MarketWatch

Specialty-Service Lines: Salvos In The New Medical Arms Race

Trends signal a return to the physician-hospital dynamics that predated the rise of managed care.

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ABSTRACT: Hospitals and physicians are developing and marketing discrete and profitable specialty-service lines. Although closely affiliated specialist physicians are central to hospitals' service-line products, other physicians compete directly with hospitals via physician-owned specialty facilities. Specialty-service lines may be provided in a variety of settings, both inside and outside traditional hospital walls. Thus far, the escalating battle between hospitals and physicians for control over specialty services has not affected hospital profitability. However, as the scope of care that can be safely performed in the outpatient arena expands, physician competition for control over specialty services may threaten hospitals' financial health. [*Health Affairs* 25 (2006): w337–w343; 10.1377/hlthaff.25.w337]

Hospitals and physicians have traditionally been distinct as categories of health care providers, but the hospital-physician dichotomy appears to be breaking down. An emerging categorization of health care providers might be based on specialty-service lines, which encompass both hospitals and physicians.

In this paper we present evidence that across the United States, hospitals and physicians are organizing and marketing services based on specific diseases, organ systems, and populations. Examples are heart institutes, cancer centers, orthopedic hospitals, women's and children's services, and gastroenterology endoscopy suites. A few of these specialty-service lines are freestanding specialty hospitals; more are centers within a general hospital and include physician specialists; and an increasing number are physician-owned ambulatory specialty facilities. In some instances, hospitals and physicians collaborate in running a specialty-service line; in other cases, they compete ferociously. The bottom line is a simple unifying theme behind this multifaceted array of institutions: specialty medicine.

Specialty-service lines are a step in the evolution of hospital and physician business strategies during the past decade. In the mid-1990s, hospitals primarily competed on price by providing services desired by managed care plans. These plans were contracting on behalf of large numbers of enrollees, usually in health maintenance organization (HMO) products that limited individual subscriber choice.[1] However, by 2000, nonprice competition was becoming increasingly important, and hospitals were reviving strategies targeted toward

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individual physicians who referred patients and toward consumers directly.

With the decline of risk contracting and a return to fee-for-service (FFS) payment, hospitals were relieved of the need to manage costs for defined populations. They returned to the traditional business model of filling beds with well-insured patients. Faced with growing competition for patients, both from other hospitals and from ambulatory-based care, hospitals quickly adopted strategies dedicated to increasing the flow of patients into the hospital.[2] In short, hospitals resumed what in the 1980s James Robinson and Hal Luft described as a "medical arms race," a form of competition tending to increase, rather than reduce, costs.[3]

In some ways, the first decade of the twenty-first century has seen a reemergence of hospital and physician interactions that were dominant prior to the managed care era, when hospitals competed for physicians' loyalty by building the best facilities and obtaining the most up-to-date technologies. Contrary to mainstream economic theory, hospitals in more competitive environments had higher costs per case and per day than those in less competitive environments, when other factors were controlled for.[4]

Although public policy attention has focused on specialty services provided by physician-owned specialty hospitals, resulting in a temporary federal moratorium on these facilities, the phenomenon of specialty services is a more pervasive development.[5] Moreover, the rapid expansion of physician-owned ambulatory diagnostic and treatment facilities is threatening hospitals' hegemony over a number of service lines. Aware of the threat posed by specialist physicians' ability to raise capital on their own, some hospitals have established joint ventures with physicians, primarily as a defensive move.[6] In short, while hospitals find a competitive need to promote a service-line orientation, an approach that requires the committed participation of key physicians, at the same time they often face growing competition from physician-owned service lines.

In this paper, our main objective is to track the evolution of the specialty-service-line strategy as it has matured in recent years. We describe the providers adopting specialty-service lines and their motivations, the range of administrative structures they use to organize these services, the extent to which service-line development actually reorganizes care versus purely serving as a branding and marketing strategy, and the nature of resulting changes in hospital-physician relationships.

Study Data And Methods

This research was conducted as part of Round Five of the Community Tracking Study (CTS) site visits completed between December 2004 and June 2005. These visits—which explore local changes in the financing, organization, and delivery of health care—have been conducted biennially since 1996 in twelve communities randomly selected from markets across equal-size strata of population size, managed care penetration, and geographic region. In Round Five, a total of 1,008 semistructured interviews were conducted in person and by telephone with major health care system stakeholders.

