

Physician-owned specialty hospitals

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Statement of
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Committee on Energy and Commerce
U.S. House of Representatives

Chairman Deal, Congressman Brown, distinguished Subcommittee members. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss physician-owned specialty hospitals.

Proponents claim that physician-owned specialty hospitals are the focused factory of the future for health care, taking advantage of the convergence of financial incentives for physicians and hospitals to produce more efficient operations and higher-quality outcomes than conventional community hospitals. Detractors counter that because the physician-owners can refer patients to their own hospitals they compete unfairly, and that such hospitals concentrate on only the most lucrative procedures and treat the healthiest and best-insured patients—leaving the community hospitals to take care of the poorest, sickest patients and provide services that are less profitable.

The Congress, in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), imposed an 18-month moratorium that effectively halted the development of new physician-owned specialty hospitals. That act also directed MedPAC and the Secretary of the Department of Health and Human Services to report to the Congress on certain issues concerning physician-owned heart, orthopedic, and surgical specialty hospitals.

To answer the Congress's questions, MedPAC conducted site visits, legal analysis, met with stakeholders, and analyzed hospitals' Medicare cost reports and inpatient claims

from 2002 (the most recent available at the time). From its empirical analyses, MedPAC found that:

- Physician-owned specialty hospitals treat patients who are generally less severe cases (and hence expected to be relatively more profitable than the average) and concentrate on particular diagnosis-related groups (DRGs), some of which are relatively more profitable.
- They tend to have lower shares of Medicaid patients than community hospitals.
- In 2002, they did not have lower costs for Medicare inpatients than community hospitals, although their inpatients did have shorter lengths of stay.
- The financial impact on community hospitals in the markets where physician-owned specialty hospitals are located was limited in 2002. Those community hospitals competing with specialty hospitals demonstrated financial performance comparable to other community hospitals.
- Many of the differences in profitability across and within DRGs that create financial incentives for patient selection can be reduced by improving Medicare's inpatient prospective payment system (IPPS) for acute care hospitals.

These findings are based on the small number of physician-owned specialty hospitals that have been in operation long enough to generate Medicare data. The industry is in its early stage, but growing rapidly. Some of these findings could change as the industry develops and have ramifications for the communities where they are located and the Medicare program. We did not evaluate the comparative quality of care in specialty hospitals, because the Secretary is mandated to do so in a forthcoming report.

We found that physicians may establish physician-owned specialty hospitals to gain greater control over how the hospital is run, to increase their productivity, and to obtain greater satisfaction for them and their patients. They may also be motivated by the financial rewards, some of which derive from inaccuracies in the Medicare payment system.

Our recommendations concentrate on remedying those payment inaccuracies, which result in Medicare paying too much for some DRGs relative to others, and too much for patients with relatively less severe conditions within DRGs. Improving the accuracy of the payment system would help make competition more equitable between community hospitals and physician-owned specialty hospitals, whose physician-owners can influence which patients go to which hospital. It would also make payment more equitable among community hospitals that currently are advantaged or disadvantaged by their mix of DRGs or patients. Some community hospitals have invested disproportionately in services thought to be more profitable, and some non-physician owned hospitals have specialized in the same services as physician-owned specialty hospitals.

We also recommend an approach to aligning physician and hospital incentives through gainsharing, which allows physicians and hospitals to share savings from more efficient practices and might serve as an alternative to direct physician ownership. Because of remaining concerns about self-referral; need for further information on the efficiency, quality, and effect of specialty hospitals; and the time needed to implement our

recommendations, the Commission also recommends that the Congress extend the current moratorium on specialty hospitals until January 1, 2007.

