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DON'T BANK ON BIG MEDICINE: THE VIRTUE OF SPECIALTY HOSPITALS

Robert Steinbuch*

I. INTRODUCTION

In *Placing Profits Above Hippocrates: The Hypocrisy of General Service Hospitals*, I discussed some of the inappropriate means that general service hospitals (GSHs) have used against specialty hospitals to preserve the former's market dominance.¹ In response to *Placing Profits Above Hippocrates*, the Chief Executive Officer of the St. Vincent Medical Center (Peter Banko) wrote to me—as well as to the head of the University for whom I work (Chancellor Joel Anderson)—to say why he, Peter Banko, believed that *Placing Profits Above Hippocrates* was, well, wrong. In this article, I respond to Mr. Banko's primary concerns.²

Specialty hospitals, frequently physician owned, focus on a specific medical field³—often high dollar fields, such as orthopedics, cardiology, surgery, and women's care.⁴ General service hospitals, in contrast, are full service entities and generally are “nonprofit”⁵ institutions.⁶ GSHs typically

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1. Robert Steinbuch, *Placing Profits Above Hippocrates: The Hypocrisy of General Service Hospitals*, 31 U. ARK. LITTLE ROCK L. REV. 505 (2009).

2. This article repeats portions of *Placing Profits Above Hippocrates* to introduce new readers to the discussion. For the convenience of the readers, the citations will be to the original sources rather than *Placing Profits Above Hippocrates*.

3. *Battle Lines Drawn over Specialty Hospitals*, AAMC REPORTER (May 2006), available at <http://www.aamc.org/newsroom/reporter/may06/specialty.htm> [hereinafter AAMC REPORTER].

4. John K. Iglehart, *The Emergence of Physician-Owned Specialty Hospitals*, 352 NEW ENG. J. MED. 78, 78 (2005), available at <http://content.nejm.org/cgi/reprint/352/1/78.pdf>.

5. A nonprofit seeks to make profits, but they are not distributed to owners. Rather, they are reinvested into the entity after all expenses, including salaries of the Board and executives are paid. See GARY M. GROBMAN, *THE NONPROFIT HANDBOOK: EVERYTHING YOU NEED TO KNOW TO START AND RUN YOUR NONPROFIT ORGANIZATION* 25 (4th ed. 2005).

6. Iglehart, *supra* note 4, at 79. (“The GAO also reported that more than ninety percent of the specialty hospitals that have opened since 1990 are for-profit entities, as compared with twenty percent of all general hospitals. Specialty hospitals are much less likely than general hospitals to have emergency departments (forty-five percent vs. ninety-two percent) or to treat Medicaid or uninsured patients. In 2001, specialty hospitals accounted for an estimated \$871 million, or one percent, of Medicare's spending on inpatient services, nearly

make their highest profit from cardiac, orthopedic, and general surgical services.⁷ As a consequence of their desire to hold onto their most profitable cases, GSHs often attempt to undermine the development of competing specialty hospitals.⁸

GSHs typically criticize specialty hospitals by arguing that (1) the specialty hospitals threaten the viability of GSHs by competing for revenue-generating cases, which GSHs often use to finance “unprofitable” services such as emergency rooms, and (2) the existence of specialty hospitals fosters conflicts of interest for physicians who refer patients to their own hospitals.⁹

II. UNDERMINING SPECIALTY HOSPITALS

In Little Rock, Arkansas, the three most notable GSHs are University of Arkansas for Medical Sciences Hospital, Saint Vincent Infirmary Medical Center, and Baptist Medical Center. There are also two specialty hospitals: the Arkansas Heart Hospital and the Arkansas Surgical Hospital. These specialty hospitals actively compete on the claim that they generally provide better care than that provided at GSHs.¹⁰

In *Placing Profits Above Hippocrates*, I discussed how some GSHs have adopted economic credentialing policies, i.e., rules based on “economic criteria unrelated to quality of care or professional competence in determining a physician’s qualifications for initial or continuing hospital medical staff membership or privileges.”¹¹ This stands in contrast to what occurred

two-thirds of which went to facilities that treat patients with cardiac disorders.”).

7. *Id.* at 78.

8. *Id.* at 83.

9. AAMC REPORTER, *supra* note 3. (“The AAMC is concerned that specialty hospitals treat disproportionately low shares of very sick and uninsured and under-insured patients, create conflicts of interest, and negatively impact the revenue centers of teaching hospitals,” said Richard Knapp, executive vice president of the AAMC and head of the office of government relations.”); Sujit Choudhry, Niteesh K. Choudhry & Troyen A. Brennan, *Specialty Versus Community Hospitals: What Role for the Law?: A Paradox Exists in the Mixed Market/Regulatory Posture of U.S. Health Care*, HEALTH AFFAIRS: THE POLICY JOURNAL OF THE HEALTH SPHERE (Aug. 9, 2005), available at <http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.361/DC1> [hereinafter Choudhry et al.] (“General hospitals warn that specialty hospitals threaten their financial viability and quality of care by reducing the volume of procedures performed in full-service settings.”).

