Testimony of

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Specialty Hospitals: Assessing Their Role in the Delivery of Quality Health Care

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Chairman Deal, Representative Brown, distinguished committee members, thank you for inviting me to testify today about physician-owned specialty hospitals. At the Centers for Medicare & Medicaid Services (CMS), we remain deeply committed to improving the quality of patient care and to increasing the efficiency of Medicare spending. As you know, how Medicare pays for medical services can significantly impact quality and medical costs for our beneficiaries and our overall health care system. By carefully examining interactions between physicians and hospitals, we can consider how the financial incentives created by the Medicare program might be improved, to help ensure not only that Medicare pays accurately but that Medicare's payment rules promote quality of care for Medicare beneficiaries and other hospital patients. To that end, Section 507(b)(2) and (b)(3) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires HHS to study a set of important quality and cost issues related to specialty hospitals, and to report to Congress on our findings. I am here today to present the results and recommendations from the CMS report and the actions we will take.

In the CMS report on specialty hospitals we found some notable results. For example, we found specialty hospitals provide high patient satisfaction, high quality of care and patient outcomes in some important dimensions, greater predictability in scheduling and services, and significant tax contributions to the community. However, our results and those of others indicate that the activities and impacts of these hospitals may also reflect imperfections in current Medicare payment systems and differences in patients served, not simply efficiency and quality differences. Our current payment systems may not

provide appropriate incentives for maximizing quality and costs for our overall beneficiary population. Therefore, we expect to proceed with significant administrative reforms to our payment systems, similar to those recommended by Medicare Payment Advisory Commission (MedPAC) in its specialty hospital report to Congress. In addition, we plan to comprehensively review the procedures used to qualify specialty hospitals.

Specifically, CMS has developed four key recommendations for physician-owned specialty hospitals. First, to help reduce the possibility that specialty hospitals may take advantage of imprecise payment rates in the inpatient hospital prospective payment system (IPPS), CMS is analyzing MedPAC's recommendations to improve the accuracy of the payment rates for inpatient hospital services and expects to adopt significant revisions in FY07. CMS will fully examine and simulate the changes and proceed with those that actually lead to significant improvements in the accuracy of our payment system. Second, we will reform payment rates for ambulatory surgical centers (ASCs). In particular, our report showed that some physicians may have an ownership interest in entities that describe themselves as small orthopedic or surgical "hospitals" to which they refer patients. We speculate that these entities may describe themselves as hospitals rather than ASCs in part to take advantage of the more favorable payment rates that apply under the hospital outpatient prospective payment system (OPPS) as opposed to the ASC payment system. This is problematic from CMS' perspective, however, since the Medicare program defines a "hospital" as an entity that provides care "primarily" to inpatients. To the extent that such an entity is not, in fact, primarily providing care to inpatients, it is inappropriately categorized as a hospital and should not be treated as one under the Medicare program. CMS is currently planning to reform the ASC fee schedule to diminish the divergences in payment levels that create artificial incentives for the creation of small orthopedic or surgical hospitals. CMS plans to implement these ASC payment reforms in conjunction with other revisions to the ASC fee schedule required by the MMA by January 1, 2008. Third, to address the concern that entities such as those described above may be concentrating primarily on outpatient care, CMS will scrutinize whether specialty hospitals meet the definition of a hospital. Specifically, we will

analyze existing data to assess whether specialty hospitals meet the requirement that to be defined as a hospital it must provide primarily inpatient care. Fourth, we will carefully review our criteria for approving and starting to pay new specialty hospitals. CMS wants to be assured that, given their limited focus, specialty hospitals meet core requirements that we determine are necessary for the health and safety of our beneficiaries. In addition, we wish to consider how EMTALA applies to specialty hospitals, with particular reference to potential transfer cases arising in the emergency departments of other hospitals. All four of these issues raise important policy concerns. CMS plans to review our procedures for examining such hospitals, and we will instruct our state survey and certification agencies to refrain from processing further participation applications from specialty hospitals until this review is completed and any indicated revisions are implemented. We expect to complete this process by January 2006.

