U.S. Senate Committee on Finance

For Immediate Release
Wednesday, May 11, 2005

Grassley, Baucus Introduce Bill to Rein in Physician-owned Specialty Hospitals

WASHINGTON – Sen. Chuck Grassley, chairman of the Committee on Finance, and Sen. Max Baucus, ranking member, today introduced legislation to rein in the growth of physician-owned specialty hospitals. The bill comes after a March Finance Committee hearing and a series of government reports showing these hospitals treat patients who are less sick and hence more profitable, do not have lower costs than community hospitals, and treat lower shares of Medicaid patients.

The bill prohibits physicians from referring Medicare and Medicaid patients to new specialty hospitals in which they have an ownership interest. Grassley and Baucus have set the effective date of the bill at June 8, 2005, regardless of when it is enacted – a current moratorium expires on that date.

"Specialty hospitals continue to raise a number of troubling issues," Grassley said. "Congress needs to take additional action to address these issues. Physician-owned specialty hospitals treat the most profitable patients and services, leaving community hospitals to treat a disproportionate share of less profitable cases, Medicaid patients and the uninsured."

Baucus said, "I am an advocate of efficient and innovative health care. But I don't think it is fair to promote a system in which physicians can send healthier and more profitable patients to hospitals they own while referring less profitable patients with more extensive health problems to other institutions. The playing field needs to be level."

In addition to prohibiting physician referrals to new specialty hospitals in which the physicians have an ownership interest, *The Hospital Fair Competition Act of 2005*:

-- directs the Health and Human Services secretary to make a number of technical payment improvements to minimize the disparity in relative profitability within diagnostic related groups – the Medicare Payment Advisory Commission recommended these changes;

– places certain restrictions on existing –"grandfathered" – specialty hospitals;

-- and permits certain coordinated care incentive arrangements between physicians and hospitals.

Congress placed the moratorium on the development of physician-owned specialty hospitals for 18 months until June 8, 2005. There were concerns about the rapid growth of these facilities, physician self-referral, whether these specialized hospitals might be an unfair form of competition, and the impact these hospitals may be having on the health care system as a whole.

A current law and section-by-section analysis follows.

The Hospital Fair Competition Act of 2005
Sponsored by Senators Chuck Grassley and Max Baucus

Current Law and Section-by-Section Analysis

General: The "Hospital Fair Competition Act of 2005" improves the accuracy of Medicare's inpatient hospital prospective payment system (PPS); bans physician owners from self-referring to new specialty hospitals, while allowing existing specialty hospitals to continue operations with certain restrictions; and allows coordinated care incentive arrangements (also known as "gainsharing") to foster improved physician-hospital efficiency. These changes would be effective June 8, 2005, regardless of date of enactment.

Section 2: Improving Accuracy of Medicare's Inpatient Prospective Payment System

Section 2(a): Use of Costs Rather Than Charges in Establishing DRG Weights

Current Law: The Health and Human Services Secretary pays hospitals for inpatient Medicare services according to fixed amounts known as diagnosis related groups (DRGs). Each DRG is intended to cover the costs of treating an average patient with a particular diagnosis. The Secretary, who has broad authority to calibrate DRG weights, currently calculates weights based on hospital charges. MedPAC has found that hospitals tend to charge more for ancillary services (labs, radiology, drugs, etc.) than for routine services (room and board, nursing care, etc). This is because hospitals use different markups for services delivered in different hospital departments. As a result, surgical procedures, which tend to use more ancillary items, tend to have higher charges compared to medical services, which depend more on routine nursing care. Calibrating DRG weights based on charges rather than costs causes Medicare to pay too much for some services, not enough for others.

Proposed Change: The Secretary is directed to recalibrate DRG weights based on costs at least once every five years.

Section 2(b): Calculation of DRG Weights at Hospital Level

Current Law: The Secretary currently calculates DRG weights based on the national average of all hospital charges for a particular DRG. As a result, each DRG case nationwide carries equal weight in determining the average charge for all hospitals. But some hospitals may have significantly higher charges for certain cases, and may also have more of these types of cases relative to other hospitals, skewing the payment rate for particular DRGs.

Proposed Change: The Secretary is directed to calculate average charges at the hospital level for each DRG. Calculating relative weights based on hospital-specific values -- rather than on the national average of charges -- mitigates differences among hospitals in overall setting of charges.

Section 2(c): Adjustment of DRG Weights to Account for Outliers

Current Law: Hospitals receive outlier payments for certain, very expensive cases. These outlier payments are currently included in calculation of the DRG weights. Because high-cost DRGs (such as certain cardiac procedures) tend to have more outliers than low-cost hospitalizations, the payment system is skewed toward DRGs which have a relatively large amount of outliers.

Proposed Change: The Secretary is directed to adjust the DRG weights to account for differences in the frequency of outliers, thus mitigating their impact on the DRG weights.

Section 2(d): Accounting for Severity of Illness in Inpatient PPS

Current Law: The Secretary has broad authority to define DRGs according to medical condition and treatment. The Secretary currently uses approximately 500 DRGs, intended to reflect the variable costs of treating patients with particular diagnoses. MedPAC has found that the current grouping of DRGs does not adequately account for patients' severity of illness, and this inaccuracy may contribute to provider selection of certain Medicare patients.

Proposed Change: The Secretary is directed to examine the current DRGs to ensure that they appropriately capture patients' differing severity of illness.

Section 3: Prohibition on Certain Physician Self Referrals

Current Law: The Medicare Modernization Act (MMA) of 2003 imposed an 18-month moratorium, expiring June 8, 2005, on physician referrals to specialty hospitals in which the physician had an ownership or investment interest. This ban does not apply to hospitals already in operation or under development, as determined by the Secretary, before November 18, 2003. These "grandfathered" specialty hospitals are prohibited from increasing their number of physician investors and expanding their scope of services, and may only increase their bed size by a maximum of 5 beds.

Proposed Change: New specialty hospitals would be prohibited from having any ownership or investment interest by physicians who refer Medicare and Medicaid patients to the facility. In essence, this would exclude specialty hospitals from the "whole hospital" exemption in the Stark self referral laws. Existing specialty hospitals could continue to operate under current law, but grandfathered hospitals would be prohibited from increasing their number of physician investors, increasing the percent of individual investment and aggregate physician investment in the facility, expanding their scope of services, and increasing their number of beds or operating rooms.

Section 4: Coordinated Care Incentive Arrangements ("Gainsharing")

Current Law: In July 1999, the HHS Office of the Inspector General (OIG) cited section 1128A(b)(1) of the Social Security Act in barring arrangements that create incentives for physicians to "reduce or limit" care for Medicare and Medicaid beneficiaries. However, the IG stated that "hospitals may align incentives with physicians to achieve cost savings through means that do not violate [the Act]."

Proposed Change: The Secretary is directed to establish criteria under which hospitals and physicians can align incentives and benefit from hospital cost-containment measures, as long as financial incentives affecting physician referrals are minimized and such arrangements do not compromise quality of care.