialty hospitals as hospitals that have greater than two-thirds of patients' treatments based on specific illnesses or surgical procedures. *Id.* The definition also excludes long-term care hospitals. *Id.*

¹⁹ GAO SPECIALTY HOSPITAL NATIONAL MARKET SHARE, *supra* note 14, at 3.

²⁰ *Id.* at 2.

²¹ *Id.* at 4.

²² Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173, § 507, 117 Stat. 2295–97 (2003), § 507. The ban was limited to an eighteen month period that ended June 8, 2005. *Id.* During this period, physicians could not invest in new cardiac, orthopedic, and surgical specialty hospitals not already under construction; see GAO SPECIALTY HOSPITAL NATIONAL MARKET SHARE, *supra* note 14, at 3. The ban applies to physician investments in GAO-defined specialty hospitals. *Id.*

continue to struggle with how to address problems surrounding specialty hospitals.²³

B. How Specialty Hospitals Differ from Their Competitors

One of the issues in the specialty hospital debate is what effect physician-owned specialty hospitals have on local full service community hospitals.²⁴ Because federal legislation does not precisely define full service community hospitals, the author assumes all non-specialty hospitals are included in this definition. The moratorium focuses on the specific harms physician-owned specialty hospitals cause their competitors.²⁵ But this limited focus fails to address some of the major distinguishing factors between specialty hospitals and non-specialty hospitals. According to the GAO, approximately 80% of all non-specialty hospitals operate with public or private not-for-profit status.²⁶ By comparison, 70% of both physician and non-physician-owned specialty hospitals operate as for-profit entities.²⁷ As a result, the vast majority of specialty hospitals are not required to provide the community benefits that are required for not-for-profits to retain federal tax exempt status.²⁸ Beyond the effects of physician ownership, most of the other differences between specialty and non-specialty hospitals stem from the fact that specialty hospitals are less likely to provide the community benefits required of not-for-profit hospitals.²⁹ Some of the community benefits generally required of not-for-profits include operating a twenty-four hour emergency room, providing charity care, and participating in Medicare and Medicaid programs.³⁰

²³ The moratorium on specialty hospitals ended in June, but the Centers for Medicare and Medicaid Services are not processing new applications for participation in government reimbursement programs. HEALTHCARE FIN. MGMT. ASS'N, HFMA POLICY WATCH—AUGUST 2005: MORATORIUM ENDS, BUT CMS KEEPS SPECIALTY HOSPITALS ON HOLD, http://www.hfma.org/publications/HFM_Magazine/updata.htm [hereinafter HFMA POLICY WATCH] (last visited Feb. 28, 2006).

²⁴ See *id.*

²⁵ *Id.*

²⁶ GAO SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, *supra* note 12. Statistics were not available to determine the exact number of physician-owned specialty hospitals. The difficulty in determining physician ownership is that the hospital ownership can be placed in a family member's name.

²⁷ *Id.*

²⁸ See Rev. Rul. 69-545, 1969-2 C.B. 117.

²⁹ GAO SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, *supra* note 12.

³⁰ Rev. Rul. 69-545, *supra* note 28.

Specialty hospitals are less likely to have an emergency room or offer twenty-four hour emergency care.³¹ Operating an emergency department can expose hospitals to tremendous financial liability through federal EMTALA laws.³² Overall, emergency services can be one of the more cost intensive areas of a hospital from a direct financial as well as from a potential medical liability standpoint.³³

Regardless of the costs of these services, most hospitals simply do not offer community benefits unless required.³⁴ Many of the purported differences between specialty and non-specialty hospitals parallel the general differences in most not-for-profit hospitals and their for-profit competitors.³⁵ It is undisputed that the costs of community benefits are significant, but whether these services should be required of all hospitals is part of a larger debate. The equity of federal tax exemption laws and how they affect hospital competition is beyond the scope of this comment, but some of the effects of specialty hospitals' failure to provide community benefits are discussed below.

Although specialty hospitals may not be burdened with many of the costs of non-specialty hospitals, the real fight is over revenue.³⁶ Most general acute care hospitals serve a wider range of patients than the limited niche served by specialty hospitals.³⁷ For patient services provided, hospitals receive revenue from a select number of payers, including government and private payers.³⁸ Most specialty hospitals have limited their focus to more profitable service lines.³⁹ Analysts acknowledge that specialty hospitals are likely to siphon future patient revenue away from the non-specialty hospitals in their market. As a result, non-specialty hospitals are

³¹ GAO SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, *supra* note 12 at 4, 19–20. Fewer than half of specialty hospitals surveyed had twenty-four hour emergency departments. *Id.*

³² See *Burditt v. U.S. Dep't of Health & Human Servs.*, 934 F.2d 1362, 1366–70 (5th Cir. 1991). EMTALA requires hospitals to provide stabilizing treatments to persons with emergent conditions or in active labor regardless of their ability to pay. See *id.* at 1371. EMTALA violations can result in fines and private causes of action against hospitals. See *id.*

³³ See e.g. SPURWAY, *supra* note 7.

³⁴ See TEX. HEALTH & SAFETY CODE ANN. § 311.046 (Vernon 2001); see generally GAO SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, *supra* note 12, at 4.

³⁵ Michael I. Sanders, *Health Care Joint Ventures Between Tax-Exempt Organizations and For-Profit Entities*, 15 HEALTH MATRIX 83, 84 (2005).

³⁶ See generally DEVERS ET AL., *supra* note 13.

³⁷ *Id.*

³⁸ See *id.*

³⁹ See also GAO SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, *supra* note 12, at 22–23.

likely to suffer from the loss of revenue.⁴⁰ The harm caused by revenue loss is likely to have a compounding effect because most non-specialty hospitals rely on profitable service lines to “cross-subsidize” unprofitable services and uncompensated care.⁴¹

One example of how specialty hospitals focus on more profitable service lines is that they are less likely to rely on Medicaid revenue.⁴² This may be explained in part by the fact that specialty hospitals are less likely to provide extensive emergency and trauma care services.⁴³ Although the exact reasons remain unclear, experts should acknowledge that state Medicaid programs often reimburse hospitals at or below the hospitals’ costs for patient treatment.⁴⁴ Some evidence also exists that specialty hospitals have a tendency to treat patients with less serious illnesses.⁴⁵ These phenomena may be the result of physicians cherry-picking the best patients and sending them to specialty hospitals where these physicians have an ownership interest.⁴⁶

Proponents of specialty hospitals claim that they are more efficient than traditional general hospitals.⁴⁷ The efficiency arguments have some credence. For example, from an intuitive perspective, the specialization of labor generally allows for gains in efficiency.⁴⁸ Most specialty hospitals are organized to provide services along the same lines as doctors’ specialties.⁴⁹ Specialty hospitals can design their facilities and processes to allow for the efficient use of time and

⁴⁰ DEVERS ET AL., *supra* note 13.

⁴¹ *Id.*

⁴² GAO SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, *supra* note 12, at 21, fig. 5. Specialty hospitals do appear, however, to treat a similar number of Medicare patients as non-specialty hospitals. *Id.*

⁴³ *Id.* at 4.

