Issue Brief
Findings from HSC

SPECIALTY HOSPITALS: FOCUSED FACTORIES OR CREAM SKIMMERS?

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Hospitals specializing in cardiovascular and orthopedic procedures are developing rapidly throughout the country, raising challenging questions for communities and policy makers. Proponents argue that specialty hospitals could improve quality and reduce costs, yet skeptics note that specialty hospitals might reduce quality, increase costs and decrease access to basic services. The Center for Studying Health System Change (HSC) site visit findings suggest that the relatively high profit margins of these select procedures and specialists' desire to increase control over the care environment and increase their income are among the key reasons for this specialty hospital building boom. Policy makers are exploring a range of responses with the goal of allowing specialty hospitals to compete and innovate while minimizing the potential for quality, cost and access problems.

The Rise of Specialty Hospitals

The United States has a long tradition of some types of specialty hospitals (e.g., children's, rehabilitation and eye and ear), but those focusing on cardiovascular and orthopedic procedures are relatively new, and they are rapidly increasing in number. Evidence of the burgeoning of specialty hospitals comes from HSC's site visits and local reports from around the country. Between 1997 and 2002, 11 specialty hospitals emerged in the 12 communities HSC studies.[1] Local newspaper accounts describe similar developments in many other places. While comprehensive national data on these types of specialty hospitals are not available, one report estimated that 50 or more such hospitals have already opened, and many more are under construction.[2] This trend appears to be a continuation of providers' increasing emphasis on inpatient and outpatient specialty services and physician ownership in outpatient facilities.

The reasons for specialty hospital development are complex and vary across markets, but analysis suggests that three factors are important drivers of this trend nationally: relatively high reimbursements for certain procedures, physicians' desire for greater control over management decisions affecting productivity and quality and specialists' desire to increase their income in the face of reduced reimbursement for professional services.

Since the first site visits in 1996-97, hospital executives have reported that surgical admissions are much more profitable than medical admissions, and that certain surgical procedures (e.g., cardiovascular and orthopedic) are among the most profitable. It is unlikely that payers intended to create these distortions in payment rates. Concerning management control, a specialty hospital might give physicians greater voice in decisions of importance to them such as hiring, staffing levels, scheduling and purchasing equipment. They can also help specialists to raise their income by increasing their productivity and sharing a portion of the profits from the facility if they are owners.

Indianapolis Case Study: Affairs of the Heart

Indianapolis provides an excellent example of how and why specialty

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hospitals are increasing in number. Since late 2000, in a metropolitan area with only 1.6 million residents, four heart hospitals and one orthopedic hospital have opened, are under construction or are in the planning stages. Four hospital systems dominate the landscape and increasingly compete for high-tech, specialty services, and several relatively large single-specialty physician groups practice in multiple systems.

The flurry of specialty hospital development began when several cardiology groups affiliated with one of the area's four hospital systems, Community Health Network (CHN), initiated discussions about building a heart hospital with MedCath, a national for-profit cardiovascular service company. These physicians had pressed CHN to build a new heart hospital in which they could share ownership interest, but they were turned away. The competitive threat posed by a heart hospital jointly owned by its cardiologists and MedCath convinced CHN to build a freestanding heart hospital with the physicians owning up to a 30 percent share through a joint venture arrangement.

CHN took several other steps in response. To minimize competition with its own cardiac service programs, CHN consolidated its cardiovascular programs into the new hospital. To compete with other hospital systems, it located the specialty hospital in an affluent suburban area historically dominated by another major hospital system, St. Vincent, and added approximately 29 new beds to accommodate future growth. Finally, CHN built the new heart hospital within two miles of its own community hospital to facilitate transfer of emergency and other patients needing nonspecialty services.

CHN was not the only hospital to bend under pressure from specialists who threatened to partner with MedCath. CareGroup, with approximately 90 cardiologists and 55 internists and other clinicians, provides care to approximately 30 percent of all patients in the St. Vincent hospital system. When CareGroup told St. Vincent it was about to sign an agreement with MedCath, the hospital agreed to build a new freestanding heart hospital one mile away from its general hospital and give the doctors a 50 percent ownership stake.

Unlike CHN, St. Vincent did not consolidate cardiovascular services. The new heart hospital will compete with St. Vincent's existing cardiovascular surgery programs, and all 122 of the heart hospital's beds represent expanded capacity. In addition, the new hospital intends to operate a very limited emergency department and use St. Vincent Indianapolis for backup care.

Given the increased competition from specialty heart hospitals and the "MedCath threat," the other two major Indianapolis hospital systems developed their own heart hospitals without physician ownership involvement. Clarian Health System relabeled a consolidation and modest expansion of its existing cardiovascular surgery and research programs as a heart hospital, and St. Francis Hospital and Health Centers announced plans to build a freestanding heart hospital of its own.

