Specialty Hospitals, Ambulatory Surgery Centers, and General Hospitals: Charting A Wise Public Policy Course

How can we bring about a more efficient system without hurting a group of people who are already badly hurt?

by David Shactman

ABSTRACT: The number of U.S. specialty hospitals and ambulatory surgery centers has been increasing. Advocates of these facilities believe that they will increase competition and improve health services. General hospitals, however, complain that specialty facilities select only the most profitable patients, which reduces general hospitals’ ability to pay for care of the uninsured and other unprofitable services. Physician ownership also raises conflict-of-interest concerns. Congress has enacted a moratorium on payments to new specialty hospitals as it ponders the questions that will determine future policy. Can the competitive playing field be leveled, or will future development of these facilities be highly regulated or banned?

The number of specialty hospitals in the United States tripled between January 1990 and March 2003, and the number of ambulatory surgery centers (ASCs) doubled between 1991 and 2001.1 These providers specialize in performing a limited number of specific medical procedures. Because of their specialization, they claim that they can achieve higher quality, greater efficiency, and lower cost than general hospitals can.

General hospitals claim that the competitive playing field is not level. They contend that specialty facilities cater to only the most profitable patients, thereby draining revenue away from full-service community hospitals. That revenue is needed to cross-subsidize care for the poor and uninsured as well as unprofitable services that specialty facilities do not provide. Furthermore, most specialty facilities are at least partly owned by physicians, who can financially benefit from referring or not referring patients to their own facilities.

Responding to the controversy, the federal government has essentially stopped the building of new specialty hospitals by instituting an eighteen-month moratorium on payments for physician services in new hospitals in which physicians have an ownership interest. Existing specialty hospitals and those well under development have been grandfathered and thus are not affected by the moratorium. In addition, the government has frozen reimbursement rates to ASCs until 2009. During the moratorium, the Medicare Payment Advisory Commission (MedPAC) and the Centers for Medicare and Medicaid Services (CMS) will study and report on these issues and advise...
Congress on charting future public policy. Meanwhile, the Council on Health Care Economics and Policy convened in Washington, D.C., on 10 September 2004, to examine these issues and to discuss the course of future public policy. This paper reports on the discussion at that meeting. To set the tone of the conference, council chair Stuart Altman asked, Do we want our hospital system to look like the airline industry? A lot of frequent flyers like the efficient, low-cost, focused airlines like Southwest and Jet Blue, but many full-service carriers have faced bankruptcy and have stopped providing services to some regions. We don't feel all that bad for the bond- and stockholders or even the airline pilots, but if community hospitals close, access to local health services will be reduced, and it is apt to be the poor and uninsured who lose services.

Value Of Specialty Hospitals

“Focused factories.” Regina Herzlinger, from the Harvard Business School, began the conference by making a strong case for the concept of focused factories: hospitals that are organized and managed to concentrate on specific surgical procedures or to specialize in particular diseases. Services are managed around the experience of the particular patient or disease and not around the physical assets of the facility. Such facilities become exceptional in their area of expertise, not only because of economies of scale but also because of the concentrated focus of management.

But the term focused factory is loosely defined. Although examples of highly focused facilities exist in other countries, most U.S. facilities have more diffuse areas of practice. Just being a stand-alone specialty hospital does not qualify as being a focused factory, yet focused clinics can exist within general hospitals. One could argue whether a specialty facility qualifies as a focused factory, but the concept of medical focus has succeeded elsewhere and could be used to improve specific areas of the U.S. health care system.

By example, Herzlinger cited focused care for diabetes. The United States spends $132 billion treating diabetes each year, she reported, but only 18.6 percent of that is spent on the disease itself. Most is spent on comorbidities. In fee-for-service (FFS) medicine, comorbid patients are typically treated by a number of doctors who provide a variety of services and yet rarely talk to one another. Care is fragmented, uncoordinated, and inefficient. “Would you rather be treated by a team of people who are totally committed to the problem and all of its co-morbidities,” Herzlinger asked, “or by an everything-for-anybody kind of institution?”

Focused treatment of disease can also have a major impact on health spending. Herzlinger explained that five diseases/conditions account for approximately half of health care costs. Coordinated, efficient treatment of these conditions could yield large returns.