⁴⁴ See generally 1 TEX. ADMIN. CODE, § 355.8061 (2005). Medicaid reimbursement for outpatient hospital services range from 80.3% to 84.48% of allowable costs. *Id.* Additional reimbursement may include Medicaid Disproportionate Share payments. See *id.*

⁴⁵ See GAO SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, *supra* note 12, at 7–8. Under Medicare hospital reimbursement, hospitals are paid a fixed amount based on the patient’s diagnosis related group. *Id.* A hospital would theoretically receive the same reimbursement for a patient with the same condition regardless of the severity of the illness. *Id.*

⁴⁶ See Angela Gonzales, *Federal Moratorium Derails Plans for Specialty Hospital*, PHOENIX BUS. J., Feb. 6, 2004, <http://phoenix.bizjournals.com/phoenix/stories/2004/02/09/story1.html> (last visited Feb. 28, 2006).

⁴⁷ See *Review and Outlook in the (Specialty) Hospital*, *supra* note 11.

⁴⁸ See generally GAO SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, *supra* note 12, at 23–24.

⁴⁹ See *id.*, *supra* note 22, at 2. Specialty hospitals are generally organized based on cardiac, orthopedic, or surgical services which correspond directly to individual physician practice specialties.

resources. As a result, physicians may be able to work more efficiently in their day to day functions. Some of these efficiencies may exist because physicians are given greater authority in hospital management.⁵⁰ Others point to the fact that specialization allows specialty hospitals to manage hospital resources more effectively.⁵¹ For example, specialty hospital purchasing departments can purchase more effectively because unlike non-specialty hospitals with broader missions, they do not have to prepare for the myriad of contingencies. If specialty hospitals are truly more efficient than their competitors, then the result may ultimately lead to lower costs in health care services through competition. Regardless of the reasons, specialty hospitals are more profitable than non-specialty hospitals, as non-specialty hospitals have had lower total profit margins than for-profit specialty hospitals.⁵²

Questions have also been raised about the effects specialty hospitals have on quality of care.⁵³ Some critics have suggested that specialty hospitals may present safety concerns.⁵⁴ Most concerns stem from the fact that specialty hospitals are less likely to have on-site emergency departments.⁵⁵ On the other hand, specialty hospital proponents claim these hospitals are able to provide higher quality care.⁵⁶ To assist in sorting out these concerns, the moratorium legislation also required studies of specialty hospital safety and quality concerns.⁵⁷

III. DISCUSSION AND ANALYSIS

Many of the questions raised by physician-owned specialty hospitals should cause us to reconsider the measures we use to regulate hospital competition. Attempts at increasing hospital compe-

⁵⁰ DEVERS ET AL., *supra* note 13.

⁵¹ See *Review and Outlook in the (Specialty) Hospital*, *supra* note 11.

⁵² GAO SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, *supra* note 12, at 25–26. During 2001, not-for-profit general hospitals had a 3.1% total facility margin in comparison to a 9.7% total facility margin for for-profit specialty hospitals. *Id.* During the same period, not-for-profit Medicare inpatient margins were 8.9% compared to 9.4% for specialty hospitals. *Id.*

⁵³ CINDY BORGMEYER, AM. ACADEMY OF FAM. PHYSICIANS, SPECIALTY HOSPITAL ISSUE COMES TO CAPITOL HILL—MEDPAC, CMS STUDIES RAISE MORE QUESTION AND OFFER FEW ANSWERS, Apr. 4, 2005, <http://www.aafp.org/x33692.xml> (last visited Feb. 28, 2006).

⁵⁴ See Gonzales, *supra* note 46.

⁵⁵ See GAO SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, *supra* note 12, at 17–19.

⁵⁶ See *Review and Outlook in the (Specialty) Hospital*, *supra* note 11.

⁵⁷ See Medicare Prescription Drug, Improvement, and Modernization Act of 2003, *supra* note 22.

tition may have long-lasting harmful effects, while other attempts to create fair competition may not go far enough. Although many suggest we need to introduce more competition in the hospital market, most fail to recognize the complexity of the existing web of health care regulations. Finding the appropriate balance is often difficult, and regulations may need to be altered over time as the market adjusts. The current dilemma over specialty hospitals reflects many of these challenges. The challenge to policymakers is to find a way to encourage competition, while also ensuring that regulatory gaps are not unfairly exploited.⁵⁸

A. The Recent Moratorium on Physician Investment in Specialty Hospitals

Many of the differences between specialty and non-specialty hospitals point to the core issue of whether physician-owned specialty hospitals have an unfair advantage, or whether they promote much needed efficiencies in the hospital market.⁵⁹ Congress recently refused to extend an existing moratorium on physician investment in specialty hospitals.⁶⁰ The Medicare Modernization Act provided for an eighteen-month moratorium on physician ownership in “specialty” hospitals.⁶¹ The Act’s moratorium prevented physician-owned specialty hospitals, not in existence prior to Nov. 10, 2003, from receiving Medicare funds.⁶² Other provisions of the Act required government agencies to produce studies examining the effects physician-owned specialty hospitals have on their competitors, how utilization patterns differ, and how their cost structures differ from other hospitals.⁶³ Although the moratorium provided for a complete ban on physician investment in specialty hospitals,⁶⁴ some commentators and a GAO report suggest that the spread of

⁵⁸ DEVERS ET AL., *supra* note 13, at 4.

⁵⁹ *See id.*

⁶⁰ *See* HFMA POLICY WATCH, *supra* note 23.

⁶¹ *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, *supra* note 22.

⁶² *Id.* (The moratorium went into effect during March 2004.).

⁶³ *Id.* (The studies will consider specialty hospitals’ effect on community hospitals.). The Act also requires separate studies related to specialty hospital utilization and Medicare reimbursement. The moratorium expired June 8, 2005.

⁶⁴ *Id.* The moratorium removes a previous exception to Medicare self-referral laws regarding physician ownership of entire hospitals.

specialty hospitals may be more prevalent in states without certificate of need laws.⁶⁵

B. How Hospitals Were Dealing with the Problem Before the Moratorium

Prior to the moratorium's ban on physician investment in specialty hospitals, some non-specialty hospitals had already taken preventative measures.⁶⁶ Many hospitals went to great lengths to prevent or mitigate the effects specialty hospitals had in their communities.⁶⁷ Some started extensive media campaigns promoting the merits of the existing hospital's services in preparation for future specialty hospital competition.⁶⁸ Other hospitals even began to look like specialty hospitals by changing their names and specializing in the types of services offered.⁶⁹

Hospitals may be hesitant to take a direct stand against physician investment in specialty hospitals because they do not want to jeopardize relationships with physicians in their community. As a result, many hospitals have used trade groups to voice their opposition to physicians investing in specialty hospitals.⁷⁰ Some hospitals have implemented more controversial methods, such as revoking hospital privileges for physicians who invest in specialty hospitals.⁷¹ Revoking a physician's admitting privileges to a hospital can significantly deter potential physician owners.⁷² A physician faces a significant financial risk if he or she is stripped of the ability to refer patients to a hospital. The controversial use of evaluating physi-

⁶⁵ DEVERS ET AL., *supra* note 13; see GAO SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, *supra* note 12, at 15.

⁶⁶ See *id.*

⁶⁷ See Beth Aaron, *Lubbock Heart Hospital Opens Despite Concerns*, DAILY TOREADOR, Feb. 26, 2004, <http://www.dailytoreador.com/media/paper870/news/2004/02/26/LocalNews/Lubbock.Heart.Hospital.Opens.Despite.Concerns1278247.shtml?norewrite&sourcedomain=www.dailytoreador.com> (last visited Feb. 28, 2006).

⁶⁸ See *id.*

⁶⁹ See DEVERS ET AL., *supra* note 13.

