HB

511

REPRESENTATIVE RALPH SAMUELS

HOUSE DISTRICT 29

House Bill 511
Sponsor Statement

""An Act relating to the certificate of need program for health care facilities; and providing for an effective date."

The Certificate of Need review process, which is administered by the Department of Health and Social Services, establishes a set of statutory criteria to guide the development of new healthcare facilities and services in Alaska. Among the objectives of the program are ensuring reasonable access to needed healthcare services throughout the state without unnecessary service duplication and assuring that the need, cost, type, level, quality, and feasibility of providing any new health services be subject to review and assessment prior to any offering or development. In that process, a focus is placed on managing growth in capital expenditures in order to ensure that the new services will provide high-quality services in a cost-effective manner.

With the demand for healthcare services constantly evolving and technology rapidly changing, the resulting impact on the state's existing statutes must be addressed from time to time. It is in that vein that I am sponsoring this piece of legislation. Current state law governing this program requires any person wishing to expend $1,000,000 or more to construct a health care facility, alter the bed capacity of a health care facility, or add a category of health services provided by a health care facility, must apply for a Certificate of Need. That law leaves a gaping hole in state oversight in that any person who wishes to establish or alter a health care facility or related service may circumvent the Certificate of Need process by simply leasing space and equipment. This legislation seeks to "level the playing field" by subjecting all those seeking to provide these services to the same rules.

Additionally, the number of Alaska's children and youth who are sent out of state for residential psychiatric treatment has skyrocketed from 83 children in FY98 to 528 children in FY02. The state infrastructure must be developed to provide a comprehensive system of behavioral health care. However, uncontrolled growth could result in a system focused on the most intensive care, not necessarily the most effective or needed care. While the state is anxious to build up the necessary in-state capacity needed to serve Alaskan children with in-state care, without safeguards in place, secure care could quickly be overbuilt. Since all children and youth served by residential psychiatric treatment centers (RPTCs) are paid for by Medicaid after 30 days in an out-of-home placement, this becomes a Medicaid issue. Adding secure residential psychiatric treatment facilities to the Certificate of Need (CON) program would be an advantage to the state in managing the way in which the service delivery system is developed.

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Amendment # 1 Adopted 3/04/04
HB 511
Offered House HESS

Page 2, line 8, 12, 16, 19, 21, 24, 27, 29, and 31, delete [SECURE]

Page 3, line 3, 7, and 15, delete [SECURE]

Page 3, line 26, after "of" delete [ADMINISTRATION] and insert **Health and Social Services**

Page 3, line 30 and 31, delete all material and insert

(10) Residential psychiatric treatment center (RPTC) means therapeutically appropriate and medically necessary diagnostic, evaluation and treatment services provided by a secure or semi-secure psychiatric facility, or inpatient program in a psychiatric facility, which are

1. under the direction of a physician;
2. include active treatment of a professionally developed and supervised individual plan of care designed to achieve the recipient's discharge from inpatient status at the earliest possible time that must be intensively and collaboratively delivered by an interdisciplinary team involving medical, mental health, educational, and social service components.
3. are provided 24 hour days for children with severe emotional or behavioral disorders; and,
4. licensed by the Department of Health and Social Services.

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF ADMINISTRATIVE SERVICES

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March 15, 2004

The Honorable Peggy Wilson, Chair
The Honorable Carl Gatto, Vice-Chair
House HESS Committee
State Capitol, Room 104 and 411
Juneau, AK 99801-1182

Dear Representatives Wilson and Gatto:

Recently, members of the House Health Education and Social Services (HESS) Committee received correspondence from Tanana Valley Clinic regarding HB 511-Certificate of Need Bill. The correspondence alleges that the Certificate of Need program has approved 99% of all the projects submitted for CON consideration, which is not accurate.

To clear up any confusion on the subject, the department completed an analysis of Certificate of Need approvals, disapprovals, etc. and in *Attachment #1* have provided the analysis.

Also attached for your information, in *Attachment #2*, is a summary of Questions and Answers related to Certificate of Need.

We have also had questions concerning the number and activity of "competing applications", *Attachment #3* includes information on this subject.

I hope this information is useful to all members of the House HESS Committee. If you have any further questions I will be available on Thursday March 18, 2004 to testify on HB 511 you can also contact me at 465-1630.

Sincerely,

Janet Clarke

Janet Clarke
Assistant Commissioner

cc: Representative John Coghill, Capitol Building 204
Representative Paul Seaton, Capitol Building, Room 428
Representative Kelly Wolf, Capitol Building, Room 418
Representative Sharon Cissna, Capitol Building, Room 420
Representative Mary Kapsner, Capitol Building, Room 424
Joel Gilbertson, Commissioner
Sherry Hill, Special Assistant

RESPONSE TO TVC ASSERTIONS

Tanana Valley Clinic has asserted that 1) the CON review process automatically "rubber stamps" hospital projects; 2) none of the non-hospital CONs are approved; 3) that the true purpose of the CON program is to protect hospitals from competition; and 4) that 99% of applicants are approved, which indicates that CON is an unnecessary and expensive process. The clinic urges that the program be eliminated.

1) Rubber Stamping: There are 5 possible outcomes to a certificate of need review 1) approval as requested; 2) denial; 3) partial approval (which could be considered partial denial); 4) approval but with special conditions; and 5) withdrawal of an application. The Commissioner has the authority to approve an application, but may attach special conditions such as allowing an activity to be shelled in but delaying full implementation until a certain use rate is reached.

The Department has reviewed 36 certificate of need applications since 1996; 61% were approved as requested and 39% were not approved as requested. Of those not approved as requested, 11% were denied, 11% partially approved, 6% withdrawn and 14% were given special conditions that had to be met. (See attached chart. Percentages are more than 100% because a decision may include both a special condition and partial approval).

Of the 39% that were not approved as requested: 50% of the denials or partial approval/denials were for hospitals or collocated facilities (hospital and nursing home together), 38% were for Ambulatory Surgery Centers; and 12% were freestanding nursing home beds. 50% of withdrawn applications were for nursing home beds and 50% for acute inpatient psych beds. 60% of the special conditions were for acute hospitals and 40% for acute inpatient psych beds. ***The fact that only 61% of all applications are approved as requested, that hospitals and nursing homes are denied or given conditional approval shows that there is no "rubber stamping" going on.***

2) Non-hospital CON approval: Most of the approved CON applications are from acute care hospitals, nursing homes and kidney dialysis centers because they are required to go through the CON process while other organizations are not required to go through the process or can avoid the process in some way. Most ambulatory surgery centers are able to lease equipment or space in a building and avoid CON. Only 6 CON applications for freestanding ambulatory surgery centers have been received since the inception of the CON program 27 years ago. Fifty percent of these were approved. Independent diagnostic testing facilities are not required to go through the CON process, so no applications have ever been received from them. Other non-acute care hospital facilities that have had CON applications approved include free-standing nursing home facilities, freestanding psychiatric hospitals, and kidney dialysis centers. Although there are no longer any Intermediate Care facilities for the Mentally Retarded in the Alaska, the CON applications for these services were approved in the past.

3) The CON program protect's hospitals from competition: It is difficult to imagine that the CON program is protecting hospitals from competition since many ambulatory surgery centers are able to avoid CON and independent diagnostic centers are not covered by CON. Since 1996 a number of freestanding facilities in Anchorage, Wasilla and Kenai have been built without a CON that would have required a CON if built by a hospital. For example, Alaska Open

imaging has opened facilities in Wasilla, Anchorage and Soldotna without a CON and purchased a PET scanner. Providence had to go through the CON process to get approval for a PET scanner. Anchorage Fracture Clinic purchased an MRI, and several ASCs in Anchorage were able to develop projects without a CON that hospitals would have to go through the CON process to build of buy the equipment. A private group of physicians built a cardiac cath lab without a CON. Also, if the Department's goal is to protect hospitals from competition, why do hospitals appeal our decisions?