International experience. Jon Chilingerian, from Brandeis University, provided an international perspective on focused factories. He cited well-known examples of medical focus around the world, including the Shouldice hernia hospital in Canada, Aravind Eye Clinic in India, and obstetric fistula clinics such as the Addis Ababa Hospital in Ethiopia. Chilingerian reported that the National Health Service (NHS) in England plans to open fifty facilities that will treat 300,000 patients annually for specialized treatments such as hip and knee replacements and uncomplicated cardiac surgeries.

Among the examples he cited was the Coxa Hospital in Finland, which specializes in hip and knee replacements. Long waiting lists and high readmission rates characterized the sixty-four hospitals in Finland that had been performing these procedures. Coxa now has complication rates of 0.1 percent versus 10–12 percent in Finland’s general hospitals, and more patients go straight home after surgery. Shouldice Hospital in Ontario, Canada, has focused only on simple inguinal hernias for more than sixty years, and it has the lowest recurrence rates in the world. It is less expensive to fly someone round-trip from Boston to the Shouldice Hospital for three days and pay the entire bill than to have the procedure done locally. Furthermore, patients recuperate and return to work much faster because of the na-
ture of the Shouldice procedures. As a result of its success, the Shouldice case study is taught in virtually every U.S. business school.

**Potential Concerns About Specialty Facilities**

The entry of specialty facilities will increase competition in health care, noted Paul Ginsburg, president of the Center for Studying Health System Change. But whether that is good or bad depends on whether it encourages innovation in service delivery or if it is simply based on pricing distortions and conflicts of interest. Ginsburg laid out four categories of major concerns.

- **Reimbursement distortions.** It is clear that some medical services are reimbursed at levels that make them highly profitable, while others consistently lose money. Opponents of specialty hospitals claim that the industry has developed heart and orthopedic hospitals because they are two of the most profitable medical services. Specialty hospitals, which can “cream skim” the most profitable services and do not have to bear the cost of providing other less attractive services, can underprice general hospitals and achieve success without innovation.

  Even within diagnosis-related groups (DRGs), profits can vary because of differences in severity. Medicare reimburses according to the average cost per DRG, making less severe cases more profitable than more complex cases. Opponents claim that specialty hospitals “cherry pick” less severe patients. Thus, the pricing system is distorted both across and within different services.

  The obvious market solution would be to correct pricing distortions. Ginsburg noted that changes in technology cause distortions over time because regulatory systems are slow to adjust to changes in productivity. Herzlinger blamed the distortion on administered prices in general, which too often provide the wrong incentives. The FFS reimbursement system pays for individual procedures and not outcomes or episodes of care; Medicare pays a specified amount for a defined group of services but will not increase the payment if additional valuable services are provided. Neither system varies its reimbursement to account for differences in quality.

  Herzlinger cited the example of Duke University Hospital, which developed a focused factory for congestive heart failure. The project reduced hospitalizations and lengths-of-stay and reduced total costs by 40 percent, or $8,600 per patient. But because there were fewer complications and hospitalizations, the hospital actually lost money, and the project was discontinued. Herzlinger recommended market-based pricing for Medicare, bundled episodes of care, and risk-adjusted payments, but she did not elaborate on how the current U.S. system might be changed to include those elements.

- **Disruption of general hospitals’ cross-subsidies.** One of the oft-repeated arguments against specialty hospitals is that general hospitals need the profitable patients they might lose to specialty facilities to cross-subsidize the unprofitable services they are required to provide. Nearly everyone present agreed that if these services were paid for explicitly, the market would perform more efficiently and competition from focused factories would be far less problematic. But such changes, at least in the near term, are nearly impossible politically, particularly the expense of covering the forty-five million uninsured Americans.

- **Conflicts of interest.** Physicians’ ability to refer patients to facilities that they own is highly controversial. The Stark anti-self-referral laws prohibit doctors from referring patients to an entity in which they have an ownership interest. However, there are several important exceptions.

  First, doctors can self-refer to their own offices in which they personally provide nearly all of the services. In such cases, they can also provide ancillary services, because it is efficient and convenient to do so. The potential for overuse is limited because physicians can only personally provide the quantity of services they can fit into one workday.