10. *See, e.g.*, AAMC REPORTER, *supra* note 3 (“Officials at Houston’s Texas Orthopedic Hospital said specialty hospitals can perform routine orthopedic procedures three times faster than the average general hospital, with an infection rate of less than one percent and high patient satisfaction.”).

11. American Medical Association, 2003 Legal Issues: Economic Credentialing—Issues and Answers (2003), <http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/current-legal-topics/2003.shtml> (last visited Feb. 12, 2009) [hereinafter AMA, *Economic Credentialing*]. *See* James W. Marks and Jayme R. Matchinski, *Conflicts Credential-*

“[h]istorically, [where] hospital credentialing decisions ha[d] been based almost exclusively on qualitative criteria and a physician’s clinical competence.”¹² GSHs typically argue that in order to be able to offer essential but “unprofitable” services, such as an emergency room, obstetrics, pediatrics, and critical care, they need to “protect” their market in highly lucrative practice areas, such as orthopedics and cardiology.¹³ As such, GSHs have been known to:

refuse to grant initial or continuing staff privileges to physicians who own or have other financial interests in competing healthcare entities, refer patients to competing entities, have staff privileges at any other area hospitals, or fail to admit some specified percentage of their patients to the hospital. Alternatively, the hospital might require a physician seeking privileges to sign a loyalty oath or pledge to perform a certain percentage of medical services at the hospital.¹⁴

The AMA opposes the consideration of economic criteria unrelated to patient care in deciding whether to grant privileges to physicians.¹⁵

The AMA believes that the practice of conditioning a physician’s medical staff privileges on an agreement to refer patients only to that hospital is a violation of the anti-kickback law Whether called loyalty oaths or conflict of interest policies, the effect is the same. These practices . . . negatively impact a physician’s prerogative regarding patient care as well as patient choice.¹⁶

In *Mahan v. Avera St. Luke’s*, doctors challenged in court the policy of economic credentialing in South Dakota.¹⁷ In that case, a hospital refused to credential doctors because they apparently had a competing financial inter-

ing: Hospitals and the Use of Financial Considerations to Make Medical Staffing Decisions, 31 WM. MITCHELL L. REV. 1009, 1015 (2005). See also Beverly Cohen, *An Examination of the Right of Hospitals to Engage in Economic Credentialing*, 77 TEMP. L. REV. 705, 708 (2004); Judith E. Orie, *Economic Credentialing: Bottom-Line Medical Care*, 36 DUQ. L. REV. 437, 441 (1998).

12. John W. Jones, *Legal Implications of Economic Credentialing*, PHYSICIAN’S NEWS DIGEST (April 2006), available at <http://physiciansnews.com/law/406jones.html>.

13. Elizabeth A. Weeks, *The New Economic Credentialing: Protecting Hospitals from Competition by Medical Staff Members*, 36 J. HEALTH L. 247, 248 (2003), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=959196#.

14. *Id.*

15. AMA, *Economic Credentialing*, *supra* note 11.

16. *Id.*

17. 621 N.W.2d 150 (S.D. 2001); Choudhry et al., *supra* note 9. *But see* Jones, *supra* note 12.

est.¹⁸ The South Dakota Supreme Court ruled that the hospital *could* base its decision to grant or deny credentials for economic reasons rather than quality of care.¹⁹

The court . . . recognized that the hospital relied on ‘the profitable neurosurgical services’ in order to be able to continue offering ‘other unprofitable services’ in the . . . area. The court’s decision seemed informed by the unique economics of hospital financing that require cost-spreading [to] fund[] treatment for uninsured and underinsured patients.²⁰

In Little Rock, the situation of Janet Cathey, a gynecologist, presents a conspicuous example of economic credentialing.²¹ For twenty years her medical practice was centered at the Baptist Medical Center.²² Baptist is the largest health care system in Arkansas and is the preferred provider for Arkansas Blue Cross and Blue Shield, the state’s biggest health insurer.²³ Indeed, Baptist is Blue Cross’s only acute care hospital in Little Rock.²⁴ Cathey’s *husband* joined a group of Baptist doctors who were opening the Arkansas Surgical Hospital.²⁵ In anticipation of competition from the new Arkansas Surgical Hospital, Baptist established an economic credentialing policy,²⁶ prohibiting doctors “with a direct *or indirect* financial interest in a competing hospital” from having privileges at Baptist’s hospitals.²⁷ Indeed, “[t]he [new] policy applies not only to physician investors in such facilities, but also to their immediate family members—with no right to a hearing or appellate review.”²⁸

Cathey was informed by Baptist that under the terms of the new conflict-of-interest policy, once Arkansas Surgical Hospital opened, her appointment and clinical privileges at Baptist would end.²⁹ Thus, as a result of her husband’s involvement in Arkansas Surgical Hospital, Cathey was no longer entitled to admit patients or perform procedures at Baptist.³⁰ Because

18. *Mahan*, 621 N.W.2d at 153.

