
Those terms and more are key components in a health care battle with no easy answers. Do specialty hospitals – those offering a single service such as heart or orthopedic care – simply meet consumer needs and offer opportunities for improved care at a lower price? Or are they siphoning revenue-generating procedures from general hospitals and threatening the latter’s existence?

Gary Campbell, CEO of the Heart Center of Indiana along the Meridian Street corridor that encompasses Indianapolis and Carmel, says his facility is the “hospital of the future. Our physicians, respiratory therapists, nurses, pharmacists – they do nothing but cardiovascular. They know what to expect.”
Russ Towner, co-director of the Kokomo Community Health Care Initiative for DaimlerChrysler who previously worked on similar issues for General Motors, says, “We do have concerns about specialty hospitals” and quickly rattles off excess capacity driving up health care costs, physician ownership/self-referral and patient safety.

There are also plenty of opinions that trend more toward the middle of the road. Bob Morr, vice president of the Indiana Hospital & Health Association (IHHA), has seen his organization debate the merits and drawbacks of the new kids on the block in numerous meetings over the past year.

“What our members have said is they’re not ready to give up on competition,” Morr relates. “But if there is going to be competition, we have to make sure there is an even playing field, and we have to protect that safety net access.”

There are those terms again. It’s time for a primer on the issue.

**Identifying the players**

Specialty hospitals are not a new phenomenon, with children’s and women’s facilities among the most likely to have been established several decades ago. The areas of expertise in recent years, however, have switched primarily to cardiac, orthopedic and surgical care. A number of the specialty facilities are for-profit and owned, at least in part, by some of the physicians who work there.

A U.S. General Accounting Office (GAO) report released in October 2003 identified 100 specialty hospitals, with another 26 under development. Two-thirds of the existing facilities and more than half of the planned operations were in seven states – Arizona, California, Kansas, Louisiana, Oklahoma, South Dakota and Texas.

GAO also reported that more than 90% of the specialty hospitals opened since 1990 were for-profit. In an April 2003 report, it found that 70% of specialty hospitals had some degree of physician ownership. Overall, nearly 73% of physicians with admitting privileges were not investors in the hospitals.

Morr says that the IHHA discussion has evolved from one on specialty hospitals to “a debate on competition vs. regulation. We had the regulatory model – federal regulations and state certificate of need programs that faded away in the mid-1980s – for a couple of decades. There are no good overall studies that say competition is better than regulation.”

Rules vary between general hospitals and specialty hospitals in such areas as construction requirements, data gathering and data sharing. This creates an uneven playing field, according to Morr.

Safety net refers to general hospitals and their role of providing health care services to those in need. As cardiac and other revenue-producing specialties branch out on their own, the traditional hospital is left with costly emergency room operations and other expensive programs.

The Stark law (named after U.S. Rep. Pete Stark, chief sponsor of the legislation) generally prohibits physicians from referring Medicare patients for specific health care services to facilities (such as clinical laboratories, diagnostic imaging centers and physical therapy facilities) in which they have financial interests. An exception permits such referrals when physicians have an ownership interest in an entire hospital. Specialty hospital critics contend that such facilities are smaller in size and scope and that the Stark exception should not apply.

Certificate of need (CON) – prior state approval before increasing health care capacity – was a federal requirement between 1975 and 1986. According to the GAO, 37 states still maintain some form of CON. Indiana’s CON program was considered by some to be more of a rubber stamp, with automatic approval granted in most cases.

In no surprise, most of the new specialty hospitals are being built in states without CON laws. Overall, 83% of specialty hospitals, 55% of general hospitals

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**Indiana’s Hospital Rankings**

<table>
<thead>
<tr>
<th>Metric</th>
<th>Indiana</th>
<th>National rank**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost per case</td>
<td>$7,101.10</td>
<td>28</td>
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<tr>
<td>Cost per day</td>
<td>$1,277.76</td>
<td>26</td>
</tr>
<tr>
<td>Expense per capita</td>
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<td>20</td>
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<tr>
<td>Inpatient utilization per 1,000 population</td>
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<td></td>
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<tr>
<td>Beds</td>
<td>3.1</td>
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<tr>
<td>Admissions</td>
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<td>28</td>
</tr>
<tr>
<td>Days</td>
<td>662.0</td>
<td>31</td>
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<tr>
<td>Outpatient utilization per 1,000 population</td>
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<tr>
<td>Emergency visits</td>
<td>395.7</td>
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<tr>
<td>Total visits</td>
<td>2,287.3</td>
<td>18</td>
</tr>
</tbody>
</table>

* Generally includes financial data for fiscal years ending in 2002  
** The higher the ranking, the better, as states are ranked from highest numerical value to lowest numerical value. For example, in cost per case, 27 states have a higher dollar figure than Indiana’s average  

Source: American Hospital Association Hospital Statistics, 2004 edition

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“Our operations tend to be much more efficient. Our length of stay is much shorter than in traditional hospitals.”