4) 99% of applicants are approved, which indicates that CON is unnecessary:
This is not true. As can be seen from the data supplied on the attached page ***only 61% of the applications were approved as requested*** and overall, ***11% of the applications were denied outright***. The fact that most applications are approved is exhibited as proof that the program has little or no effect. If the number of projects denied is the benchmark for showing how well certificate of need is working, then the more projects denied the better, and the very best program would deny all applications. This obviously isn't true. Over time, healthcare providers gain expertise in writing applications and the CON process and gain an understanding of the trends in healthcare. They avoid the time and expense of applying for projects that are unlikely to be approved. Technical assistance and current state plans produced by senior services and behavioral health help eliminate poorly conceived and marginal projects before submission of a CON application. Development of new review criteria and standards in the new State Health Systems Plan will help even more. In the regulation of healthcare, just as in the promotion of health, prevention is by far the most effective strategy.

Projects that are denied may be few and far between, but the ongoing cost of one poorly planned project will last for many years. As someone once said, build it and they will come. Over the 28-year life of one CON program in a sparsely populated state, 573 nursing home beds, 468 acute care hospital beds, 9 ambulatory surgery suites, 144 substance abuse beds, 60 psych beds, and 30 rehab beds were denied. This resulted in the avoidance of nearly $200 million in construction costs alone and an additional $240 million in annual operating costs. Also, going through the CON process has resulted in improved project planning for many facilities. The brief information that TVC gathered from the internet to develop their assertions does not present the whole picture. For example, the 1996 Providence-Seward Medical Center project looks like it was a blanket approval as requested, and it was. However, the Department spent years working with the applicant and informed them that a 35-bed facility recommended by outside consultants was not feasible and had a poor chance of being approved. As a result, they submitted an approvable application.

Certificate of need programs have assisted other agencies in promoting changes in service delivery methods. In particular, it has been helpful in changing the direction of the long-term care industry and psychiatric care in Alaska and other states. It has been a tool used to slow nursing home bed growth to allow development of home and community based alternatives to nursing homes. Since many patients can be served in either a hospital or residential setting, the CON program has been helpful in defining the continuum of care.

The cost of Medicaid is a serious problem facing Alaska. Commissioner Gilbertson is working to contain that. CON is only one of the tools needed to contain costs, but it is an important one.

CERTIFICATE OF NEED DECISIONS FROM 1996-2003

	No. of CON Decisions*	Approved as Requested	CONs Denied	Partial** Approval	Withdrawn	Special Conditions	Shape Helped by CON***
2003	6	4	0	1	0	1	0
2002	6	4	0	0	0	2	2
2001	3	2	0	1	0	0	1
2000	1	1	0	0	0	0	0
1999	9	3	3	1	1	1	0
1998	5	3	1	1	0	1	1
1997	4	3	0	0	1	0	1
1996	2	2	0	0	0	0	1
Total	36	22	4	4	2	5	6
%	100%	61%	11%	11%	6%	14%	17%

*Number of CON applications approved, denied or withdrawn in that year.

Other CONs may have been in progress, but not finished.

** Partial approval means that part of the project was approved and part denied.

*** CON efforts influenced shape or scope of project before it was submitted or helped outcome.

CON Influences Project or Assists by being there:		
1996	PSMC	Number of beds reduced from 20 to 6 - a change from prior proposals
1997	Valley Hosp	CON influenced the withdrawel ofapplication after assisting with moratorium
1998	WFC	Included adult day and 10 assisted living beds
1999	API	Withdrew due to planning prob, need for alternatives CON gave time
2001	BRH	Included Kidney Dialysis in CON App
2002	PAMC	Psych design included Single Pt of entry & DET
2002	Valdez	No of acute & NH beds influenced

Special Conditions:		
1998	ARH	May not convert Surg Suite to OHC for 5 years.
1999	PAMC	Open Heart shelled, not avail for 5 yrs.
2002	PAMC	8 Psych Beds Shelled until higher use
2002	API	8 Beds shelled until higher use
2003	MSVMC	Conditions for shelled space and Cath Lab

Partial Approval/Denial or Complete Denial:		
1998	SPH	10 Nursing home beds not approved/delayed
1998	FSC	Denied an extension or modification due to lack of need
1999	FBKS Surg	3 denials, TVC, McGuire & FMH
1999	SPH	Partial Denial - only 5 NH Beds approved
2001	FMH	Partial Denial - Reduced acute beds, healing garden
2003	WFC	Denied conversion but offered 5 -bed unit.

Certificate of Need Questions & Answers

Question: What types of projects are required to submit a certificate of need application and go through the review process?

Answer: Any health care facility project that involves the expenditure of $1 million or more for construction, renovation or the purchase of new equipment, and any project, regardless of cost, that converts space into nursing home beds is required to submit a certificate of need application.

Question: Are there any types of "health care facility" projects that are currently exempt from the certificate of need program?

Answer: Projects are exempt from certificate of need if: 1) the project cost is under the $1 million threshold; 2) the project is for routine maintenance or routine replacement regardless of the cost; 3) the project is for specifically exempted Pioneer Homes, private physicians' offices, or dentists' offices; or 4) the project is not included in the definition of "health care facility."

Question: Will the definition of a "health care facility" change if HB 511 passes?

Answer: Yes. If HB 511 passes, two additional types of facilities will be added to the list of those projects that may be required to go through the CON process: 1) Residential Psychiatric Treatment Centers (RPTCs), and 2) independent diagnostic testing facilities.

Question: Are all projects exempt from certificate of need if they fall below the dollar threshold?

Answer: All projects that fall below $1 million are exempt from certificate of need except for space converted to nursing home beds, which must submit a CON application regardless of the cost.

Question: What are the components of the certificate of need (CON) process?

- Submission of a letter of intent - (includes who, what, where, how large, the cost and timeline);
- Letter of intent (LOI) determination - a decision is made as to whether a CON is required;
- 60-Day wait - A CON application may be submitted 60 day after the LOI determination;
- Completeness Check - The application is checked for completeness, and more information is requested if the application is incomplete. The applicant has 60-days to submit information;
- Review Period - The analysis document must be submitted to the Commissioner in 90 days;
- Public Notice & Public Comment – Public notice is given at the beginning of a review and the public comment period runs concurrently with the review,
- Commissioner's Decision - The Commissioner makes the decision, which is published, and
- Appeal - The applicant has 30 days to appeal if dissatisfied.

Question: If I apply for a certificate of need, how long will it take for a decision?

Answer: Once your application is received and declared complete, a review document must be submitted to the Commissioner for a decision within 90 days. The Commissioner does not have a timeline to make a decision, but generally makes one in about two weeks

Question: How much does it cost to prepare a certificate of need application?

Answer: That depends on the size of the project, its complexity and whether it is controversial. A rule of thumb is that a certificate of need application should not cost more than 1% of the total project cost with a maximum of $25,000. Health Facilities Planning and Development, a consulting firm that writes approximately 70% of all CON applications for facilities in Washington State and has done at least 4 applications in Alaska, charges approximately $15,000 per application, regardless of the size of the facility.