19. *Id.* at 156–59; Choudhry et al., *supra* note 9.

20. Weeks, *supra* note 13, at 251–52 (footnote omitted).

21. Berkely Rice, *Economic Credentialing: When Hospitals Play Hardball*, MEDICAL ECONOMICS (Sept. 15, 2006), available at <http://medicaleconomics.modernmedicine.com/memag/article/articleDetail.jsp?id=370384>.

22. *Id.*

23. *Id.*

24. *Id.*

25. *Id.*

26. *Id.*

27. Rice, *supra* note 21 (emphasis added).

28. *Id.*

29. *Id.*

30. *Id.*

most of her patients were insured by Arkansas Blue Cross and Blue Shield, Cathey's loss of privileges at Baptist would destroy her practice and deny her patients the choice of care they once had.³¹ That is, the largest insurer in Arkansas (like most insurance companies) directs its customers to certain hospitals—usually GSHs.³² So, even if Cathey wanted to perform surgical services at a specialty hospital, her patients' insurance company would not have paid for a significant portion of the expenses that would have been covered had the patients gone to Baptist. Thus, economic credentialing—coupled with the oligopolistic arrangements that GSHs have with major insurance companies—effectively squelches significant competition from specialty hospitals.

Similarly, Baptist stripped privileges from six cardiologists who are part-owners of Little Rock's Arkansas Heart Hospital.³³ Cathey and the cardiologists sued separately.³⁴ The cardiologists were granted a preliminary injunction, but, on appeal, the Arkansas Supreme Court remanded the case back to circuit court (trial court) for further findings.³⁵ On remand, the circuit court again granted a preliminary injunction on behalf of the cardiologists, and that injunction was also appealed. The Arkansas Supreme Court affirmed that injunction.³⁶ And, after trial, the circuit court issued a permanent injunction against Baptist in February 2009, enjoining the application of its economic credentialing policy.³⁷

Much has been written on whether economic credentialing is anti-competitive.³⁸ Some courts have found it not so,³⁹ and GSHs have suc-

31. *Id.*

32. As Mr. Banko stated in his letter to me, "Arkansas Blue Cross Blue Shield represents 75% of the insured market in Arkansas, so there is little to no negotiation based on price in that segment of the population." Letter from Peter D. Banko, President and Chief Executive Officer, St. Vincent Health Ctr. to author, at 1 (Aug. 14, 2009) (on file with author).

33. Rice, *supra* note 21.

34. Cathey obtained an injunction against Baptist and settled shortly thereafter. Cathey v. Baptist Health, No. CV-2005-5701 (Cir. Ct. Ark. Apr. 18, 2005).

35. Baptist Health v. Murphy, 362 Ark. 506, 511, 209 S.W.3d 360, 364 (2005).

36. Baptist Health v. Murphy, 365 Ark. 115, 132, 226 S.W.3d 800, 813 (2006).

37. Baptist Health v. Murphy, No. CV-2004-2002 (Cir. Ct. Ark. Feb. 27, 2009).

38. See Anne S. Kimbol, *The Debate Over Specialty Hospitals: How Physician-Hospital Relationships Have Reached a New Fault Line Over These "Focused Factories"*, 38 J. HEALTH L. 633, 663 (2005) (arguing that specialty hospitals are helpful entities and that there should be limits on economic credentialing); Tracy A. Powell, *The Permissibility of Conflicts Credentialing (A/K/A Economic Credentialing) by Traditional Hospitals as a Response to the Growth of Specialty Hospitals*, 20 HEALTH LAW. 17 (2007) (concluding that laws governing economic credentialing are not settled but that economic credentialing may be legal in some cases); Weeks, *supra* note 13 (concluding that many of the new forms of economic credentialing violate state and federal antitrust statutes). See generally William E. Berlin, *Antitrust Implications of Competition Between Physician-Owned Facilities and General Hospitals: Competition or Exclusion?*, 20 HEALTH LAW. 1 (2008) (detailing recent de-

cessfully argued that they should not be required to hire employees who are at the same time actively competing with them.⁴⁰

In addition to the use of economic-credentialing policies, GSHs have sought to legislatively and regulatorily eliminate specialty hospitals. GSHs often argue that (1) the specialty hospitals threaten the viability of GSHs by skimming off revenue-generating cases that finance unprofitable basic services and (2) the specialty hospitals create conflicts of interest when physicians refer patients to their own hospitals for financial reasons.⁴¹ Through the first argument, GSHs seek to subsidize unprofitable areas within their hospitals by reducing consumer choice. Through the second argument, GSHs seek to impose non-market-based (i.e., ethical) restrictions only on the actions of doctors with financial stakes in specialty hospitals.

There is no doubt that society needs both the profitable and currently “unprofitable” groups within GSHs. The question is how to ensure continued viability of GSHs or other entities providing the services not available at specialty hospitals. GSHs often attempt to do so by running specialty hospitals out of business through competitive *and* noncompetitive devices. The cost of such a proposal is that the often better care provided at specialty hospitals—for the areas that they cover—will be lost in an effort to subsidize the unprofitable centers at GSHs. In *Placing Profits Above Hippocrates*, I stated that such an approach is not good for public health.