  Provision of services in doctor-owned ASCs can be seen as an extension of this rea-
soning. Stark II limits outside referrals because it requires that doctors personally treat a high percentage of patients they refer—as if they were seeing their own patients in their own offices. Not everyone agrees with the legal distinction between ASCs and specialty hospitals. Nevertheless, because ASCs treat only outpatients and because doctors must perform most of the services themselves, hospitals have not expressed strong opposition. The fact that hospitals are part owners of many ASCs could explain their support for this exception.

The most controversial exception is known as the “whole-hospital” exception. Doctors may refer to a self-owned facility if it is a whole hospital as opposed to a limited-service facility such as a magnetic resonance imaging (MRI) center. The theory is that a doctor is apt to own such a small percentage of a whole hospital that the financial incentive to self-refer would be insignificant. It is this third exception that has become most controversial.

Chip Kahn, president of the Federation of American Hospitals, told conferees that the advent of focused specialty hospitals is not the full-service hospitals that legislators envisioned. Rather, he said, “they are subdivisions or single-service hospitals with emergency departments that Congress did not intend to except.” These facilities are much more threatening to hospitals than ASCs are because they perform high-revenue inpatient services, provide profitable ancillaries such as imaging and lab services, and receive patient referrals. Doctors can also have sizable ownership. Mark Miller, executive director of MedPAC, announced preliminary findings from a forthcoming MedPAC report that 20 percent of physician-investors own more than 15 percent of the facilities.²

Kahn argued that a proper interpretation of the Stark legislation would make self-referral to physician-owned specialty hospitals illegal. Most of the discussion, however, focused on market rather than legal concerns about conflict of interest. Conflicts of interest can result in selective referral or induced demand, or both. Selective referral, often called “cherry picking,” occurs when doctors send the patients with the best payer status or those who are apt to yield the most profit to their own facilities, and they refer other, less financially attractive, patients to the general hospital. Induced demand occurs when suppliers can affect demand for services. A large body of literature shows that utilization increases when providers can profit from performing more procedures.³

Proponents of specialty facilities cite reasons other than financial motivation for why doctors favor physician ownership. Thomas Mallon, chief executive officer (CEO) of Regent Surgical Health, explained that there is a forty-five-minute surgical turnaround in a general hospital, compared with a seven-to-ten-minute turnaround in a good focused factory. Contrast that to a typical general hospital, where physicians lose half to a full day a week sitting in the physicians’ lounge waiting for turnaround. Specialty centers are focused on providing what the physician needs in terms of equipment, supplies, and specially trained nurses.

Uwe Reinhardt, from Princeton University, expressed skepticism about the lack of financial motivation:

If we think physicians are economic creatures, isn’t it reasonable to believe they are concerned with revenues to cover their costs? There is a kind of piety there that hardly seems realistic.

But John Rex-Waller, CEO of National Surgical Hospitals, insisted that if you ask doctors why they are setting up surgical hospitals,

financial incentives are way, way, way down on the list. The incentive is that they start surgery at 7 a.m. They never get bumped. They can perform five surgeries and be back in their office around noon. The lion's share of their income is reimbursement for the surgery, and that amount is the same no matter where they practice. It isn’t the small percentage of the facility fee, but the ability to work efficiently and perform more surgeries that is the driving factor.

“If that is the case,” Altman asked, “why is physician ownership necessary at all? If these facilities could thrive on their own merits, why...
not dispose of the physician ownership controversy? Would you go out of business if doctors could practice and not own?"

Mallon noted that imaging and physical therapy centers have survived physician divestment. But Rex-Waller contended that physicians' engagement would be lost: Physicians are engaged in the way the facility is set up, the equipment that is purchased, the way it is managed and operated, and the control of costs. Everyone's incentives are aligned. “When someone owns a house,” Rex-Waller noted, “they are going to look after it. But if someone is renting a house, they don't care.”

Excess capacity. The final concern outlined by Ginsburg was that development of specialty facilities could result in excess capacity. In many parts of the provider industry, he noted, there does not seem to be enough competition to eliminate excess capacity. With too much capacity, fixed costs constitute a greater portion of revenue, and costs per unit of service increase. In addition, the volume of procedures is spread over a greater number of facilities, and quality can be reduced. When there is excess capacity in other industries, Ginsburg noted, stockholders generally bear the cost, and consumers win. But in health care, it is the consumer who can suffer from higher cost and lower quality of care.

