Specialty Hospitals Under the Knife
By Drew Armstrong, CQ Staff

Sioux Falls, S.D., is a story of two hospitals. On the east side of town is Avera McKennan Hospital. About three miles west is Sioux Valley Hospital, recently renamed “Sanford Health.” Like any two hospitals in a smaller market, they compete to an extent. But that’s not the problem.

The trouble started in the late 1990s, when Sanford’s cardiologists began arguing with hospital administrators about control over admissions, equipment and other issues. When the cardiologists told the hospital that things had to change or else they’d leave, the hospital played hardball and let them walk. Not long after, the cardiologists partnered with investors and built their own 55-bed hospital to perform heart procedures and compete with Sanford, joining a trend that was developing among heart and orthopedic specialists across the country. At the last minute, the doctors offered Sanford and Avera McKennan a stake in the deal. Avera took it — and even put its name on the heart hospital. Sanford passed.

Ever since, it hasn’t been pretty.

The Avera Heart Hospital and another local facility, Sioux Falls Surgical Center, are what are known as specialty hospitals. Owned by physicians, often in partnership with outside investors, the facilities focus on the lucrative surgical procedures that constitute the financial foundation of most community hospitals and, rivals argue, eat away at their ability to operate in the black.

Healthy Competition Or Double-Dipping?

Like Sioux Falls, official Washington has had a difficult relationship with specialty hospitals and has been somewhat conflicted about whether they’re damaging the nation’s already stressed health care system. After letting them proliferate unregulated for half a decade, in 2003 Congress passed legislation to temporarily ban new specialty hospitals, then extended the ban in fits and starts until allowing it to expire in August 2006. In the six months since, at least 30 new specialty hospitals have broken ground, even as some members of Congress mull yet another prohibition.

Many doctors like specialty hospitals because they give doctors much more control over patient care, as well as the ability to collect both reimbursement fees that otherwise would go to the hospital and the physician fees that insurers pay them. Most community hospitals believe that specialty hospitals have a built-in competitive advantage because doctors can refer patients they first treat at the community hospital to the specialty facility for surgery and thus capture revenue for the for-profit physician ventures.

“To me, Sioux Falls is the perfect little microcosm of what’s going on,” says Molly Gutierrez, executive director of Physician Hospitals of America (PHA).

There are between 130 and 140 specialty hospitals in the United States, almost all developed before the 2003 ban took effect. Since the ban expired in August 2006, the debate over whether a new prohibition is needed has begun to resonate in the House and Senate again.

If you’re keeping score in Sioux Falls, it gets worse. PHA, the specialty-hospital industry’s trade and lobbying group, is located on the east side of town, in the offices of Sioux Falls Surgical Center. And, believe it or not, the general hospitals’ national and state lobbying organization — the Coalition of Full-Service Community Hospitals — is located just across Sioux Falls on Sanford’s campus, where angry administrators began mobilizing colleagues after the cardiology group’s defection. Both have hired guns in Washington, but the really bad blood is in Sioux Falls. “It makes perfect sense,” says Gutierrez, “because this is where the action is happening on the ground level.”
The Ban: Round Two

The debate over renewing the ban on specialty hospitals revolves around the Senate Finance Committee, where Chairman Max Baucus of Montana and ranking Republican Charles E. Grassley of Iowa have been the most vocal proponents. Under the Republicans, Grassley led the effort to prohibit specialty hospitals, and under Democrats, Baucus has been just as adamant. “We want to stop specialties,” Baucus said Feb. 13 when asked whether he planned to try to legislate another ban. “They’re not good for the country.”

Words like those have probably kept specialty hospitals from expanding even faster than they have. With lobbyists expecting a congressional hearing and possible legislation on the issue sometime this year, physicians and investors may be waiting for a more certain political climate.

The original ban was included in the 2003 Medicare drug bill, which Grassley and Baucus helped write. Originally intended to be permanent, the ban was watered down into an 18-month moratorium in the interest of promoting more competition in the health market. “It was just an arbitrary date that was picked out” in the spirit of compromise, says Jennifer Bell, who was at the time a Republican aide with the Finance Committee and helped write the law. Bell is now a lobbyist for the Coalition of Full-Service Community Hospitals, which is pushing for a permanent prohibition.

Lobbyists and experts expect that a Democrat-controlled House will give Baucus and Grassley another try at a permanent ban.

They may have a partner in Democratic Rep. Pete Stark of California, chairman of the Ways and Means Health Subcommittee, according to Paul Ginsburg, president of the Center for Studying Health System Change. Republican leaders in recent Congresses, such as Energy and Commerce Chairman Joe L. Barton of Texas, supported allowing the institutions to proliferate.

