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## Specialty Hospitals: Can General Hospitals Compete?

Laura A. Dummit, *Principal Research Associate*

**OVERVIEW** — *The rapid increase in specialty cardiac, surgical, and orthopedic hospitals has captured the attention of general hospitals and policymakers. Although the number of specialty hospitals remains small in absolute terms, their entry into certain health care markets has fueled arguments about the rules of “fair” competition among health care providers. To allow the smoke to clear, Congress effectively stalled the growth in new specialty hospitals by temporarily prohibiting physicians from referring Medicare or Medicaid patients to specialty hospitals in which they had an ownership interest. During this 18-month moratorium, which expired June 8, 2005, two mandated studies of specialty hospitals provided information to help assess their potential effect on health care delivery. This issue brief discusses the research on specialty hospitals, including their payments under Medicare’s hospital inpatient payment system, the quality and cost of care they deliver, their effect on general hospitals and on overall health care delivery, and the regulatory and legal environment in which they have proliferated. It concludes with open issues concerning physician self-referral and the role of general hospitals in providing a range of health care services.*

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# Specialty Hospitals: Can General Hospitals Compete?

Specialty hospitals, which provide a limited set of procedures or services, have created quite a stir among policymakers and the general hospital community. The growth of physician-owned specialty hospitals, in particular, has brought to the fore fundamental, unresolved concerns about the structure and financing of the American health care system. Any discussion of specialty hospitals touches on questions about financial incentives and profits in health care delivery; financing public health, uncompensated care, and other public programs; and the general hospital and its place in the delivery of care—questions that have been posed for years.

## BACKGROUND

Recent growth in specialty hospitals—predominately cardiac, surgical, and orthopedic hospitals—has rekindled the debate about whether competition among health care providers spurs innovation and drives down costs or whether it threatens access to certain services or for certain patients by fragmenting service delivery.<sup>1</sup> Advocates of competition claim that these “focused factories” can produce their services more efficiently than general hospitals, give patients the amenities they want, and provide physicians with more control over medical processes. Specialty hospitals may address perceived unmet needs in their communities and serve as a wake-up call to general hospitals that they need to be responsive to both patients and physicians to remain viable. Opponents claim that specialty hospitals put general hospitals at financial risk by taking the more profitable cases and avoiding the underpaid responsibilities often shouldered in broader-based institutions. In addition, physician ownership of specialty hospitals raises concerns about physician conflicts of interest. Some argue that financial incentives to selectively refer more profitable patients or boost utilization of services may color clinical decisions.

The number of specialty hospitals billing Medicare that are partly owned by their referring physicians increased from 67 to 76 between 2003 and 2004.<sup>2</sup> Concentrated in a few states, these hospitals are more likely to be located where there is minimal state regulation of the number of hospital beds or facilities, no dominant hospital, and a large, single-specialty physician group practice.<sup>3</sup> They comprise three general types of ventures: national chains that partner with local physicians, joint ventures between a general hospital and local physicians, and physician groups that go it alone. Specialty hospitals may have a larger impact on health care in their communities than their small numbers and size may imply because they affect physician referrals to general hospitals, where physicians practice, and the delivery of care in neighboring general hospitals.

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202/872-1390  
202/862-9837 [fax]  
nhpf@gwu.edu [e-mail]  
www.nhpf.org [web]

**Judith Miller Jones**  
*Director*

**Sally Coberly**  
*Deputy Director*

**Monique Martineau**  
*Publications Director*

Because of concerns about the rapid increase in physician-owned specialty hospitals, Congress, in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), implemented an 18-month moratorium, which expired June 8, 2005, that effectively stopped their growth. Whether the growth will resume at the same rate is unclear, although a recent analysis from the Government Accountability Office (GAO) indicated that 40 specialty hospitals had requested permission to continue to develop or expand under the moratorium.<sup>4</sup> This is likely the lower boundary on the number of new specialty hospitals that will open in the next year or two. General hospital representatives indicated to GAO that the increase in new specialty hospitals would be rapid, whereas specialty hospital representatives said that the increase would be modest and gradual.