How many and where

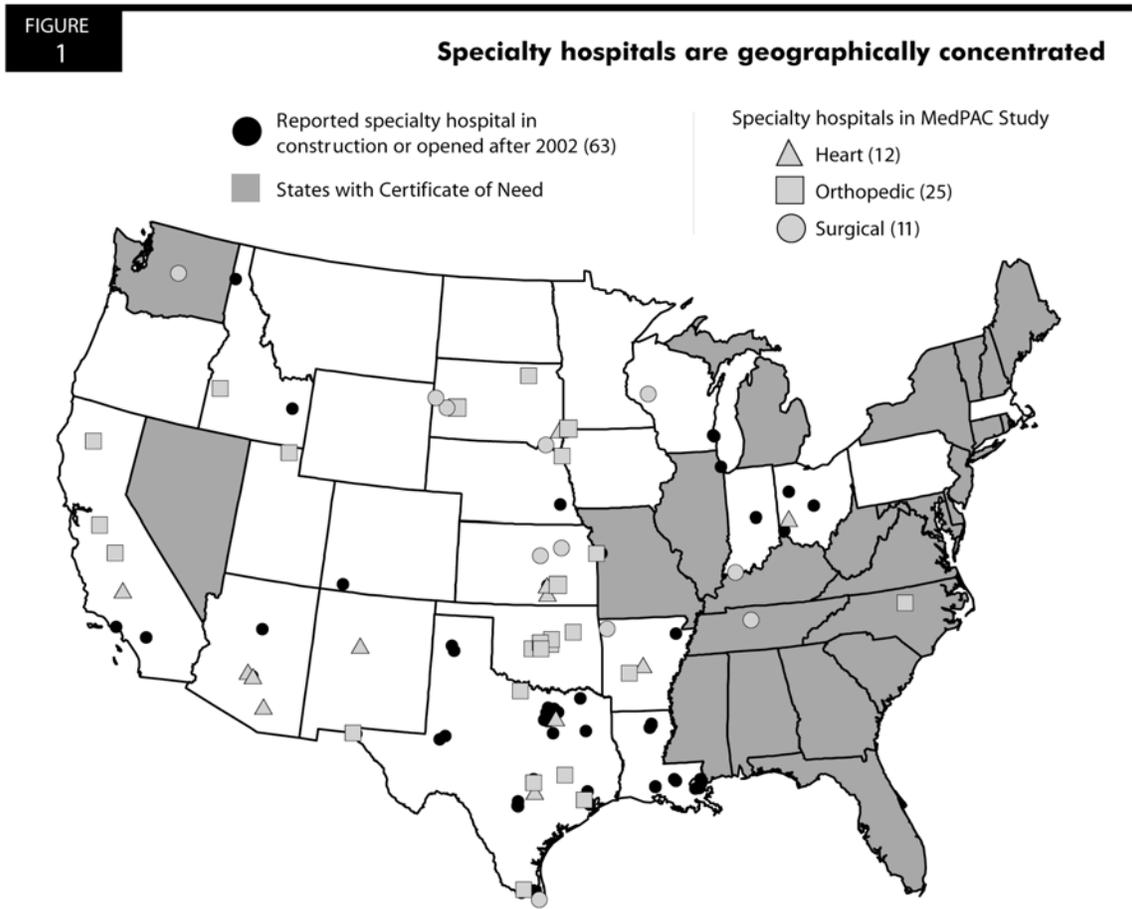
We found 48 hospitals in 2002 that met our criteria for physician-owned specialty hospitals: 12 heart hospitals, 25 orthopedic hospitals, and 11 surgical hospitals.

(Altogether there are now approximately 100 specialty hospitals broadly defined, but some opened after 2002 and did not have sufficient discharge data for our analysis; others are not physician-owned or are women's hospitals that do not meet our criteria for surgical hospitals.) Specialty hospitals are small: the average orthopedic specialty hospital has 16 beds and the average surgical specialty hospital has 14. Heart hospitals are larger, averaging 52 beds.

Many specialty hospitals do not have emergency departments (EDs), in contrast to community hospitals where the large majority (93 percent) do. Those that have EDs differ in how they are used, and that may influence how much control the hospital has over its schedule and patient mix. For example, 8 of the 12 heart hospitals we examined have EDs, and the heart hospitals we visited that had EDs were included in their area's emergency medical systems' routing of patients who required the services they could provide. In contrast, even when surgical and orthopedic specialty hospitals have EDs, they are often not fully staffed or included in ambulance routings.

Specialty hospitals are not evenly distributed across the country (Figure 1). Almost 60

percent of the specialty hospitals we studied are located in four states: South Dakota, Kansas, Oklahoma, and Texas. Many of the specialty hospitals that are under construction or have opened since 2002 are located in the same states and markets as the specialty hospitals we studied. As the map shows, specialty hospitals are concentrated in states without certificate-of-need (CON) programs.



Motivations for forming physician–owned specialty hospitals and critics objections

Physician control over hospital operations was one motivation for many of the physicians we spoke with who were investing in specialty hospitals. In the physician-owned specialty hospitals we studied, the cardiologists and surgeons want to admit their patients, perform their procedures, and have their patients recover with minimal disruption.