CMS' Study of Physician-Owned Specialty Hospitals

Section 507(a) of the MMA placed a moratorium on physician-investor referrals of Medicare or Medicaid patients to new specialty hospitals (thus effectively halting the development of new specialty hospitals) for an 18-month period and required HHS to study referral patterns of specialty hospital physician-owners, to assess quality of care and patient satisfaction, and to examine the differences in uncompensated care and tax payments between specialty hospitals and community hospitals. CMS contracted with RTI International, an independent research organization, to conduct the technical analysis.

In addition, Section 507(a) of the MMA added a new paragraph (7)(A) to section 1877(h) of the Social Security Act. That paragraph defined a specialty hospital for the purposes of the moratorium as a hospital in one of the 50 States or the District of Columbia that is primarily or exclusively engaged in the care and treatment of one of the following:

- patients with a cardiac condition;
- patients with an orthopedic condition;
- patients receiving a surgical procedure; or

- patients receiving any other specialized category of services designated by the Secretary (none have been designated thus far.)

The MMA also required a complementary MedPAC study of certain issues related to the payments, costs, and patient severity at specialty hospitals. For purposes of identifying appropriate specialty hospitals for the MMA study, MedPAC used the following criteria.[1] Specialty hospitals must:

- be physician-owned;
- specialize in certain services – at least 45 percent of their Medicare cases must be in cardiac, orthopedic, or surgical services or at least 66 percent must be in two major diagnostic categories, with the primary one being cardiac, orthopedic, or surgical cases;
- have a minimum volume of at least 25 total Medicare cases during 2002; and
- have submitted Medicare cost reports and claims for 2002.

CMS generally followed the MedPAC report criteria, but with an additional requirement that cardiac and orthopedic hospitals perform at least five major procedures. To be considered a cardiac specialty hospital, 45 percent or more of a hospital's Medicare cases must have been in the Major Diagnostic Category (MDC) 5, Diseases and Disorders of the Circulatory System. Orthopedic hospitals must have had 45 percent of their cases in MDC 8, Diseases and Disorders of the Musculoskeletal System and Connective Tissue. For surgery hospitals, 45 percent or more of their discharges must have involved a surgical procedure.

Although the researchers used national data for as many aspects as possible of this analysis, some key questions related to quality, cost, and community impact required the detailed analysis of richer data than have been available previously. Consequently, the analysis involved the collection of a considerable amount of new data related to the ownership, performance, and impact of specialty hospitals. The analysis included information about the environment in which specialty hospitals and community hospitals

[1] Report to the Congress: Physician-Owned Specialty Hospitals," MedPAC, March 2005

in the same geographic areas operate, and sensitive and proprietary non-public data on such issues as ownership. Because only a small number of specialty hospitals met the criteria for inclusion in this CMS report, and a subset of 11 was analyzed in some cases, caution should be used in making generalization based on the data.

These data were collected in six diverse market areas around the country. In particular, to conduct this detailed analysis, RTI International made site visits to 11 specialty hospitals in six market areas around the country including Dayton, OH; Fresno, CA; Rapid City, SD; Hot Springs, AR; Oklahoma City, OK; and Tucson, AZ. These 11 hospitals comprise about one-sixth of the 67 cardiac, surgery, and orthopedic specialty hospitals that were in operation as approved Medicare providers by the end of 2003. The researchers selected these market areas because they were thought to represent a range of the circumstances in which specialty hospitals operate. Within each market area, the researchers interviewed specialty hospital managers, physician owners, and staff in order to gather information that was needed to answer the questions posed by Congress. In addition, they interviewed executives at several local community hospitals to evaluate their views and concerns with respect to the specialty hospitals. To assess patient satisfaction with specialty hospitals, the study used patient focus groups composed of beneficiaries treated in cardiac, surgery, orthopedic and competitor hospitals

In addition to these detailed analyses within six market areas, researchers used Medicare claims data from the entire national population of physician-owned specialty hospitals to assess the quality of care. They specifically used inpatient hospital quality indicators developed by the Agency for Health Research and Quality (AHRQ) to assess quality of care at all the specialty hospitals and local competitor community hospitals. To estimate total tax payments and uncompensated care for these hospitals they used data obtained from Internal Revenue Service (IRS) submissions and financial reports, as well as from the hospitals themselves.

CMS' Research Findings Regarding Physician-Owned Specialty Hospitals

Based on this research, we reached a number of conclusions that are described below.

Cardiac Hospitals Differ from Surgery and Orthopedic Hospitals

The empirical evidence clearly shows that cardiac hospitals differ substantially from surgery and orthopedic hospitals as shown in Chart 1.