– Gary Campbell  
Heart Center of Indiana
and 50% of the U.S. population are located in states without CON requirements.

Finally, the moratorium provision in the Medicare bill reflects the overall lack of information about the impact of specialty hospitals. In its conclusions, the GAO report admits no attempt was made to determine the financial impact on general hospitals.

Heart of the matter

The Indianapolis area has received its share of national notoriety for the proliferation of cardiac facilities in recent years. The specialty hospital issue is not confined, however, to central Indiana.

Morr lists orthopedic and heart facilities in Fort Wayne, a women’s hospital in Newburgh (near Evansville), a cardiac center in South Bend and some specialty growth in Lake County among the recent additions. All cannot be lumped into a single category, as some are connected to existing facilities and/or replacing other services.

There are two other areas of note within the state. A private heart hospital in New Albany, jointly owned by Cardiovascular Hospitals of America and a group of Louisville-based cardiologists, is being planned, along with an expansion of heart services at the city’s Floyd Memorial Hospital.

Lafayette, already home to two hospitals, may see a third as the Arnett Clinic, which Morr calls the largest specialty clinic in the state, has announced plans to build its own hospital. Asked by a Lafayette newspaper whether three hospitals can survive in the city, Morr’s response, “Only time will tell.”

The central Indiana focus picked up steam with the release of several 2003 reports from the Center for Studying Health System Change (HSC), a Washington, D.C.-based policy research organization.

Local physician group discussions with MedCath, a national for-profit cardiovascular service company, got the ball rolling. Partially in response to the threat of competition, the Community Health Network built the Indiana Heart Hospital and St. Vincent Health developed the Heart Center of Indiana. Both include partial physician ownership.

In addition, St. Francis Hospital and Health Centers proceeded with construction of a long-planned heart facility at its Indianapolis campus, and Clarian Health System categorized a consolidation and expansion of its existing programs as a heart hospital.

Morr says the net result is no new heart programs. The IU/Methodist merger into Clarian resulted in a reduction from two to one. Community replaced its existing heart program and St. Francis is in the process of doing the same. St. Vincent Hospital maintained its heart services, making the Heart Center of Indiana a new competitor.

Alwyn Cassil, spokeswoman for HSC, says Indianapolis is somewhat unique in that it has “all these different models that have developed.” Much more, however, needs to be discovered about their potential impact.

“Our analysis was through a qualitative approach,” she states. “The GAO came in and crunched some numbers, but it is an area that is ripe for additional quantitative research. What are the different patient characteristics, the acuity levels, the outcomes?”

The answers are not simple, Cassil adds, with inequities in the health care payment system only increasing the challenge. The potential of current overpayments for cardiovascular and orthopedic services, among others, and underpayments in other areas offers the opportunity for specialty hospitals “to prosper without improving quality or lowering costs.”

Bob Morr says Indiana Hospital & Health Association members have been divided on the issues surrounding specialty hospitals.
That would apply as the second half of the HSC report titled, “Specialty Hospitals: Focused Factories on Cream Skimmers?” Cassil warns not to dismiss the focus factories’ portion of the argument as “specialization can potentially be very good.”

### Making distinctions

Dave Ruskowski, vice president of marketing for St. Francis, describes its Cardiac & Vascular Care Center as a “natural evolution of our growth. It’s really a relocation, an expansion of our existing program.”

He asserts that the decision to expand was made at least 10 years ago, with renovation of the existing facilities on the Beech Grove campus taking place before a new and expanded operation became absolutely necessary. Reconfiguring space to meet changing technology needs and adding beds (106 in the new center) for a rapidly growing population in Johnson County and surrounding areas were the primary motivators.

Distinctions must be made, Ruskowski declares, between the different types of new hospitals coming into play. Organizational realignments and expansions are a part of the business; allowing for-profit entrepreneurs to enter the market becomes a threat. Admitting that others feel quite differently, Ruskowski says St. Francis supports a two-year moratorium on ambulatory outpatient facilities and service development while a study committee examines the issue. Hospitals or physicians creating new facilities with entrepreneurs should be put on hold, although hospital partnerships with their own medical staffs should be allowed.

“Every state surrounding us has certificate of need. People are coming to Indiana to establish profitable service centers,” he claims. “If they strip out the few profitable services, that could be the end of the not-for-profit community-based hospital. We have to look at how that can be stopped.”