With these concerns in mind, Ginsburg seemed to capture the conflicting trade-offs when he cited his theory of the second-best:

> In a perfect world, competition might be the best system. But if you have a lot of market distortions, competition may not make you better off, and you have to decide either not to have the competition or work on fixing the distortions.

Politics Weighs In

The dilemma posed by Ginsburg—whether to allow competition or fix the distortions—is perhaps the reason that Congress opted for an eighteen-month moratorium. Instead of implementing a decisive policy, Congress ordered MedPAC to examine the issues and to report back by the beginning of March 2005. Mark Miller reported that MedPAC would examine physician-owned heart, orthopedic, and surgical hospitals and analyze their potential financial impact on general hospitals. Concurrently, the CMS is conducting a related study on quality.

Findings from the MedPAC study indicate that specialty hospitals do concentrate on certain DRGs and treat relatively low-severity cases within them. They also treat a lower proportion of Medicaid patients. However, specialty hospitals do not have lower Medicare costs per case, and although they change the competitive dynamic, so far these hospitals have had little financial impact on community hospitals.

Most importantly, MedPAC is recommending changes in the payment system that could virtually eliminate the financial incentive for patient selection. These changes include use of hospital-specific relative values, refined DRGs to adjust for severity, cost-based rather than charge-based weights, and improved adjustments for outliers. MedPAC also recommends allowing “gain-sharing” arrangements in which hospitals could legally share cost savings with doctors without physician ownership. Finally, it recommends extending the moratorium until 1 January 2007 to allow time for further study and for implementation of its recommendations.

Two questions arise: Can the financial incentives for selection really be eliminated; and, if so, is that sufficient to level the competitive playing field? Hanging in the balance is the question of whether to eliminate the whole-hospital exception.

Linda Fishman, then of Hogan and Hartson, acknowledged that both sides are already lobbying Congress, briefing Hill staff, and presenting position papers. “This was one of the most contentious issues in last year’s Medicare prescription drug debate,” she reported, “and I assume that contention will carry over to this Congress.”

The Bellwether Question

Altman looked for some consensus among the conferees. “Is there anybody that would argue against a focused delivery system,” he
asked, “if you could get rid of the pricing distortions and cross-subsidies?” Few would take up that argument, but, given that distortions exist, the important policy question is, What do we do about them?

Perhaps Ginsburg formulated the bellwether question of the conference: “Should we focus first on leveling the playing field and blocking competition, or do we first allow competition that might generate the momentum to level the playing field?”

Altman admitted that there could be benefits from specialty competition but warned that if specialty facilities become 20–30 percent of the market, the hospital delivery system could look like the airline industry: “In the process of bringing about a more efficient and possibly higher quality system, will we hurt a group of people who are already badly hurt?”

Would the uninsured be hurt? Stuart Butler, from the Heritage Foundation, asked why the two were necessarily related. If we had focused factories that led to superior care, competitive pricing, and greater efficiency, why would there be a trade-off between that and moving toward universality?

Altman responded that in reality, such a relation does exist. Billions of dollars in uncompensated care are disproportionately provided by community hospitals. On the margin, if these services were pulled away, hospitals would have to cut back on providing free services or go under. Some, he noted, have already gone under.

Butler asked Altman if he would be troubled by having a system in which he might receive inferior care at a general hospital because of the need to preserve hit-or-miss cross-subsidies. Altman responded:

It does trouble me, and I can see the value of having some of this catalyst in there. But you know that I, and most people in this room, want to have people covered. And I’m willing to live with a second- or third-best alternative. I’d rather have a first or second, but I don’t want to see these cross-subsidies eliminated until we have universal coverage and a decent payment system. Personally, that’s my call, and I’m willing to put up with some inefficiency.

**Sharp Differences of Opinion remained unresolved.** One area the conference neglected to explore was “middle ground.” Although many opposed increased competition from specialty facilities without first correcting market distortions, they also regretted opportunities that might be missed if an outright ban were to be imposed. But there was little discussion about how some distortions could be reduced while some focused specialty centers could be encouraged. Perhaps the MedPAC recommendations will provide some alternatives.

**NOTES**


