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the implications of reimbursement changes for specialty hospitals

AT A GLANCE

Although proposed Medicare reimbursement changes may reduce financial incentives to develop specialty hospitals, other anticipated reimbursement changes, such as pay for performance, could perpetuate current growth trends. Hospital executives will need to develop new tools for coping with the continued development of specialty hospitals.

Specialty hospitals are not a new phenomenon. Hospitals that focus specifically on care for women, children, cancer, rehabilitation, and long-term healthcare needs, among other types of specialty hospitals, have been part of the American healthcare landscape for decades. However, the recent rapid growth of specialized facilities, particularly those focused on cardiac care, orthopedics, and surgical procedures and owned in whole or in part by physicians, is a relatively new trend, and one that has developed into one of the most hotly debated and divisive healthcare issues of the day.

How will proposed reimbursement changes affect specialty hospital development? Some reimbursement changes may reduce financial incentives to develop specialty hospitals. However, other anticipated reimbursement changes, such as pay for performance, could perpetuate current growth trends.

The Emergence of the Specialty Hospital

What exactly is a specialty hospital? While there is no universally accepted definition, some common characteristics can be identified. Several governmental authorities and nongovernment researchers who have studied specialty hospitals have gravitated toward an algorithm for identifying such institutions. These studies have tended to characterize a facility as a specialty hospital if a percentage of inpatients—typically ranging from 45 percent to 66 percent—fall into no more than two major diagnosis categories, such as diseases of the circulatory system (as in the case of cardiac and orthopedic specialty hospitals), or are classified in surgical diagnosis-related groups (as in the case of surgical specialty hospitals).

Using these criteria, researchers have found that the modern specialty hospital differs in many ways from its more traditional cousin. Whereas the traditional specialty hospital has tended to be a large institution that is known locally or nationally as a center of excellence in its particular field (e.g., Children's Hospital of Philadelphia or Manhattan Eye, Ear & Throat Hospital), contemporary specialty hospitals tend to be smaller, with limited service lines and a local focus. Orthopedic and surgical specialty hospitals tend to have a median of 16 beds, compared with short-term,

general acute care hospitals, which have a median of 170 beds (U.S. Government Accountability Office, GAO-03-683R, April 18, 2003, p. 7). Heart hospitals tend to be larger, averaging 52 beds, but still considerably smaller than the typical general acute care hospital (Medicare Payment Advisory Commission, Report to Congress, March 2005, p. 4). Orthopedic and surgical specialty hospitals also tend to have a very low average daily census—4.5 patients per day—while cardiac specialty hospitals average 40.4 patients per day (M. O. Leavitt, Secretary of the U.S. Department of Health and Human Services, *Study of Physician-Owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003*, May 2005, p. 4).

The number of specialty hospitals has increased dramatically in the past decade. According to one government study, 92 specialty hospitals were open for business in 2003, a threefold increase from the 29 in existence in 1990 (GAO-03-683R, April 18, 2003, pp. 3 and 5).

Although specialty hospitals are developing around the country (there is at least one specialty hospital in 28 states), they tend to be concentrated in states with favorable regulatory conditions. Virtually all of the specialty hospitals that opened since 1990 are located in states with no or minimal applicable certificate-of-need requirement, such as Arizona, California, Kansas, Louisiana, Oklahoma, South Dakota, and Texas (GAO-04-167, October 2003, pp. 11 and 15).

Specialty hospital developers also seek out areas with favorable demographic trends. Most specialty hospitals are located in small and mid-sized urban areas (i.e., those with a total population of fewer than 1 million people) with growing populations, such as Austin, Texas; Wichita and Manhattan, Kan.; Little Rock, Ark.; and Sioux Falls, S.D. (MedPAC Report to Congress, March 2005, p. 7).

Why the Fuss?

This latest brand of specialty hospitals and their rapid growth are causing concern in the hospital community, state legislatures, and Congress. While many

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complaints have been leveled, two primary objections have emerged. First, critics contend that specialty hospitals siphon off profitable patient populations and cases, and undermine the ability of general acute care hospitals to support less profitable patients and services. General acute care hospitals depend on cross-subsidization of services and patients to maintain financial viability: Patients with private insurance underwrite underinsured and uninsured patients, and more favorably reimbursed services, such as cardiac care and orthopedic surgery, support poorly reimbursed services, such as emergency departments.

The second objection concerns physician ownership of specialty hospitals. General acute care hospitals charge that physician ownership of specialty hospitals provides these facilities with an unfair advantage given the influence physicians have over the facility to which a patient will be admitted. About 70 percent of the specialty hospitals in existence or under development have some physician owners (GAO-04-167, October 2003, p. 9). Physicians' combined ownership shares averaged slightly more than 50 percent of the hospital, although the average share owned by an individual physician was less than 2 percent at half the hospitals (GAO-04-167, October 2003, p. 9).

Regulatory Reactions

Congress has been keenly focused on, and deeply divided over, specialty hospital development. In 2003, Congress amended the Stark Law to impose an 18-month moratorium during which physician-investors in new specialty hospitals could not refer Medicare patients to those hospitals. The 2003 moratorium effectively stifled development of new specialty hospitals.

Congress continued to debate specialty hospitals throughout 2005, as the American Hospital Association and other hospital lobbying organizations pressed for a permanent ban on physician self-referrals to specialty hospitals.