Other physicians may try to follow suit. Orthopedics Indianapolis, a single-specialty medical group, has announced plans to build its own 40- to 60-bed orthopedics hospital, but hasn't yet raised the needed capital.

General Hospitals' Response

The spate of specialty hospital construction is unnerving general hospitals, which worry that the new facilities will draw away profitable patients and undermine their ability to achieve the volume needed to provide high-quality, low-cost specialty services and to cross-subsidize other basic services. For example, cardiology services alone can account for 25 percent of all hospital stays and 35 percent or more of community hospitals' revenue.[3] These specialty services are quite profitable, in part because payer reimbursement formulas may not be keeping up with productivity gains.[4] Hospitals have responded to the threat of specialty hospital development in a variety of ways.

Some general hospitals build their own specialty facility so they can maintain their revenue stream and retain the physicians who otherwise might leave to develop a competing freestanding hospital. By offering physicians some of the advantages of a freestanding facility (e.g., increased productivity), hospitals have sought to prevent physicians from creating competing facilities. Hospitals have often attempted to keep down expenses by consolidating services from multiple hospitals or replacing older facilities.

A second response is to form joint ventures with local physicians to build a

specialty hospital. This approach retains a portion of the revenue that otherwise would be lost and keeps the doctors involved. As one hospital CEO who took this route characterized it, "Ideally, I'd like to have a whole loaf of bread. But if I can't have that, I'd rather have a half a loaf than none."

A third response is to fight back by "economically credentialing" physicians. Hospitals have tried to deny admitting privileges to physicians who have ownership interests in competing inpatient or outpatient specialty facilities. Some courts have upheld these actions, and several cases are pending.

When none of these three responses is possible or effective, general hospitals may lose patients and revenue to specialty hospitals, forcing them to take other steps, such as cutting back on services or patients that lose money or trying to negotiate higher prices for other services.

Specialty hospitals, and the competitive response they evoke from general hospitals, raise fundamental questions about quality, costs and access to care. To date, solid evidence addressing these questions is sparse, but insight into specialty hospitals' potential impact on patients and communities can be garnered through debates between proponents and opponents and related health services research.

Monitoring Quality and Cost

Research shows that higher volume is associated with better quality[5] and leads to lower per-case costs. Drawing on the theory of focused factories,[6] proponents argue that specialty hospitals can secure high volumes, thereby improving quality and reducing costs. By focusing on a very narrow range of services, specialty hospitals increase the number of times they perform a procedure, develop physician and team expertise and innovate.

Opponents argue that specialty hospitals cannot secure a high enough volume to improve quality and reduce costs without taking patients away from community hospitals. When more hospitals compete for the same or lower volume of services, quality may decline and per-case costs may increase because each hospital has less volume and excess capacity is rarely eliminated. Moreover, services may be overused and total spending may increase because specialty and community hospitals are filling beds inappropriately. Previous studies of other types of facilities and services have shown that overutilization is a significant quality problem and may be even more of a problem when physicians are owners.[7]

Only if demand increases will new specialty hospitals and general hospitals both have enough volume to provide high-quality, low-cost services. Demand for specialty services may increase for several reasons, including population growth, aging, higher functioning and quality of life expectations and poor health due to unhealthy behaviors (e.g., smoking, obesity). However, other factors may offset rising demand. For example, new technology such as the drug-eluting stent promises to reduce the need for coronary-bypass-graft surgery by allowing more people to be treated with less invasive procedures (e.g., angioplasty) or to live longer with the stent before surgery is required.[8]

Another central issue is whether specialty hospitals have other mechanisms besides high volume to improve quality and reduce costs. Specialty hospital proponents argue that optimal facilities for delivering specialty services can be built, the newest technology and equipment used and a select group of managers and health professionals can continuously improve all aspects of care. Opponents argue that new facilities alone are unlikely to improve quality and reduce costs, and it is not clear whether specialty hospitals have any unique ability to innovate and improve care.

How emergency patients and those with multiple conditions are handled is another key quality issue. While some specialty hospitals are required by state licensure to have a full-service emergency department, others only have the capacity to handle emergencies related to the specialty services they provide. Specialty hospitals with limited emergency departments may not have arrangements in place to make timely transfers to general hospitals when necessary. They also might not have physicians on staff to provide timely medical care for conditions in which they do not specialize.

Finally, it is unclear how much competition specialty hospitals will stimulate. The additional specialty capacity could lead to lower prices paid by health plans as a result of increased competition. However, price competition will be limited when large general hospitals systems own specialty hospitals and negotiate for them.