We interviewed senior executives at two to four of the largest hospital systems or freestanding hospitals in each of the twelve markets, including chief executive officers (CEOs), chief financial officers (CFOs), vice presidents for planning, and heads of nursing; state hospital association and local medical society executives; medical group CEOs; senior executives at two to four of the largest health plans and employers in each market; and others with perspectives on the development of service lines. We asked respondents about the greatest policy, regulatory, and market pressures faced by hospitals and physicians, the strategies hospitals and physicians had adopted to respond to these pressures, and any changes in their strategies in the previous two years. We also included questions specifically about specialty-service competition, hospital capacity expansions, hospital-physician relations, specialty hospital development, hospitals' pricing policies, hospital and physician contracting with health plans, and hospitals'

quality-reporting activities.

Two researchers participated in each interview and corroborated notes. Notes were typed into Microsoft Word and then were coded by two researchers for relevant content and analyzed in qualitative software, Atlas.ti. The coding allowed for sorting of text messages according to relevant topic areas discussed or specific questions asked during the interviews. This allowed an assessment of the weight of the evidence supporting each finding, as well as the opportunity to provide specific quotes that represent widely expressed viewpoints. We triangulated responses across different types of respondents, noted instances of disagreement between respondents, and looked for disconfirming evidence.

Study Findings

■ **The ubiquity of service-line branding.** We interviewed representatives from thirty-three hospitals/hospital systems in the twelve CTS communities. In every market, hospitals and physicians were developing single specialty services, the most common being heart (33), cancer (24), orthopedics (18), and several spine centers.[7] Some cardiac service lines limited themselves to cardiac surgery, while others also encapsulated medical cardiology and cardiac imaging. Hospitals and associated physicians have also developed niche inpatient services, such as bariatric surgery, and outpatient services, such as sleep centers.

The term "service-line competition" and the equivalent "product-line competition" have become ubiquitous. Hospital executives and senior officials in all twelve HSC markets frequently and matter-of-factly refer to their service-line competitive strategies. In the words of one respondent: "I became the CEO, started the service lines, got the ship profitable."

Hospitals and their associated physicians that previously marketed their entire organization generically to the public are increasingly marketing branded specialty-service lines. Typically, special service units are branded as "hospitals," "centers," or "institutes"—for example, the Heart Hospital of Indiana (Indianapolis), the Seattle Cancer Treatment and Wellness Center, the Baptist Cardiac and Vascular Institute in Miami, and the Jack Stevens Heart Center in Little Rock. In recent years, Indianapolis has seen the development of four heart centers, two as physician-hospital joint ventures and two as wholly hospital-owned ventures; one is a freestanding heart hospital, and the others represent distinctly branded and administered service lines within general hospitals.

■ **How service lines are organized.** In contrast to traditional general services, such as care on hospital medical-surgical floors or diagnostic imaging, as noted, service lines focus on particular diseases, organ systems, or populations. Typical service lines include cancer centers, heart institutes, women's and children's hospitals, stroke centers, and related ancillary services.

Service lines may be housed on separate floors within a hospital, be in separate administrative units (in- or outpatient) within a hospital, represent organizations within a hospital but with a distinct managerial structure ("hospital within a hospital"), be an entirely separate specialty hospital, or be physician owned. A hospital within a hospital, while situated in a wing of a general hospital, might have distinct ownership, such as a hospital-physician joint venture.

Specialty-service lines come in a wide variety of organizational forms. At one end of the spectrum of physical distinction from general hospitals is the independent specialty hospital—for example, the Arkansas Heart Hospital, the Indianapolis Orthopedics Hospital, and the Arizona Heart Hospital. These stand-alone specialty hospitals (which, when involving major physician ownership, have become the focus of national attention resulting in the temporary moratorium on reimbursement under Medicare) may be owned by a group of physicians, often with private venture capital; by a hospital system; or as a joint venture of a hospital system and physician-investors.

At the other end of the spectrum are floors within hospitals that do not have an independent staff or administration, are not considered a separate cost center or profit center, and do

not have their own business plan. Examples are coronary care units, an orthopedics floor, or a labor and delivery suite integrated into the structure of a general hospital but marketed to the public as a unique service.