⁷⁰ See AHA *Assesses Specialty Hospital Impact*, 58 HEALTHCARE FIN. MGMT. 26 (Dec. 1, 2004).

⁷¹ DEVERS ET AL., *supra* note 13, at 4.

⁷² FTC/DOJ *Hearings on Health Care and Competition Law and Policy*, (Mar. 27, 2003) (statement of Dennis I. Kelly, Executive President of Dev. and Gov't Relations for MedCath Corps.), available at <http://www.ftc.gov/ogc/healthcarehearings/doc/030327denniskelly.pdf> (last visited Feb. 28, 2006).

cians based on financial performance is known as economic credentialing.⁷³

Another option hospitals have used to prevent physician defection to specialty hospitals involves partnering with physicians in a new specialty hospital of their own.⁷⁴ Competing hospitals have offered a joint venture option to physicians to prevent other hospitals from entering their hospital market.⁷⁵ The option for hospitals to joint venture with physicians was also subject to the moratorium's ban.⁷⁶

C. Self Referral Laws and Specialty Hospitals

In most business settings, an ownership interest or participation in profits may help align the goals of company representatives and employees with the goals of the organization.⁷⁷ While physician ownership may provide an effective incentive to benefit the individual organization, questions remain as to whether these incentives provide positive effects on a hospital market. Specialty hospital proponents claim that they are able to operate more efficiently than other hospitals.⁷⁸ Their competitors dispute the claims of efficiency and argue that physician-owners have unfair advantages because they control patient referrals.⁷⁹

The idea of restricting physician referrals for health care services is not a novel concept. The federal Anti-Kickback statute has long prevented any remuneration in exchange for government-funded business.⁸⁰ The Anti-Kickback statute also prevents any remuneration in exchange for the referral of patients covered under a federal health care program such as Medicare or Medicaid.⁸¹ Prohibited referrals were eventually expanded to include so called phy-

⁷³ See AM. COLLEGE OF MED. QUALITY, POLICY 23: ECONOMIC CREDENTIALING, <http://www.acmq.org/policies/policy23.htm> (last visited Feb. 28, 2006). Economic credentialing is the use of financial information to evaluate physician performance. Historically, most physicians have been reviewed based upon quality measures.

⁷⁴ DEVERS ET AL., *supra* note 13, at 2-3.

⁷⁵ See *id.*

⁷⁶ See Medicare Prescription Drug, Improvement, and Modernization Act of 2003, *supra* note 22.

⁷⁷ See Richard S. Saver, *Squandering the Gain: Gainsharing and the Continuing Dilemma of Physician Financial Incentives*, 98 Nw. U. L. REV. 145, 148 (2003).

⁷⁸ See generally DEVERS ET AL., *supra* note 13, at 3.

⁷⁹ *Id.*

⁸⁰ See 42 U.S.C. §§ 1320a-7b (2004).

⁸¹ *Id.*

sician “self-referrals” under the Stark law.⁸² The Stark law was implemented in response to studies that showed higher utilization of some Medicare services occurred when physicians referred patients to facilities in which they had a financial relationship.⁸³ When the Stark law was created, this type of physician self-referral behavior was not subject to Anti-Kickback statute prohibitions.⁸⁴ Since its original passage, the scope of the Stark law has been expanded to include a wide range of designated health services such as ownership of outpatient labs, radiology, and dialysis centers, etc.⁸⁵

Although the current Stark laws prevent physicians from referring patients to a health care facility if a financial relationship exists, the law includes numerous exceptions.⁸⁶ Prior to the moratorium, one exception allowed physician investment in “whole” hospitals, but not individual hospital departments.⁸⁷ The recent moratorium temporarily removed the ownership of specialty hospitals from the Stark law’s whole hospital exception.⁸⁸

Self-referral laws could technically be applied to almost every aspect of a physician’s business if all of the current exceptions to the Stark law were removed.⁸⁹ In the past, the federal government applied self-referral laws to areas where some evidence of abuse existed.⁹⁰ The recent moratorium on specialty hospitals requires a

⁸² See Joan H. Krause, *Regulating, Guiding, and Enforcing Health Care Fraud*, 60 N.Y.U. ANN. SURV. AM. L. 241, 250–51 (2004). The limitation is restricted to government-funded programs such as Medicare and Medicaid. *Id.* The Stark law is named after California Congressman Fortney “Pete” Stark who authored the original bill that first came into effect during 1989. See 101 Pub. L. No. 239, § 6204, 103 Stat. 2106 (1989) (codified at 42 U.S.C. § 1395nn (2004)).

⁸³ See *id.*

⁸⁴ 42 U.S.C. § 1395nn (2004). The law’s prohibition is limited to referrals related to the federal Medicare program. Because of the tremendous role of the Medicare program in health care revenue, the prohibition effectively bans the practice for all health care facilities. See TEXAS ACUTE CARE HOSPITAL FACT SHEET, <http://www.dshs.state.tx.us/chs/hosp/fact2003.pdf> (last visited Feb. 28, 2006). For example, Medicare accounted for 40% of billed acute care Texas hospital charges during 2003. *Id.*

⁸⁵ 42 U.S.C. § 1395nn(h)(10) (2004).

⁸⁶ See 42 U.S.C. § 1395nn (2004). For example, physicians can refer patients to ambulatory surgery centers (ASCs). 42 U.S.C.A. § 1395nn (West 2004) (citing the Notes of Decision, 5, U.S. ex rel. Barrett v. Columbia/Healthcare Corp., 251 F. Supp. 2d 28 (2003)).

⁸⁷ *Id.* § 1395nn(d)(3)(c).

⁸⁸ Medicare Prescription Drug, Improvement, and Modernization Act of 2003, *supra* note 22.

⁸⁹ This is because the majority of physicians have some ownership interest in their practices. See 42 U.S.C. § 1395nn.

⁹⁰ See Pat Miller, *Recent Development in the Stark and Anti-Kickback Statutes*, 48 MAY ADVOCATE (IDAHO) 14 (2005).

study of utilization trends of physician referrals to specialty hospitals where they have an ownership interest.⁹¹

D. Why Self-Referral Alone May Not Answer Some Problems Presented by Specialty Hospitals

The current ban relies on the use of federal physician self-referral laws related to government health care programs. As mentioned above, self-referral laws have continuously grown in scope since they were first implemented.⁹² The effectiveness of self-referral laws is also a serious question considering the inherent nature of physician self-referral.⁹³ If the ban on physician investment in specialty hospitals is extended, some of the questions raised by the debate will not be resolved. The self-referral laws will continue to allow numerous exceptions that would most likely allow similar conduct on a smaller scale.⁹⁴ Banning future physician investment in specialty hospitals will also fail to address effects of physician-owned specialty hospitals that already exist. The moratorium permitted existing physician owned specialty hospitals to continue to operate, but limited their expansion.⁹⁵

Another problem with the current federal ban on all future physician-owned specialty hospitals is that it may be overly restrictive.⁹⁶ Although physician ownership may cause conflicts of interest at some levels, a relatively small percentage of physician ownership seems unlikely to have a significant influence on where a physician refers patients.⁹⁷ A less severe solution may be to restrict physician ownership over some percentage threshold. Determining what threshold is appropriate would present significant challenges to determine what level of physician ownership presents problems. Also, establishing a percentage threshold may only have a limited effect considering the relatively small levels of physician ownership

⁹¹ Medicare Prescription Drug, Improvement, and Modernization Act of 2003, *supra* note 22, at § 507(b)(2).