Stark has long opposed allowing physicians to refer patients to facilities in which they have ownership, and he added language to budget reconciliation bills in 1989 and 1993 barring such “self-referrals.” But at the time he drafted the prohibitions, known collectively as the “Stark Law,” specialty hospitals did not yet exist, although some physicians did have ownership interests in general hospitals. The language’s “whole hospital exception” operated under the presumption that the physician-owned general hospitals’ business and investments would be so diverse that they would not provide untoward incentives to focus on any specific type or care or service.

But as income pressures on physicians intensified throughout the mid-1990s, entrepreneurial doctors determined that they could build facilities focused on just one profitable service line and sidestep the Stark Law by calling the enterprise a “whole hospital.” Most of the specialty hospitals were focused on lucrative cardiac or orthopedic services, which community hospitals typically use to subsidize money-losing departments such as emergency rooms or burn units. By setting up stand-alone departments and calling them hospitals, critics contend, doctors are double-dipping and steering money toward themselves and their investment partners.

Fishing for Savings

New specialty-hospitals legislation could take several forms. “At one extreme is an outright ban,” says a Democratic Finance Committee aide. “At the other end of the spectrum we have a couple of options available to us that are sort of incremental.”

Lawmakers, for example, could grandfather in the existing specialty hospitals while prohibiting establishment of new ones. They could also take steps to require that doctors disclose their financial interests in the facilities to which they’re referring patients, or they could pass another temporary ban to give the government more time to study the issue.
Another solution under consideration is adjusting the government’s Medicare and Medicaid reimbursement rates for cardiac and orthopedic procedures to make them less lucrative. Theoretically, that would offer at least one less reason for doctors to cherry-pick these services. Doctors, however, would still receive the fees usually paid to the hospital, a dollar amount that would probably outweigh any adjustments to payment rates.

In a time of tight budgets, ban proponents’ success will probably boil down to whether they can prove that a prohibition on specialty hospitals will save the government money by reducing the number of expensive procedures Medicare and Medicaid pay for. Congress could then use the projected savings to justify higher spending on other initiatives, such as the State Children’s Health Insurance Program, or SCHIP, which is due to be reauthorized this year. If savings can be quantified, some experts predict, a ban could be attached to must-pass legislation later this year.

“If you can shut down self-referral, one can presume from a federal standpoint that you can incur savings” by banning specialty hospitals and the physician self-referral they enable, Bell says. “If you get down to a situation where you need votes or you’re close . . . and you can save dollars, I think it does put it over the top.”

Jean Mitchell, a Georgetown University health economist, has found that the existence of specialty hospitals leads to higher numbers of expensive, profitable procedures in the geographic regions where they operate. In a soon-to-be-published study in the peer-reviewed journal Medicare Care Research and Review, Mitchell compares the rate of complex back surgeries in the Northeast, where there are no specialty hospitals, with the rate in South Dakota, where eight exist. Between 2000 and 2004, the number of profitable complex back surgeries went up by 193 percent in New England but stayed below one per 10,000 Medicare beneficiaries. In South Dakota, specialty hospitals drove up the rate of complex back surgeries by 294 percent, to almost 11 for every 10,000 Medicare patients. “If you chopped off the share done by specialty hospitals, the rate would be lower than New England,” Mitchell says. For less profitable surgeries, the number of surgeries by physician owners of specialty hospitals did not go up nearly as much.

The high costs that come with more elaborate surgeries have prompted some private insurers to refuse to admit specialty hospitals to their networks, specifically in Kansas, Oklahoma and Texas, according to Mitchell.

Some health experts note that new restrictions on specialty hospitals won’t resolve declining physician reimbursements, fragmented care and other trends that prompted the rise of the industry in the first place.

“It’s like squeezing a balloon,” says Richard Gundling, vice president of product development at the Healthcare Financial Management Association. “You squeeze one part, it pops up somewhere else. It’s symptomatic,” he says, adding that if lawmakers want to get to the root of the source, they’ll have to address the larger, thorny issue of physician self-referral.

As it is, the specialty-hospital lobby is facing an uphill battle, says Randy Fenninger, a Washington lobbyist for PHA since 2001. On Feb. 14, PHA board members flew to Washington to meet with members and their staff, including aides to Baucus and Stark. A Democratic Finance Committee aide didn’t seem swayed by the group’s arguments but declined to comment on what was discussed. Stark’s staff refused to comment.

The biggest challenge, Fenninger says, is trying to counter lawmakers’ sympathies for general hospitals, which are often viewed as cornerstones of local communities. “There’s just a history of relationships there, and it’s very, very strong,” Fenninger says. “That makes lobbying this issue very difficult. You are the newcomer on the block . . . and you’ve got to deal with a lot of flak.”

In the words of one pro-specialty-hospital lobbyist, Democrats “have much bigger fish to fry” on their health care agenda. However, if Democrats start looking for cost savers to pay for other
health programs, the general-hospital industry might be all too happy to toss specialty hospitals into the frying pan.

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Source: CQ Weekly