	Cardiac	**Orthopedic and Surgical**
Average Daily Census	40	5
Percent Medicare Inpatient Days	67	36
Aggregate Percent of Physician Ownership in sample of hospitals visited	34	80
Individual Ownership Shares per Physician in sample of hospitals visited	Range: 0.1 to 9.8 Median: 0.6 Mean: 0.9	Range: 0.1 to 22.5 Median: 0.9 Mean: 2.2

Chart 1

Compared to surgery and orthopedic hospitals, cardiac hospitals tend to have a higher average daily census, an emergency department, and other features, such as community outreach programs while surgery and orthopedic hospitals more closely resemble ambulatory surgical centers, focusing primarily on outpatient services. All cardiac hospitals reportedly were built exclusively for cardiac care. The average daily census of the 16 cardiac hospitals that were open for more than one year in 2003 was 40 patients. For surgery and orthopedic hospitals, the aggregate average daily census of inpatients is about 5 patients. Cardiac hospitals treated 38,000 Medicare cases in 2003, and Medicare beneficiaries account for a very high proportion (about two-thirds) of inpatient days in those hospitals nationwide. In surgery and orthopedic hospitals, Medicare patients account for about 36 percent of the inpatient days in these facilities. The small number of inpatient cases at surgery and orthopedic hospitals precluded the development of meaningful findings for this group on several of the dimensions of performance that we examined. For all of these reasons, our report examines cardiac hospitals and orthopedic/surgical hospitals separately.

The degree of physician ownership also differed between cardiac hospitals and surgery and orthopedic hospitals. In the study hospitals, the aggregate physician ownership averaged approximately 34 percent for the cardiac hospitals in the study. Physicians

generally own a large share of the interest, averaging 80 percent in aggregate, for the surgery and orthopedic hospitals in the study. The balance is typically owned by a non-profit hospital or national corporation. The average ownership share per physician in cardiac hospitals visited is 0.9 percent, with individual ownership share per physician ranging from 0.1 percent to 9.8 percent, and a median of 0.6 percent. In surgery and orthopedic hospitals visited, the average ownership share per physician is 2.2 percent, with individual ownership shares per physician ranging from 0.1 percent to 22.5 percent, with a median of 0.9 percent.

Referral Patterns

CMS' findings on physician-owner referral patterns indicate that physician owners refer or admit the majority of Medicare patients in most specialty hospitals. However, these physicians do not refer their patients exclusively to the specialty hospitals that they own. They also refer patients to the local community hospital competitors.

CMS found that physicians in general are constrained by where they refer patients because of several factors, including patient preferences, managed care networks, specialty hospital location, and taking emergency department "call" from local competitor hospitals. Using ownership data provided by the 11 specialty hospitals, we found Medicare referrals to physician-owned hospitals came primarily from physician-owners. The proportion of all Medicare cardiac cases in three cardiac specialty hospitals visited, referred by physician-owners, ranged from 61% to 82%. In five orthopedic hospitals visited, physician-owners referred between 48% and 98% of the orthopedic cases, and in one surgery hospital, physician-owners referred 90% of the cases.

CMS also examined the extent to which physician-owners refer Medicare patients to other facilities, and how these patients differ from the patients referred to the specialty facility, given the financial incentive to refer patients to their own facility. In two cardiac hospitals visited, owners had a clear preference for referring cases to their own hospital, with 65% and 75% of all their cases admitted to their hospital. In the third specialty cardiac hospital visited, owners referred almost the same percentage of cases to their facilities as to competitor hospitals in the area. Physician-owners in all orthopedic and

surgery specialty hospitals visited, except for one, referred most of their orthopedic or surgery inpatient cases to their competitor hospitals. This is not surprising, given the very small inpatient census at these specialty hospitals. Consequently, CMS did not see clear, consistent patterns of preference for referring to specialty hospitals among physician owners relative to their peers.