⁹² See *AHA Assesses Specialty Hospital Impact*, *supra* note 70.

⁹³ See generally *DEVERS ET AL.*, *supra* note 13 (the extensive list of exceptions illustrates the inherent nature of physician self-referral).

⁹⁴ See 42 U.S.C. § 1395nn.

⁹⁵ Medicare Prescription Drug, Improvement, and Modernization Act of 2003, *supra* note 22, at § 507(a)(1)(B)(B).

⁹⁶ See generally David Shactman, *Specialty Hospitals, Ambulatory Surgery Centers, and General Hospitals: Charting a Wise Public Policy Course*, *HEALTH AFF.*, May–June 2005, at 868, 871.

⁹⁷ See generally GAO *SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION*, *supra* note 12, at 27 (stating that MedCath officials find that specialty hospitals are no cause for concern and that their business profits are similar to profits earned by for-profit general hospitals).

in current facilities.⁹⁸ Although specialty hospitals are generally physician-owned, most are comprised of both physician and non-physician investors.⁹⁹ Over half of all physicians investing in specialty hospitals had ownership shares of less than 2%.¹⁰⁰ In instances, however, physician ownership is much more concentrated as single physician groups own the majority interest in some hospitals.¹⁰¹

Some valid reasons do exist to restrict all levels of physician ownership in specialty hospitals. For example, allowing a physician to invest in a hospital with little or no risk is essentially the same as a direct payment to a physician to encourage referrals to a certain facility. One of the problems with the similarity of these two behaviors is that payment of any remuneration to a physician in exchange for Medicare referrals is a violation of the Anti-Kickback statute.¹⁰² If physician ownership in specialty hospitals is allowed, similar referral behavior would exist that does not violate Anti-Kickback regulations.¹⁰³

Some may question why other existing hospitals do not simply offer physicians ownership in their hospitals. The answer is that they do.¹⁰⁴ As mentioned above, this is one of the tactics existing hospitals use to compete with physician-owned specialty hospitals.¹⁰⁵ This is problematic because it is harder for an existing hospital to sell an interest in its existing hospital.¹⁰⁶ Most existing hospitals are larger than their specialty counterparts.¹⁰⁷ As a result, offering a physician an ownership percentage in an existing facility would be less likely to induce physician referrals because their ef-

⁹⁸ See GAO SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, *supra* note 12, at 8–9. “The majority of physicians who worked in specialty hospitals had no ownership interest in the facilities.” *Id.* For half of physicians with an ownership interest, the ownership interest comprised less than 2% of the respective specialty hospitals. GAO SPECIALTY HOSPITAL NATIONAL MARKET SHARE, *supra* note 14, at 10.

⁹⁹ GAO SPECIALTY HOSPITAL NATIONAL MARKET SHARE, *supra* note 14, at 14.

¹⁰⁰ *Id.*

¹⁰¹ *Id.*

¹⁰² See 42 U.S.C.A § 1320a-7b (West 2004).

¹⁰³ This is because allowing a physician to refer a patient to their own hospital would allow a physician to grant a pecuniary benefit to his or herself through a referral.

¹⁰⁴ GAO SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, *supra* note 12, at 9.

¹⁰⁵ See *supra* Section III.B.

¹⁰⁶ GAO SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, *supra* note 12, at 7.

¹⁰⁷ GAO SPECIALTY HOSPITAL NATIONAL MARKET SHARE, *supra* note 14, at 7.

forts would be diluted by the hospital's other businesses.¹⁰⁸ Further, most existing traditional hospitals are not nearly as profitable as specialty hospitals.¹⁰⁹ It is unlikely that a physician or other investors would want to invest in an unprofitable hospital.

Existing self-referral laws also prevent hospitals from offering a physician an ownership interest in a subdivision of a hospital.¹¹⁰ These regulations keep existing hospitals from carving out a division of a hospital and offering it to physicians to encourage them to refer patients or order services in a particular hospital subdivision.¹¹¹ It is likely that this regulatory prohibition of self-referrals has been a contributing factor in the increase in smaller specialty hospitals. Instead of purchasing a hospital subdivision, specialty hospitals essentially operate as a freestanding subdivision of a whole hospital.

Offering physicians ownership in existing hospitals also triggers not-for-profit tax exemption issues.¹¹² The majority of hospitals in the United States are not-for-profit facilities.¹¹³ Of these not-for-profit hospitals, some are owned by state and local government, and some are private not-for-profits operated by religious or other charitable organizations.¹¹⁴ Not-for-profit hospitals are more restricted in their ability to offer physician ownership in their existing facilities.¹¹⁵ Not-for-profits encounter problems because they must provide benefits to the public and not private persons or investors.¹¹⁶ Some private not-for-profits have been able to skirt these requirements by joint venturing with physicians in new specialty hospi-

¹⁰⁸ Gil Bachman, *Financial Impact of Physician Ownership in Specialized Healthcare Centers*, 28 WYO. LAW. 36, 38 (2005).

¹⁰⁹ See MEDICARE PAYMENT ADVISORY COMM'N (MEDPAC), REPORT TO THE CONGRESS: PHYSICIAN-OWNED SPECIALTY HOSPITALS (Mar. 2005), available at http://www.medpac.gov/publications/congressional_reports/mar05.spechospitals.pdf (last visited Feb. 28, 2006); LAURA A. DUMMIT, NAT'L HEALTH POL'Y FORUM, SPECIALTY HOSPITALS: CAN GENERAL HOSPITALS COMPETE? (Jul. 13, 2005), available at http://www.nhpf.org/pdfs_ib/IB804_SpHospitals_07-13-05.pdf (last visited Feb. 28, 2006).

¹¹⁰ See 42 U.S.C. § 1395nn (2004).

¹¹¹ *Id.*

¹¹² See Rev. Rul. 56-185 (a not-for-profit hospital cannot operate for the benefit of private individuals or restrict access to a particular group of physicians).

¹¹³ See GAO SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, *supra* note 12 at 8.

¹¹⁴ See generally AM. HOSPITAL ASS'N (AHA), FAST FACTS ON U.S. HOSPITALS FROM AHA HOSPITAL STATISTICS, http://www.aha.org/aha/resource_center/fastfacts/fast_facts_US_hospitals.html (last visited Feb. 28, 2006).

¹¹⁵ See generally Rev. Ruling 69-545; Rev Ruling 56-185.

¹¹⁶ See Rev. Rul. 69-545 at 4-5 (stating that a "hospital may not be operated, directly or indirectly, for the benefit of private interests").

tals.¹¹⁷ However, public or government operated not-for-profits generally lack the flexibility to joint venture with physician owners.¹¹⁸ Another problem with offering physicians ownership in a hospital is that it will inevitably reduce the overall revenue share for an existing hospital. Some hospitals have nevertheless taken the joint venturing approach as the lesser of two evils, sharing revenue with physicians compared to losing all of it.¹¹⁹

E. Using Government Reimbursement to Affect Hospital Competition

One question raised by the moratorium is whether any additional efforts to address specialty hospitals should come from the federal or state level. Although the moratorium's ban on physician investment in specialty hospitals ended on June 8, 2005¹²⁰, the question remains what, if any, additional measures may be required. As discussed above, the recent ban was limited to participants in the federal Medicare program.¹²¹ Even though the ban is technically limited in its application to hospitals receiving Medicare, in reality no hospital system can operate without relying on Medicare reimbursement to some degree.¹²² This is why the federal government establishes its authority to set health policy through the Medicare and Medicaid programs instead of Congress' Commerce Clause powers.¹²³

The statute, MMA 2003, containing the moratorium also indicated that Medicare hospital reimbursement may be altered to account for differences in physician-owned specialty hospitals.¹²⁴ Altering federal and state Medicare and Medicaid hospital reim-

¹¹⁷ Michael I. Sanders, *Healthcare Joint Ventures Between Tax-Exempt Organizations and For-Profit Entities*, 15 HEALTH MATRIX 83, 85 (2005).

