MedPAC: Keep Specialty Hospitals on Hold

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WASHINGTON — Congress should extend the Medicare Modernization Act's moratorium on the construction of physician-owned specialty hospitals for another 18 months, a federal advisory panel has recommended.

The Medicare Payment Advisory Commission in draft recommendations had set the extension for 1 year, but later changed it to 18 months after commission members decided that more time was needed to study the full impact of these hospitals, often deemed as "cream skimmers" for attracting more profitable patients away from community hospitals.

MedPAC data indicate that specialty hospitals tend to concentrate on certain diagnosis-related groups (DRGs), treating relatively lower-severity patients within them, and lower shares of Medicaid patients. So far, they've had little financial impact on community hospitals, MedPAC analysts claim.

Commissioners at a January meeting decided to forgo tougher language that would have eliminated the "whole hospital" exemption, a provision in the self-referral regulations that allows physicians to refer patients to a hospital in which they have an investment interest as long as the interest is in the entire hospital.

Eliminating the exemption "is not the right step to take at this time due to the limited amount of data we have at this point on specialty hospitals and their performance," MedPAC chairman Glenn Hackbarth said.

Existing specialty hospitals and hospitals under development were still eligible for the whole hospital exemption under the 2003 Medicare reform law, but new hospitals were not, effectively placing a moratorium on their construction. The original moratorium, set to expire in June, would effectively go on until Jan. 1, 2007, if MedPAC's recommendation were adopted.

In a statement, Rick Pollack, executive vice president of the American Hospital Association, commended MedPAC for extending the moratorium. "This decision sends an important message to Congress that physician ownership and self-referral can cause serious conflict of interest concerns," he said.

In other recommendations slated for MedPAC's March report to Congress, commissioners voted on several measures to refine the DRGs used to determine hospital payments to better account for differences in severity of illness among patients:

▶ The Department of Health and Human Services should base the DRG relative weights on the estimated cost of providing care rather than on charges, and on the national average of hospitals' relative values in each DRG.

▶ Congress should give the Department of Health and Human Services secretary authority to adjust the DRG relative weights to account for differences in the prevalence of high-cost outlier cases. Case-mix measurement and outlier policies should be developed over a transitional period. ■