Overall, the Medicare cardiac patients treated in community hospitals are more severely ill than those treated in cardiac specialty hospitals in most of the study sites. This generally is true for patients admitted both by physicians with ownership in specialty hospitals and by other physicians without such ownership. That is, our analysis found no difference in referral patterns to community hospitals between physician owners and non-owners in this aspect of referrals. However, though it does not appear to result from selective referral by physician owners compared to non-owners, there is some variation in patients treated, with cardiac hospitals in some areas having higher average severity than in the community hospitals. Although the number of cases was too small to draw definitive conclusions for the orthopedic and surgery specialty hospitals, the severity level of cases involving the same or similar procedures appears to be much lower in these specialty hospitals than in the competitor hospitals.

The analysis of patients transferred out of cardiac hospitals also does not suggest any particular pattern. The proportion of patients transferred from cardiac hospitals to community hospitals is about the same, around one percent, as the proportion of patients transferred between community hospitals. The proportion of severely ill patients transferred from cardiac hospitals to community hospitals is similar (slightly higher but without statistical significance) to patients in the same diagnosis related group (DRG) who are transferred between community hospitals. The number of cases transferred from surgery and orthopedic hospitals is too small to derive meaningful results on this type of analysis.

Quality of Care and Patient Satisfaction

Based on claims analysis using the AHRQ quality indicators and methodology, measures

of quality at cardiac hospitals are generally at least as good and in some cases better than the local community hospitals. Complication and mortality rates are lower at cardiac specialty hospitals even when adjusted for severity. Because of the small number of discharges, a statistically valid assessment could not be made for surgery and orthopedic hospitals. Specialty hospitals generally provide a more uniform set of services and have fewer competing pressures than community hospitals, and thus are able to provide more predictable scheduling and patient care. Patient satisfaction is very high in both cardiac hospitals and surgery and orthopedic hospitals. Medicare beneficiaries mentioned large private rooms, quiet surroundings, adjacent sleeping rooms for family members if needed, easy parking, and good food. Patients also have very favorable perceptions of the clinical quality of care they receive at the specialty hospitals.

Uncompensated Care and Tax Benefits

To calculate their taxes paid and the uncompensated care they provided as a proportion of net revenues, the specialty hospitals visited provided proprietary financial information. The specialty hospitals pay real estate and property taxes, as well as income and sales taxes, whereas non-profit community hospitals do not pay any of these taxes. Overall, the proportion of net revenue that specialty hospitals devote to both uncompensated care and taxes significantly exceeds the proportion of net revenues that community hospitals devote to uncompensated care. Real estate and property tax payments stay in the local community, as does a share of sales tax payments in most areas. It should be noted that the physician-owned specialty hospitals visited reported very little Medicaid utilization, which, on average, ranged from zero to six percent.

To summarize, we found that physician owners refer or admit the majority of Medicare patients in most cardiac hospitals, but these physicians do not refer their patients exclusively to the specialty hospitals that they own. Patients treated at cardiac specialty hospitals are less severely ill than at community hospitals; however both the owners and non-owners refer patients of high and low severity in the same way. Both send a greater proportion of the more severe patients to the community hospital. In addition, quality of care is as good or better and patient satisfaction is very high in cardiac hospitals.

Although the small number of patients in surgery and orthopedic hospitals prevented valid measurement of quality, patients expressed very high satisfaction. Furthermore, the total proportion of net revenue that specialty hospitals devote to both uncompensated care and taxes significantly exceeds the proportion of net revenues that community hospitals devote to uncompensated care. In addition, real estate, property, and a portion of sales tax payments stay in the local community.

Recommendations Regarding Physician-Owned Specialty Hospitals

After consideration of the results of our study and that of (MedPAC)[2], we offer the following four recommendations. These recommendations require administrative steps, which CMS will take under its current authority.

- Reform payment rates for inpatient hospital services through Diagnosis Related Group (DRG) refinements
- Reform payment rates for ambulatory surgical centers (ASCs)
- More closely scrutinize whether entities meet the definition of a hospital
- Review procedures for approval for participation in Medicare

Recommendation 1: Reform Payment Rates for Inpatient Hospital Services through Diagnosis Related Group (DRG) Refinements

To help reduce the possibility that specialty hospitals may take advantage of imprecise payment rates in the inpatient hospital prospective payment system (IPPS), MedPAC has recommended several changes to improve the accuracy of payment rates in the IPPS.