¹¹⁸ See generally Rev. Rul. 69-545 at 4-5.

¹¹⁹ Roger D. Strode, *Hospital-physician Joint Ventures Threat or Opportunity?*, HEALTHCARE FIN. MGMT. (Jul. 2004).

¹²⁰ See Medicare Prescription Drug, Modernization, and Improvement Act of 2003, *supra* note 22.

¹²¹ *Id.*

¹²² See DEVERS ET AL., *supra* note 13.

¹²³ See David B. Kopel & Glenn H. Reynolds, *Taking Federalism Seriously: Lopez and the Partial Birth Abortion Ban Act*, 30 CONN. L. REV. 59 (1997) (Congress's use of the Commerce Clause to enforce the Partial Birth Abortion Act is a unique use of federal power).

¹²⁴ Medicare Prescription Drug, Improvement, and Modernization Act of 2003, *supra* note 22 (requiring Medicare Payment Advisory Commission (MedPAC) to study any differences in the costs of patient care between physician-owned specialty hospitals and their competitors). *Id.*

bursement may be necessary because reimbursement issues may contribute to specialty hospitals' success and accompanying problems.

Most of the problems result from the fact that Medicaid and Medicare hospital reimbursement payments are generally less than hospitals receive from private or commercial sources.¹²⁵ As mentioned above, specialty hospitals have a tendency to treat greater numbers of patients that provide favorable reimbursement.¹²⁶ As a result, Medicare and Medicaid hospital reimbursement compounds the effect of non-specialty hospitals' loss of patients by providing specialty hospitals the incentive to treat less sick patients. Furthermore, because Medicare (hospital) reimbursement is evaluated on a retrospective basis, differences in cost structures for specialty hospitals are less likely to be considered in establishing hospital reimbursement until several years after the payment has occurred.¹²⁷ Because the adequacy of Medicare reimbursement is evaluated after payment is received, inequities in reimbursement cannot be corrected until months or years after they are discovered.

F. Why State and Local Governments May Have More Flexibility to Address Problems Presented by Specialty Hospitals

Beyond other changes from the federal government, a number of options have been suggested that may be implemented at the state or local level.¹²⁸ State and local governments have the unique power to address problems specific to their communities. Although they may be in the best position to offer solutions to the specialty hospital problem,¹²⁹ state and local authorities lack the resources necessary to affect local hospital market conditions.¹³⁰

¹²⁵ See Tammy Lundstrom, *Under Reimbursement of Medicaid and Medicare Hospitalizations as an Unconstitutional Taking of Hospital Services*, 50 WAYNE L. REV. 1243, 1251 (2005).

¹²⁶ MEDPAC, REPORT TO THE CONGRESS, *supra* note 109.

¹²⁷ See CTRS. FOR MEDICARE & MEDICAID SERVS., HOSPITAL INFORMATION RESOURCE FOR MEDICARE, <http://www.cms.hhs.gov/providers/hospital.asp> (last visited Feb. 28, 2006).

¹²⁸ Rebecca Bethard, Note, *Physician Self-Referral: Beyond Stark II*, 43 BRANDEIS L.J. 465, 474-75 (2005).

¹²⁹ See *id.* at 473-74.

¹³⁰ NICHOLAS JOHNSON & BOB ZAHRADNIK, CTR. ON BUDGET AND POL'Y PRIORITIES, STATE BUDGET DEFICITS PROJECTED FOR FISCAL YEAR 2005, at 3 (2004), <http://www.cbpp.org/10-22-03sfp2.pdf> (last visited Feb. 28, 2006).

One reason for the current balance of power is related to the federal government's increasing role in the health care market.¹³¹ Since the birth of Medicare and Medicaid, the federal government has been the primary source of United States health care policy.¹³² This shift of power from the local to federal government may have presented many of the problems in our health care market. Geographic proximity is a likely determinant of where patients receive hospital services.¹³³ As a result, most hospital markets are defined in terms of geography.¹³⁴ Because of the local nature of hospital markets, it makes sense to place control of the health care market at the local level.

State and local governments can still affect health care policy in some capacity. This is reflected in states' ability to direct some Medicaid and Children's Health Insurance Program (CHIP) funding, but the majority of Medicare policy rests entirely with the federal government.¹³⁵ Nevertheless, states have the power to regulate hospital markets.¹³⁶ Some states have statutes banning self-referral activity by physicians in a wide range of circumstances.¹³⁷ Commentators have claimed that state self-referral laws have prevented the spread of specialty hospitals in these states.¹³⁸ Certain states also require physicians to disclose financial incentives to patients.¹³⁹ Disclosure is a related measure that may also have some effect on consumers' utilization of specialty hospitals. Some states require physicians to disclose any financial incentives they receive from treatment relationships.¹⁴⁰

¹³¹ See Bethard, *supra* note 128, at 466.

¹³² See *id.*

¹³³ This factor is probably less likely for specialized hospital care. See Greg Scandlen, *Reply: MSAS Can be a Windfall for the Rest of the US, too*, 49 CATH U. L. REV. 679, 686 (2000).

¹³⁴ See Robyn Whipple Diaz, *Unequal Access: The Crisis of Health Care Inequality for Low-Income African-American Residents of the District of Columbia*, 7 J. HEALTH CARE L. & POL'Y 120, 122 (2004).

¹³⁵ See Dayna Bowen Matthew, *The "New Federalism" Approach to Medicaid: Empirical Evidence that Ceding Inherently Federal Authority to States Harms Public Health*, 90 KY. L.J. 973, 973-74 (2001).

¹³⁶ See Amy Gremminger White, Comment, *Paying for Patients: Choice of Law, Conflicts of Interests and Evolving Standards of Health Care Remuneration*, 39 TEX. INT'L L.J. 327, 329 (2004).

¹³⁷ Maureen Kwiecinski, Comment, *Limiting Conflicts of Interest Arising from Physician Investment in Specialty Hospitals*, 88 MARQ. L. REV. 413, 430-31 (2004).

¹³⁸ See *id.* at 425-26.

¹³⁹ *Id.* at 430-31.

¹⁴⁰ *Id.*

One may ask why hospitals do not simply hire their physicians and provide traditional incentives for employee behavior. These measures are generally prohibited in most states through reliance on the corporate practice of medicine doctrine.¹⁴¹ The corporate practice of medicine doctrine places protections on the doctor-patient relationship and prevents hospitals from directly employing physicians.¹⁴² This doctrine emerged from ethical concerns that physicians' loyalty to their patients would be compromised if physicians were employed by non-physicians.¹⁴³ One commentator has suggested that policymakers' failure to address the corporate practice of medicine has caused some of the fundamental problems in our health care market.¹⁴⁴ Many of the significant problems in our current health care system are related to the ineffectiveness of traditional market forces to control demand for health care and hospital services.¹⁴⁵ As the specialty hospital dilemma illustrates, physicians hold the power to limit demand for hospital and other health care services.¹⁴⁶ The effect of the corporate practice of medicine has been to create a virtual monopoly for licensed physicians.¹⁴⁷ The corporate practice of medicine has been weakened or eliminated in a number of states, but it still exists in some shape or form in most states.¹⁴⁸

Although this doctrine still significantly affects our ability to introduce competition into our health care system¹⁴⁹, any benefits are likely to be long term in nature. As a result, banning the corporate practice of medicine doctrine is unlikely to have any immediate effects on the issues presented by specialty hospitals.