History of Concurrent (Competing) Certificate of Need Reviews

There have been only 6 concurrent reviews since the inception of the CON program in 1976. Only 8.2% of all applications since 1990 were reviewed concurrently. 7 AAC 07.060(a), states: "In the commissioner's discretion, the agency shall defer commencement of the review process for a period not to exceed 60 days after the determination that the application is complete to enable the state agency and the appropriate health systems agency to receive and consider concurrently applications from each person who has submitted a letter of intent... proposing an activity within the appropriate health service area which is similar to the activity proposed by the applicant." ***Key Points: A letter of intent must be in hand from a competing project in order for a concurrent review to be allowed and a competing application must be submitted within 60 days after the first application has been declared complete.*** The six concurrent reviews are:

1982	**Charter Medical Corporation submitted a CON to construct a $12.2 million 80-bed psychiatric/alcohol/drug abuse hospital in Anchorage. An application for a 34-bed, $3.4 million alcohol/drug hospital was received from Advanced Health Systems/Raleigh Hills. Comprehensive Care Corporation submitted a letter of intent for $5.5 million, 50-bed alcohol/drug treatment hospital but did not submit an application. Charter and Advanced Health Systems were approved.**
1982	**Providence Hospital submitted a CON application for an $80 million, 150-bed addition and Humana Hospital (now Alaska Regional) submitted a CON for a $21.6 million, 93-bed addition. The projects were approved, but reduced to 53 additional beds and 39 additional beds respectively.**
1985	**Heritage Place (Soldotna) and South Peninsula Hospital (Homer) submitted CON applications for 60 nursing home beds. Heritage Place was approved for 45 nursing beds and a shelled in space for 15 additional beds to be opened later when use increased. South Peninsula's request for 60 beds was denied.**
1985	**Camai Care Center, Palmer; Careage Nursing Center, Wasilla; and Cook Inlet Housing Development Corporation submitted CON applications for 90-bed nursing facilities. Cook Inlet Housing Development Corporation was approved to build a 60-bed facility and 30 assisted living beds at a cost of $8.8 million. This facility was named the Mary Conrad Center. Careage was denied, Camai Care approved, but was later denied a time extension due to lack of process.**
1995	**Fairbanks Memorial Hospital (FMH) submitted a CON application for outpatient services including ambulatory surgery, and Fairbanks Surgery Center (FSC) submitted a CON for a freestanding ambulatory surgery center. Only the surgery portion of the FMH CON was reviewed concurrently with the FSC CON. Both were approved. FSC was later denied due to lack of progress.**
1999	**Tanana Valley Clinic, Fairbanks Surgery Center, Inc. and Fairbanks Memorial Hospital submitted CON applications for 5 surgery suites and 4 procedure rooms costing $11 million. None of the applicants were approved.**

Attachment #3

Alaska State Hospital & Nursing Home Association

We're helping people care for people!

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February 27, 2004

Representative Peggy Wilson
Chair, House Health & Social Services Committee
Alaska State Legislature
State Capitol Building, Room 104
Juneau AK 99801-1182

Dear Representative Wilson:

Unfortunately I am unable to attend Tuesday's hearing on HB 511, " An Act Relating to Certificate of Need", but I wanted to make certain that the Alaska State Hospital and Nursing Home Association, ASHNHA, expressed its support for passage of this important legislation.

HB 511 strengthens the Department of Health & Social Services ability to guard against overdevelopment of Alaska's critical health care infrastructure. Of particular importance to ASHNHA are the following two provisions:

- **Section 2, lines 4 and 5 amending AS 18.07.031**:
  This new language clarifying that the "net present value of a lease for space occupied by or the equipment required for a health care facility" is included in the meaning of the term "expenditure".

  This language is important because it removes the potential for health care developers to circumvent CON law by leasing rather than purchasing needed space or equipment. ASHNHA sees this language as vital to preserving a level playing field for all in a very competitive health care market place.

- **Section 4, lines 20, 21 and 22 amending AS 18.07.111(8):**
  This new language adds additional health care provider types to the definition of "health care facility". ASHNHA strongly supports this change as it recognizes that an independent diagnostic testing facility is another health care category that, if not monitored, can lead to excess capacity in the community.

ASHNHA appreciates the opportunity to submit these comments in support of HB 511. Alaska's health care market already faces economic challenge from an increasing number of uninsured Alaskans that current providers must serve. Existing capacity in the health care system must be used fully to enable Alaska's providers to offset this largely uncompensated care. To allow capacity to grow in a community without giving the Department an opportunity to assess the need for this additional investment invites serious problems. Questions such as the sustainability of all providers already in the

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market, and the impact on overall cost of care as developers expand profitable parts of the health care system without a commensurate requirement to assume a proportionate share of the uncompensated care, are examples of questions that the department must address to assure a level playing field for all providers, and to assure sustainability of the health care system as a whole.

ASHNHA's many members hope your Committee will agree with this analysis and pass HB 511 from your Committee favorably. Thank you.

Sincerely,

Rod Betit

Rod L. Betit
President/CEO

Cc: Representative Ralph Samuels

Health care regulation and Alaska
An Overview

Prepared by Mike Powers, CEO/Administrator, Fairbanks Memorial Hospital
and Denali Center
February, 2004

Regulation is pervasive in healthcare and serves many good purposes. Physician licensure is an easy example of a case where the rule of law confers benefits greater than those of the marketplace. Furthermore, effective regulation is highly specific. This limits, at times, the lessons that can be learned from the experiences of other states in addressing the common problem of ensuring the greatest possible degree of consumer choice consistent with overall public benefit. For, as in so may other areas, Alaska differs dramatically from the rest of the United States in its health care.

Special considerations in the Alaskan market:

1. Alaska has an extremely low population density, resulting in a uniquely high proportion of sole community providers.

2. There are significant physician shortages in psychiatry, internal medicine, and obstetrics. In Ohio, 14 delivery programs have closed since repeal of CON in 1996. Could that happen here, as profits dwindle and recruitment costs rise? The competitive model suffers pervasive physician supply shortages since they work to concentrate physician power to an extent not witnessed in the lower 48.

3. Even where physician shortages do not exist, certain specialties are highly concentrated. One cardiology group handles the whole state. One radiation therapy group services the whole state. There is only one ophthalmologist in Fairbanks.

4. Tertiary services are unusually distant. Most tertiary services are available only in Anchorage, a six to seven hour drive from Fairbanks; even air transport requires three hours including the time taken to arrange logistical support.

5. Not all tertiary/quaternary services are available in Alaska and residents sometimes must travel to the lower 48. Over 500 children currently receive inpatient psychiatric treatment out-of-state.

6. Alaska's demographics are skewed toward younger populations, and the State has a higher proportion of males.

7. Labor turnover is extremely high. This is party due to the fact that many health care workers are military dependants. Fairbanks experiences a 25% turnover in labor annually.

8. Many expenses are unusually high. Construction costs are inflated by sub-arctic construction seasons, and the need for special construction materials.

9. The State has a high proportion of Alaska Natives; who use, to some extent, their own system of healthcare.

10. The State has an unusually high percentage of charge-based payers, including Medicaid.

11. There is no managed care in the State and no rate setting.

12. An uncommonly high level of commercial insurance leads to high potential for moral hazard, for both provider and patient.

Many of these factors combine to make cherry-picking unusually attractive. Sole community providers are responsible for the spectrum of local care. Since they are necessarily monopolies, cross-subsidies are possible. They are social institutions that accept responsibilities other than marketplace gain, thus making cross-subsidies unavoidable if any measure of charity care is going to be provided. The high-margin services providing the subsidies are attractive targets for opportunists, who do not use the profits to subsidize other services. They can easily under-price the monopoly and still collect windfall profits, or as economists say, "rents."

This does not create competition. It merely exploits the social mission of the monopoly by converting a community benefit to a shareholder benefit. Cross-subsidies are a public good with positive social "spillovers." Allowing predatory entry reduces the ability to cross-subsidize and converts a portion of the subsidy to private profit. The cost of the subsidy will not be eliminated from the system altogether, however. It provides the majority of the entrant's profits, and rates are not monitored by the state apart from CON reviews. Certificate of Need is one means of recognizing and dealing with these unusual features.

Loss of Cross-Subsidy

Under deregulation, cross-subsidies become excess profits. Eliminating cross-subsidies while allowing excess profits does not lower the cost of health care. Transforming cross-subsidies into excess profits, that is, moving funds from public-use to private-use, does not address the issue of how the community will continue to provide subsidized services when the subsidy is reduced. An understanding of this dynamic explains the social benefit of shielding community providers from predatory entrants.

Deregulation will not reduce costs because as deregulation reduces the supply of cross-subsidy funds from certain individual services, providers will react. They may try to increase the utilization of other well-insured areas to make up the loss, thereby shifting the lost subsidy to other payers, as has been observed in other markets. This is more easily accomplished in a state without managed care and its incentives for utilization

review, like Alaska. Therefore, for these reasons alone, usage rates can be expected to increase with capacity. Furthermore, in a state without rate review, rates themselves will also increase.