In general, CMS agrees with MedPAC that the accuracy of IPPS payment rates should be improved, and the emergence of specialty hospitals clearly illustrates the need for such change. We have initiated analysis of MedPAC's recommendations and intend to simulate the changes so we can explore the impacts on hospitals. Consequently, CMS addressed this issue briefly in the preamble to the notice of proposed rulemaking for the FY 2006 update to the IPPS. After completing further analysis, we will consider making

[2] Report to the Congress: Physician-Owned Specialty Hospitals," MedPAC, March 2005

recommendations for change in the notice of proposed rulemaking for the FY 2007 update, if such revisions lead to a significant increase in accuracy of payments. We may expect to adopt significant revisions in our payment system to address these issues in FY07. The exact details of how these payment revisions can best lead to significant improvements in payment accuracy and thus to better incentives for hospital quality and efficiency will reflect further work in our upcoming regulations. CMS plans to publish this notice in April 2006 and make any resulting changes, after considering public comment, effective starting in October 2006.

A. Refine DRGs to more fully capture differences in severity of illness

MedPAC recommends that CMS refine the current DRGs to fully capture differences in severity of illness among patients. In making this recommendation, the Commission recognizes several implementation issues regarding potential low-volume DRGs and changes in hospital coding and reporting behavior. In particular, MedPAC recommends that the Secretary project the likely effect of reporting improvements on total payments and make an offsetting adjustment to the standardized amounts.

CMS will propose changes to the DRGs to better reflect severity of illness. There is a standard list of diagnoses that are considered complications or co-morbidities (CC). These conditions, when present as a secondary diagnosis, may result in payment using a higher weighted DRG. Currently, 3,285 diagnosis codes appear on this list, and 121 paired DRGs are differentiated based on the presence or absence of a CC. Our analysis indicates that the majority of cases assigned to these DRGs fall into the "with CC" DRGs. CMS believes that it is possible that the CC distinction has lost much of its ability to differentiate the resource needs of patients, given the long time since the original CC list was developed and the incremental nature of subsequent changes in an environment of major changes in the way inpatient care is delivered.

CMS is planning a comprehensive and systematic review of the CC list for the IPPS rule for FY 2007. As part of this process, we will consider revising the standard for determining when a condition is a CC. For instance, we expect to use an alternative to

the current method of classifying a condition as a CC based on how it affects the length of stay of a case. Similar to other aspects of the DRG system, CMS will consider the effect of a specific secondary diagnosis on the charges or costs of a case to evaluate whether to include the condition on the CC list.

CMS also is considering a selective review of the specific DRGs, such as cardiac, orthopedic, and surgical DRGs, that are alleged to be overpaid and that may create incentives for physicians to form specialty hospitals. We will selectively review particular DRGs based on statistical criteria such as the range or standard deviation among charges for cases included within the DRG. It is possible specific DRGs have high variation in resource costs and that a better recognition of severity would reduce incentives for hospitals to select the least costly and most profitable patients within these DRGs. Any analysis CMS does would balance the goal of making payment based on accurate coding that recognizes severity of illness with the premise that the IPPS is a system of payment based on averages. We agree with MedPAC that, in refining the DRGs, we must continue to be mindful of issues such as the instability of small volume DRGs and the potential impact of changes in hospital coding and reporting behavior. As the Commission noted, previous refinements to DRG definitions have led to unanticipated increases in payment because of more complete reporting of patients' diagnoses and procedures. Therefore, CMS is concerned with our ability to account for the effect of changes in coding behavior on payment. We must consider how to mitigate the risk that the program could pay significantly more without commensurate benefit to Medicare patients.

CMS also will evaluate the use of alternative DRG systems, such as the all-patient refined diagnosis-related groups (APR-DRGs), in place of Medicare's current DRG system. APR-DRGs have a greater number of DRGs that could relate payment rates more closely to patient resource needs, and thus reduce the advantage of selecting healthier patients. This could have a substantial effect on all hospitals, however, and CMS believes we must thoroughly analyze these options and their impacts before advancing a proposal.

B. Base DRG weights on estimated cost of providing care

MedPAC recommends that CMS base the DRG relative weights on the estimated cost of providing care rather than on charges.

CMS does not have access to any information that would provide a direct measure of the costs of individual discharges. However, claims filed by hospitals do provide information on the *charges* for individual cases. At present, we use this information to set the relative weights for the DRGs. CMS obtains information on costs from the hospital cost reports, but this information is at best at the department level: it does not include information about the costs of individual cases. Consequently, the most straightforward way to estimate costs of an individual case is to calculate a cost-to-charge ratio for some body of claims (e.g., for a hospital's radiology department), and then apply this ratio to the charges for that department.