Physician control, they believe, makes this possible in ways community hospitals cannot match because of their multiple services and missions. Control allows physicians to increase their own productivity for the following reasons:

- fewer disruptions to the operating room schedule (for example, delays and canceling of cases that result from emergency cases),
- less “down” time between surgeries (for example, by cleaning the operating rooms more efficiently),
- heightened ability to work between two operating rooms during a “block” of operating room time, and
- more direct control of operating room staff.

The other motivation to form specialty hospitals is enhanced income. In addition to increased productivity resulting in more professional fees, physician investors also could augment their income by retaining a portion of the facility profits for their own and others’ work. Although some specialty hospitals have not made distributions, the annual distributions at others frequently have exceeded 20 percent of the physicians’ initial investment, and the specialty hospitals in our study had an average all-payer margin of 13 percent in 2002, well above the 3 to 6 percent average for community hospitals in their markets.

Critics contend that much of the financial success of specialty hospitals may revolve around selection of patients. Physicians can influence where their patients receive care, and physician ownership gives physician-investors a financial incentive to refer profitable

patients to their hospital. If the payment system does not adequately differentiate among patients with different expected costs, and the factors determining cost, such as severity of illness, can be observed in advance, then the physician has an incentive to direct patients accordingly. At the extreme, some community hospitals claimed physicians sometimes transferred low complexity patients out of the community hospitals to specialty hospitals that the physicians owned, while transferring high complexity patients into the community hospitals. Referrals of healthier (more profitable) patients to limited-service specialty hospitals may not harm less complex patients. Nonetheless, critics argue that referral decisions should not be influenced by financial incentives, and therefore, they object to physician ownership of specialty hospitals. Critics also argue that eventually community hospitals' ability to provide less profitable services (which are often subsidized by more profitable services) would be undermined.

Restrictions on physician self-referral have a long history in the Medicare program. The anti-kickback statute, the Ethics in Patient Referrals Act (the Stark law), and their implementing regulations set out the basic limitations on self-referral and create exceptions. The primary concern was that physician ownership of health care providers would create financial incentives that could influence physicians' professional judgment and lead to higher use of services. In addition, self-referral could lead to unfair competition if one facility was owned by the referring physician, and competing facilities were not. Because hospitals provide many kinds of services, an exception was created that allowed physicians to refer patients to hospitals in which they invest. This is the "whole hospital" exception. Physician investors have a greater opportunity to influence

profits at single-specialty hospitals—which generally provide a limited range of services—than at full-service hospitals.

Do physician-owned specialty hospitals have lower costs?

We compared physician-owned specialty hospitals to three groups of hospitals.

Community hospitals are full service hospitals located in the same market. *Competitor* hospitals are a subset of community hospitals that provide at least some of the same services provided by specialty hospitals in that market. And *Peer* hospitals are specialized, but not physician owned.

After controlling for potential sources of variation, including patient severity, we found that inpatient costs per discharge at physician-owned specialty hospitals are higher than the corresponding values for peer, competitor, and community hospitals. However, these differences were not statistically significant.

Lengths of stay in specialty hospitals were shorter, in some cases significantly so, than those in comparison hospitals. Other things being equal, shorter stays should lead to lower costs. The apparent inconsistency of these results raises questions about what other factors might be offsetting the effects of shorter stays. Such factors might include staffing levels, employee compensation, costs of supplies and equipment, initial start-up costs, or lack of potential economies of scale due to smaller hospital size. These results could change as the hospitals become more established and as the number of specialty hospitals reporting costs and claims increases.

Who goes to physician-owned specialty hospitals, and what happens to community hospitals in their markets?

Critics of specialty hospitals contend that physicians have financial incentives to steer profitable patients to specialty hospitals in which they have an ownership interest. These physicians may also have an incentive to avoid Medicaid, uninsured, and unusually costly Medicare patients. Critics further argue that if physician-owned hospitals take away a large share of community hospitals' profitable patients, community hospitals would not have sufficient revenues to provide all members of the community access to a full array of services.