In early 2006, Congress approved more specialty hospital legislation. However, this time, Congress refused to impose an outright ban on physician self-referrals to specialty hospitals. Instead, Congress directed the Centers for Medicare and Medicaid Services to withhold new provider numbers from specialty hospitals while the agency prepares a strategic and implementing plan regarding physician investment in specialty hospitals that addresses issues related to proportionality of investment return, *bona fide* investments, annual disclosure of investment information, and the provision of Medicaid and charity care by specialty hospitals.

The legislation directed CMS to publish an interim report within three months of enactment, and a final report three months later.

What's Next?

In accordance with the statute, CMS submitted an interim report to Congress on May 9, 2006. The interim report detailed a variety of steps that the agency has already taken to address specialty hospital development, and announced several additional steps that it intends to take over the next few months.

Although the question remains of whether CMS or Congress will impose regulatory restrictions on specialty hospitals, such as limits on physician ownership or minimum inpatient volumes, the focus at this point seems to be on revising Medicare reimbursement schemes to minimize the financial incentives to specialize and profit thereby.

CMS took initial steps to refine payments under the hospital inpatient prospective payment system in FY06 when it expanded the number of cardiovascular DRGs within MDC 5 (diseases and disorders of the circulatory system), a commonly billed MDC by cardiac specialty hospitals, to more accurately reflect within-DRG differences in severity of illness and more closely relate reimbursement with resource utilization during these patient admissions.

For FY07 and FY08, CMS has proposed two additional major hospital payment reforms intended in part to quell specialty hospital development: revamping the methodology CMS uses to determine DRG weights, and replacing the current DRG classification system with an expanded classification system too better reflect patient diagnosis and severity of illness.

The Reimbursement Conundrum

Reimbursement changes that seek to minimize the financial incentives and competitive advantages associated with specialty hospitals may alter the financial appeal of such institutions.

CMS's most recently proposed changes would profoundly affect Medicare payment to specialty hospitals. According to CMS, cardiac and orthopedic specialty hospitals would experience, on average, an 11.7 percent and 9.4 percent decline in Medicare payments, respectively, from these two changes, while surgical specialty hospitals would experience a more modest, but nonetheless significant, Medicare reimbursement decrease of 7.2 percent. However, these may not be the silver bullet policymakers are seeking.

For starters, it is not clear whether CMS will implement the changes as proposed, or when any such changes would be implemented. The proposed inpatient PPS changes would affect specialty hospitals and general hospitals alike. Many general hospitals have also invested heavily in recent years in cardiac and orthopedic services, and are concerned about the potential impact of the proposed changes. As such, there is considerable pressure on CMS to postpone implementation of the two proposed changes, and to use the additional time to further refine the proposals. To the extent CMS concedes by delaying implementation and moderating the impact on the service lines preferred by specialty hospitals, the financial disincentive to specialize may not be sufficient.

Moreover, CMS's plan may simply shift specialty hospital development to other service lines. CMS is proposing to shift reimbursement from historically overcompensated services to those perceived to be underpaid. Generally, the two proposals would shift

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payments away from surgical services, decreasing payment for such services by approximately 6.9 percent, and toward medical services, increasing payment for those services by approximately 7.3 percent, according to CMS. If indeed specialty hospital development is the result of profit-seeking investors gravitating toward high-margin service lines, it will not be long before the next wave of investment identifies and exploits the new high-margin areas.

Finally, the move to link payment with performance is likely to further fuel specialty hospital growth. The Deficit Reduction Act directs CMS to begin linking payment with performance beginning in FY09. Exactly how CMS will do that is still not known. Nonetheless, specialty hospitals may be well-positioned to capitalize on that evolution.

Studies indicate that specialty hospitals do indeed provide patients with high-quality care (see, e.g. Leavitt). Several studies examining common quality indicators, such as mortality, length of stay, and discharge destination, also suggest that specialty hospitals provide higher quality care than general acute care hospitals (see, e.g., Leavitt, pp. 36-48). To the extent that payers compensate hospitals based on achieving certain quality measures, financial incentives may remain to develop hospitals that can focus on a limited scope of services and healthier patient population, and, as such, attain high-quality outcomes and, thus, higher reimbursement.

These incentives may also have consequences for general acute care hospitals. A central tenet of the focused factory model is that the high volume of particular procedures will improve outcome quality. However, absent an increase in demand, the high procedural volumes at specialty hospitals may mean lower volumes in general hospitals. One recent study concluded that high cardiac surgery rates at specialty hospitals were the result of increasing market share, not increasing demand (MedPAC Report to Congress, March 2005, p. 17). This finding suggests specialty hospitals may be cannibalizing existing demand, meaning fewer procedures for general acute care hospitals. To the extent that quality and volume are linked, lower volumes at general hospitals could compromise the quality of care at those institutions and consequently reduce reimbursement.

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Likewise, favorable patient selection at specialty hospitals could adversely affect patient mix at general acute care hospitals. Only half of all specialty hospitals have emergency departments (MedPAC Report to Congress, March 2005, p. 5). Specialty hospitals also tend to lack the resources to treat patients with significant co-morbidities and multiple needs, and either reject or transfer these patients. This dynamic may further skew severity of illness across the two settings, again leaving general acute care hospitals with sicker patient populations.

A Force to be Reckoned With

Despite recent efforts to curtail specialty hospital growth, these facilities are likely to be a growing fixture on the healthcare landscape. Although recently proposed reimbursement changes may reduce financial incentives to develop specialty hospitals in the short-term, these changes are not likely to have long-term consequences. Further, other anticipated reimbursement changes, such as pay for performance, could perpetuate current growth trends. Much uncertainty remains, but one thing is clear: Policymakers and hospital executives will need to develop new tools for coping with the rapid growth of specialty hospitals. ●

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