This procedure is not without disadvantages. Assignment of costs to departments is not uniform from hospital to hospital, given the variability of hospital accounting systems, and cost information is not available until a year or more after claims information. In addition, the application of a cost-to-charge ratio that is uniform across any body of claims may result in biased estimates of individual costs if hospital charging behavior is not uniform. CMS uses estimated costs, based on hospital-specific, department-level cost-to-charge ratios, in the outpatient prospective payment system. The accuracy of this procedure has generated some concern, and without further analysis, the extent to which inpatient payment rates would be improved by adopting this method is not clear.

CMS will closely examine the impact of changing the current charge-based DRG weights to cost-based DRG weights, but we recognize that such a change is complex and requires further study. CMS will consider the following issues in performing this analysis:

- The effect of using cost-to-charge ratio data, which is frequently older than the claims data currently used to set the charge-based weights,

- The impact of changes in hospitals' charging behavior that may have resulted from the recent modifications to the outlier payment methodology.
- Whether using this method has different effects on DRGs that have experienced substantial technological change compared to DRGs with more stable procedures for care.
- The effect of using a routine cost-to-charge ratio and department-level ancillary cost-to-charge data as compared to either (1) an overall hospital cost-to-charge ratio or (2) a routine cost-to-charge ratio and an overall ancillary cost-to-charge ratio, particularly considering earlier studies performed for the Prospective Payment Assessment Commission indicating that an overall ancillary cost-to-charge ratio led to more accurate estimates of case level costs.[3]
- Whether developing relative weights by estimating costs from charges multiplied by cost-to-charge ratios compared to using only charges improves payment accuracy.
- How payments to hospitals would be affected by MedPAC's suggestion to recalibrate weights based on costs every few years and to calculate an adjustment to charge-based weights for the intervening periods.

C. Base DRG weights on national average of hospitals' relative values in each DRG

MedPAC recommended that CMS base DRG weights on the national average of hospitals' relative values in each DRG. At present we set the relative weights using standardized charges (adjusted to remove the effects of differences in area wage costs, indirect medical education, and disproportionate share payments). In contrast, MedPAC proposes that Medicare set the DRG relative weights using non-standardized hospital-specific charges. Each hospital's non-standardized charges would become the basis for determining the relative weights for the DRGs for that hospital. These relative weights would be adjusted by the hospital's case-mix index when combining each hospital's relative weights to determine a national relative weight for all hospitals. This adjustment

[3] Cost Accounting for Health Care Organizations, Technical Report Series, I-93-01, ProPAC, March 1993, page 6. Using a cost report package, the contractor simulated single and multiple ancillary cost-to-charge ratios and found that inpatient ancillary costs were 2.5 percent understated relative to what hospitals thought their costs were with the single cost-to-charge ratio, and 4.9 percent understated with the multiple cost-to-charge ratios.

is designed to reduce the influence that a single hospital's charge structure could have on determining the relative weight when it provides a high proportion of the total nationwide number of discharges in a particular DRG.

We will analyze the possibility of moving to hospital-specific relative values while conducting the analysis outlined above in response to the recommendations regarding improved severity adjustment and using charges adjusted to estimated cost using cost-to-charge ratios to set the relative weights. CMS would like to note that we currently use this method to set weights for the long-term care hospital prospective payment system. This method is utilized for long-term care hospitals because of the small volume of providers and the possibility that only a few providers provide care for certain DRGs. Thus, the charges of one or a few hospitals could materially affect the relative weights for these DRGs. In this event, looking at relative weights within hospitals first can offset the hospital-specific effects on DRG weights. Significantly, a 1993 RAND Report on hospital-specific relative values noted the possibility of DRG compression (or the undervaluing of high-cost cases and overvaluing of low-cost cases) if we were to shift to a hospital-specific relative value method from the current method for determining DRG weights. CMS will need to consider whether the resulting level of compression is appropriate.