Supporters counter that the specialty hospitals are engaging in healthy competition with community hospitals and that they are filling unmet demand for services. They acknowledge that community hospital volumes may decline when they enter a market, but claim that community hospitals can find alternative sources of revenue and remain profitable even in the face of competition from physician-owned specialty hospitals. We found:

- Physician-owned heart, orthopedic, and surgical hospitals that did not focus on obstetrics tended to treat fewer Medicaid patients than peer hospitals and community hospitals in the same market. Heart hospitals treated primarily Medicare patients, while orthopedic and surgical hospitals treated primarily privately insured patients.

- The increases in cardiac surgery rates associated with the opening of physician-owned heart hospitals were small enough to be statistically insignificant for most types of cardiac surgery. It appears that specialty hospitals obtained most of their patients by capturing market share from community hospitals.
- Though the opening of heart hospitals was associated with slower growth in Medicare inpatient revenue at community hospitals, on average, community hospitals competing with physician-owned heart hospitals did not experience unusual declines in their all-payer profit margin.

Note that most specialty hospitals are relatively new, and the number of hospitals in our analysis is small. The impact on service use and community hospitals could change over time, especially if a large number of additional specialty hospitals are formed.

Do specialty hospitals treat a favorable mix of patients?

Specialty hospitals may concentrate on providing services that are profitable, and on treating patients who are less sick—and therefore less costly. Under Medicare’s IPPS, payments are intended to adequately cover the costs of an efficient provider treating an average mix of patients, some with more and some with less complex care needs. But if differences in payments do not fully reflect differences in costs across types of admissions (DRGs) and patient severity within DRGs, some mixes of services and patients could be more profitable than others. Systematic bias in any payment system, not just Medicare’s, could reward those hospitals that selectively offer services or treat patients with profit margins that are consistently above average. We found:

- Specialty hospitals tend to focus on surgery, and under Medicare’s IPPS, surgical DRGs are relatively more profitable than medical DRGs in the same specialty.
- Surgical DRGs that were common in specialty heart hospitals were relatively more profitable than the national average DRG, those in orthopedic hospitals relatively less profitable, and those in specialty surgical hospitals had about average relative profitability.
- Within DRGs, the least severely ill Medicare patients generally were relatively more profitable than the average Medicare patient. More severely ill patients generally were relatively less profitable than average, reflecting their higher costs but identical payments. Specialty hospitals had lower severity patient mixes than peer, competitor, or community hospitals.
- Taking both the mix of DRGs and the mix of patients within DRGs into account, specialty hospitals would be expected to be relatively more profitable than peer, competitor, or community hospitals if they exhibited average efficiency.

Table 1 shows the expected relative profitability for physician-owned specialty hospitals and their comparison groups. The expected relative profitability for a hospital is: the ratio of the payments for the mix of DRGs at the hospital to the costs that would be expected for that mix of DRGs and patients if the hospital had average costs—relative to the national average expected profitability over all cases. It is not the actual profitability for the hospital.

Heart specialty hospitals treat patients in financially favorable DRGs and, within those, patients who are less sick (and less costly, on average). Assuming that heart specialty hospitals have average costs, their selection of DRGs results in an expected relative profitability 6 percent higher than the average profitability. Heart hospitals receive an additional potential benefit (3 percent) from favorable selection among patient severity classes. As a result, their average expected relative profitability value is 1.09.

Reflecting their similar concentration in surgical cardiac cases, peer heart hospitals also benefit from favorable selection across DRGs, though not as much as specialty heart hospitals. However, peer heart hospitals receive no additional benefit from selection among more- or less-severe cases within DRGs. Both specialty heart and peer heart hospitals have a favorable selection of patients compared with community hospitals in the specialty heart hospitals’ markets, as well as with all IPPS hospitals.

Type of hospital	Number of hospitals	Expected relative profitability due to selection of		
		DRGs	Patient severity	DRGs and patient severity
All nonspecialty IPPS hospitals	4,375	1.00	1.00	1.00
Heart hospitals				
Specialty	12	1.06	1.03	1.09 ^{ab}
Peer	36	1.04	0.99	1.03 ^b
Competitor	79	1.01	1.00	1.00
Community	315	0.99	1.01	1.01
Orthopedic hospitals				
Specialty	25	0.95	1.07	1.02 ^{ab}
Peer	17	0.95	1.01	0.96
Competitor	305	1.00	1.00	1.00
Community	477	1.00	1.01	1.01
Surgical hospitals				
Specialty	11	0.99	1.16	1.15 ^{ab}
Peer	25	1.00	1.06	1.06 ^b
Competitor	237	0.99	1.01	1.01
Community	289	0.99	1.01	1.01