Eventually, the cross-subsidies lost to new entrants will be replaced by higher prices and increased usage elsewhere. This dynamic itself creates new opportunities for rent-seeking entrepreneurs and the cycle begins again. Total costs shift and rise overall, in an ever-tighter spiral of increasing costs until the system of subsidies collapses altogether.

Competition

In the lower 48, managed care brings insurance into the heart of the medical decision-making process. It does it with explicit concern for costs. This doesn't happen in Alaska since there is no managed care; physicians enjoy a degree of decision-making latitude long since extinguished elsewhere.

In the lower 48, managed care companies often make the facility choice for patients by restricting their options. This process allows hospitals to become involved in patient-directing behaviors through their managed care contracts, and makes price a part of the referral decision. In the lower 48, managed care companies often play a negotiating role, weakening the physician referral autonomy and introducing a measure of price competition. This doesn't happen here and managed care is unlikely to enter the market.

Without managed care as a vehicle, hospitals in Alaska have a greatly reduced ability to compete with physicians for patient flow. This differential market power makes a mockery of the notion of a level playing field where marginal utility equals marginal cost and to determine the amount consumed. Hospitals simply don't, and won't, have access to the only medical decision-making process in Alaska – that of the physician. Therefore, for example, Alaskan hospitals would inevitably lose business to a captive surgeon-owned surgery center. Not because they're more expensive, not because they're less convenient, not because they're less efficient – but because they don't have the same power over the decision-making as physicians. That is, "physician self-referral puts the hospital at a potentially significant disadvantage when it competes for patients with surgeon-owned ASCs."[1]

Managed care companies in the lower 48 also employ extensive utilization review mechanisms to reduce moral hazard. These curbs are also significantly absent in Alaska, so the problem of moral hazard is severe, and moral hazard is a powerful factor in escalating health care costs, especially when combined with physician ownership of facilities.

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[1] William J. Lynk and Carina S. Longley. *The Effect of Physician-Owned Surgery Centers on Hospital Outpatient Surgery*. Health Affairs. Vol. 21 Number 4. July August 2002: Page 219.

For these reason, and others, the growth of managed care in the lower 48 led to decreased reliance on CON as a cost and utilization control mechanism in many states. For along with their onerous choice-limiting mechanisms, they do bring a measure of price-based market discipline to the health care marketplace. We do not advocate the establishment of managed care in Alaska, even if it could be made to work here. There are other ways to achieve its benefits while avoiding its limitations.

What we do advocate is an understanding of the intricate market dynamics at work in Alaskan healthcare and the necessity for a measure of government oversight and regulation greater than that required to ensure free, informed choice in the markets for other goods and services. Leveling the playing field in Certificate of Need regulations is a good place to start.

GAO
Accountability • Integrity • Reliability
United States General Accounting Office
Washington, DC 20548

April 18, 2003

The Honorable Bill Thomas
Chairman
Committee on Ways and Means
House of Representatives

The Honorable Jerry Kleczka
House of Representatives

Subject: *Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served*

Specialty hospitals represent a small but growing segment of the health care industry. These hospitals specialize in providing care for certain conditions, such as cardiac care, or performing certain procedures, such as orthopedic surgery. Specialty hospitals are not an entirely new phenomenon, as children's and other types of specialty hospitals have existed for decades. Consequently, it is challenging to distinguish between the old and new types of specialty hospitals. One aspect that sets apart the newer genre of specialty hospitals is that many are owned, in part, by the physicians who work in them.

Advocates contend that, because of their focused mission, specialty hospitals can provide high-quality specialty services more efficiently than general hospitals. Because specialty hospitals can tailor their facilities and resources to best fit the needs of certain types of patients, individuals treated in such hospitals may enjoy relatively greater convenience and comfort. Specialty hospitals may also offer physicians financial and work environment advantages. Advocates have stated that the focused mission and dedicated resources of specialty hospitals allow physicians to treat more patients than they could in general hospitals. Physicians may gain financially from this increased productivity. If they are part owners, physicians may also share in the financial gains that accrue to the hospital. Physicians in specialty hospitals may also have more control over patient scheduling and the purchasing of desired equipment.

However, concerns have been raised by general hospitals and others in the health care community that specialty hospitals are siphoning off the most financially rewarding portions of general hospitals' business. Representatives of general hospitals contend that specialty hospitals concentrate on the most profitable procedures and serve patients that have fewer complicating conditions—leaving general hospitals with a sicker, higher-cost patient population. Part of the concern is that physician ownership in specialty hospitals creates incentives to concentrate on

patients who are less sick than other patients with the same diagnosis, as a hospital is typically paid a fixed, lump-sum amount for treating someone with a given diagnosis. Hospitals can benefit financially by treating a disproportionate share of less ill patients because the payment amounts for these patients are not reduced to reflect the fact that fewer services are needed. Critics contend that this practice of drawing away a more favorable selection of patients makes it more financially difficult for general hospitals to fulfill their broad mission to serve all of a community's needs, including charity care, emergency services, and stand-by capacity to respond to community-wide disasters.

A federal law, known as the Stark anti-self-referral law, generally prohibits physicians from referring Medicare patients to facilities in which they (or their immediate family members) have financial interests.[1] The law was enacted after several studies found that physicians with ownership interests in separate clinical laboratories, diagnostic imaging centers, or physical therapy providers tended to make more referrals to them and order substantially more services at higher costs.[2] The Stark self-referral prohibitions do not apply in the case of specialty hospitals, however, because the law does not prohibit physicians who have ownership in an entire hospital from referring patients to that hospital.[3] It is likely that any referral or decision made by a physician who has a stake in an entire general hospital would produce little personal economic gain because such hospitals tend to provide a diverse and large group of services. However, the Stark law does prohibit physicians who have an ownership interest only in a hospital subdivision from referring patients to that subdivision. Concern exists with respect to specialty hospitals, that since they are usually much smaller in size and scope than general hospitals and closer in size to hospital departments, that their physician owners could influence their hospitals'—and therefore their own—financial gain through practice patterns and referrals.

In light of these concerns, you asked us to provide information on the prevalence of specialty hospitals, their characteristics in terms of ownership and patients treated, and the effect specialty hospitals have on the greater hospital communities in which they operate. We are preparing a comprehensive report to be issued later this year that will address these issues. This report provides available information on the

- share of the national hospital market comprising specialty hospitals,
- extent to which physicians have ownership interests in specialty hospitals, and
- patients served by specialty hospitals compared with those served by general hospitals, in terms of illness severity.

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[1] 42 U.S.C. § 1395nn(a)(1)(A) (2000).

[2] U.S. General Accounting Office, *Medicare: Referrals to Physician-Owned Imaging Facilities Warrant HCFA's Scrutiny*, GAO/HEHS-95-2 (Washington, D.C.: Oct. 20, 1994). Jean Mitchell and Elton Scott, "Physician Ownership of Physical Therapy Services," *Journal of the American Medical Association*, vol. 268 (Oct. 21, 1992). For additional discussion of the topic, see Jennifer O'Sullivan, *Health Care: Physician Self-Referrals "Stark I and II,"* Congressional Research Service 97-5 EPW (Dec. 6, 1996).

[3] 42 U.S.C. § 1395nn(d)(3) (2000).

Our work focused on hospitals that tended to treat patients for a limited group of diseases or conditions or that tended to perform surgical procedures. Specifically, we considered a hospital to be a specialty hospital if the diagnosis-related group (DRG) classification for two-thirds of its Medicare patients (or two-thirds of all of its patients where such data were available) fell into no more than two major diagnosis categories, such as diseases of the circulatory system (cardiac), or if at least two-thirds of its patients were classified in surgical DRGs. We excluded hospitals that specialized in providing long-term care or otherwise had missions that were largely distinct from the missions of short-term, acute care general hospitals.[4] We classified the hospitals that fit these criteria into five specialty types—cardiac, orthopedic, surgical, women's, and other specialty. Because the other-specialty category contained a diverse set of hospitals that could not be compared to one another, we excluded hospitals in that category.[5] The information in this report is derived from our analysis of hospital inpatient discharge data, various administrative databases, and responses to our survey of specialty hospitals. We analyzed Medicare inpatient discharge data from all hospitals nationwide to help identify specialty hospitals. We also obtained Healthcare Cost and Utilization Project (HCUP) data on all patient discharges in 2000 from hospitals located in six states.[6] These states contained 26 urban specialty hospitals, slightly more than one-fourth of the existing specialty hospitals we identified. The all-patient discharge data from hospitals in these states were used to help identify specialty hospitals and analyze the relative illness severity among patients at specialty and general hospitals. For more detail regarding our specialty hospital criteria and analysis methodology, see the enclosure at the end of this report. Our work was performed from September 2002 through April 2003 in accordance with generally accepted government auditing standards.