D. Adjust DRG weights to account for differences in prevalence of high-cost outlier cases

One of MedPAC's recommendations is to adjust DRG weights to account for prevalence of high-cost outlier cases. Although MedPAC's language suggests that the law would need to be amended for CMS to adopt this suggestion, we believe the statute may give the Secretary broad discretion to consider all factors that change the relative use of hospital resources in calculating the DRG relative weights. Under current Medicare policy, CMS includes all the charges associated with high-cost outlier cases to determine the DRG relative weight. We believe that MedPAC's recommendation developed from a concern that including high-charge outlier cases in the relative-weight calculation results in overvaluing DRGs that have a high prevalence of outlier cases. However, CMS

believes, that excluding outlier cases completely in calculating the relative weights would be inappropriate. Doing so would undervalue the relative weight for a DRG with a high percentage of outliers by not including that portion of hospital charges that is above the median but below the outlier threshold. We believe it would be preferable to adjust the charges used for calculating the relative weights to exclude the portion of charges above the outlier threshold but to include the charges up to the outlier threshold. At this time, CMS will further analyze these ideas as we consider the other changes recommended by MedPAC.

CMS believes the recommendations made by MedPAC have significant promise in improving the accuracy of rates in the inpatient hospital prospective payment system. We agree with MedPAC that they should be analyzed even in the absence of concerns about the proliferation of specialty hospitals for reasons related to payment advantages rather than reasons related to quality and efficiency of care. However, improving payment accuracy should reduce inappropriate incentives for specialty hospital proliferation, to the extent that Medicare payments currently provide significantly higher margins for certain identifiable and predictable categories of patients. CMS plans to aggressively identify payment reforms to address these concerns.

E. Provide a transition for these changes

MedPAC explicitly recommended that a transition period be included for adopting any changes. Before proposing changes to the DRGs, CMS would need to model the impact of any specific proposal and verify our authority under the statute, to determine whether any changes should be implemented immediately or over a period of time. We do note that when replacing the existing DRG system with a revised DRG system that fully captures differences in severity, there likely would be unique complexities in creating a transition from one DRG system to another. CMS' payment would be a blend of two different relative weights that would be determined by using two different systems of DRGs. The systems and legal implications of such a transition or any other major change to the DRGs could be significant.

Recommendation 2: Reform Payment Rates for Ambulatory Surgical Centers (ASCs)
The results presented elsewhere in this testimony indicate that as a group surgical and orthopedic hospitals are different from cardiac hospitals. The cardiac hospitals tend to have more inpatient beds and to more closely resemble community hospitals (for instance, by participating in community emergency medical service protocols). Physicians may be participating in the ownership of small orthopedic or surgical hospitals rather than in ASCs in part to take advantage of payment differences between hospital outpatient departments and ASCs. An important goal of Medicare's planned reform of the ASC fee schedule is to reduce such divergences of payment levels between these settings when resource costs consumed in producing the same service in the two settings are similar.

Section 626 of the MMA requires and sets parameters for a revision to the ASC fee schedule. The existing fee schedule is comparatively crude, especially relative to recent changes in outpatient medical practice, with only nine payment rates used for approximately 2500 different services. Consequently, each payment cell spans a broad set of clinically heterogeneous services. In addition, the basic structure of rates has not been updated since 1990. This has resulted in a situation in which payment rates for particular services in ASCs differ significantly from those in hospital outpatient departments, where Medicare pays using the more differentiated and current outpatient prospective payment system. In many instances, the payments for particular services are significantly higher in hospital outpatient departments. Insofar as these divergences do not reflect differences in the needs of patients treated in the two settings or the resources used in treating them, they create incentives for development of specialty hospitals, where the outpatient services are paid under the outpatient prospective payment system. Reforming the ASC fee schedule to 1) use the same payment categories in the two settings so payments an be compared and 2) to adjust payment rates where the resource costs consumed in providing the same services are similar can materially reduce these divergences and mitigate incentives that now favor proliferation of specialty hospitals.

The MMA requires that the new ASC payment system be implemented after December

2005 and not later than 2008. Making these reforms is a substantial undertaking. The MMA requires CMS to take into account recommendations by the Government Accountability Office, based in turn on its survey of the relative costs of services performed in ASCs, which is currently underway. Following the completion of the GAO survey and report, CMS will design the new payment rates and complete notice-and-comment rulemaking.