### Certificate of Need (CON) States*

**June 2003**

<table>
<thead>
<tr>
<th>Type of Hospital</th>
<th>Specialty Hospitals opened 1990-2003</th>
<th>Specialty Hospitals under development</th>
<th>General Hospitals</th>
<th>U.S. Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-CON states</td>
<td>83%</td>
<td>100%</td>
<td>55%</td>
<td>50%</td>
</tr>
<tr>
<td>CON states</td>
<td>17%</td>
<td>4%</td>
<td>45%</td>
<td>50%</td>
</tr>
</tbody>
</table>

* 37 states maintained some degree of CON in 2002

Source: American Health Planning Association, AHA, GAO and the U.S. Census Bureau.

The question of whether new facilities negatively add to the health care cost crisis is one that can’t be answered at this time. Morr says those who call for an end to further construction “suggests someone has made an analysis that construction is a contributing factor. We just don’t know that.”

Ruskowski emphasizes that the St. Francis position is no indictment against physicians gaining a larger financial stake. “We are not in any way wanting to put restrictions on physicians investing or sharing in margins. That’s why we asked for the exception (internal hospital/physician development). We don’t want to halt them. We have to be able to invest in it with them.”

### New brand of hospital

Campbell, the Heart Center of Indiana CEO, was recruited to Indiana for this position after spending most of his career in Ohio. He has awaited the opportunity to build anew, after being involved as an executive in a number of turnarounds of troubled facilities.

“I always wanted the opportunity to develop a hospital from scratch, to start with a blank sheet. We’re not constrained by 100 years of tradition, by a facility that is 20 or 30 years old. Most people say this doesn’t look like a hospital,” a statement Campbell is proud of.

He explains that there is a “stepsister” relationship with the St. Vincent hospitals in Indianapolis and Carmel. While

Technology allows for enhanced patient monitoring and evaluation at the Heart Center of Indiana.
Ohio Group Works to Block Specialty Hospitals

Specialty hospitals have been a rarity in Indiana’s neighbor to the east. Yet, the members of the Ohio Hospital Association (OHA) felt strongly enough about the potential threat to push for a moratorium on such facilities in the state legislature.

Establishment of a stand-alone orthopedic hospital in central Ohio in the spring of 2002 brought the issue to the attention of several OHA board members. Meetings and discussions with membership determined that specialty hospitals were not an issue in all parts of the state. Mary Yost, vice president of public affairs for the OHA, says there was a consensus, however, of the potential for future concern.

According to Yost, an earlier Ohio case and word-of-mouth caused the trepidation. The Dayton Heart Hospital, a partnership between national provider MedCath and a local existing hospital, opened in 1999. The incumbent facility, already in financial difficulty, was forced into bankruptcy less than a year later.

“What our hospital members had heard,” Yost recalls, “was that joint ventures may not be the way to go. What they had been told was that these hospitals were taking a line of service that belonged to the (general) hospitals and sharing the revenue.”

Ohio eliminated its certificate of need requirement in the mid-1990s. Concerned about both the physician self-referral element and the safety net impact on full-service community hospitals, legislation was introduced early in 2003. The House version passed in September 2003 would have created a 24-month moratorium on new for-profit specialty hospitals and created a legislative committee to study the issue. The bill was pending in the state Senate when the Medicare bill with similar provisions was passed by Congress.

As the Ohio legislation moved forward with an opportunity for passage, 56 notices of intent were filed with the State Department of Health for new specialty facilities. Yost says not many have gone forward to this point, with most apparently offered to qualify for grandfather provisions if a moratorium had passed.

Although pleased with the call for study on the national level, Yost says the association “needs to keep educating lawmakers, both state and federal. They need to be informed about the (potential) impact of physician-owned hospitals on general hospitals.”

Resource: Mary Yost, Ohio Hospital Association, at (614) 221-7614 or www.ohanet.org
Large rooms and computers enhance family comfort and patient care.

Legislators Support Additional Study

The future of specialty hospitals was the subject of several bills in the 2004 session of the Indiana General Assembly. As of mid-February, it appeared further study was the likely outcome.

Initial legislation called for re-enacting the state’s certificate of need program or imposing a construction moratorium on new facilities. There appeared to be no support for either in the Senate Health & Provider Services committee. An overwhelming amount of information from hospital, employer and insurance representatives led to an amendment requiring the Health Finance Commission to study the issue during the 2004 interim.

Bill Corley, CEO of Community Health Network, testified on the issue before both House and Senate committees. His question to legislators: Why did the state let its previous certificate of need program lapse? Their answer, Corley says, was “it didn’t work and it didn’t control health care costs.”

Corley doesn’t believe anything has changed in that regard. He does, however, support a study that goes beyond the certificate of need/moratorium questions.

“We have to get patients, insurance companies, employers and providers to all sit down together,” he explains, “to see what we can do in Indiana to reduce health care costs. All four of those parties have to come to the table.”