III. ST. VINCENT’S RESPONSE

In response to *Placing Profits Above Hippocrates*, Peter Banko, Chief Executive Officer of St. Vincent Health System, wrote to dispute my conclusions. He agreed that economic credentialing is not the answer to address the existence of physician-owned specialty hospitals, but he took issue with the various other points raised in *Placing Profits Above Hippocrates*. As Mr. Banko stated:

velopments in case law, antitrust legislation, and potential defenses to litigation against economic credentialing); Beverly Cohen, *An Examination of the Right of Hospitals to Engage in Economic Credentialing*, 77 TEMP. L. REV. 705 (2004) (surveying case law, state law and federal law and concluding that there are few instances in which economic credentialing is foreclosed).

39. See, e.g., *Mahan v. Avera St. Luke’s*, 621 N.W.2d 150, 160 (S.D. 2001) (citing *Imperial v. Suburban Hosp. Ass’n, Inc.*, 862 F. Supp. 1390, 1401 (D. Md. 1993)); *Hutton v. Mem’l Hosp.*, 824 P.2d 61, 63 (Colo. App. 1991); *Sarin v. Samaritan Health Ctr.*, 440 N.W.2d 80, 82 (Mich. Ct. App. 1989); *Lewin v. St. Joseph Hosp.*, 146 Cal. Rptr. 892, 906–07 (Cal. Ct. App. 1978).

40. Cohen, *supra* note 38, at 729 (citing *Rosenblum v. Tallahassee Reg’l Med. Ctr.*, No. 91-589, slip op. at 3 (Fla. Cir. Ct. June 18, 1992)).

41. AAMC REPORTER, *supra* note 3.

I am not an economist or an attorney, but I live in the practical world of health care each and every day. I would like to take this opportunity to present to you a deeper rationale why physician owned specialty hospitals are not in the best interest of our medical community and our community as a whole.⁴²

Mr. Banko states his general thesis as:

[L]imited service physician owned specialty hospitals are not in the best interest of our society. They are truly competitive agents entering an irrational health care market where pricing is controlled and information is limited. They drive up utilization of expensive health care services that increases costs for the employers and, consequently, every consumer. They skim profitable health care services and profitable patients that are used to subsidize unprofitable yet essential services (emergency, obstetrical, and psychiatric care as well as care for the Medicare population) and care for the poor and underserved. The quality of their care is good for those without complication or co-morbidities, but truly disastrous for those that need extra attention and support.⁴³

I address Mr. Banko's main concerns below.

A. Competitive Forces in Health Care

As Mr. Banko states: "True competition does not exist in the health care market. Therefore, you cannot use competitive market argument to support the existence of physician owned specialty hospitals."⁴⁴

My argument in *Placing Profits Above Hippocrates*, however, was not that the health care environment reflects a purely competitive market. It surely does not. But market competition does exist, and should be considered, in the health care field. Hospitals routinely put on television and print advertisements promoting quality, services, and physicians. In fact, St. Vincent advertises in various forms, including with large billboards proclaiming, inter alia, that it is the first Accredited Chest Pain Center in Little Rock. (Arkansas Heart Hospital is the second.) This is a direct appeal to consumers—using competitive market forces to attract business. Moreover, few dispute that "[c]ompetition in health care markets benefits consumers because it helps contain costs, improve quality, and encourage

42. See Letter from Peter D. Banko, President and Chief Executive Officer, St. Vincent Health Ctr., to author, *supra* note 32.

43. *Id.* at 3.

44. *Id.* at 1.

innovation,”⁴⁵ although, as Mr. Banko’s position makes clear, not all support this notion.⁴⁶

Mr. Banko continues that “[h]ealth care is not a rational market (in the truest sense of definition) for the following reasons.”⁴⁷ Mr. Banko states that “[c]onsumers of health care suffer from a lack of adequate information about what services they need to buy and which providers offer the best value proposition.”⁴⁸ This is true. But, again, it does not serve as a basis to eschew market forces in health care.⁴⁹ Consumers often access comparative data and quality grading on hospital quality.⁵⁰ Further, insurance companies often post comparative hospital data on their websites;⁵¹ Medicare provides comparative data between medical facilities;⁵² and legislation has promoted better informed health-care consumers.⁵³

Moreover, informational disadvantages are always a reality in any market system.⁵⁴ The goal with such circumstances is to increase consumer

45. FTC Bureau of Competition, *Competition in the Health Care Marketplace*, <http://www.ftc.gov/bc/healthcare/> (last visited Mar. 7, 2010).

46. Harvard Business School, Porter and Teisberg on Redefining Health Care, <http://www.hbs.edu/rhc> (last visited Mar. 7, 2010) (“Health care is on a collision course with patient needs and economic reality. In today’s dysfunctional health care competition, players strive not to create value for patients but to capture more revenue, shift costs, and restrict services. To reform health care, we must reform the nature of competition itself.”).