¹⁴¹ See, e.g., Nicole Huberfeld, *Be Not Afraid of Change: Time to Eliminate the Corporate Practice of Medicine Doctrine*, 14 HEALTH MATRIX 243 (2004) (laws that prohibit physician employment by hospitals helped establish the form of our current health care system and exacerbate some of the current problems related to costs and quality).

¹⁴² See *id.* at 251–52.

¹⁴³ See *id.* at 248.

¹⁴⁴ See *id.* at 276.

¹⁴⁵ See, e.g., John C. Render, *Recognition of Health Care Market Anomalies: Comments on a Paper by Professor James Blumsteins*, 31 IND. L. REV. 119, 121–23 (1998).

¹⁴⁶ See *id.* at 121.

¹⁴⁷ See Huberfeld, *supra* note 141, at 249.

¹⁴⁸ See *id.* at 252–53.

¹⁴⁹ See *id.* at 276.

G. Certificate of Need and Related Measures that Can Be Used to Regulate Hospital Competition

Beyond creating self-referral laws or other long-term solutions, states can advance additional measures to ensure fair competition among specialty and non-specialty hospitals. Some possible options include: 1) establishing CON laws to evaluate proposed specialty hospitals on a case-by-case basis; 2) requiring future specialty hospitals to provide a certain amount of community benefit such as participating in state Medicaid programs or operating emergency departments; or 3) imposing taxes on existing and future specialty hospitals that do not provide some level of community benefit.

H. Are State Certificate of Need Laws the Solution?

Numerous efforts to control health care costs have been made through the years, and these measures take a variety of shapes and forms.¹⁵⁰ One early attempt at health care cost control is the advent of CON laws. CON laws require approval from a state agency before adding hospital services.¹⁵¹ They have focused primarily on controlling growth in hospital capacity.¹⁵²

States began passing CON laws during the 1970s.¹⁵³ Congress later provided federal funding to all states that implemented CON laws.¹⁵⁴ After Congress removed the requirement in 1986, CON laws were stricken in several states.¹⁵⁵ As of 2002, CON laws still existed in some form in thirty-seven states.¹⁵⁶ Whether CON laws have resulted in any cost savings is open for debate,¹⁵⁷ but we continue to struggle with some of the core problems CON laws attempted to address.¹⁵⁸

Our health care system has rarely introduced true competition among hospitals. This is because restrictions such as CON laws pre-

¹⁵⁰ See generally STATE HEALTH CARE COST CONTAINMENT IDEAS (Jul. 2003), <http://www.ncsl.org/programs/health/healthcostsrpt.pdf> (provides a wide assortment of past state cost containment proposals) (last visited Feb. 28, 2006).

¹⁵¹ GAO SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, *supra* note 12, at 15.

¹⁵² See *id.*

¹⁵³ See *id.*

¹⁵⁴ See generally National Health Planning and Resources Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (1975) (The primary goals of the original legislation were to restrict the rapid expansion of health care costs and to more effectively distribute health care resources.).

¹⁵⁵ GAO SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, *supra* note 12, at 15.

¹⁵⁶ *Id.*

¹⁵⁷ See *id.*

¹⁵⁸ See Al Baker, *Panel Urges Closing of Some State Hospitals*, N.Y. TIMES, Nov. 19, 2004, at B5.

vented competition in many hospital markets.¹⁵⁹ CON laws focused on reducing the supply of hospital services available in order to reduce costs.¹⁶⁰ Some of the effects of CON laws are discussed below.

By most accounts, CON laws remain very controversial.¹⁶¹ The idea of limiting competition is contrary to our society's general belief in free market ideals. Most critics point out the fact that CON laws rarely achieved their purported cost savings goals.¹⁶² Many also point to situations in some states where CON laws were not managed effectively.¹⁶³

Regardless of the past successes or failures of CON laws, states that implement them have not encountered the rapid growth of specialty hospitals expected.¹⁶⁴ Over 80% of existing specialty hospitals are located in states without some form of CON laws.¹⁶⁵

CON laws could provide the broadest and most restrictive measure to prevent the future spread of specialty hospitals. As mentioned, states without CON laws have accounted for the largest number of specialty hospitals.¹⁶⁶ CON laws can provide an effective method to determine if a proposed specialty hospital will provide a net benefit to a health care market. CON laws allow for each decision to be studied thoroughly before specialty hospitals are allowed to operate.¹⁶⁷ The possible effects a specialty hospital may have on a health care market may not be completely understood without taking significant time and resources to analyze what effect the CON laws may have on a specialty hospital.

States generally place control of the CON process with the state agency that also oversees health facility licensing.¹⁶⁸ Most

¹⁵⁹ See Patrick John McGinley, *Beyond Health Care Reform: Reconsidering Certificate of Need Laws in a "Managed Competition" System*, 23 FLA. ST. U. L. REV. 141, 167 (1995) (certificate of need laws in Florida should be relaxed or efforts to implement a managed competition model will be unsuccessful).

¹⁶⁰ See *id.* at 143.

¹⁶¹ See *id.*

¹⁶² See *id.* at 157.

¹⁶³ Jim Summers & Michael Nowicki, *Due Diligence and Leadership: Healthcare Managers with Some Gray in Their Hair May Recall a Time When No One in Healthcare Had Heard of Due Diligence*, HEALTHCARE FIN. MGMT., June 1, 2004. Former Louisiana Governor Edwin Edwards admitted that CON approvals had taken place in exchange for political favors when Louisiana had CON laws. *Id.* Edwin Edwards was later convicted on unrelated corruption charges and is currently in federal prison. *Id.*

¹⁶⁴ See GAO SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, *supra* note 12, at 15.

¹⁶⁵ *Id.*

¹⁶⁶ *Id.*

¹⁶⁷ A more detailed account of how CON laws operate is described below.

¹⁶⁸ See, e.g., FLA. STAT. ANN. § 20.42(3) (West 2004).

states with CON laws generally require approval prior to expanding existing health care services or health care facilities.¹⁶⁹ CON laws may be defined as “a written statement issued by the agency evidencing community need for a new, converted, expanded, or otherwise significantly modified health care facility, health service, or hospice.”¹⁷⁰ A health care facility may include, “a hospital, long-term care hospital, skilled nursing facility, hospice, or intermediate care facility for the developmentally disabled.”¹⁷¹ The scope of included services and facilities subject to the CON process varies greatly from state to state.¹⁷²

To receive a CON, an application must be made with the respective state agency that reviews the application for specific criteria.¹⁷³ The criteria generally evaluate how the existing health care facilities and services serve the existing populations.¹⁷⁴ Generally, a public hearing may also be held to receive input from the local community.¹⁷⁵ After reviewing the application, the agency will either recommend granting the CON or not granting it.¹⁷⁶ If the applying party is denied the application, an administrative hearing and judicial review may be available.¹⁷⁷

Congress originally intended to limit increasing costs of health care, reduce superfluous health care services, and provide for equitable distribution of reasonably-priced quality care.¹⁷⁸ Preventing new competition from entering the health care market has been one of the greatest criticisms of CON laws. CON laws, by creating barriers to hospital market entry¹⁷⁹, may restrict potentially beneficial competition. This may explain why specialty hospitals have been more concentrated in states without CON laws.¹⁸⁰ It is possible that

¹⁶⁹ *See id.*

¹⁷⁰ FLA. STAT. ANN. § 408.032(3) (West 2004).