Corley, who says he “absolutely believes it is more cost effective to specialize in particular procedures,” also cautions that specialty facilities are indeed a threat to community hospitals. He compares hospitals to financial advisor agencies that have seen a decentralization of services.

“People in our business need to understand there is no way they are going to be able to keep all the business in hospitals. More health care is going to be provided on an outpatient basis and in-home in the future,” he offers. “If you’re in hospital administration, status in the past was measured by the number of beds in your facility. What’s happening now is a decentralization of the health care business.”

Resource: Bill Corley, Community Health Network, at (317) 355-1411

parent company St. Vincent Health owns those facilities, it is a 50/50 partner in the Heart Center with the physician-owned Care Group. The cardiac facilities at St. Vincent-Indianapolis are a competitor just like the operations of other health systems, Campbell adds.

Why is the Heart Center of Indiana (and undoubtedly many of the other newer facilities in Indiana and across the country) not your parents’ or grandparents’ hospital? These facilities represent the new wave, including:

- A “non-institutional” lobby that welcomes, not worries, patients and visitors
- All private guest (not patient) suites in which beds are available for family members, who are encouraged to stay around the clock if they desire
- Room service that is more reminiscent of a hotel than a hospital
- Computers in every room to assist with patient education and communication, as well as providing staff access to the all-digitized medical records (a major advantage of starting from scratch and not having to introduce technology to years of paper files)
- What Campbell calls the best people in the business – 350 hired out of more than 4,500 applicants – and a number of research programs that enhance the existing knowledge base

Do all the above mean higher quality care? Although outcomes data and quality information is beginning to be collected and analyzed at a higher level than in the past, Campbell says, “That data is very difficult to make user-friendly for consumers. It’s hard for the consumer to sort through that.”

He says the statistics show that the Heart Center is among the top facilities in the country in regard to complexity of its cases. When faced with what he terms the decision of going with the “big box concept” of a general hospital or a specialty facility, he boasts, “I do know we can do what we do better than anyone else.”

Towner, for one, would like to see the evidence. In the case of heart hospitals, he says more facilities in the community will lessen the number of procedures at each. Medical literature, he adds, suggests that the “more you do something, the better you do it.”

In similar fashion, Towner believes the excess capacity drives up health care costs. He cites a lack of analysis of whether new facilities are needed, and the fact that someone – patients and the employers who provide their insurance – must pay the associated costs.

Hospital officials counter that Indiana’s high smoking and obesity rates, indicative of an overall unhealthy lifestyle, produce the need for additional beds. St. Francis simply ran out of room at its Beech Grove campus, according to Ruskowski. The 60 beds at the Heart Center are always filled, Campbell relates, with guests coming from 270 different zip codes in the first year-plus of operation. A continuation of the 20-25 procedures a day will likely mean an expansion to 120 beds.

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Heart of the Matter
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Adding up the costs

The bottom line regarding specialty hospitals is the bottom line. How can a 60-bed Heart Center, for example, with the latest in expensive high-tech equipment overcome what Campbell calls the “diseconomies of scale?”

“The answer has to come in operating costs. Our operations tend to be much more efficient. Our length of stay is much shorter than in traditional hospitals – two days shorter than the average on a diagnosis-to-diagnosis basis. The question is, ‘Can you accumulate enough of those operating efficiencies to offset the other costs?’

The answer is not known at this time. The cost questions, however, also impact the safety net provision. HSC reports that cardiology services can account for up to 25% of stays and 35% of revenues at community hospitals. If a major portion of that money is going to specialty facilities, how can the general hospitals survive?

In Indianapolis, Wishard Hospital would appear to be at the top of that list of struggling providers. Hospital officials declined to comment on the impact of specialty hospitals on their operations.

Towner is among those citing the lack of current information available.

“Quality is something that needs to be looked at. The fact that all these facilities are built to expand should be an additional concern. That generates the question of utilization and higher costs. We need to look at certificate of need and see if that is a longer-term solution. Everything needs to be looked at.”

The IHHA board of directors is not in favor of re-establishing certificate of need regulations or a moratorium. It does, however, support further analysis.

“We think study needs to be done. We need better information,” Morr agrees. “Part of the issue is having good data instead of best guesses. We are in favor of a study commission. We need to get all the information on the table before enacting laws.”

INFORMATION LINK

Resources: Gary Campbell, Heart Center of Indiana, at (317) 583-5000 or www.theheartcenter.com

Russ Towner, Kokomo Community Health Care Initiative, at (765) 454-1868

Bob Morr, Indiana Hospital & Health Association, at (317) 633-4870

Alwyn Cassil, Center for Studying Health System Change, at (202) 264-3484 or www.hschange.org

Dave Ruskowki, St. Francis Hospital & Health Centers, at (317) 782-7991 or www.stfrancishospitals.org

General Accounting Office study at www.gao.gov/new.items/d04167.pdf