In the MMA, Congress also mandated reports on specialty hospitals from the Medicare Payment Advisory Commission (MedPAC) and the Secretary of the Department of Health and Human Services (DHHS). In March 2005, MedPAC issued its report on specialty hospitals, which examined the mix of patients and costs among such hospitals and their financial effect on general hospitals.<sup>5</sup> MedPAC recommended modifications to Medicare's hospital payment system that would minimize unintended payment advantages to certain hospitals and extend the moratorium to allow time to evaluate its payment recommendations and learn more about specialty hospitals. The May 2005 DHHS report, completed by the Centers for Medicare & Medicaid Services (CMS), compared the referrals to and quality of care in specialty hospitals and general hospitals.<sup>6</sup> Based on this report, CMS indicated that it would evaluate revisions to Medicare's payment systems, including those recommended by MedPAC, and examine whether specialty hospitals meet existing definitions of hospitals.<sup>7</sup>

Even with the release of these two mandated studies, and the GAO research that preceded them,<sup>8</sup> important questions about the effects of specialty hospitals on health care delivery have not been fully addressed. How would Medicare payment changes affect the growth in specialty hospitals? What is the quality of care provided in specialty hospitals? What is the cost of care? Do specialty hospitals disadvantage the general hospitals in their markets? How do general hospitals respond to competition from specialty hospitals? Do specialty hospitals generate additional referrals for services? Do the financial interests of physician-owners affect their clinical decision making? The answers to these questions are likely to vary across health care markets and may change over time as health care providers and payers adapt to these new facilities.

## **MEDICARE PAYMENT POLICY AND SPECIALTY HOSPITALS**

To respond to its mandate to examine the mix and costs of patients treated in specialty hospitals, MedPAC conducted an extensive analysis of Medicare's hospital inpatient prospective payment system (IPPS) and the relation between IPPS payments and costs of care in specialty hospitals.

Under the IPPS, Medicare pays hospitals a per case amount that varies depending on the expected resource use of the patient, as measured by the patient's diagnosis-related group (DRG) assignment. One of approximately 500 DRGs is assigned to each Medicare patient on the basis of diagnosis, secondary diagnoses, procedures, and certain patient characteristics. Each DRG is associated with a payment amount meant to reflect the average cost of patients within that group. This case-mix adjustment to Medicare payments is intended to ensure that hospitals are not financially rewarded or penalized by their mix of patients. MedPAC's analysis, however, demonstrated that this adjustment is flawed, such that some hospitals are inadvertently advantaged and others are disadvantaged by their patient mix.

MedPAC found that, in comparison to general hospitals, specialty hospitals were financially rewarded due to favorable Medicare payments for certain types of patients they were more likely to treat. Payments for some

DRGs are higher, relative to average costs, than payments for other DRGs. In addition, because the DRG payments reflect the average cost of patients within the group, patients who are less severely ill are less costly to treat than other patients in the same DRG. MedPAC found that specialty hospitals tended to treat patients in the more profitable DRGs or that they had a higher share of the less severely ill patients within each DRG than general hospitals, or both. As a result, specialty hospitals were more profitable than general hospitals based on their mix of patients. According to MedPAC's analysis, in 2002, if cardiac hospitals had average costs, they would have been 9 percent more profitable than other average-cost hospitals. Surgical and orthopedic specialty hospitals also tended to treat less severely ill patients than general hospitals. According to MedPAC's estimates, surgical hospitals would have been 15 percent more profitable than other average-cost hospitals and orthopedic hospitals would have been 2 percent more profitable.

Medicare's payment methods for outpatient services may also be a consideration for specialty hospitals. Some specialty hospitals had been ambulatory surgical centers (ASCs) that became licensed as a hospital. This would allow a facility to be paid for more procedures by Medicare and to treat patients who may need to remain overnight after surgery. Medicare limits the surgical procedures it will cover in an ASC, but not in a hospital outpatient department. Therefore, by converting to a hospital, a facility can expand the services it provides to Medicare patients. Further, the payment would be based on Medicare's hospital outpatient prospective payment system (OPPS) amounts, which are often higher than the ASC rates.<sup>9</sup> The range of patients could be further expanded because of the ability to keep patients overnight. In this case, Medicare would pay the full DRG rate.

Medicare payment policies may inadvertently advantage specialty hospitals relative to general hospitals and ASCs. MedPAC recommended modifications to the IPPS to reduce differences in relative profitability

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across DRGs and narrow the expected cost differences across patients within the same DRG. CMS is considering these recommendations, as well as modifications to ASC payments that may minimize disparities in payment across sites. Changes to the IPPS to reduce the financial advantages or disadvantages associated with patient mix would redistribute payments among all hospitals. Similarly, changes to ASC payments would affect relative payments across all outpatient providers.

## **SPECIALTY HOSPITALS: HIGHER QUALITY? LOWER COST CARE?**

Proponents of competition in health care delivery argue that specialty hospitals can raise the quality and lower the cost of care. Hospitals that perform a high number of certain procedures, such as open heart surgery and coronary bypass, have been shown to have better outcomes than hospitals that have less experience.<sup>10</sup> Therefore specialty hospitals, by allowing physicians and hospital staff to focus their expertise, may deliver higher quality care. In addition, specialization may offer opportunities to lower the cost of providing a service. By designing a hospital specifically for performing particular services or training specialized staff, these focused factories may be able to reduce the time and resources required for the services they provide.

