Recommendations Regarding Physician-Owned Specialty Hospitals

Section 507(c) of the Medicare Modernization Act (MMA) requires the Secretary to transmit to Congress any recommendations for administrative or statutory changes relative to specialty hospitals. After consideration of the results of the study reported above and that of the Medicare Payment Advisory Commission (MedPAC)[1], we offer the following recommendations.

Reform Payment Rates for Inpatient Hospital Services

To help reduce the possibilities 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, we agree that improving the accuracy of IPPS payment rates would be desirable. While the emergence of specialty hospitals makes pointed the need for such improvement, we believe such changes should be desirable in any case. Consequently, we are already proceeding to analyze the options MedPAC has discussed. We expect to fully analyze and simulate the changes so we can explore the impacts on hospitals. Consequently, we have addressed this matter briefly in the preamble to the notice of proposed rulemaking for the FY 2006 update to the IPPS to put the public on notice of our plans. After completing further analysis, we will consider proposing appropriate changes in those areas that are subject to regulation in the notice of proposed rulemaking for the FY 2007 update. We expect to publish this notice in April 2006 and make any resulting changes, after considering public comment, effective starting in October 2006.

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

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

We expect to make changes to the DRGs to better reflect severity of illness. As we indicated earlier, there is a standard list of diagnoses that are considered complications or comorbidities ("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

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

these DRGs fall into the "with CC" DRGs. We believe 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.

We are 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, we expect to 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.

Another option we are considering is 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 expect to 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 we do 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. As part of our analysis of possible refinements to the DRGs, we have concerns with our ability to account for the effect of changes in coding behavior on payment.

Another avenue we anticipate evaluating is use of alternative DRG systems, such as the all-patient refined diagnosis-related groups (APR-DRGs), in place of Medicare's current DRG system. Such a system, with a greater number of DRGs, could relate payment rates more closely to patient resource needs, and thus reduce the advantages of selection of desirable patients ("cream skimming") within DRGs by specialty hospitals. A change of this sort could have substantial effects across all hospitals, however, and we believe we must thoroughly analyze such options and their impacts on the various types of hospitals before advancing a proposal. In addition, as is noted above, we are concerned about our ability to account for the effect of changes in coding behavior on payment if we were to significantly expand the number of DRGs; we must consider how to mitigate the risk that the program could pay significantly more without commensurate benefit to Medicare patients.

2. Base DRG weights on estimated cost of providing care

MedPAC has recommended that we should base the DRG relative weights on the estimated cost of providing care rather than on charges.

We do not have access to any information that would provide a direct measure of the costs of individual discharges. 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. We obtain 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, however, because assignment of costs to departments is not uniform from hospital to hospital, given the variability of hospital accounting systems, and because 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. Thus, it is alleged that hospitals mark-up lower cost services less than higher cost services, and to the extent they do so application of a uniform cost-to-charge ratio will result in underestimates of the costs of higher cost services and vice versa. We use 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 accuracy of inpatient payment rates would be improved by adopting this method is not obvious.

We will closely analyze the impact of a change from the current charge-based DRG weights to cost-based DRG weights. We note that such a change is complex and requires further analysis. 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 we use to set the charge-based weights, and the impact on these data of any changes in hospitals' charging behavior that resulted from the recent modifications to the outlier payment methodology (68 FR 34494; June 9, 2003);

- 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.[2]

- Whether developing relative weights by estimating costs from charges multiplied by cost-to-charge ratios versus by using only charges improves payment accuracy.

- How payments to hospitals would be affected by MedPAC's suggestion, intended to simplify implementation, to recalibrate weights based on costs every few years and to calculate an adjustment to charge-based weights for the intervening periods.

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

MedPAC recommended that we should 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 and in indirect medical education and disproportionate share payments). In contrast, MedPAC proposes that Medicare set the DRG relative weights using unstandardized, hospital-specific charges. Each hospital's unstandardized 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 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. We note that we use this method at present to set weights for the long-term care hospital prospective payment system. We use this method 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; the charges of one or a few hospitals could thus materially affect the relative weights for these DRGs. In this event, looking at relatives within hospitals first can smooth out the hospital-

[2] 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.

specific effects on DRG weights. 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. We will need to consider whether the resultant level of compression is appropriate.

4. 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. While MedPAC's language suggests that the law would need to be amended for us 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, we include all the charges associated with high-cost outlier cases to determine the DRG relative weight. We believe that MedPAC's recommendation springs 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, we believe, 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, we expect to further analyze these ideas as we consider the other changes recommended by MedPAC.

We believe that these recommendations made by MedPAC, or some variants of them, have significant promise in improving the accuracy of rates in the inpatient payment prospective payment system. We agree with MedPAC that they should be analyzed even in the absence of concerns about the proliferation of specialty hospitals. However, until we have completed further analysis of these options and their effects, we cannot predict the extent to which they will provide payment equity between specialty and general hospitals. In fact, we must caution that any system that groups cases and provides a standard payment for cases in the group – that is, the IPPS among other Medicare payment systems -- will always present some opportunities for providers to specialize in cases where they believe margins are better. Improving payment accuracy should reduce these opportunities, and they may do so to the extent that Medicare payments no longer provide a significant impetus to further development specialty hospitals.