Concerns About Access to Other Services

In addition to quality and cost concerns, consumers' access to other basic services may decrease if the same volume is spread across more hospitals. By drawing the most profitable services and patients away from general hospitals, specialty hospitals could undermine general hospitals' ability to cross-subsidize services that are not profitable. For example, general hospitals may curtail emergency services, close burn or psychiatric units or provide less community outreach and fewer prevention services.

Physicians' ownership interest in specialty hospitals creates an additional opportunity to select profitable patients, further jeopardizing general hospitals' ability to provide basic services. Recent research shows that referral patterns of physicians with an ownership interest in ambulatory surgery centers differ from those of their peers.[9] By selectively referring better-paying patients, physician-owners can increase their profits without offering a higher quality of care or achieving lower costs. Traditionally, privately insured patients have been the most profitable, while Medicaid and uninsured patients have been the least.

Although specialty hospitals' ability to improve quality and reduce costs is unclear, such hospitals could be financially successful nevertheless because of their ability to focus on lucrative services and patients. There has been very little research on whether and how patients treated by specialty hospitals differ from those treated by general hospitals. Two unpublished studies reported conflicting results, with one indicating that some specialty hospitals treat more severely ill patients who are probably more expensive to treat, and the other indicating that one specialty hospital treated less severely ill patients.[10]

The challenge for policy makers is to give specialty hospitals the chance to fulfill their promise as focused factories while limiting their opportunities to prosper from cream skimming.

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Policy Implications

The rapid rise of specialty hospitals and the issues they raise about quality, costs and access have federal and state policy makers considering a variety of responses. Existing federal law sets some limits on physicians' ability to refer patients to facilities in which they have an ownership interest but currently exempts "whole" hospitals. The American Hospital Association and others have proposed extending the law to specialty hospitals. Other proposals include:

- requiring specialty hospitals to accept Medicare, Medicaid and indigent patients;
- imposing the same quality and patient safety standards on specialty and general hospitals;
- requiring specialty hospitals to have full-service emergency departments or to partner with nearby hospitals and have policies in place regarding when to transfer patients;
- strengthening certificate-of-need laws requiring specialty hospitals to gain state approval of construction projects; and
- revising Medicare reimbursement formulas to avoid overpayment for selected procedures.

The challenge for policy makers is to give specialty hospitals the chance to fulfill their promise as focused factories while limiting their opportunities to prosper from cream skimming and preventing problems for patients and communities such activity might cause. Policy makers seek to encourage competition and give new care delivery models that have the potential to improve quality and lower costs a chance. However, they also want to maintain quality and patient safety, avoid total as well as per-case cost increases and preserve access to basic services. ●

Notes

1. Boston, Cleveland, Greenville, S.C., Indianapolis, Lansing, Mich., Little Rock, Ark., Miami, northern New Jersey, Orange County, Calif., Phoenix, Seattle and Syracuse, N.Y.
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4. For example, see Cromwell, Jerry, Janet B. Mitchell and William B. Stason, "Learning by Doing in Coronary Artery Bypass Graft Surgery," *Medical Care*, Vol. 28, No. 1 (January 1990).
5. For example, see Birkmeyer, John D., Andrea E. Siewers, Emily V. Finlayson et al., "Hospital Volume and Surgical Mortality in the United States," *New England Journal of Medicine*, Vol. 346, No. 15 (April 11, 2002).
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7. Chassin, Mark R., et al., "The Urgent Need to Improve Health Care Quality," *Journal of the American Medical Association*, Vol. 280, No.11 (Sept. 16, 1998); Gray, Bradford, *The Profit Motive and Patient Care: The Changing Accountability of Doctors and Hospitals*, Cambridge, Mass.: Harvard University Press (1991).
8. Becker, Cinda, "Stuck in the Middle: The Highly Anticipated Drug-Eluting Stents Are Good for Patients, but Are They Good for Hospitals?" *Modern Healthcare* (Oct. 21, 2002).
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10. Dobson, Al, "A Comparative Study of Patient Severity, Quality of Care and Community Impact at MedCath Heart Hospitals," The Lewin Group (September 2002) (Executive Summary posted on MedCath's Web site at: *www.medcath.com/index.asp?INTR_ElementID=corp_Study)*; Winslow, Ron, "Fed-Up Cardiologists Invest in Own Hospital: They'll Regain Autonomy but Critics See a Grab for More Profitable Care," *Wall Street Journal* (June 22, 1999) cites a study by Health Care Report Cards Inc. of Lakewood, Colo., that suggests patients at a MedCath hospital in McAllen, Texas, are less severely ill.