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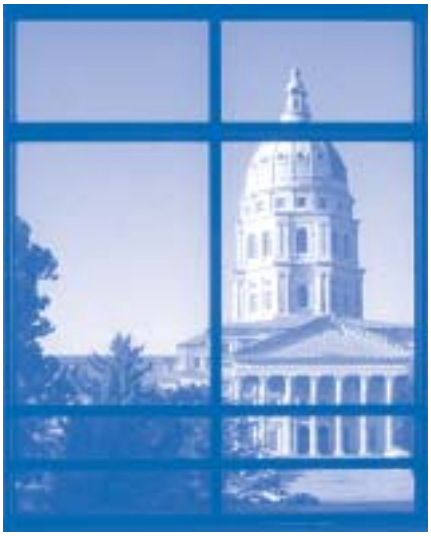

Issue Brief

KANSAS HEALTH INSTITUTE

New Research on Specialty Hospitals

Kansas-specific study in progress

Sheldon Weisgrau

Key Research Findings

- Patients treated at specialty hospitals are not as sick as patients at general hospitals and, as a result, tend to be more profitable.
- The financial impact of specialty hospitals on community hospitals thus far appears to be limited.
- Patient outcomes are similar at specialty and general hospitals, after adjusting for severity of illness and procedural volume.
- Specialty hospitals treat fewer Medicaid and uninsured patients than general hospitals, but the sum of their tax payments and uncompensated care is higher.

Background

Recent national research on specialty hospitals paints a mixed picture. On one hand, it indicates that specialty hospitals, as critics have claimed, treat less severely ill and more profitable patients than general hospitals. However, contrary to critics' claims, it does not indicate that specialty hospitals have done measurable financial harm to general hospitals. Still unclear is the degree to which competition from specialty hospitals is making it more difficult for general hospitals to provide a full range of services.

"Specialty hospitals, as critics have claimed, treat less severely ill and more profitable patients than general hospitals."

Specialty hospitals are usually organized as for-profit entities with some physician ownership. Unlike general hospitals, specialty hospitals focus on single clinical specialties, such as cardiology or orthopedics. Kansas is home to at least 10 specialty hospitals, a high proportion of the 100 or so operating nationwide.

Because of the concentration of specialty hospitals in the state, the Kansas Health Institute and the Kansas Department of Health and Environment are analyzing patient data to assess the impact of these facilities on the delivery of care in Kansas communities. The data will be used to write a report for Kansas policymakers and regulators.

The Issue

Although hospitals that serve particular populations, such as women or children, have been common for some time, the growth in acute-care hospitals that offer a limited set of services is a recent phenomenon. Most of these facilities are located in states, like Kansas, that do not regulate the development of new hospitals.

Supporters of specialty hospitals claim their focused approach of providing a high volume of a narrow scope of procedures develops economic efficiencies, clinical expertise and improved patient outcomes. These hospitals often feature new facilities and equipment, and enhanced patient amenities.

Specialty hospital critics believe that physician investment creates a conflict of interest and steers referrals of high-profit patients from full service general hospitals to specialty hospitals. Critics argue that the loss of profitable patients hinders the ability of general hospitals to subsidize services that lose money, such as emergency departments, and provide community benefits, such as uncompensated care, and prevention and screening programs. They note that many specialty hospitals do not provide such community-oriented programs and by catering to high-income and insured patients do not provide their "fair share" of services to the Medicaid population and the uninsured.

In response to these concerns, Congress imposed an 18-month moratorium on physician referrals of Medicare patients to new specialty hospitals in which the referring physicians have ownership interests. The moratorium, which effectively halted the certification of new specialty hospitals because of the high proportion of Medicare patients treated in these facilities, expired in June 2005. However, the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers the Medicare and Medicaid programs, has delayed processing new certification applications from specialty hospitals as it considers whether payment and policy changes are necessary to level the playing field. CMS anticipates it will be ready to resume processing applications by January 2006.

Stark Law

Under a federal statute first enacted in 1989 and expanded in 1993 and 1994, physicians are prohibited, in most circumstances, from referring patients to facilities and hospital departments in which they have ownership interest. (This statute is commonly referred to as the "Stark law.") Because specialty hospitals are considered "whole hospitals," referrals to these facilities from physician investors are not subject to the self-referral prohibitions of the Stark law as presently written.

Recent Research

To address concerns about the impact of specialty hospitals, three federal agencies recently conducted studies: the Government Accountability Office (GAO), an agency that studies federal programs and expenditures on behalf of Congress; the Medicare Payment Advisory Commission (MedPAC), an agency that advises Congress on issues affecting the Medicare program; and CMS (the CMS study was conducted with RTI International, a North Carolina-based research firm). Researchers from the University of Iowa College of Medicine and Georgetown University have also recently published relevant studies.

The following summary discusses what the recent research reveals about the characteristics of specialty hospitals, the patients they treat, their finances and their quality of care.