Results in Brief

Specialty hospitals represent a small but growing share of the national market. In February 2003, the 92 cardiac, orthopedic, surgical, and women's hospitals that we identified and were open for business accounted for less than 2 percent of the short-term, acute care hospitals nationwide. Recent growth in specialty hospitals has been rapid—the number of facilities has tripled since 1990 and another 20 facilities are under development. Because specialty hospitals tend to be relatively small, they account for a somewhat low share of inpatient spending relative to their share of hospitals. The specialty hospitals in existence in fiscal year 2000 accounted for about 1 percent of Medicare spending for inpatient services.

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[4]Thus, we excluded hospitals that specialized in providing rehabilitation or in treating mental disorders, alcohol or drug problems, respiratory conditions, or newborns and children.

[5]The other-specialty category contained 18 hospitals that specialized in a variety of other areas, such as eye and ear, nose, and throat procedures.

[6]Data were from all hospitals in Arizona, California, New Jersey, New York, and North Carolina and the hospitals located in three regions of Texas.

About 70 percent of the specialty hospitals in existence or under development had some physician owners, according to our 2003 specialty hospital survey results. Among these hospitals, total physician ownership averaged slightly more than 50 percent. The average share owned by an individual physician was more than 2 percent at half the hospitals, while it was less than 2 percent at the other half. In about one-fifth of the hospitals with some degree of physician ownership, the largest share owned by an individual physician was at least 15 percent. Nearly all specialty hospitals with physician owners reported that some of the owners were members of a single group practice. The largest share owned by physicians in a single group practice was more than 25 percent at half the hospitals and less than 25 percent at the other half. In about 1 out of 10 specialty hospitals with physician owners, physicians in a single group practice owned 80 percent or more of the hospital.

We found that patients at specialty hospitals tended to be less sick than patients with the same diagnoses at general hospitals, although we did not determine the clinical and economic importance of this finding. Our analysis of all inpatient discharge data from the 25 urban specialty hospitals for which these data were available—about one-fourth of all specialty hospitals we identified nationwide—showed that 21 of the 25 specialty hospitals treated lower proportions of severely ill patients than did area general hospitals. For example, at an urban cardiac hospital in Arizona, about 17 percent of patients with the most commonly treated diagnoses were severely ill, whereas at 26 general hospitals in the same urban area, about 22 percent of patients treated for the same diagnoses were severely ill. For all four specialty hospital types included in our study—cardiac, orthopedic, surgical, and women's—the median percentage of severely ill patients treated was lower than that for general hospitals. Four of the 25 specialty hospitals were exceptions, as they had treated patients that were as sick, or sicker, than the patients at general hospitals.

The American Surgical Hospital Association and two major specialty hospital chains—MedCath Corporation and National Surgical Hospitals—provided comments on a draft of this report. Representatives from these groups stated that physician ownership of specialty hospitals did not affect physician referral behavior and that our physician ownership discussion was potentially misleading. Our report provides information on the extent of physician ownership of specialty hospitals but, because of data limitations, we did not attempt to analyze the relationship between ownership and referral patterns. The specialty hospital representatives also questioned the extent to which the illness severity differences we reported might apply to specialty hospitals not in our sample and the economic significance of these differences. The illness severity differences that we report are based on an analysis of thousands of claims from more than one-fourth of the specialty hospitals that we identified. We did not attempt to assess the economic significance of these differences. A more complete summary of their comments and our evaluation of their comments is included at the end of this report.

Background

The fixed-rate, lump-sum payments that health care payers typically make to hospitals for inpatient care for patients with a given diagnosis, regardless of the costs of serving particular patients, are designed to promote efficiency by discouraging hospitals from providing unnecessary services as a way to boost revenues. However, these lump-sum payments foster undesirable incentives, as hospitals may gain financially by serving a disproportionate share of low-cost patients. The mechanics of Medicare's hospital payment system illustrate this principle.

Under its system of prospective payments, Medicare pays a predetermined rate for each hospital discharge, based on the patient's diagnosis and whether the patient received surgery. In other words, the payments reflect an average bundle of services that the beneficiary is expected to receive as an inpatient for a particular diagnosis. Discharges are classified according to a list of DRGs. DRG payment rates are based on the expected cost of the diagnosis group's typical case compared with the cost for all Medicare inpatient cases. The DRG payment is not adjusted for within-DRG differences in severity of illness.[7] Therefore, hospitals have a financial incentive to treat as many patients as possible whose costs are low relative to the average patient in each DRG.

Specialty Hospitals Represent a Small but Growing Share of the National Market

In February 2003, there were 17 cardiac, 36 orthopedic, 22 surgical, and 17 women's hospitals that met our specialty hospital definition and were open for business.[8] These 92 hospitals represent about 2 percent of all short-term, acute care hospitals nationwide. (See fig. 1.) The most recent Medicare discharge data indicate that the 80 specialty hospitals in existence in 2001 accounted for slightly less than 1 percent of Medicare spending for inpatient services.

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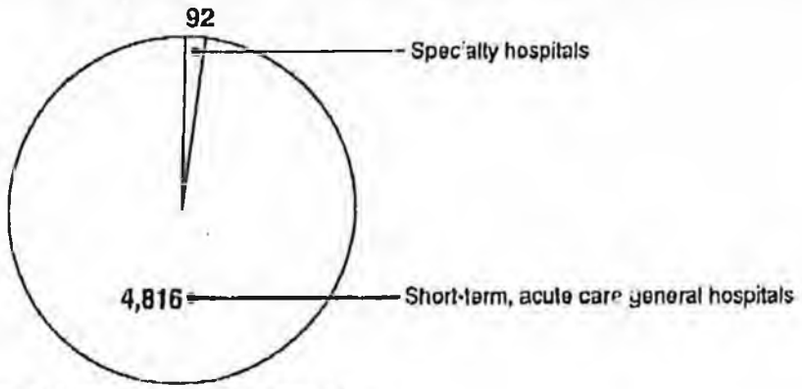
[7]An "outlier" policy exists to make additional payments to hospitals when their costs for a particular patient are extraordinarily high compared with the DRG rate for that patient's diagnosis group.

[8]Although we used several methods to identify specialty hospitals, the counts included in this report should not be interpreted as a complete census of the specialty hospitals in existence or under development. In particular, it is likely that our estimate of the number of women's hospitals is low. See the enclosure for a discussion of this issue.

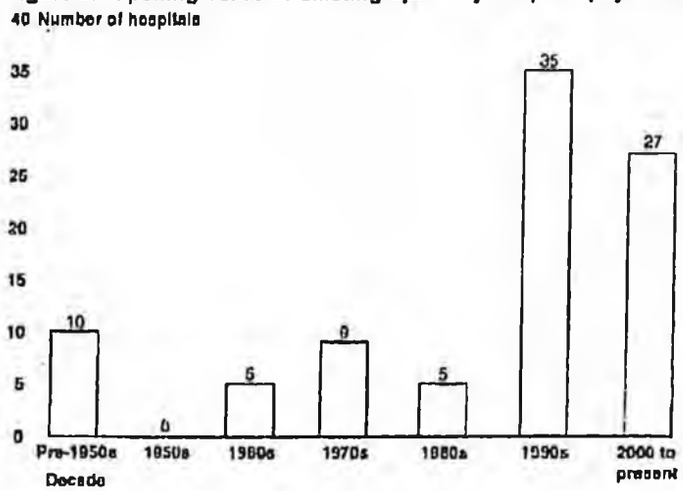
Figure 1: Number of Specialty Hospitals Relative to All Short-term, Acute Care General Hospitals, 2003



Sources: GAO and American Hospital Association (AHA).