One example of a "hospital within a hospital" is the Indiana Heart Hospital, a hospital-physician joint venture. The hospital is located on one of the campuses of the Community Health Network hospital system but is operated as a joint venture between the system and a group of cardiologists. Another example is the Cathedral Heart and Vascular Institute located in St. Michael's Hospital in Newark, New Jersey. The institute has a dedicated physician and nursing staff and is a financial profit center for the remainder of the hospital.

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In other cases, a heart, cancer, or stroke center will have its own floor, nursing staff, and manager but is otherwise an integral part of the hospital and dependent on general hospital resources. Some specialty services in this configuration negotiate separate contract clauses with health plans, while others do not. Some hospitals assign a dedicated nursing staff to their specialty-service lines; others do not. Some respondents were candid in explaining that the service-line orientation related mostly to seeking more patients to use their profitable services rather than involving major administrative or clinical restructuring.

In the outpatient setting, specialty-service-line orientation and organization are much simpler, reflecting the long-standing specialization of physicians. Although ambulatory surgery centers (ASCs) provide a venue for a range of surgical procedures, other new physician-owned entities are dedicated to particular clinical services. Typical new ambulatory facilities that follow the specialty-service-line orientation are dedicated to gastrointestinal (GI) endoscopy, diagnostic imaging, sleep disorders, peripheral vascular disease ("varicose vein centers"), cosmetic surgery, radiation therapy, and cancer chemotherapy.

■ **Reasons for service-line competition.** *Locking in physician admissions.* Hospitals must compete to attract specialist physicians to admit patients to their specialized services. Thus, hospitals have adopted various strategies to make their service lines compatible with physicians' professional and financial interests.

Tapping into consumer choice. Hospitals and physicians are attuned to consumers' growing clinical savvy and heightened expectations, particularly the aging baby-boomer generation. The direct-to-consumer (DTC) specialty-service strategy uses billboards, radio, print advertising, and occasionally television. In northern Miami's battle for heart patients, three billboards could be found on a short stretch of Biscayne Boulevard, touting three competing heart centers.

Creating profit centers. The specific service lines that are flourishing are usually those that are well reimbursed for hospitals and physicians. A CEO of a prominent academic health center commented, "We are going to focus on the tertiary and quaternary services that are high margin where we perform well and have the possibility of gaining market share. This is not a very hard decision." Hospitals in several CTS markets have expanded profitable service lines while seeking to reduce or eliminate money-losing mental health services.

Image and reputation. Certain services were seen as important for a hospitals' and physicians' image with particular constituencies, whether or not these services were profitable. Less profitable women's and children's services enhance a community reputation. Aside from being profitable and high volume, heart surgery was generally seen as a "must-have" service line, because of its reputational value.

Typically, hospitals and physicians will declare their own service line to be a "center of excellence," whether or not health plans or other third parties have bestowed such a designation. A Seattle physician noted about hos-

pital advertising for cardiac care: "They will say they are the best at a particular service, but there is no measurement to back the claim." For most specialized services, there is a paucity of validated quality data to help consumers verify hospitals' claims of expertise.

■ **Service lines and physicians.** Specialist physicians who practice in specialty-service facilities have differing relationships with the sponsoring entities. A specialty service may be supported by a closed physician staff with only a few physicians allowed to admit patients; an open staff; or a combination, with one or two employed physicians as leaders of community physicians with staff privileges. Respondents thought that specific physician commitments were essential for the financial viability of service lines. To obtain physician commitments, respondents reported that hospitals need to respond to physicians' concerns over issues such as scheduling, having the newest equipment, and working with nurses dedicated to that service.

In a number of circumstances, the open-staff model does not support the specific center-of-excellence program being built or marketed. During the past two years a number of hospitals in the twelve CTS sites have moved to employ crucial physicians. Examples are the Greenville Hospital System in South Carolina and the Swedish Medical Center in Seattle. The Swedish Medical Center's decision to hire prominent neurosurgeons and orthopedic surgeons produced a major political problem for the CEO, who barely survived a no-confidence vote by the medical staff. Many of the staff were concerned that although the hospital was nominally maintaining an open staff, it would siphon off many cases from the voluntary admitting staff, who might as a result be relegated to second-class status.