Hospital Characteristics

Although single-specialty physician-owned hospitals are often categorized generally as "specialty hospitals," both GAO and CMS identified key differences between types of specialty hospitals. Cardiac hospitals, for example, more closely resemble full service general hospitals than orthopedic and surgical hospitals, which are more like ambulatory surgery centers. Cardiac

hospitals, however, are still smaller, more likely to be physician-owned and less likely to have emergency departments than general hospitals. GAO also found that specialty hospitals—regardless of their focus—are more likely than general hospitals to be organized on a for-profit basis.

Patient Selection

The CMS study found that physician ownership has some influence in directing patients to specialty hospitals, but it is not substantial. In contrast, the Georgetown study, which focused only on cardiac hospitals, found that physician owners treat significantly higher volumes of well-insured patients at their own facilities.

The research buttresses a key criticism of specialty hospitals—that they treat a healthier patient population than general hospitals. All of the studies found that patients treated in specialty hospitals are less severely ill than patients treated in general hospitals. Even among patients with the same diagnoses, those treated in specialty hospitals are less likely to have secondary illnesses and complications.

Some members of Congress have recently expressed concerns that specialty hospitals serve a significantly smaller share of ethnic and racial minority Medicare patients than community hospitals. These Congressmen have requested a CMS investigation.

Financial Performance

MedPAC found that the less severely ill patients treated at specialty hospitals tend to be more profitable than the patients treated at general hospitals. These patients are more profitable because Medicare pays a set amount for a patient with a particular diagnosis, but some may have fewer complications and require fewer days in the hospital and less intensive treatment. Specialty hospitals also focus on the treatment of patients with specific diagnoses, many of which are more profitable than the broader range of patients treated in general hospitals. As a result of these findings, it is commonly believed that specialty hospitals have a negative financial impact on general hospitals. However, the available research does not demonstrate that specialty hospitals have done measurable financial harm to the general hospitals with which they compete.

MedPAC and CMS both found that specialty hospitals serve a lower proportion of Medicaid patients and provide less uncompensated care than general hospitals, supporting the contention that they limit their services to a more affluent, well-insured population. However, CMS also pointed out that because for-profit facilities pay taxes, from which not-for-profit hospitals are exempt, the "net community benefit," measured as the sum of uncompensated care and tax payments as a proportion of net revenue, is higher in specialty hospitals than in general hospitals. CMS did not attempt to quantify the value of other community services provided by general hospitals that may not be offered by specialty hospitals.

MedPAC concluded that much of the financial benefit experienced by specialty hospitals is due to specific factors within the Medicare payment system. In response to this finding, CMS recently made revisions to Medicare payment rules that better delineate differences in severity of illness in several categories of patients frequently treated in specialty hospitals. These changes, which took effect on Oct. 1, 2005, decrease payments for some cases and increase payments for others. The overall impact of these changes on referral patterns and hospital finances remains to be seen.

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Additional changes to Medicare payments to better adjust for severity of illness and more accurately reflect the actual costs of providing care are still under development.

Quality of Care

The CMS and University of Iowa studies examined quality of care and patient outcomes at cardiac and general hospitals. The researchers focused only on cardiac specialty hospitals because of their high inpatient utilization compared to orthopedic and surgical hospitals. The studies found no significant differences in mortality rates between specialty and general hospitals after adjusting for patient characteristics and procedural volume. One set of adjustments was intended to ensure that severity of illness and other patient factors did not influence the results. Similarly, because there have been claims that there are advantages to specialization above and beyond the "volume effect," in which better outcomes are related to higher procedural volumes, the researchers adjusted for volume to standardize the analysis.

CMS also found high levels of patient satisfaction with the services and amenities at specialty hospitals.

Next Steps

It is clear that patients treated in specialty hospitals are not as sick as those treated at general hospitals, and there is some evidence that referral patterns are influenced by physician ownership of cardiac hospitals. Less clear, however, is the financial impact of specialty hospitals on general hospitals and the services they provide. In addition, much of the existing research focuses only on the Medicare population, and none directly assesses the effects of the relatively heavy concentration of specialty hospitals in Kansas.

To obtain a clearer picture of what is happening in Kansas, KHI and KDHE are analyzing the evolving impact of specialty hospitals on Kansas communities. This analysis will examine what happens to general hospital utilization, profit margins and services when specialty hospitals enter the market.

More Information

This Issue Brief and a previous Issue Brief on specialty hospitals, titled "The Growth of Specialty Hospitals in Kansas: What Effects Do They Have on Community Health Services?" can be found online at *www.khi.org*.

KANSAS HEALTH INSTITUTE

The Kansas Health Institute is an independent, nonprofit health policy and research organization based in Topeka, Kansas. Established in 1995 with a multi-year grant from the Kansas Health Foundation, the Kansas Health Institute conducts research and policy analysis on issues that affect the health of Kansans.

KANSAS HEALTH INSTITUTE
212 SW Eighth Avenue, Suite 300
Topeka, Kansas, 66603-3936
Telephone (785) 233-5443
Fax (785) 233-1168
www.khi.org

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