Note: IPPS (inpatient prospective payment system), APR–DRG (all-patient refined diagnosis-related group), DRG (diagnosis-related group). Expected relative profitability measures the financial attractiveness of the hospital’s mix of Medicare cases, given the national average relative profitability of each patient category (DRG or APR–DRG severity class). The relative profitability measure is an average for each DRG category, based on cost accounting data. Thus, small differences (for example, 1 or 2 percent) in relative profitability may not be meaningful. Specialty hospitals are specialized and physician owned. Peer hospitals are specialized but are not physician owned. Competitor hospitals are in the same markets as specialty hospitals and provide some similar services. Community hospitals are all hospitals in the same market as specialty hospitals.

^a Significantly different from peer hospitals using a Tukey mean separation test and a $p < .05$ criterion.

^b Significantly different from nonpeer community hospitals using a Tukey mean separation test and a $p < .05$ criterion.

Source: MedPAC analysis of Medicare hospital inpatient claims and cost reports from CMS, fiscal year 2000–2002.

In contrast to the heart hospitals, neither orthopedic specialty hospitals nor their peers seem to have a favorable DRG selection. However, by treating a high proportion of low-severity patients within their mix of DRGs, specialty orthopedic hospitals show selection that appears to be slightly favorable overall (1.02). Surgical specialty hospitals show a very favorable selection of patients overall (1.15) because they also treat relatively low-severity patients within the DRGs.

Payment recommendations

The Congress asked the Commission to recommend changes to the IPPS to better reflect the cost of delivering care. We found changes are needed to improve the accuracy of the payment system and thus reduce opportunities for hospitals to benefit from selection. We recommend several changes to improve the IPPS.

The Commission recommends the Secretary should improve payment accuracy in the IPPS by:

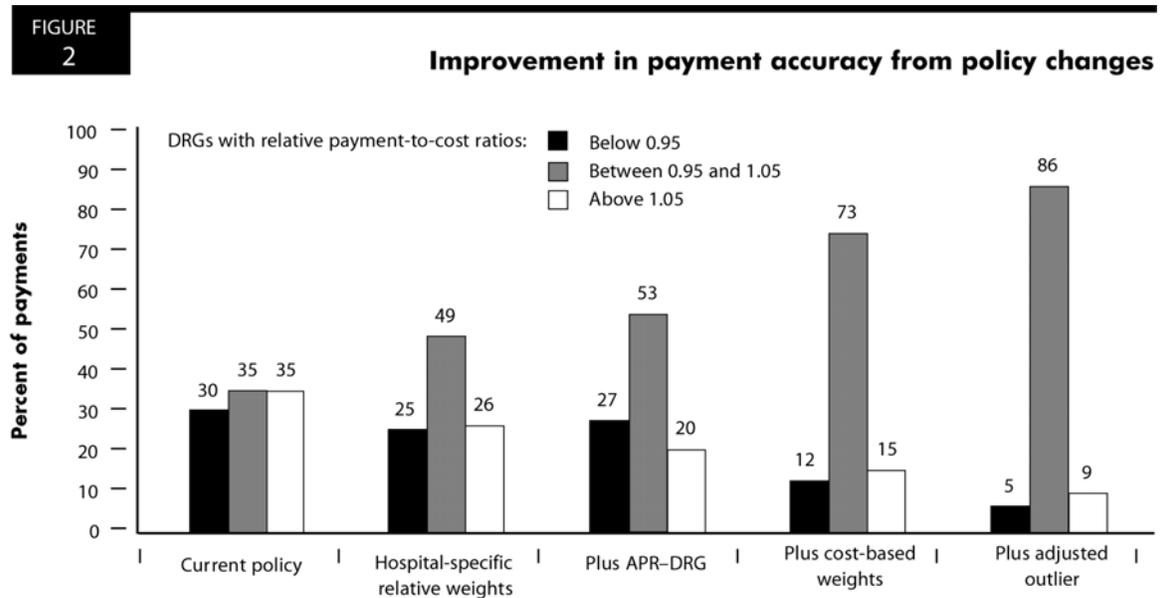
- refining the current DRGs to more fully capture differences in severity of illness among patients,
- basing the DRG relative weights on the estimated cost of providing care rather than on charges, and
- basing the weights on the national average of hospitals’ relative values in each DRG.