47. Each of Mr. Banko’s primary rationales will be addressed in seriatim.

48. Banko, *supra* note 32, at 1.

49. See Barrett S. Moore, Comment, *Trust Me, I Do This All the Time: Comparative Provider Statistics and Informed Consent in Arkansas*, 31 U. ARK. LITTLE ROCK L. REV. 609, 610 (2009) (“In 1990, the New York State Department of Health undertook a state-wide study of open-heart surgeries, controlling—for the first time in any study of that scale—the independent variables of physician and hospital choice. After controlling for twenty additional components that could account for variation in the surgical risk factor, the New York Department of Health found a marked difference between the success rates of New York’s individual hospitals and heart surgeons. This study allowed patients, for the first time, to evaluate a doctor or hospital as an independent risk factor.”).

50. See, e.g., HealthGrades, *Research Hospitals, Doctors, and Nursing Homes*, <http://www.healthgrades.com> (last visited Mar. 7, 2010).

51. See, e.g., Blue Access for Members, Blue Cross Blue Shield, <http://bcbsil.sqctool.com/> (log-in required) (last visited Mar. 31, 2010).

52. See, e.g., U.S. Department of Health & Human Services, *Medicare Hospital Compare*, <http://www.hospitalcompare.hhs.gov/> (last visited Mar. 31, 2010).

53. See, e.g., SUSAN S. LAUDICINA ET AL., BLUE CROSS BLUE SHIELD ASS’N, STATE LEGISLATIVE HEALTH CARE AND INSURANCE ISSUES: 2007 SURVEY OF PLANS 6 (2007), available at <http://www.cahc.net/documents/Acr17.pdf> (“[Arkansas] [l]awmakers enacted two laws to promote greater provider transparency. Under HB 1513, the Arkansas Hospital Association will make price and quality information about its member hospitals available to the public. Hospital-acquired infection rates will also be publicly disclosed (HB 2735).”).

54. Nobelprize.org, *The Prize in Economics 2001—Press Release*, http://nobelprize.org/nobel_prizes/economics/laureates/2001/press.html (“Many markets are characterized by *asymmetric information*: actors on one side of the market have much better information than those on the other. Borrowers know more than lenders about their repay-

knowledge and prevent misrepresentation in the market place,⁵⁵ not to eliminate market forces and patient choice. The fact that GSHs themselves advertise with the goal of creating informed consumers demonstrates at least a recognition of market forces and consumer choice in health care.

B. Doctors' Profit Motives

Mr. Banko continues that because

patients don't know a great deal about medicine, they rely on the opinion of physicians for decision-making. Consequently, the physician becomes the agent of the patient. Since physicians are paid on a fee-for-service basis, if they don't have enough work or income, they can increase the amount of services for their patients (with a simple stroke of a pen on a prescription pad).⁵⁶

While some of what Mr. Banko asserts may be true, it is not clear (1) how this differs between GSHs and specialty hospitals, (2) how this situation differs from other service industries, and (3) how this argues in favor of eliminating specialty hospitals.

Mr. Banko seems to suggest that physicians, or at least those at specialty hospitals, are not ethical or cannot serve as trusted advisors to their patients. This criticism seems misplaced. Notwithstanding attempts at economic credentialing by many GSHs and, in part, as a result of court decisions striking down such policies, many of the physician investors in specialty hospitals are still on staff at GSHs.⁵⁷ While they do not have ownership stakes in the GSHs, they—no less the doctors who are full-time employees of the GSHs—have an interest in the GSHs making profits, as well as the unit in which they work.

ment prospects, managers and boards know more than shareholders about the firm's profitability, and prospective clients know more than insurance companies about their accident risk.”).

55. Robert Steinbuch, *Preventing Under-Equipped Medical Facilities from Killing Heart-Attack Patients: Correcting Inefficiencies in the Current Regulatory Paradigm for Providing Critical Health-Care Services to Patients with Acute Coronary Syndrome*, 17 HEALTH MATRIX 17, 46–50 (2007).

56. Banko, *supra* note 32, at 1.

57. See, e.g., MICHAEL O. LEAVITT, SECRETARY OF HEALTH AND HUMAN SERVICES, STUDY OF PHYSICIAN-OWNED SPECIALTY HOSPITALS REQUIRED IN SECTION 507(C)(2) OF THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003, at 34 (2005) [hereinafter HHS REPORT] (“We found that a significant number of specialty hospital owners ‘took emergency call’ at competitor hospitals, which was to the benefit of both the specialty hospital owners and the competitor hospitals. Local acute general competitors needed the expertise of specialty hospital physician owners to treat (and share the burden of) its ED patients.”).