As a foundation for these payment reforms, the MMA also requires a comparison of the relative costs of services delivered in ASCs versus hospital outpatient departments. Therefore we are exploring relating the ASC fee schedule directly to the outpatient prospective payment system, using the same or very similar ambulatory payment classifications (APCs). Because this course of action is already ongoing, we do not recommend any further changes, however, we will continue to look at the ASC payment system.

Recommendation 3: Closer Scrutiny of Whether Entities Meet the Definition of a Hospital
Section 1861(e) of the Social Security Act provides that in order to be a hospital, an institution must be engaged, among other things, primarily in furnishing services predominantly to inpatients. This requirement is incorporated in CMS' regulations on conditions of participation for hospitals. If any institution applies for a Medicare provider agreement as a hospital, but is unable to meet this requirement, its application will be denied. In addition, an institution that currently has a Medicare hospital provider agreement but does not presently meet the requirement of engaging in furnishing services primarily to inpatients would be subject to termination of its provider agreement.

The results of our study suggest that some entities providing specialty care may concentrate primarily on outpatient care and consequently do not meet the definition of "hospital" in section 1861(e) of the Social Security Act. While many such entities concentrate on surgical or orthopedic care, anecdotal evidence suggests that some entities specializing in cardiac care also may not meet the definition of a hospital.

CMS notes in advisory opinions, concerning whether a requesting entity is or is not "under development" and therefore subject to or exempt from the 18-month moratorium on specialty hospitals, that, among other things, the requesting entity must meet the definition of a hospital. Some entities that describe themselves as specialty hospitals may be primarily engaged in furnishing services to outpatients, and consequently might not meet the definition of a hospital. Therefore, although an entity may be "under development" for purposes of exemption from the moratorium, if we determine that it is not primarily engaged in inpatient care at the time it seeks certification to participate in the Medicare program, its application for a provider agreement as a hospital will be denied. Furthermore, if we were to determine that a specialty hospital operating under an existing provider agreement is not, or is no longer, primarily engaged in treating inpatients, the hospital may have its provider agreement terminated.

Recommendation 4: Review of Procedures for Approval for Participation in Medicare
To be approved for participation in the Medicare program, a hospital must meet the statutory definition of a hospital noted above and the hospital conditions of participation. Hospitals must also meet, for example, Federal civil rights requirements and advanced directive requirements. Compliance with the hospital conditions of participation is determined through the Medicare survey process or through accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA). Once a hospital has been found to meet all participation requirements, CMS must complete various administrative processes before a hospital can bill Medicare (e.g., issuing a tie-in notice and a provider number).

As noted earlier in this testimony, we are concerned that some specialty hospitals may not meet the definition of a hospital. We also want to be assured that, given their limited focus, specialty hospitals meet such core requirements that we determine are necessary for the health and safety of our beneficiaries. In addition, we wish to consider how EMTALA should apply to specialty hospitals, in particular with reference to potential transfer cases arising in the emergency departments of other hospitals.

To address these concerns, we plan to revisit the procedures by which applicant hospitals are examined to insure compliance with relevant standards. We will instruct our fiscal intermediaries to refrain from processing further participation applications from specialty hospitals until this review is completed and any indicated revisions are implemented. During this six-month review period, we expect to conduct a comprehensive review of our procedures. In the course of this review, we will confer with state survey and certification units, the JCAHO, and the AOA. During the same period, we will also assess whether revisions of our standards may be appropriate, in particular in connection with the EMTALA. We will solicit public input on these issues through a town hall meeting or other forums. With regard to any EMTALA changes that we may consider, we also note that we are currently operating an EMTALA technical advisory group where interested parties can also provide testimony on this issue. Depending on the results of this input and review, we will draft appropriate instructions to implement revised procedures, and we will consider whether to proceed with changes to the regulations. We expect to complete revisions to these procedures by January 2006.

Conclusion

Mr. Chairman, thank you for this opportunity to discuss our report on physician-owned specialty hospitals. We have been thoroughly studying this important topic, with extensive collection and analysis of the data, as part of our ongoing efforts to provide a strong factual foundation for implementing policy decisions that help patients get the highest quality health care possible at the lowest cost. As part of our careful evaluation of this multi-dimensional issue, we strive to ensure the best possible alignment of Medicare's financial incentives with our goal of improving the quality of care provided to our beneficiaries while avoiding unnecessary costs. CMS looks forward to continuing to work with you closely on this issue. I thank the committee for its time and would welcome any questions you may have.