All of these actions are within the Secretary’s current authority.

The commission also recommends the Congress amend the law to give the Secretary authority to adjust the DRG relative weights to account for differences in the prevalence of high-cost outlier cases.

Taken together, these recommendations will reduce the potential to profit from patient and DRG selection, and result in payments that more closely reflect the cost of care while still retaining the incentives for efficiency in the IPPS. Figure 2 shows that the share of IPPS payments in DRGs that have a relative profitability within 5 percent of the national average would increase from 35 percent under current policy to 86 percent if all of our recommendations were implemented. At the hospital group level, under current policy, heart hospitals’ expected relative profitability from their combination of DRGs and

patients is above the national average profitability for all DRGs and patients. Following our recommendations, that ratio would be about equal to the national average. Physician-owned orthopedic and surgical hospitals would show similar results.



Note: DRG (diagnosis-related group), APR-DRG (all-patient refined diagnosis-related group).
 Source: MedPAC analysis of Medicare hospital inpatient claims and cost reports from CMS, fiscal year 2000-2002.

These payment system refinements would affect all hospitals—both specialty hospitals and community hospitals. Many hospitals would see significant changes in payments, and, although our recent analysis suggests that hospitals’ inpatient profitability increases as selection becomes more favorable, a transitional period would mitigate those effects and allow hospitals to adjust to the refined payment system. Thus, the Commission recommends the Congress and the Secretary should implement the payment refinements over a transitional period.

Making these payment system improvements and designing the transition will not be simple tasks. We recognize that the Centers for Medicare & Medicaid Services (CMS) has many priorities and limited resources, and that the refinements will raise some difficult technical issues. These include the potentially large number of payment groups created, possible increases in spending from improvements in coding, rewarding avoidable complications, and the burden and time lag associated with using costs rather than charges. Nevertheless, certain approaches that we discuss in this report, such as reestimating cost-based weights every several years instead of annually, could make these issues less onerous. The Congress should take steps to assure that CMS has the resources it needs to make the recommended refinements.

Recommendations on the moratorium and gainsharing

The Commission is concerned with the issue of self-referral and its potential for patient selection and higher use of services. However, removing the exception that allows physician ownership of whole hospitals would be too severe a remedy given the

limitations of the available evidence, although we may wish to reconsider it in the future. Our evidence on physician-owned specialty hospitals raises some concerns about patient selection, utilization, and efficiency, but it is based on a small sample of hospitals, early in the development of the industry. We do not know yet if physician-owned hospitals will increase their efficiency and improve quality. We also do not know if, in the longer term, they will damage community hospitals or unnecessarily increase use of services. The Secretary's forthcoming report on specialty hospitals should provide important information on quality. Further information on physician-owned specialty hospitals' performance is needed before actions are taken that would, in effect, entirely shut them out of the Medicare and Medicaid market. In addition, the Congress will need time during the upcoming legislative cycle to consider our recommendations and craft legislation, and the Secretary will need time to change the payment system. Therefore, the Commission recommends that the Congress extend the current moratorium on specialty hospitals until January 1, 2007. The current moratorium expires on June 8, 2005. Continuing the moratorium will allow time for efforts to implement our recommendations and time to gather more information.

Aligning financial incentives for physicians and hospitals could lead to efficiencies. Physician ownership fully aligns incentives; it makes the hospital owner and the physician one in the same, but raises concerns about self-referral. Similar efficiencies might be achieved by allowing the physician to share in savings that would accrue to the hospital from reengineering clinical care. Such arrangements have been stymied by provisions of law that prevent hospitals from giving physicians financial incentive to reduce or limit care to patients because of concerns about possible stinting on care and quality. Recently, the Office of Inspector General has approved some narrow gainsharing arrangements, although they have been advisory opinions that apply only to the parties who request them.

The Commission recommends that the Congress should grant the Secretary the authority to allow gainsharing arrangements between physicians and hospitals and to regulate those arrangements to protect the quality of care and minimize financial incentives that could affect physician referrals.

Gainsharing could capture some of the incentives that are animating the move to physician-owned specialty hospitals while minimizing some of the concerns that direct physician ownership raises. Permitting gainsharing opportunities might provide an alternative to starting physician-owned specialty hospitals, particularly if the incentives for selection were reduced by correcting the current inaccuracies in the Medicare payment system.