¹⁷¹ *Id.* § 408.032(8).

¹⁷² *See e.g.* MISS. CODE ANN. § 41-7-191 (West 2004) (Certificate of need is required prior to new construction, relocation of health care facility, increases in the number of beds, major equipment purchases, and the introduction specific health care services including: open heart services, cardiac catheterization, psychiatric services, chemical dependency services, radiation therapy, diagnostic imaging, home health services, etc.).

¹⁷³ *E.g.*, FLA. STAT. ANN. §408.035 (West 2004).

¹⁷⁴ *See, e.g., id.*

¹⁷⁵ *E.g.*, FLA. STAT. ANN. § 408.039(3)(b) (West 2004).

¹⁷⁶ FLA. STAT. ANN. § 408.039(4)(b) (West 2004).

¹⁷⁷ *See, e.g.*, FLA. STAT. ANN. § 408.39(5)-(6) (West 2004).

¹⁷⁸ *See* McGinley, *supra* note 159, at 148.

¹⁷⁹ *Id.*

¹⁸⁰ *See* GAO SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, *supra* note 12, at 15.

specialty hospitals would be able to enter health care markets with CON laws, but the barriers to entry may be too great to overcome.

Many of the initial reasons for establishing CON laws no longer exist.¹⁸¹ Originally, CON laws existed to reduce the market supply of hospital services.¹⁸² CON laws were brought about to prevent increases in the number of beds in a given health care market without a specific identified need for the increase in bed capacity.¹⁸³ In the current reimbursement environment, hospitals no longer have the same incentive to keep patients for longer stays to cover their fixed costs.¹⁸⁴

Although CON laws have had arguably little or no effect on reducing health care costs,¹⁸⁵ CON laws can still serve a valid purpose. The legislation that placed the moratorium on specialty hospitals provided for studies to be conducted to determine the potential harm specialty hospitals have on community hospitals.¹⁸⁶ CON laws may allow for a less restrictive solution than a total ban on all physician-owned specialty hospitals. This is because CON laws can be tailored to allow proposed physician-owned specialty hospitals in specific situations. For example, most of the criticisms of specialty hospitals focus on their lack of emergency services, lack of participation in Medicaid and harm to community hospitals.¹⁸⁷ Beyond these general requirements, CON laws could focus on other aspects of specialty hospitals. Some states' CON laws require a proposed hospital to provide these type of services before a CON will be granted.¹⁸⁸ For example, Florida allows expedited CON review in a number of circumstances.¹⁸⁹ Some of the requirements necessary for a hospital providing open heart cardiac services to receive a CON exemption include:

The applicant's payor mix at a minimum reflects the community average of Medicaid, charity care, and self-pay patients or the applicant must certify that it will provide a minimum of 5% of

¹⁸¹ See McGinley, *supra* note 159, at 148.

¹⁸² See *id.* at 145-47.

¹⁸³ *Id.* at 146.

¹⁸⁴ *Id.* at 171. Diagnosis Related Group reimbursement does not pay hospitals based on their actual costs or length of stay. *Id.* DRGs pay a fixed amount and thereby give hospitals the incentive to reduce length of stay and actual costs. *Id.*

¹⁸⁵ See *id.* at 157.

¹⁸⁶ Medicare Prescription Drug, Improvement, and Modernization Act of 2003, *supra* note 22.

¹⁸⁷ See GAO SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, *supra* note 12, at 4.

¹⁸⁸ See, e.g., FLA. STAT. ANN. § 408.036 (West 2005).

¹⁸⁹ See *id.*

Medicaid, charity care, and self-pay to open heart surgery patients.¹⁹⁰

Even though physician-owned hospitals are much more prevalent in states without CON laws,¹⁹¹ implementing new CON laws may prove difficult. This is because new CON laws would do nothing to address specialty hospitals that are already operating. Furthermore, many states removed CON laws because of their perceived lack of effectiveness at controlling costs.¹⁹² In general, placing stringent requirements on all hospitals as a condition of operation may not always be the most efficient way to regulate hospital competition.

I. Requiring Hospitals to Provide Community Benefits

Requiring hospitals to provide some amount of charity care or community benefits may be another viable approach. As mentioned above, these requirements can be imposed through a CON process. Outside of CON requirements, community benefit requirements already exist for not-for-profit hospitals.¹⁹³ As mentioned above, this requirement is necessary for not-for-profit hospitals to justify their exemption from federal income taxes and local property taxes.¹⁹⁴ Community benefits could be based on similar requirements by state and federal law. Community benefits may include providing emergency services, treating Medicaid and Medicare patients, providing charity care, etc.¹⁹⁵ One of the benefits of a community benefit requirement is that it could address many of the complaints about specialty hospitals.¹⁹⁶ Also, a community benefit requirement could address both existing hospitals and future planned hospitals as well by imposing an ongoing requirement instead of a front-end licensing requirement.

One of the problems associated with a community benefit requirement for all hospitals is that it would impose costs on existing for-profit hospitals without providing an additional accompanying tax exemption. Not-for-profit hospitals are already required to pro-

¹⁹⁰ *Id.*

¹⁹¹ See GAO SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, *supra* note 12, at 15.

¹⁹² *Id.*

¹⁹³ See generally Rev. Rul. 69-545 (community benefits may include services such as operating an emergency room open for all persons regardless of their ability to pay).

¹⁹⁴ *Id.*

¹⁹⁵ See Rev. Rul. 56-185; Rev. Rul. 69-545.

¹⁹⁶ See generally GAO SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, *supra* note 12, at 3.

vide community benefits to justify their federal tax exempt status.¹⁹⁷ In contrast, community benefits are generally not required of for-profit hospitals because they are required to pay federal income tax on their profits and also local or state taxes.¹⁹⁸ Imposing a community benefit standard on all hospitals would probably be an overly broad solution, but it also may serve to address a broader health care goal than merely addressing physician-owned specialty hospitals.

Some states have imposed more specific community benefit requirements on not-for-profit hospitals.¹⁹⁹ For example, Texas requires not-for-profit hospitals to provide 5% charity care in proportion to their other revenues.²⁰⁰ One solution would be to require a lesser community benefit requirements of hospitals that did not maintain not-for-profit status. Trying to determine quantifiable community benefits also may present problems. Controversy often has surrounded exactly how to quantify some of the community benefits provided by not-for-profit hospitals.²⁰¹

Some states without CON laws already require licensed hospitals to have some type of emergency room to maintain a hospital license.²⁰² The effect of the emergency room requirement alone, however, may not be as significant as some have suggested. The emergency room requirement already exists in some states and has had little effect on the number of specialty hospitals within their borders.²⁰³

¹⁹⁷ See Rev. Rul. 69-545.

¹⁹⁸ See *id.* (Community benefit requirements are not imposed on for profit hospitals by the federal government.)

¹⁹⁹ See *id.*

²⁰⁰ TEX. HEALTH & SAFETY CODE ANN. § 311.045 (Vernon 2004); see also Kevin M. Wood, Comment, *Legislatively-Mandated Charity Care for Nonprofit Hospitals: Does Government Intervention Make any Difference?*, 20 REV. OF LITIG. 709, 725 (2001).