Further, the then Secretary of the Health and Human Services Administration disagrees with the assertion that physician owners of specialty hospitals excessively refer patients to their own institutions relative to their peers at GSHs:

We examined the extent to which physician-owners refer Medicare patients to other facilities, given the financial incentive to refer patients to their own facility. In two cardiac hospitals visited, owners had a clear preference for referring inpatient cases to their owned hospital, with 65% and 75% of all their cases admitted to their hospital. In the third specialty cardiac hospital visited, owners referred almost the same percentage of cases to their facilities as to competitor hospitals in the area. Physician-owners in all orthopedic/surgery specialty hospitals visited, except for one, referred most of their orthopedic or surgery inpatient cases to their competitor hospitals. This is not surprising, given the very small inpatient census at these hospitals. *Consequently, we did not see clear, consistent patterns of preference for referring to specialty hospitals among physician owners relative to their peers.*⁵⁸

Moreover, in the cardiac hospitals in the HHS study, the average ownership share per physician in heart hospitals was only 0.9% and 2.2% for orthopedic/surgery hospitals.⁵⁹ The implication being that such a small ownership is hardly likely to incentivize doctors to act unethically.

In fact, at St. Vincent, at least some doctors also provide work on an incentive basis—where they are compensated based in part on the quantity and complexity of the procedures they perform. St. Vincent outsourced its emergency room to an excellent service provider (EmCare), which routinely has a blended pay structure, providing for greater compensation when the amount of services is increased.⁶⁰ This is the type of incentive scheme that Mr. Banko appears to criticize. I disagree with the wholesale critique of productivity-based compensation that Mr. Banko seems to be now suggesting. Such a system recognizes that while doctors might be tempted to over-treat, they are bound by ethical and scientific principles to do otherwise. Moreover, checks and balances, such as case managers, claim adjustors, utilization review managers, peer review processes, and CMS mean-

58. *Id.* at ii (emphasis added).

59. *Id.*

60. See Kelly A. Carter, Brian C. Dawson, Kori Brewer & Luan Lawson, *RVU Ready? Preparing Emergency Medicine Resident Physicians in Documentation for an Incentive-Based Work Environment*, 16 ACAD. EMERGENCY MED. 423, 423–28 (2009); John Proctor, *Gauging Emergency Physician Productivity: Are RVUs the Answer?*, AM. C. EMERGENCY PHYSICIANS, PRAC. RESOURCES, <http://acep.org/practres.aspx?id=30306> (last visited Mar. 31, 2010).

deviation databases that could result in a CMS audit if treatment patterns appear unjustified, serve to deter improper behavior.

Indeed, Mr. Banko admits that “[p]rivate insurers and government payers use a variety of controls on service availability to rein in physician inducement and practice variations to control demand similarly to how physicians can control supply.”⁶¹ Thus, the concern that doctors in specialty hospitals will somehow uniquely abuse patients’ trust and ethical principles seems further misplaced.

In addition, the concern that service providers may overstate customers’ needs—where customers may not be well-informed on their own—exists throughout any service industry.⁶² This is not typically a basis to dismiss customer choice. Rather, it is a basis for effective regulation and consumer education.⁶³

C. Transfer Protocols as a Measure of Quality—A Dangerous Comparison for GSHs

Mr. Banko states that:

I believe you could make the argument that competition can be based on quality and service and you did just that with your statement that ‘generally better care [is] provided at specialty hospitals.’ There are studies both supporting and refuting that premise, so I will speak from personal experience. St. Vincent has never transferred a patient to a physician owned specialty hospital for ‘generally better care.’ However, we do receive multiple transfers from those specialties when patients get into trouble. If you have an infection and need an infectious disease physician or you have lung issues and need a pulmonary specialist or your kidneys start to malfunction and you need a nephrologist (the list goes on),

61. Banko, *supra* note 32, at 2.

62. See, e.g., Federal Trade Commission, Taking the Scare Out of Auto Repair, <http://www.ftc.gov/bcp/edu/pubs/consumer/autos/aut13.shtm> (last visited Mar. 31, 2010) (“The best way to avoid auto repair rip-offs is to be prepared. *Knowing* how your vehicle works and how to identify common car problems is a good beginning. It’s also important to know how to select a good technician, the kinds of questions to ask, and your consumer rights.”) (emphasis added).

63. See Texas Attorney General, Consumer Protection, Car Repairs, http://www.oag.state.tx.us/consumer/car_repair.shtml (“[T]he Deceptive Trade Practices–Consumer Protection Act includes some sections that deal with auto repairs. Under this law, it is illegal to: 1. Knowingly make a false or misleading statement about the need for parts, replacement or repair services. 2. State that work has been done or parts were replaced when that is not true. 3. Represent that goods are original or new, when in fact they are second-hand or refurbished. 4. Advertise goods or services with intent not to sell them as advertised.”).

you are out of luck at that physician owned specialty hospital because those physicians aren't available to help you. In those unfortunate situations, the physician owned specialty hospital transfers you to a general service hospital (like St. Vincent) to bail you, your family, and that invested physician out of a mess.⁶⁴

However, the Secretary of Health and Human Services stated:

Based on the population of all specialty hospitals, the proportion of patients transferred from cardiac hospitals to competitor hospitals is about the same as the proportion of patients transferred between competitor hospitals. The proportion of patients transferred from cardiac hospitals to competitor hospitals who were severely ill was similar to that of patients in the same Diagnostic Related Group (DRGs) who were transferred between competitor hospitals. Consequently, *the notion that specialty cardiac hospitals are transferring more severely ill patients to general hospitals was not supported by our study*. Patients transferred into cardiac hospitals have slightly lower severity levels on average than patients transferred into competitor hospitals for cardiac services. Due to the small number of cases, no conclusions could be drawn about the severity levels of transfer patients in the physician-owned orthopedic/surgery hospitals.⁶⁵

It bears repeating that I believe St. Vincent is a very good institution and one that I would choose over various others depending on the circumstances. However, the notion that specialty hospitals are a recipe for disastrous outcomes—or that GSHs such as St. Vincent do not ever transfer patients for higher-level care—is inaccurate.

St. Vincent—as a GSH—offers a wider array of services to its patients. Thus, as Mr. Banko asserts, if a patient needs multiple services, he may be better off going to St. Vincent versus a specialty hospital. But St. Vincent itself will transfer patients to other facilities when those patients need a level of care that St. Vincent aptly decides it cannot provide. That is not a basis for denying the value of St. Vincent—or, by analogy, specialty hospitals. It is unclear why an intermediate-level care provider should argue against specialty hospitals because of transfer protocols without subjecting itself to the same criticism.

64. Banko, *supra* note 32, at 2.

65. HHS REPORT, *supra* note 57, at iii (emphasis added).

And while St. Vincent may not have transferred any patients to specialty hospitals, other GSHs, to their credit, have.⁶⁶ This interest-of-the-patient approach should be lauded, not discouraged.

In addition, a true story of one patient serves as at least some anecdotal evidence as to the usefulness of specialty hospitals. Recently, a patient with chest pain went to St. Vincent one evening because he was concerned about the risk of heart attack.⁶⁷ He was asked his age (under 30) and whether he was on any drugs (no). Upon receiving answers to these questions, he was told that the emergency room was busy and he would have to wait. After receiving the same instruction to wait fifteen minutes later, the patient left St. Vincent and went to Arkansas Heart Hospital. He was seen immediately in the emergency room. Because the patient had an irregular electrocardiogram and raised nonspecific blood enzymes, the emergency-room doctor admitted him to rule out a heart attack.⁶⁸ This strikes me as a positive outcome for the patient. I know that he was greatly relieved to have the option of going to Arkansas Heart Hospital.

D. Health Care Ownership

In discussing the lack of pure competition in the health care market, Mr. Banko aptly suggests that there are different financial obligations on health care institutions depending on their status: "Entities providing health care services can range from for-profit to not-for-profit to public entities. These ownership difference interject taxes, mandates for charity care to support 501(c)(3) status, and/or public subsidies that create imbalances in the health care market."⁶⁹

Mr. Banko is correct that there are different types of hospital ownership, including for-profit, nonprofit, and government owned. For-profit sta-

66. Interview with Carrie Helm, Chief Executive Officer, Arkansas Surgical Hospital, North Little Rock, Ark.

67. For a discussion of related issues, see Robert Steinbuch, *Regulatory Changes for the Treatment of Patients with Heart Attacks*, 99 AMER. J. CARD. 1166 (2007).

68. D.R. O'Neill, *Low-Risk Classified Chest Pain Patients: Do They Need Cardiac Monitoring in the Emergency Department and Can They Be Cared for in Non-Monitored Beds?*, 10 AUSTRALASIAN EMERGENCY NURSING J. 58, 58 (May 2007) ("All chest pain patients are triaged to monitored beds within the emergency department where they are observed awaiting test results."); Associated Press, *'Super X-Ray' Rules out Heart Attacks Faster* (Nov. 18, 2009), available at http://today.msnbc.msn.com/id/34019246/ns/health-heart_health/ ("About 6 million people each year go to hospitals with chest pain, but only a small fraction are truly having a heart attack . . . [There are many] people who did not have clear signs of a heart attack from those blood tests or EKGs, but doctors are afraid to send them home without more tests [because] [b]etween 4 percent and 13 percent of such patients will have a missed diagnosis of a heart attack, and up to one quarter of that group will die . . .").

69. Banko, *supra* note 32, at 2.

tus, however, is not indicative of just physician-owned specialty hospitals. Quorum, HCA, and other health care corporations that run GSHs are for-profit facilities, as well.

