TESTIMONY OF

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DEPUTY DIRECTOR
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BEFORE THE

HOUSE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

HEARING ON

PHYSICIAN-OWNED SPECIALTY HOSPITALS

March 8, 2005

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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BEFORE THE
SENATE COMMITTEE ON FINANCE
HEARING ON
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Senators Grassley and Baucus, 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 have important impacts on quality and medical costs, for our beneficiaries and for 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 redirected to improve quality. To that end, Section 507 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 preliminary results from the technical analysis that will underlie the CMS report for Section 507.

CMS Study

Specifically, MMA 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 to conduct the technical analysis. At this time, we are reporting on the factual findings of the RTI analysis. Any policy recommendations on this issue will have to be developed once the report on the analysis is finalized.

While national data were used for some aspects of this analysis, some questions related to quality, cost, and community impact as mandated by the MMA required the detailed analysis of data that have not been previously available. Consequently, the analysis involved the collection of a considerable amount of new data related to the performance, and impact of specialty hospitals. The analysis included information about the environment in which specialty hospitals and community hospitals in the same geographic areas operate, and sensitive and proprietary non-public data on such issues as ownership. To conduct this detailed analysis, site visits were made to 6 market areas (Dayton, OH; Fresno, CA; Rapid City, IA; Hot Springs, AR; Oklahoma City, OK; and Tucson, AZ) around the country These markets included 11 of the 59 cardiac, surgery, and orthopedic specialty hospitals that were in operation as approved Medicare providers by the end of 2003. These market areas were selected because they were thought to represent a range of the circumstances in which specialty hospitals operate. Within each market area, specialty hospital managers, physician owners, and staff were interviewed. Executives at several local community hospitals also were interviewed, in order 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, and orthopedic hospitals.

Referral patterns for all specialty hospitals were analyzed using Medicare claims data for 2003. The inpatient hospital quality indicators developed by the Agency for Health Research and Quality (AHRQ) were used to assess quality of care at the study hospitals and local community hospitals in the 6 study sites. Data obtained from Internal Revenue Service (IRS) submissions and financial reports, as well as from the hospitals themselves, were used to estimate total tax payments and uncompensated care for these hospitals.

Cardiac Hospitals Differ from Surgery and Orthopedic Hospitals

The empirical evidence clearly shows that cardiac hospitals differ substantially from surgery and orthopedic hospitals. Compared to surgery and orthopedic hospitals, cardiac hospitals tend to have a higher average daily census, an emergency room, and other features, such as community outreach programs. The average daily census of the 16 cardiac hospitals nationwide was 40 patients. All the cardiac hospitals that were operational in 2003 reported that they were built

exclusively for cardiac care. Cardiac hospitals treated 34,000 Medicare cases in 2003, and Medicare beneficiaries account for a very high proportion (about two-thirds) of inpatient days in those hospitals nationwide. In aggregate, within our sample, physicians own about a 49 percent share in cardiac hospitals; typically, a corporation such as MedCath or a non-profit hospital owns the majority share. In the study hospitals, the aggregate physician ownership averaged approximately 34 percent for the cardiac hospitals in the study. The average ownership share per physician in those hospitals was 0.9 percent, with individual ownership share per physician ranging from.1 percent to 9.8 percent, with a median of 0.6 percent and an average per physician share of 0.9 percent.

Surgery and orthopedic hospitals more closely resemble ambulatory surgical centers, focusing primarily on outpatient services. Their aggregate average daily census of inpatients is only about 5 patients. Physicians generally own a large share of the interest, averaging 80 percent in aggregate for the surgery and orthopedic hospitals in the study. 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. The balance is typically owned by a non-profit hospital or national corporation. Medicare patients account for about 40 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.

Preliminary Results

At this time, we would like to present the preliminary findings of our technical analysis. While we are still finalizing some aspects of the study, we do not expect the results to change significantly.

Our findings on physician-owner referral patterns indicate that the majority of Medicare patients in most specialty hospitals are referred or admitted by a physician owner, but that these physicians do not refer their patients exclusively to the specialty hospitals that they own. They also refer a similar but slightly lower proportion of their patients to the local community hospitals.

Overall, the Medicare cardiac patients treated in community hospitals were more severely ill than those treated in cardiac specialty hospitals in most of the study sites. This generally was true for patients admitted both by physicians with ownership in specialty hospitals and by other physicians without such ownership, indicating no difference in referral patterns for physician owners and non-owners. However, there was some variation, 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 surgery and orthopedic patients, the difference in the proportion of severely ill patients treated in community hospitals was greater for the surgery and orthopedic patients than for the cardiac patients.

The analysis of patients transferred out of cardiac hospitals did 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 patients transferred from cardiac hospitals to community hospitals who were severely ill was similar to patients in the same diagnosis related group (DRG) who were transferred between community hospitals. The number of cases transferred from surgery and orthopedic hospitals was too small to derive meaningful results on this type of analysis.

Based on claims analysis using the AHRQ quality indicators and methodology, preliminary findings show that measures of quality at cardiac hospitals were generally at least as good and in some cases were better than the local community hospitals. Complication and mortality rates were 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. Patient satisfaction was extremely high in both cardiac hospitals and surgery and orthopedic hospitals, as Medicare beneficiaries enjoyed large private rooms, quiet surroundings, adjacent sleeping rooms for family members if needed, easy parking, and good food. Patients also had very favorable perceptions of the clinical quality of care they received at the specialty hospitals.

We also used proprietary financial information provided by the specialty hospitals in the study that allowed the calculation of their taxes paid and their uncompensated care as a proportion of net revenues. Relative to their net revenues, specialty hospitals provided only about 40 percent of the share of uncompensated care that the local community hospitals provided. However, the specialty hospitals paid significant real estate and property taxes, as well as income and sales taxes, while non-profit community hospitals did not pay these taxes. As a result, the total proportion of net revenue that specialty hospitals devoted to both uncompensated care and taxes significantly exceeded the proportion of net revenues that community hospitals devoted to uncompensated care.

Medicare Payment Advisory Commission (MedPAC) Report

The MMA also required a complementary MedPAC study of certain issues related to the payments, costs, and patient severity at specialty hospitals. Based on our initial review of their report, there are several preliminary findings in our analysis that are consistent with their results:

- Both analyses found specialty hospitals generally treat less severe cases than community hospitals. The CMS analysis found this difference did not appear to be related to referrals by physician owners of less severe patients compared to referrals by other community physicians.
- Additionally, MedPAC's analysis of the payer shares for specialty and community hospitals is consistent with the CMS finding that specialty hospitals provide less uncompensated care than community hospitals as a whole. In addition, the CMS analysis found that specialty hospitals pay a substantial proportion of their net revenues in taxes, so that total payments for uncompensated care plus taxes are a higher proportion of total revenues at specialty hospitals.
- MedPAC's analysis also found large differences in relative profitability across severity classes within DRGs, which create financial incentives to select low severity patients. MedPAC has recommended refining the DRGs to reduce these incentives and we are currently evaluating their recommendations.

Conclusion

Mr. Chairman, thank you for this opportunity to discuss the technical findings that will be incorporated into our report on physician-owned specialty hospitals. We have been thoroughly studying this important topic, with extensive collection and analysis of new data, as part of our ongoing efforts to provide a strong factual foundation for implementing policy decisions that help patients get the high quality health care possible at the lowest cost. We will act expediently to incorporate these findings to complete our study and prepare our final results and recommendations for your review. As part of our careful evaluation of this multi-dimensional issue, we are also assessing what authority we have in this area to assure the best possible alignment of Medicare's financial incentives with our goal of improving 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.