The number of these facilities has grown rapidly in recent years—as of March 2003, the number of specialty hospitals had tripled from the 29 that existed in 1990. (See fig. 2.)

Figure 2: Opening Years of Existing Specialty Hospitals, by Decade

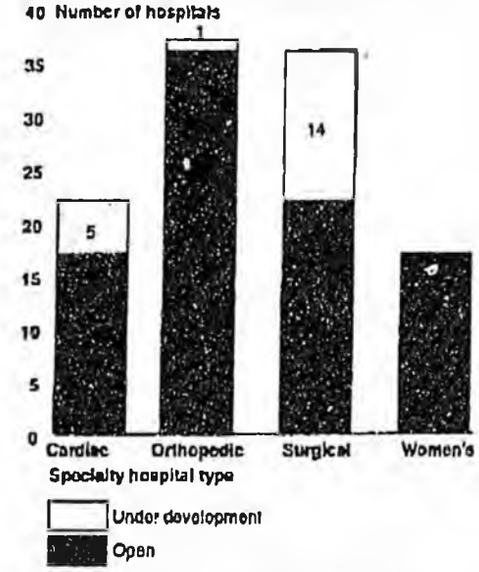


Sources: GAO and Centers for Medicare and Medicaid Services (CMS).

Note: Data are from the GAO specialty hospital universe file (2003) and the CMS Medicare Providers of Service file (2002).

An additional 20 specialty hospitals are now under development, most of which specialize in surgical care. (See fig. 3.)

Figure 3: Number of Specialty Hospitals Open and Under Development, by Specialty Type

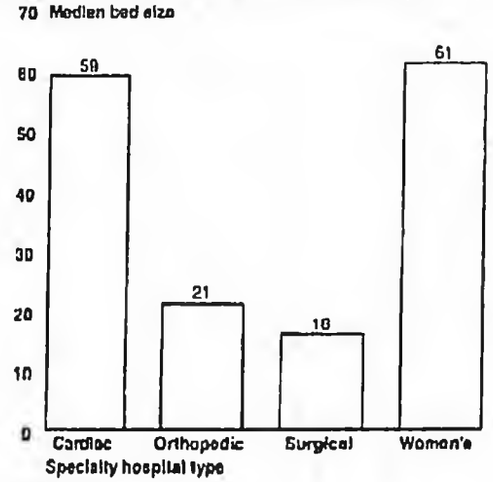


Sources: HCUP, CMS, industry groups, and hospital chains.

Note: Data are from HCUP (2000) and CMS Medicare Provider Analysis and Review (MedPar) file (2001). Data on the number of women's hospitals under development were not readily available.

In terms of beds, specialty hospitals are relatively small. In our study, surgical care facilities were the smallest, with a median of 16 beds, compared with a median of 61 beds for women's hospitals. (See fig. 4.) In contrast, the average short-term general hospital had approximately 170 beds.

Figure 4: Median Number of Beds in Specialty Hospitals, by Specialty Type



Source: GAO.

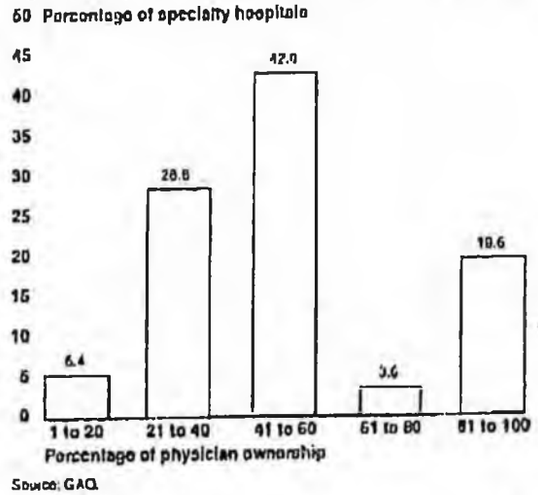
Note: Data are from GAO's specialty hospital survey (2003).

Physician Ownership of Specialty Hospitals Is Common, but Shares Owned by Individual Physicians or Physician Group Practices Vary Widely

Our survey of the more than 100 specialty hospitals in existence or under development indicates that about 70 percent of specialty hospitals had some physician owners.[b] Of the specialty hospitals with any degree of physician ownership, physicians' combined ownership shares averaged slightly more than 50 percent of the hospital. About one-fifth of specialty hospitals were owned entirely, or nearly so, by physicians. (See fig 5.) Physicians owned 20 percent or less of the hospital in relatively few specialty hospitals.

[b]Approximately 80 percent of specialty hospitals returned our survey, although the response rate on certain questions was somewhat lower. Physician ownership information was self-reported by hospitals and does not reflect ownership by physician family members.

Figure 5: Specialty Hospitals by Extent of Physician Ownership

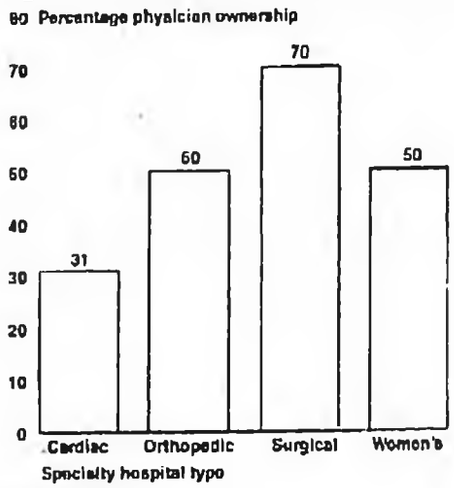


Source: GAO.

Note: Data are from GAO's specialty hospital survey (2003). Data include the approximately 70 percent of specialty hospitals that reported some degree of physician ownership.

Physicians tended to own somewhat smaller percentages of cardiac hospitals and larger percentages of surgical hospitals. (See fig 6.)

Figure 6: Median Percentage of Hospital Owned by Physicians, by Specialty Type

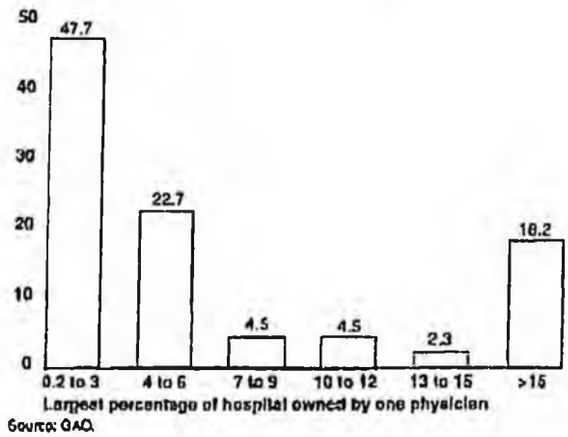


Source: GAO.

Note: Data are from GAO's specialty hospital survey (2003). Data include the approximately 70 percent of specialty hospitals that reported some degree of physician ownership.

On average, individual physicians owned relatively small shares of their hospitals. At half the specialty hospitals with physician ownership, the average individual share was less than 2 percent; at the other half, it was greater than 2 percent. Some physicians owned substantially larger shares. In nearly one-fifth of the specialty hospitals with some physician ownership, the largest share owned by a single physician was 15 percent or greater. (See fig. 7.)