Some hospitals attract physicians not through employment but by joint venturing with a subset of physicians who remain independent practitioners, often as members of a single-specialty medical group. For example, two hospital systems in Indianapolis entered into joint ventures with cardiologists to develop heart hospitals. Hospitals sometimes enter into joint ventures to maintain some percentage of the specialized-service revenue instead of losing it all to a physician-owned facility.

■ **The escalating battle for control of specialty services.** Hospital, physician, and health plan respondents in most CTS markets concurred that over the past few years there has been a rapid proliferation of ambulatory facility–based alternatives to specialty services previously only provided in hospitals. Ambulatory facilities, often involving physician ownership, are not new; ASCs have existed for decades. Yet respondents in some markets reported that new ASCs have mushroomed in recent years in part because more surgical procedures can now be safely performed outside of the hospital. In the imaging realm, the 64-slice computed tomography (CT) scan imaging that performs the equivalent of a coronary angiogram is increasingly being offered by cardiologists in their offices.[8]

Hospital respondents complained that profitable GI endoscopies are now performed in outpatient settings, often owned by gastroenterologists. Some hospitals have shut down their endoscopy suites, except for use in emergencies, because of insufficient volume to support them.

Respondents identified a number of factors at work that encourage movement of service lines to community-based sites: (1) Growing physician entrepreneurship and interest in gaining additional sources of income. In the words of a physician in Phoenix, "We don't make any money seeing patients; we make it with ancillary services under Medicare." Or in the words of a Seattle hospital executive, "Reimbursement for physicians is zippo, so they are taking the cream out of the hospital." (2) Rising consumer expectations for one-stop shopping, by which a diagnostic and treatment plan can be carried out during a single visit under the control of the recommending physician. (3) Growing physician demand for control over working conditions, such as procedure scheduling and nurse hiring. One impetus for hospital specialty-service reorganization is responsiveness to physician demands to

avoid having specialists move their work outside the hospital.

Implications For Hospitals' Financial Health

A number of hospital executives pointed to the potential for substantial loss of hospital income as one of the leading pressures hospitals face. As one respondent said, "Doctors want into the hospitals' pockets." Many respondents saw the movement of much more care from hospital to physician-controlled sites as inevitable, leading to what one described as a "profound shift" in locus of care, with ominous implications for hospital finances.

Yet hospital and health plan respondents agreed that hospitals have not yet suffered financially because they have recouped revenue losses from outmigrated services by raising prices for profitable specialty-service lines. As one respondent in Indianapolis, a community with four competing heart centers, commented, "Hospital prices never fall."

Some health plan respondents thought that the proliferation of physician-based alternatives to hospital care had led to price competition for those services. Health plans in Greenville and Orange County (California) steer patients to nonhospital sites to take advantage of price discounts. In northern New Jersey and Little Rock, however, some health plans will not pay for magnetic resonance imaging (MRI), CT, and positron-emission tomography (PET) scans performed in specialists' offices. Health plan respondents broadly agreed that physicians' ability to engage in self-referral when they have an ownership interest increases the use of those services.

Discussion And Concluding Comments

CTS site visits from 2000–01 documented that a medical arms race had resurfaced with the demise of risk contracting. During the next four years, the arms race quickened its pace and is now firmly associated with specialty-service-line competition among hospitals and physician-owned facilities. Yet health plans and purchasers in CTS markets do not think that service-line competition will bring down costs. Similar to their views on the effects of specialty hospital development, these respondents believe that modest reductions in prices as a result of increased competition over particular service lines are offset by increased volume of those services as a result of (1) aggressive marketing by providers directly to consumers and (2) specialist physicians' ability to induce demand for services.[9]

Although volume-increasing self-referral is clearly an issue for physician-owned facilities, physicians also have a stake in the success of hospital-sponsored service lines, whether in hospital-physician joint ventures or in the growing number of hospital programs in which employed physicians represent a core component of the service and whose compensation is based partly on revenues generated. Payers are also concerned about hospitals' raising rates for inpatient services over which they have effective monopolies, to recoup any loss of volume to service-line competitors.

It seems clear that the intent of the Stark law limitations on physician self-referral has not been achieved, largely because physicians have figured out how to take advantage of the broad exception in the law for services provided by self-referral that occurs within their own practices or for services they personally provide.[10] Unless Congress is willing to limit internal referrals, other policy tools will be needed to moderate the escalating medical arms race.