Moreover, for-profit hospitals have the same obligation to contribute to the care of the uninsured and under insured, but they *also* pay a significant amount of taxes that nonprofits such as St. Vincent avoid. As a consequence, the Secretary of Health and Human Services concluded:

The specialty hospitals in the study provided financial information that allowed us to compute their taxes paid and their uncompensated care as a proportion of net revenues. Because the specialty hospitals are much smaller than their competitors, their share of the total uncompensated care in the community was very small. On the other hand, the specialty hospitals paid real estate and property taxes, as well as income and sales taxes, whereas non-profit community hospitals did not. *As a result, the total proportion of net revenue that specialty hospitals devoted to uncompensated care and taxes combined exceeded the proportion of net revenues that community hospitals devoted to uncompensated care.*⁷⁰

E. Treatment for All

Mr. Banko suggests that specialty hospitals do not treat all patients: “Federal mandates for emergency care (and subsequent stabilizing care) regardless of ability to pay bind hospitals to provide treatment for all. Our mission at St. Vincent Health System calls us to provide treatment for all, but physician owned specialty hospitals have managed to avoid these mandates.”⁷¹ Mr. Banko continues, stating, “Roughly, 85% of the hospitals in the United States lose money on Medicare patients.”⁷²

70. HHS REPORT, *supra* note 57, at iii–iv (emphasis added) (“Considering only the hospitals in the six study sites, the specialty hospitals provide a greater level of net community benefits, as we defined it, than competitor hospitals. Even if costs in excess of Medicaid payments are considered as uncompensated care, both cardiac and orthopedic/surgery specialty hospitals in the study still contributed a higher level of net community benefits than competitor hospitals. Only if Medicare DSH payments are not offset against uncompensated care in the NFP hospitals, is the net community benefit of competitor hospitals similar to the cardiac hospitals, but it would still be less than the orthopedic hospitals. The cardiac hospitals in this study provided a not insubstantial level of uncompensated care that exceeded the levels provided by competitor hospitals, after offsetting DSH payments.”). *Id.* at 59.

71. Banko, *supra* note 32, at 2.

72. *Id.* at 3.

However, specialty hospitals routinely treat a diverse patient base, including a very large Medicare component.

All of the cardiac hospitals (16 were operational in 2003 for more than a year) were built exclusively for cardiac care. They treated about 38,000 Medicare cases, which represent 80% of the cases treated in 2003 by all physician-owned specialty hospitals. Medicare patients account for a very high proportion of inpatient days, averaging 67% nationwide.⁷³

Moreover, specialty hospitals are subject to the same EMTALA regulations applied to all hospitals, and in Arkansas all licensed acute care hospitals must have emergency rooms.⁷⁴ With that said, GSHs—being much larger institutions than specialty hospitals—typically have much larger emergency rooms than specialty hospitals. The size of the emergency room is a direct function of the overall size that the institution itself (GSH or specialty hospital) voluntarily has chosen to become.

IV. CONCLUSION

Mr. Banko and I have different philosophies. Mr. Banko wants patients to be directed to GSHs like his, so that they may spread the wealth of profitable centers in the hospital to the “unprofitable” ones. Mr. Banko describes his position as follows:

Stroke care, diabetes care, trauma care, emergency care, obstetrical care, and psychiatric services are just a few of the highlights of the other unprofitable services at general service hospitals. Dealing with a car accident or a stroke with a parent or your new baby or the stigma of mental health services is certainly where general service hospitals benefit you and our community each and every day (relying on more profitable services to pay for those that can't).⁷⁵

Of course, the “unprofitable” centers provide useful services. Profitability, however, is an issue of finance, not medicine. As a patient advocate, a patient relative, and a patient myself, I want the best care available—especially for critical health issues, such as cardiac care. After all, heart disease remains the number one killer of Americans.⁷⁶ And the Secretary of

73. HHS REPORT, *supra* note 57, at ii.

74. 42 U.S.C. § 1395dd (2006).

75. Banko, *supra* note 32, at 3.

76. See Steinbuch, *supra* note 55, at 17.

Health and Human Services seems to think that I might at times be better off at a specialty hospital:

Based on an analysis of the claims from the population of specialty hospitals, the cardiac hospitals delivered a high quality of care that was as good as *or better* than their competitor hospitals. Because of the small number of discharges, a statistically valid assessment could not be made for orthopedic/surgery hospitals. Patient satisfaction was very high in both cardiac and orthopedic/surgery hospitals, as Medicare beneficiaries enjoyed large private rooms, quiet surroundings, adjacent sleeping rooms for their family members if needed, easy parking and good food.⁷⁷

So, the inquiry becomes how do we pay for the services that Mr. Banko describes as “unprofitable.” He wants to do so by eliminating for patients the option of going to hospitals that—according to the Secretary of Health and Human Services—potentially provide better care for what Mr. Banko undoubtedly views as the greater good of redistributing profits to spread income to subsidize “unprofitable” areas within his hospital.

I would seek an alternative approach. I am not comfortable with big medicine deciding where I and other patients can go for treatment and what quality of care I and other patients can get. I prefer an approach that leaves greater, not less, control and choice of health care in the hands of not-so-uninformed patients, their families, and their personal doctors. That freedom of choice, I believe, is essential for quality health care and best reflects the American spirit.

77. HHS REPORT, *supra* note 57, at iii (emphasis added).