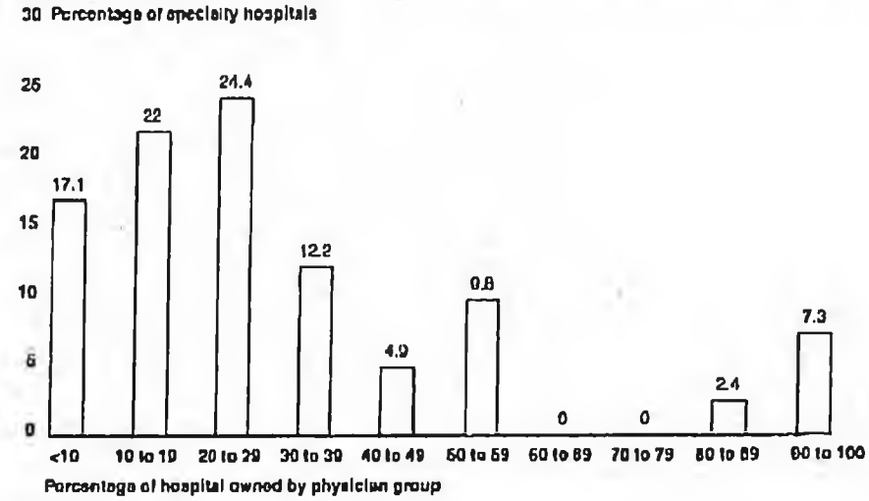
Figure 7: Largest Share of Specialty Hospital Owned by an Individual Physician



Note: Data are from GAO's specialty hospital survey (2003). Data include the approximately 70 percent of specialty hospitals that reported some degree of physician ownership.

Nearly all specialty hospitals with physician owners reported that some of the owners were members of a single group practice. The largest percentage of each hospital owned by physicians in a single group varied widely—at half the hospitals the largest percentage was more than 25 percent and at the other half it was less than 25 percent. In about 1 in 10 specialty hospitals, physicians in a single group practice owned 80 percent or more of the hospital. (See fig 8.)

Figure 8: Largest Ownership Share by Physicians in a Single Group Practice at Specialty Hospitals



Source: GAO.

Note: Data are from GAO's specialty hospital survey (2003). Data include the approximately 70 percent of specialty hospitals that reported some degree of physician ownership.

Specialty Hospitals Tend to Treat a Lower Percentage of Severely Ill Patients than General Hospitals

Some patients are more severely ill than others—even when compared to individuals who have the same principal diagnosis. Differences in age, secondary diagnosis, and other complicating conditions can affect the severity of patients' illnesses and the amount and cost of the resources required for their treatment.

To determine whether there were differences in illness severity between the patients treated at specialty hospitals and the patients treated at general hospitals, we analyzed calendar year 2000 patient discharge data at 25 specialty hospitals. These hospitals were located in 18 urban areas in six states: Arizona, California, New Jersey, New York, North Carolina, and Texas.[10] Our group of comparison hospitals consisted of the 396 general hospitals located in the same 18 urban areas. Our comparisons included only those general hospitals that provided short-term, acute care. We used a widely recognized system, known as All Payer Refined-Diagnosis Related Groups (APR-DRG), to assign an illness severity level to each patient on the basis of the information contained in the discharge data. This system, which is frequently used by hospitals and private insurers, groups patients into one of 355 diagnosis categories and assigns one of four severity levels (minor, moderate, major, or extreme) to each patient based on patient diagnosis, age, sex, and procedure. While we examined

[10]Data on all inpatient discharges were obtained from HCUP, a federal-state-industry partnership sponsored by the Agency for Healthcare Research and Quality.

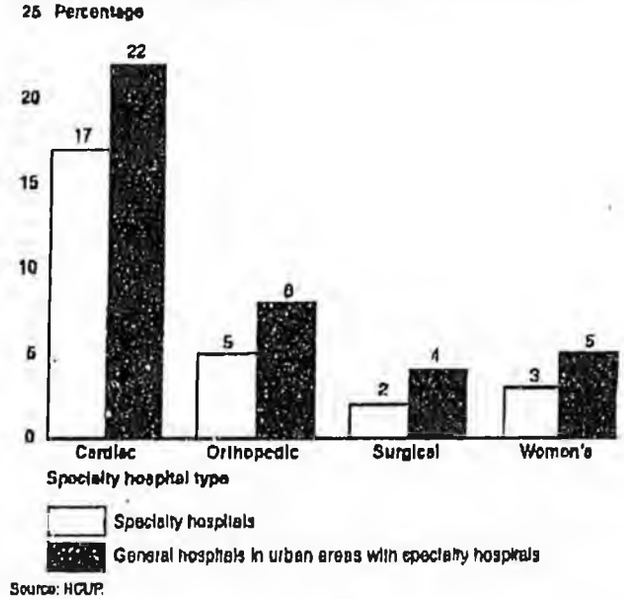
illness severity differences between specialty and general hospitals, we did not determine the clinical or economic importance of these differences."

The vast majority of specialty hospitals with HCUP data available to us—21 out of 25—treated a lower percentage of patients who were severely ill—that is, assigned to the major or extreme severity levels by the APR-DGR system—relative to patients in the same diagnosis categories treated at general hospitals in the same urban areas. For example, 3 percent of the patients in the 10 most common diagnosis categories at one Texas orthopedic hospital were classified as severely ill. A higher proportion—8 percent—of the patients in the same diagnosis categories were classified as severely ill at the 51 general hospitals in the same urban area. A cardiac hospital in Arizona provides a similar example. About 17 percent of the patients in that hospital's most common diagnosis categories were classified as severely ill. In contrast, 22 percent of the patients in the same diagnosis categories who were treated at the 26 general hospitals in the same urban area were classified as severely ill. Not all specialty hospitals treated patients who were, by comparison, less sick. Two of the 25 specialty hospitals treated a higher percentage of severely ill patients and two others treated about the same percentage as area general hospitals.

For all four specialty hospital categories—cardiac, orthopedic, surgical, and women's—the median share of severely ill patients treated was lower than the median share of severely ill patients in the same diagnostic categories treated at the corresponding general hospitals. (See fig 9.) For example, the median orthopedic hospital, in terms of patient illness severity, had 6 percent of patients in its most common diagnosis group classified as severely ill. The median general hospital in the urban areas with orthopedic hospitals had 8 percent of patients in the same diagnosis groups classified as severely ill.

"Average inpatient costs may be substantially higher for sicker individuals. In its March 2000 report to Congress, the Medicare Payment Review Advisory Commission (MedPAC) illustrated this relationship with several examples, including one for patients diagnosed with intracranial hemorrhage (APR-DRG 44). MedPAC found, based on its analysis of fiscal year 1997 Medicare data, that the estimated inpatient cost was $3,195 for patients whose illness severity was classified as minor. The estimated costs were higher for patients with the same diagnosis who were classified as more severely ill: $4,214 for moderate severity, $5,464 for major severity, and $11,255 for extreme severity. MedPAC noted that illness severity cost differences were smaller for some diagnoses and larger for others. In June 2000, MedPAC recommended that Medicare's hospital inpatient payment system be improved by accounting for illness severity differences within DRGs.

Figure 9: Median Percentage of Severely Ill Patients Treated in Specialty Hospitals and General Hospitals, by Specialty Hospital Category



Source: HCUP.

Note: Data are from HCUP (2000).

Comments Obtained from Organizations Representing Specialty Hospitals and Our Evaluation

We obtained comments from officials representing the American Surgical Hospital Association—a specialty hospital association—and from officials representing MedCath Corporation and National Surgical Hospitals—two major specialty hospital chains. Their comments, summarized below, primarily focused on physician ownership issues and our illness severity analysis. Unless otherwise noted, the following comments reflect the positions of all three organizations.

The specialty hospital representatives said that our report provided an inadequate, and potentially misleading, discussion of the financial incentives facing the physician owners of specialty hospitals. The officials believe that the average physician who invests in a specialty hospital owns such a small share that the theoretical incentive to steer relatively sick patients away from the facility is very weak. Instead, they believe that there is a strong incentive for physicians to treat patients in specialty hospitals because high-quality care can be provided efficiently in such facilities. According the representatives, our report did not sufficiently discuss the efficiency gains achieved by specialty hospitals. The representatives also noted that many physicians who work in specialty hospitals are completely unaffected by investor-related financial incentives because they have no ownership stake in the facilities.