²⁰¹ See generally Wood, *infra* note 200; James B Simpson & Sarah Strum, *How Good Samaritan? Federal Income Tax Exempts for Charitable Hospitals Reconsidered*, 14 U. PUGET SOUND L. REV. (1991).

²⁰² TEX. HEALTH & SAFETY CODE ANN. § 241.026(f) (Vernon 2004).

²⁰³ See, e.g., GAO SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, *supra* note 12, at 20 (“Texas . . . with 20 specialty hospitals, had almost twice many specialty hospitals as the state with the second highest number.”). Texas imposes an emergency room requirement for hospitals to obtain an operating license. TEX. HEALTH & SAFETY CODE ANN. § 311.046 (Vernon 2001).

J. Imposing Taxes on Specialty Hospital Services

New state or local taxes may also provide a solution to address some of the perceived problems with specialty hospitals. On the surface, a tax may sound like exactly the wrong idea, considering the already significant burden health care costs are on businesses and taxpayers.²⁰⁴ A tax on hospital services is perhaps an unpopular political alternative, but in the correct situation, a tax could provide significant benefits. Some of these benefits may include the ability of local or state tax revenue received to be eligible to draw down matching federal funds through the state's Medicaid program.²⁰⁵ This additional revenue could be used to reduce the effects of revenue losses at non-specialty hospitals.

A new tax could be targeted in the sense that it could impose a penalty on facilities that do not provide community benefits such as emergency services, treating Medicaid patients, or similar criteria. The amount of the tax could be applied on a staged basis depending on the degree of community benefit or desirable service that is performed. The resulting revenue could be used to help defray some of the costs these services have on other hospitals.

The real benefit of a tax as compared with fixed community benefit requirements is that it would allow the market to determine what services are needed, and it would not force specialty hospitals to provide services that they could not provide efficiently. A tax could even be used in the place of CON requirements.

The greatest challenge presented by establishing a tax is to ensure it is established to account properly for differences in the costs of providing community benefits. This process could become extremely cumbersome and would be less likely to work on a state-wide basis. The effect of a tax at a local level would be more likely to produce the desired results. Local hospital districts could impose the tax on area hospitals instead of using their traditional taxing methods such as property taxes.

It can be argued that the existing deficiencies in payment between government and private commercial payors are, in effect, a tax. If hospitals are using private commercial payors to cross-subsidize services provided by government payors,²⁰⁶ then an effective

²⁰⁴ See KOHN ET AL., *supra* note 4.

²⁰⁵ CTRS. FOR MEDICARE & MEDICAID SERVS., WELCOME TO MEDICAID 18.2.3(E) (2005), <http://www.cms.hhs.gov/medicaid/> (last visited Feb. 28, 2006) (Medicaid is funded by both state and federal governments.).

²⁰⁶ See generally DEVERS ET AL., *supra* note 13.

tax already exists. The ability of government payors to pay below the market rate to hospitals demonstrates the power of the federal government as a purchaser of hospital services. Non-specialty hospitals cannot operate without some reliance on government reimbursement.²⁰⁷ Although specialty hospitals appear to rely on Medicare revenue,²⁰⁸ they are a demonstration of how market forces will adapt to inefficiencies. Specialty hospitals are merely exploiting this existing gap in reimbursement between government and private payors simply because they can.

K. Going Forward

The challenges presented by specialty hospitals are complex and require significant resources to determine what actions would best address some of the problems. If specialty hospitals continue to spread, it is likely that they will ultimately cause non-specialty hospitals some harm. The harm to non-specialty hospitals, however, is likely to be more severe if policy makers do not take any remedial measures. Unfortunately, catastrophic results may occur if some of the problems that allow specialty hospitals to flourish are not addressed in the near future.²⁰⁹ But catastrophic results may be the necessary impetus to push through drastic changes to the way we regulate hospital competition and the health care market.

No easy answers are available to fix some of the problems raised by specialty hospitals. After studying the specialty hospital issue, MedPAC recently called for Congress to extend the recent moratorium for another eighteen months to further study the issue.²¹⁰ The challenge for policymakers going forward is to try to balance the government's role as a regulator and primary financer of health care services with the private market. As the problems with specialty hospitals illustrate, many of the existing policies need to be rethought. Unfortunately, there are no simple solutions to these problems.

The author suggests that a complete ban on physician investment in specialty hospitals is likely too harsh of a solution. But some restriction on physician ownership in specialty hospitals is

²⁰⁷ See JOHNSON & ZAHRADNIK, *supra* note 130.

²⁰⁸ GAO SPECIALTY HOSPITALS: GEOGRAPHIC LOCATION, *supra* note 12, at 10.

²⁰⁹ See generally, GAO UNSUSTAINABLE TRENDS, *supra* note 1.

²¹⁰ See Nora Liggett, *MedPAC Recommends Extending Stark Moratorium on Specialty Hospitals*, HEALTHLEADERS NEWS, Jan. 26, 2005, http://www.healthleadersmedia.com/view_feature.cfm?content_id=63045 (last visited Feb. 28, 2006).

necessary to prevent over-utilization of hospital services. It remains to be proven whether specialty hospitals truly operate more efficiently than their competitors. Unless specialty hospitals truly provide no benefits, banning all physician investment is not the correct solution. A balance needs to be achieved to promote possible efficiency gains, but discourage over-utilization of specialty hospital services by limiting physician investment to some degree. Finding a balance will be a difficult process, but stifling efficiency gains may have even greater repercussions.

Beyond self-referral legislation, measures such as CON laws are necessary to ensure fair hospital market competition. This is due largely to requirements imposed on some hospital operations such as providing emergency services and the resulting disparity in hospital revenue from government and commercial payors. In the absence of adequate government reimbursement to hospitals that provide community benefits, measures must exist to force new market participants to shoulder some of these cost burdens. The most effective means of accomplishing this measure is through some form of CON laws. However, to combat some of the differences between specialty and non-specialty hospitals, CON laws need to focus less on the initial granting of the hospital licenses and more on ongoing hospital operations. Changing the focus of CON laws may allow for less initial out-of-pocket start-up costs for new hospitals and ensure new hospitals are not allowed an unfair advantage in a hospital market. A shift of the burden from *ex ante* to *ex post* license also may allow for a more substantial review. This is because hospitals will be under a continuing requirement to comply with any imposed requirements such as providing emergency services or treating Medicaid patients, not just a regulatory hurdle to overcome before receiving a hospital license. As mentioned, ensuring ongoing operations provide some level of community benefits may be best enforced by a penalty tax.

IV. CONCLUSION

Although specialty hospitals present unique problems in how to better manage hospital competition, no single solution solves all of the problems presented by specialty hospitals. Self-referral laws may offer a temporary solution, but an outright ban on physician investment in specialty hospitals is an unwarranted, harsh solution. Further, a complete ban on future investment does little to address existing physician-owned hospitals.

CON laws present an effective framework to evaluate how specialty hospitals will compete in a hospital market. Current CON laws require studies of individual proposed hospitals prior to granting the hospital a license to operate. In lieu of a front-end evaluation, processes that ensure hospitals continue to compete fairly in their marketplace provide a better solution. This can be accomplished by additional community benefit standards in the form of requiring certain activities to be performed or by taxes.

In the end, no single solution provides the ultimate answer on how to fairly regulate hospital markets. The best approach allows for flexibility to suit individual hospital markets and encourages hospitals to provide healthy competition.