The proliferation of new specialty hospitals, however, may have the opposite effect on the quality and cost of health care across the entire market. If specialty hospitals admit patients needing a particular procedure who otherwise would have gone to neighboring general hospitals, the general hospitals may have difficulty achieving the volume critical to maintain expertise in performing the procedure. The impact on quality may be exacerbated because specialty hospitals tend to treat the less complex patients, leaving a disproportionate share of the more difficult patients needing that procedure for the general hospitals. With regard to their effect on cost, specialty hospitals would cause overall health care costs to go up if they were to generate admissions by admitting patients who otherwise would not have received that procedure or provide additional tests for patients before or after admission.

CMS's study of specialty hospitals concluded that, in general, specialty hospitals provide good quality of care.<sup>11</sup> Complication and mortality rates were lower in cardiac specialty hospitals than in general hospitals, even after accounting for the less severely ill patients in specialty hospitals. The study could not reach a conclusion about the quality of care in surgical and orthopedic hospitals, although the available data indicated similarly high-quality care. DHHS also found very high patient satisfaction in all three types of specialty hospitals due to the amenities they could provide. A worrisome finding, however, was that patients treated in specialty hospitals were more likely to be readmitted to a hospital than similar patients who were initially treated in a general hospital.

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Other studies of cardiac specialty hospitals indicate that quality is at least comparable to that in general hospitals. A study of two cardiac procedures (percutaneous coronary intervention and coronary-artery bypass grafting) concluded that, for these procedures, the patient outcomes were similar in specialty and general hospitals.<sup>12</sup> Although the risk of death following the procedure was lower for patients in the specialty hospitals, the specialty hospitals tended to treat healthier patients. After adjusting for patient differences and after accounting for the higher volume of these procedures performed in specialty hospitals, the risk of death was similar between specialty and general hospitals. Industry-sponsored studies, however, reported higher quality of care in cardiac specialty hospitals than in general hospitals. MedCath Corporation, which in partnership with physicians owns 12 cardiac hospitals, states that its hospitals have lower in-hospital mortality and a higher percentage of patients discharged home than comparable patients at general hospitals.<sup>13</sup> It states that the involvement of its physician-owners in the governance and operations of the hospitals contributes positively to its high quality of care.

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With regard to whether specialty hospitals provide lower cost care, MedPAC found that average Medicare inpatient costs per patient were higher in specialty hospitals than in general hospitals, although the difference was not statistically significant. This is particularly notable because the average length of stay in specialty hospitals was actually shorter than in neighboring general hospitals for the same type of patient. Specialty hospital representatives indicated that their higher costs were due to the start-up capital costs of new facilities and the taxes they pay because they are for-profit entities. The higher costs of specialty hospitals compared with general hospitals could also be due to their smaller size, so that fixed capital costs need to be allocated over fewer admissions, and their tendency to use more staff and more skilled staff.

## **SPECIALTY HOSPITALS AND THE LOCAL MARKET**

General hospitals take notice when specialty hospitals try to enter their markets. Many cry foul, claiming unfair competition from the new entrants. They assert that physician-owners identify profitable patients for referral to the specialty hospital, leaving less profitable patients for general hospitals, thus reducing the general hospital's ability to cover its costs. Some general hospitals have threatened to cancel admitting privileges for physicians who invest in specialty hospitals, whereas others have tried to get into the game by developing a focused factory of their own to keep physicians happy and to retain profitable admissions.<sup>14</sup>

GAO did not find any difference in financial performance between general hospitals competing with specialty hospitals in their markets and similar hospitals without this competition, despite concerns expressed by



general hospitals. General hospitals contend that their financial ability to continue to provide a range of services and care to those without financial resources may be undermined if specialty hospitals erode their patient care revenues. General hospitals often use revenues from profitable services to support unprofitable services, such as burn and neonatal intensive care units. These cross-subsidies have long been a key feature of health care delivery in this country. In addition, emergency departments, which are more typical in a general hospital, may attract a disproportionate share of uninsured or indigent patients to the hospital, putting further pressure on its financial position. Indeed, the MedPAC and DHHS analyses indicated that general hospitals do provide more uncompensated care and treat more Medicaid patients than specialty hospitals.

