

Specialty hospitals preserve free-market enterprise and foster healthy competition

Cardiac specialty hospitals run more efficiently and have higher-quality outcomes than their community hospital counterparts. The primary interest of cardiologists and cardiac surgeons is the efficient management of the care process to achieve the best clinical quality. This can be hard to accomplish in the larger institutional setting of the community hospital. In many cases, physicians take the financial risk of building and operating specialty hospitals only after joint venture attempts with community hospitals fail. Patients need to have access to quality-driven alternatives.

Competition raises the level of quality for the entire community

Cardiac hospitals are more efficient, patient-friendly and provide better outcomes than community hospitals because the specialty facility is totally focused on the specific needs of cardiac patients and their physicians. Quality rating organizations and insurers consistently rate physician-owned heart hospitals as providers of the highest quality cardiac care available.

Medicare's reform of the hospital Inpatient Prospective Payment System in 2006 intentionally leveled the playing field between specialty and community hospitals that provide cardiac and orthopedic care. Recently proposed rules continue this effort to negate disparities in payments between private and nonprofit hospitals so Medicare and Congress can focus on ensuring that patients receive high-quality, efficient care regardless of the setting.



- In its April 2006 study, the Medicare Payment Advisory Commission (MedPAC), an independent federal body that advises Congress on issues affecting the Medicare program, found that “the effect of specialty hospitals has not been large enough to have a statistically significant effect on community hospitals’ total profit margins.” MedPAC also found no evidence that financial incentives play a role in increased utilization of heart surgery, and that Medicare patients had shorter than expected lengths of stay in specialty hospitals.
- The Federal Trade Commission (FTC) and the Department of Justice (DOJ) believe new competitors “could provide higher quality services” than existing hospitals (July 2004).
- The Centers for Medicare and Medicaid Services (CMS) report that cardiac hospitals in some areas treat more severely ill patients than their local community hospital. Cardiac hospitals generally provide Emergency Department services and other features for their communities, such as outreach programs (March 2005).
- CMS opposed extending a moratorium on specialty hospitals.

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CAA provides national leadership on legislation that affects cardiovascular patients' quality of care and access to services, as well as the stability of cardiovascular group practices. CAA represents the interests of more than 4,500 physicians and their patients. For more information, contact CAA at 734.878.2108 or visit our website: cardiologycaa.com.

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Regulatory agencies favor competition, not marketplace limitation

The FTC and DOJ issued a special report on health care competition (July 2004) that points to the anti-competitive effects of Certificate of Need (CON) and related endeavors:

- Legislation that limits or prohibits entry of new hospital competitors “may actually increase health care costs, as supply is depressed below competitive levels.”
- Regulating supply through CONs “make much less sense today when hospitals are paid a fixed amount for services, and managed care forces them to compete both to participate in managed-care networks and then for the plans’ patients.”
- The agencies’ bottom line: CON programs and other legislative limitations “are generally not successful in containing health care costs, can pose anti-competitive risks... [they] risk entrenching oligopolists and eroding consumer welfare. ...There appear to be other, more effective means of achieving [cost control] that do not pose anti-competitive risks. A similar analysis applies to the use of CON programs to enhance health care quality and access.”

Specialty hospitals return more to the community

CMS told Congress in March 2005 that specialty hospitals return more to their communities than do nonprofit hospitals:

“...specialty hospitals paid significant real estate and property taxes, as well as income and sales taxes, while nonprofit community hospitals did not pay these taxes. As a result, the total proportion of net revenues that specialty hospitals devoted to both uncompensated care and taxes significantly exceeded the proportion of net revenues that community hospitals devoted to uncompensated care.”

Cardiology Advocacy Alliance supports:

- Competition in health care: it raises the level of quality for the entire community, and allows the laws of supply and demand to control healthcare costs.
- Disclosure of physician ownership and loan information for specialty hospitals to promote transparency, and emergency care provisions and protocols.
- Adjusting the disparities in Medicaid and Medicare to equitable and adequate levels that will preserve the safety net for nonprofit hospitals, make them less reliant on revenue from specific services, and create a level, competitive playing field that patients demand and deserve.
- Physicians’ right to own assets, on their own and in conjunction with hospital partners. Physician ownership leads to alignment with hospitals, resulting in increased quality and decreased costs.



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