The representatives stated that our illness severity analysis had several potential limitations and that our results may not apply to all specialty hospitals. The representatives said that our results are based on a sample that is too small to be representative of all specialty hospitals. MedCath representatives noted that Medicare data were available for most of the 92 specialty hospitals that we identified and that we could have increased our sample size if our illness severity analysis had been based on Medicare data. Representatives from the three specialty hospital organizations suggested that we might have obtained different results if we had analyzed more claims from the hospitals that we did include. They also stressed that our reported differences in illness severity could be misleading because we did not analyze the economic or clinical implications of the differences.

Our report discusses the concerns that some have raised regarding physician ownership of specialty hospitals and the potential effect on referrals. Data were not available on the identity of physician owners and therefore we could not determine if there was a relationship between physician ownership and referral behavior. Instead, our report provides descriptive information on the extent to which physicians own specialty hospitals. Our results show that many physicians who invest in specialty hospitals own relatively small shares. In about half the specialty hospitals the average share was 2 percent or less. However, our results also show that some physicians own considerably larger shares of 15 percent or more. Furthermore, the combined share owned by physicians who are members of a single group practice represents the majority ownership in some hospitals.

We disagree with the criticisms of our illness severity analysis. The 25 specialty hospitals included represent more than one-fourth of the facilities that we identified as meeting our criteria for a specialty hospital. We analyzed data pertaining to nearly 75,000 specialty hospital patients and approximately 900,000 general hospital patients. By focusing on the 10 most common diagnoses at each specialty hospital, we included nearly two-thirds of all patients treated at the specialty hospitals in our sample. Although an analysis of Medicare patients alone would have allowed us to increase the number of hospitals in our sample, it would have provided much less comprehensive information on the patients treated at each hospital. As we stated in our report, we did not attempt to determine the economic implications of the illness severity differences we observed between specialty and general hospitals. Research by MedPAC suggests that average treatment costs tend to rise with illness severity, as classified by the APR-DRG system, but we did not quantify the cost differences for the specific diagnoses we analyzed.

We plan no further distribution of this report until 30 days after the letter's date. At that time, we will send copies of this report to appropriate congressional committees and other interested parties. We will also make copies available to others upon request. This report will be available at no charge on GAO's Web site at http://www.gao.gov.

If you or your staffs have any questions, please call me at (202) 512-7119 or James Cosgrove at (202) 512-7029. Other contributors to this report include Hannah Fein, Zachary Gaumer, and Ariel Hill.

A. Bruce Steinwald

A. Bruce Steinwald
Director, Health Care—Economic
and Payment Issues

Enclosure

Scope and Methodology

This enclosure provides additional information on three key aspects of our analysis. First, it lists the criteria we used to define specialty hospitals and the process we followed to identify them. Second, it discusses the survey used to collect physician ownership information. Finally, it describes the data and methodological approach used to compare patient illness severity at specialty and general hospitals.

Specialty Hospital Definition and Identification

Although a standard definition for a specialty hospital does not exist, a reasonable approach is to define specialty hospitals as those that predominately treat certain diagnoses or perform certain procedures. For this report, we classified a hospital as a specialty hospital if the data indicated that

- two-thirds or more of its inpatient claims were in one or two major diagnosis categories (MDC) or
- two-thirds or more of its inpatient claims were for surgical diagnosis-related groups (DRGs).

Because our study focused on private, short-term, acute care hospitals, we eliminated from consideration hospitals that were government-owned and those that tended to provide long-term care or otherwise had missions very different from those of short-term, acute care general hospitals. Thus, we excluded

- government-owned hospitals;
- hospitals where the majority of inpatient claims were for MDCs that related to rehabilitation, psychiatry, alcohol and drug treatment, children, or newborns; and
- hospitals with fewer than 10 claims per bed per year.

Of the hospitals that met our criteria, 92 could be classified into four specialization categories: cardiac, orthopedic, surgical, and women's.[13] An additional 18 hospitals specialized in a variety of other areas, such as eye and ear, nose, and throat procedures. For this report, we focused on the specialty hospitals in the four major categories listed above.

We applied our criteria to inpatient discharge data from two different data sources: the 2001 Medicare Provider Analysis Review file and the 2000 Healthcare Cost and Utilization Project (HCUP) data set. Medicare and HCUP data both have distinct advantages and disadvantages. Medicare data contain patient information from virtually all of the nation's hospitals, but only for Medicare patients. Patients covered by Medicare are predominately age 65 or older. Consequently, some conditions—such as those that affect women of childbearing age—may be underrepresented, or

[13]This number does not include hospitals that initially appeared to be specialty hospitals, but informed us through our survey that they did not meet our criteria for a specialty hospital.

not represented at all, in Medicare data. Thus, it is likely that an identification based on Medicare data may undercount the number of hospitals that specialize in treating such conditions.

In contrast to Medicare, HCUP data provide information on all of a hospital's patients. However, HCUP data are only available for hospitals in 29 states and each state's data must be purchased separately. We obtained HCUP data from the following six states: Arizona, California, New Jersey, New York, North Carolina, and Texas.[13] These states were selected because Medicare data identified them as having potentially large concentrations of specialty hospitals.

To identify specialty hospitals that opened too recently to be included in the Medicare or HCUP data, we obtained information from the American Surgical Hospital Association and two national specialty hospital chains: MedCath Corporation and National Surgical Hospitals. These three organizations also provided information on specialty hospitals that are under development.

Source of Physician Ownership Information

To obtain information on physician ownership of specialty hospitals, we surveyed the more than 100 cardiac, orthopedic, surgical, and women's hospitals that we identified as in existence or under development. Among other questions, hospital representatives were asked about the number of physician owners, the overall percentage of the hospital owned by physicians, the largest share owned by a single physician, and the largest combined percentage of the hospital owned by physicians in a single revenue-sharing group practice. The survey was conducted from January through March 2003. Approximately 80 percent of the hospitals responded to our survey.

Severity of Illness Analysis

To compare patient illness severity at specialty and general hospitals, we analyzed 2000 HCUP data from Arizona, California, New Jersey, New York, North Carolina, and Texas. An analysis of HCUP data for these six states identified 25 specialty hospitals in 18 urban areas.[14] Patients at each specialty hospital were compared to patients in the same diagnosis categories at short-term, acute care general hospitals in the same urban area. (See table 1.) A total of 396 general hospitals were used in the comparisons.

[13]We obtained HCUP data on hospitals in three of Texas's five regions. .
[14]One specialty hospital was excluded because it was located in a rural area and we could not readily identify a set of general hospitals that should serve as the comparison group.

Table 1: Number of Urban Specialty Hospitals and Comparison General Hospitals Used in Patient Illness Severity Analysis, by Specialty Hospital Type

Specialty hospital type	Number of urban specialty hospitals	Number of urban areas	Number of general hospitals in urban areas (range)
Cardiac	7	7	5 to 26
Orthopedic	8	6	10 to 87
Surgical	3	3	2 to 51
Women's	7	7	7 to 87

Source: HCUP.

Note: Data are from HCUP (2000).

We used All Payer Refined Diagnosis Related Groups (APR-DRG), a widely recognized patient classification system developed by 3M Health Information Systems, to assign an illness-severity level (minor, moderate, major, or extreme) to each patient on the basis of the DRG information contained in the HCUP discharge data. The system, which is frequently used by hospitals and private insurers, groups patients into one of 355 diagnosis categories and assigns a severity level based on patient diagnosis, age, sex, discharge status, and procedure.

Based on numbers of patients treated, we identified the 10 most common diagnosis categories at each specialty hospital and computed the percentage of patients in each of those categories determined to be severely ill (that is, assigned to the major or extreme severity level by the APR-DRG system). We then determined the percentage of severely ill patients in the same 10 diagnostic categories treated at general hospitals located in the same urban area and used the result as a benchmark against which to compare the specialty hospitals. We repeated this process for each specialty hospital. This ensured that we compared illness severity among the types of patients typically treated at each specialty hospital to the illness severity for similar types of patients treated at area general hospitals.

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E-mail: fraudnet@gao.gov
Automated answering system: (800) 424-5454 or (202) 512-7470

Public Affairs

Jeff Nelligan, managing director, NelliganJ@gao.gov (202) 512-4800
U.S. General Accounting Office, 441 G Street NW, Room 7149
Washington, D.C. 20548