Even as specialty hospitals gain a foothold in their markets, they are dependent on neighboring general hospitals because of the breadth of services they provide to a range of patients. As stated, specialty hospitals do not treat all of the patients who need the procedures they provide. The general hospital remains the source of care for more severely ill patients, patients who may need additional services, or patients facing an emergency health event.

Representatives of specialty hospitals claim that some general hospitals that compete with specialty hospitals have become more efficient by implementing innovations, such as improved operating room scheduling or extended patient hours, that they would not have incorporated had the specialty hospitals not entered the market. In some cases, the entry of a specialty hospital may have provided general hospitals a needed push out of complacency. MedPAC found that general hospitals responded in various ways to competition from new specialty hospitals: “Some hospitals lowered their expenses by cutting staff; others instituted aggressive pricing strategies to raise revenue from private payers. Many noted their expansions into areas they view as profitable, such as imaging, rehabilitation, pain management, and neurosurgery. Through such efforts, these hospitals were often able to compensate for the revenue lost to physician-owned specialty hospitals.”<sup>15</sup>

Even if some of the general hospitals’ responses to competition from specialty hospitals are aimed at improving efficiency, general hospitals may not be able to match the efficiency of the focused factories across their entire range of services. General hospitals offer many products. Thus, most staff, equipment, and space must be versatile in order to produce multiple, often unrelated, services. General hospitals may not be able to achieve the degree of specialization—and efficiency—across all services that could be achieved with a narrower range of products. In addition, general hospitals may be expected to operate with excess capacity, for example, to meet surges in demand during flu season or to respond to a

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natural disaster or terrorist event. This stand-by capacity adds to the costs of these facilities, making it harder for them to be competitive.

How a specialty hospital affects health care delivery in a market is likely to vary and be affected by many factors, including the type of specialty hospital. Cardiac hospitals, for example, may compete for more of a general hospital's core inpatient business but may also accept more of the market's uncompensated care burden than other specialty hospitals. This is because they tend to be larger, more reliant on inpatient procedures, and more likely to have staffed emergency departments than either surgical or orthopedic hospitals. Surgical or orthopedic hospitals are more like ASCs because their inpatient capacity tends to be small and because they are unlikely to have a staffed emergency department. This means that their presence in a market could shift utilization of outpatient procedures but would be less likely to affect inpatient services, uncompensated care burdens, or the distribution of emergency patients. The pressure that a specialty hospital exerts on a given market will also depend on its line of business, its capacity, its patient mix, as well as the stability and capacity of general hospitals in the area.

## **CHANGES IN THE PRACTICE OF MEDICINE AND HEALTH CARE DELIVERY**

One of the major concerns about specialty hospitals is the financial incentives for physicians with an ownership interest to selectively refer their patients to the specialty hospital and to increase utilization through referrals for care. Physician investors in a specialty hospital share any profits generated from hospital payments—profits that otherwise would be retained by the facility. They have incentives, therefore, to make sure that the specialty hospital is fully utilized and to use information, such as secondary diagnoses, to ensure that patients who are likely to be less costly to treat than the average, in particular, are referred to the specialty hospital. Indeed, all three types of specialty hospitals had a higher proportion of the more profitable patients within the case types, as defined by the DRGs.

Specialty hospital representatives contend that their referral patterns simply represent community practice standards. It is appropriate, they say, for the less severe patients to be referred to the less intensive treatment site. Adjustments to the payment system, such as those recommended by MedPAC, would reduce but not necessarily eliminate the financial rewards for selective referrals.

Physicians' economic interests in a specialty hospital also raise concerns about utilization, although there is no evidence of physician-induced demand with respect to these hospitals.<sup>16</sup> First documented with respect to ancillary services, such as lab tests or imaging services, research has shown that physicians with an ownership interest in the laboratory or radiology

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equipment referred their patients for more tests than physicians with no ownership interest. The physician-investor has similar incentives to boost utilization of the specialty hospital, which could increase overall health care costs without a corresponding increase in quality of care.

Specialty hospitals provide workplace advantages to physicians as well as financial benefits. By being more responsive to physicians, specialty hospitals allow physicians to increase their productivity and, therefore, their billings for professional fees. In fact, interviews conducted by MedPAC and GAO indicated that many physicians turned to specialty hospitals out of frustration in trying to influence general hospitals with respect to scheduling, staffing, and other managerial issues. Physicians said they favored several characteristics of specialty hospitals, including fewer emergencies to interrupt their schedules, less down time between surgeries, and greater control over the delivery of care—all of which would directly affect their productivity. Some general hospitals may be able to adjust their management to better meet the needs of such physicians, but others may not due to competing demands or philosophies.