Medicare's and private plans' payment policies have an opportunity to narrow the payment gap between relatively profitable and unprofitable services, a gap that distorts providers' behavior and fuels the medical arms race.[11] Reducing the profitability of prominent service lines might moderate the use of DTC marketing that produces health spending growth from increased consumer demand.

Little is known about the impact of specialty-service competition on quality, largely because validated, objective quality measures for many of these services do not exist or are not being used in the twelve CTS sites. Theoretically, service-line competition could cause

quality erosions if a continued or even increased dispersion of cases among many competing facilities compromises the volume-outcome relationship that exists for many technologically oriented services, such as complex surgery.[12] In addition, quality could be compromised if more patients receive inappropriate services that a service-line provider is in business to promote.

On the other hand, some respondents argue that the so-called focused-factory orientation of evolving service lines could improve clinical quality.[13] To track the impact of care organized around service lines on quality, there is a need to develop quality measures related to the outcomes and the appropriateness of services provided by cardiac, oncology, orthopedic, and other service-line providers.

Based on our interviews, hospitals associate some of their recent financial success to the use of service-line strategies. Hospitals still have sufficient control over many profitable service lines and continued contracting leverage with managed care plans, such that rate increases from private health plans make up for losses of business to competing hospitals and physician-owned ambulatory facilities. However, as more care moves to physician-owned ambulatory sites of service through gene therapy, robotic surgery, and other "disruptive technologies," the role of the hospital in the health care system could change markedly.

Whether health care delivery is controlled by hospitals, physicians, or joint ventures between the two, one thing is certain: It is increasingly organized through specialty-service lines, which are already leading to early signs of increasing health care costs and having as-yet-unquantified effects on the quality of care. These salvos in the new medical arms race bear monitoring as the century unfolds.

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NOTES

1. K.J. Devers, L.R. Brewster, and L.P. Casalino, "Changes in Hospital Competitive Strategy: A New Medical Arms Race?" *Health Services Research* 38, no. 1, Part 1 (2003): 447–469.
2. Ibid.
3. J.C. Robinson and H.S. Luft, "Competition and the Cost of Hospital Care, 1972 to 1982," *Journal of the American Medical Association* 257, no. 23 (1987): 3241–3245.
4. Ibid.
5. J.K. Iglehart, "The Uncertain Future of Specialty Hospitals," *New England Journal of Medicine* 352, no. 14 (2005): 1405–1407.
6. T. Lake et al., "Something Old, Something New: Recent Developments in Hospital-Physician Relationships," *Health Services Research* 38, no. 1, Part 2 (2003): 471–488.
7. A single hospital system can have a number of service lines within a geographic area.
8. A.W. Leber et al., "Quantification of Obstructive and Nonobstructive Coronary Lesions by 64-Slice Computed Tomography: A Comparative Study with Quantitative Coronary Angiography and Intravascular Ultrasound," *Journal of the American College of Cardiology* 46, no. 1 (2005): 147–154.
9. R.A. Berenson, G.J. Bazzoli, and M. Au, "Do Specialty Hospitals Promote Price Competition?" Issue Brief no. 103, January 2006, http://www.hschange.org/CONTENT/816 (accessed 29 June 2006).
10. In addition, the Stark II regulations, published in 2001, expressly exempted surgical services performed by a surgical investor in an ASC from self-referral prohibitions. See J.V. Hetzel and W.C. Tomey, "Hospital-Physician Joint Ventures: Some Barriers Come Down while Others Go Up," http://citease.netspacetoday.com/kmjmlaw/publications/article.nhtml?uid=10015 (accessed 6 July 2006).
11. Ginsburg and Grossman, "When the Price Isn't Right."
12. A. Gandjour, A. Bannenberg, and K.W. Lauterbach, "Threshold Volumes Associated with Higher Survival in Health Care: A Systematic Review," *Medical Care* 41, no. 10 (2003): 1129–1141; and E.A. Halm, C. Lee, and M.R. Chassin, "Is Volume Related to Outcome in Health Care? A Systematic Review and Methodologic Critique of the Literature," *Annals of Internal Medicine* 137, no. 6 (2002): 511–520.
13. M.E. Porter and E.O. Teisberg, "Redefining Competition in Health Care," *Harvard Business Review* 82, no. 6 (2004): 65–76.