5. Provide a transition for these changes

MedPAC explicitly recommended that the changes discussed above be adopted over a transition period. Before proposing any changes to the DRGs, we 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 with regard to revising the existing DRG system with a new DRG system that fully captures differences in severity, there would likely be unique complexities in creating a transition from one DRG system to another. Our payment would be a blend of two different relative weights that would have to be determined 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.

Reform payment rates for ambulatory surgical centers

The results presented elsewhere in this report indicate that as a group surgical and orthopedic hospitals are different from cardiac hospitals. In general, 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). We believe that physicians may be participating in the ownership of small orthopedic or surgical hospitals rather than in ambulatory surgical centers (ASCs) in part in order to take advantage of inappropriate payment differences between hospital outpatient departments and ASCs. We believe that Medicare's planned reform of the ASC fee schedule will help insure that payments more accurately reflect the costs of providing care in an ASC and thereby reduce incentives for physicians to provide care in either an ASC or an outpatient department simply to realize higher profits.

Section 626 of the MMA requires and sets parameters for a revision to the ASC fee schedule. The existing fee schedule is comparatively crude, 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. Among other results of this situation are payment rates for particular services in ASCs that diverge significantly from those in hospital outpatient departments, where Medicare pays using the much more differentiated and current outpatient prospective payment system. In many instances, the payments for particular services are higher in hospital outpatient departments. Insofar as these divergences are greater than differences in the resources consumed in the two settings, they create incentives for development of specialty hospitals, where the outpatient services are paid under the outpatient prospective payment system. In reforming the ASC fee schedule, our goal is to insure that the payment systems for ASCs accurately reflect the costs of providing care in that setting. This will, in conjunction with our ongoing refinements of the outpatient prospective payment system, mitigate inappropriate incentives from this quarter 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. In making this reform, 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. Given the time needed to complete this survey, design the new payment rates, and complete notice-and-comment rulemaking, CMS plans to implement the ASC payment reform January 1, 2008. Reflecting the MMA requirement for comparison of the relative costs of services delivered in ASCs versus hospital outpatient departments, we are exploring relating the

ASC fee schedule directly to the outpatient prospective payment system, using the same or very similar ambulatory payment classifications. Linking the two systems would provide a mechanism for automatic updates of weights in the ASC system and reduce divergences between the two payments to an average percentage value.

Since this course of action is already ongoing, we do not recommend any further changes relative to this issue.

Closer scrutiny of whether entities meet the definition of a hospital

The whole hospital exception to the prohibition on self-referral by physicians, contained in section 1877(d)(3) of the Social Security Act (the Act), applies only to entities that are hospitals. However, the results presented above suggest that some entities providing specialty care may concentrate primarily on outpatient care and thus may not qualify as hospitals. 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.

Section 1861(e) of the Act provides that in order to be a hospital, an institution must, among other things, be primarily engaged in furnishing services to inpatients. This requirement is incorporated in our regulations on conditions of participation for hospitals (42 CFR § 482.1). If any institution applies for a Medicare provider agreement as a hospital but is unable to meet this requirement, its application will be denied pursuant to this provision of the regulations. In addition, an institution that currently has a Medicare hospital provider agreement but does not presently meet the requirement of primarily engaging in furnishing services to inpatients would be subject to having its provider agreement terminated pursuant to 42 CFR § 489.53.

In our advisory opinions that we issue as to whether a requesting entity is subject to the 18-month moratorium on specialty hospitals, we inform the requesting entity that, among other things, it must meet the definition of a hospital that is contained in section 1861(e) of the Act. It has come to our attention that some entities that describe themselves as specialty hospitals may be primarily engaged in furnishing services to outpatients, and thus might not meet the definition of a hospital as contained in section 1861(e) of the Act. Therefore, although an entity may be "under development" and thus could be excepted from the moratorium on physician-owner referrals to specialty hospitals, if we were to determine such entity 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 and it would not be eligible for an exception to the moratorium. Further, 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; in this event, it would lose the protection of the whole hospital exception to the prohibition on physician self-referrals.

Procedures for approval for participation in Medicare

In order 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 Federal civil rights requirements and advanced directives 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 or the American Osteopathic Association. 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).

We are concerned that some specialty hospitals, in particular, may not meet the requirement of section 1861(e)(1) that they be primarily engaged in treating inpatients. 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, pursuant to our authority under section 1861(e)(9). In addition, we wish to consider how the Emergency Medical Treatment and Labor Act (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 agents 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 Joint Commission on Accreditation of Healthcare Organizations, and the American Osteopathic Association. During the same period, we will also assess whether revisions of our standards may be appropriate, in particular in connection with EMTALA. We will solicit public input on these issues through a town hall meeting or other forum. Depending on the results of this review, we will draft appropriate instructions to implement revised procedures, and we will consider whether to proceed with changes to the regulations governing standards. We expect to complete revision to procedures by January 2006.