## LIMITS ON PHYSICIAN SELF-REFERRALS

Concerns about the effects of physicians' ability to profit from referrals on health care utilization and quality have prompted measures to control improper referrals. The anti-kickback statute, passed in 1972, is a broad criminal statute that prohibits remuneration of any sort to a physician for referring a patient for services paid by a federal health care program.<sup>17</sup> Few cases have been successfully litigated under this statute, however, because of the burden of proof of intentional violation of the statute and because the statute is generally enforced on a case-by-case basis. The Ethics in Patient Referrals Act, or "Stark laws," enacted in 1989 and expanded in 1993, prohibits physicians from referring Medicare or Medicaid patients to facilities in which they have a financial interest.<sup>18</sup> One exception allows physicians to provide and bill for ancillary services, like x-rays and lab tests, in their own offices. Another, the "whole hospital" exception, applies if the physician has a financial interest in the entire facility because an individual physician's admission practices are not likely to affect the hospital's profitability. This exception does not apply if the physician's financial interest is in a subdivision or part of a hospital. Specialty hospitals believe they are in compliance with this law because they are licensed as a hospital. General hospitals assert that specialty hospitals are more like a subdivision of a hospital, and therefore, the whole hospital exception would not apply.

Gainsharing has been proposed as a means to align the financial incentives of hospitals and physicians to improve care while avoiding some of the issues associated with physician self-referrals. MedPAC and a recent bipartisan bill on specialty hospitals endorsed gainsharing to

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achieve hospital savings.<sup>19</sup> MedPAC recommended that physicians and hospitals be allowed to share in any financial gain associated with appropriate collaborative efforts that were carefully designed to protect quality of care. The intent is to motivate physicians to work with general hospitals to realize the same sort of efficiencies expected from specialty hospitals. This could mitigate some of the frustration expressed by physicians with general hospitals, which contributed to their interest in specialty hospitals.

Gainsharing arrangements had been stymied by a ruling from the DHHS Office of Inspector General (OIG) which determined that they violate current law.<sup>20</sup> More recently, however, the OIG has indicated that it will not impose sanctions in connection with two specific gainsharing arrangements that it reviewed because the arrangements were structured to protect patients from inappropriate reductions or limits on services.<sup>21</sup> The OIG determined that properly structured arrangements could increase efficiency and reduce waste.

## THE FUTURE OF SPECIALTY AND GENERAL HOSPITALS

Although the moratorium on new specialty hospitals has expired, several open issues remain, such as potential refinements to Medicare's IPPS and ASC payments, whether gainsharing will be embraced, and the status of proposed legislation to make the moratorium retroactively permanent.<sup>22</sup> Regardless of the resolution of these issues, physician self-referrals for other services may continue to raise concerns about (a) how these referrals affect health care use and quality of care and (b) how certain unprofitable services or care for unprofitable patients will be financed. Health care providers generally benefit from higher utilization, and physicians are in a unique position to determine that use. Physician ownership of facilities or the means to provide services only intensifies these incentives. IPPS payment reforms may minimize the incentives to selectively refer to a specialty hospital but will not affect incentives to boost admissions. This is the case with respect to laboratory services physicians provide in their offices, imaging services, or other tests.<sup>23</sup> When the physician owns the means of production and has control over referrals, the financial benefits of increased use is heightened.

Specialty hospitals are the most recent provider group to create a niche by delivering services that had been provided in the general hospital. This situation has played out before with respect to outpatient surgeries, ancillary services, and even post-acute care.<sup>24</sup> In the case of specialty hospitals, competitors to the traditional general hospital may have improved service delivery through innovations and efficiencies. However, they may also have reduced the ability of general hospitals to profit from providing certain services. As the delivery of discrete services becomes more efficient, the cross subsidies that often finance unprofitable services or care to unprofitable patients may become more difficult to sustain.

## ENDNOTES

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Endnotes / continued ►

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18. Section 1876 of the Social Security Act.

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22. S. 4947.

23. For example, see MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2005, available at [www.medpac.gov/publications/congressional\\_reports/Mar05\\_EntireReport.pdf](http://www.medpac.gov/publications/congressional_reports/Mar05_EntireReport.pdf). MedPAC raises questions about whether recent growth in imaging services reflects appropriate use.

24. Under Medicare’s IPPS, hospitals are paid a per case amount that generally does not vary by services actually provided. At the inception of the IPPS, earlier and more frequent transfers to post-acute care providers did not reduce hospital Medicare revenues. However, Medicare has expanded its transfer policy so that the hospital payment is reduced for certain patients who are transferred to a post-acute care provider before they have completed an average stay in the hospital.



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