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MedPac Study – A Review of Findings Released October 28-29, 2004  
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The Medicare Payment Advisory Commission (MedPac) was mandated by last year's Medicare Modernization Act (MMA) to assess the impact of specialty, physician-owned hospitals on general hospitals and how the current diagnosis related group ("DRG") payment system should be updated to better reflect the costs of care. The transcript from the October 28-29, 2004 meeting became available on November 7, 2004. Julian Pettengill, a research director for MedPac, presented the findings.

## I. Summary Conclusions

MedPac set forth several conclusions at the October 28 and 29th meetings. These included the conclusions that: 1) surgical DRGs are generally more profitable than medical DRGs, and 2) moderate and minor severity patients are generally more profitable than major and extreme severity patients. The MedPac study further concluded that specialty hospitals had a relatively small but not insignificant patient mix advantage such that the shift towards treating patients in specific DRGs and the lower severity of patients led to approximately a 5 to 10% profitable advantage for specialty hospitals as compared to general hospitals. The Commissioners pointed out in the discussions following the presentation of the findings that the difference in the types of patients served may not have been based on improper incentives. In fact, in many situations it was noted that specialty hospitals recognize that they do not have the appropriate resources to treat very severe patients or certain types of patients.

## II. MedPac Findings

MedPac addressed three issues related to physician-owned hospitals: 1) whether Medicare's hospital inpatient payment system creates financial incentives for specialization by setting payment rates that are more profitable for some DRGs than for other DRGs; 2) whether relative profitability differs across patients with different severity of illness within DRGs thereby creating financial incentives to select patients with less severe conditions; and 3) whether specialty hospitals treat a favorable selection of Medicare patients across and within DRGs.

With regard to relative profitability, MedPac found that Medicare's current payment policies create differences in relative profitability across and within DRGs. The discrepancies in relative profitability across DRGs arise from the case-level features of the payment system, primarily the DRG relative weights and the outlier payment policy. Mr. Pettengill explained the effect of the DRG relative weights on profitability:

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The DRG weights are intended to measure the relative costliness of typical patients in each DRG. At the beginning of the prospective payment system in 1983, the DRG weights were based on costs estimated at the claim level, using charges and other information from the claims, and data from the hospitals' annual cost reports. In 1986, CMS changed to using charges alone....[b]ut over time weights that are based on charges are vulnerable to the effects of hospitals charging practices.

[For example] We know from the cost-to-charge ratios on the cost reports that hospitals typically set higher markups for ancillary services such as tests and supplies and so forth, operating room time, than they do for routine and intensive care, which would also be room, board and routine care, and they may also raise these sets of charges at different rates over time.

The MedPac study, in a fairly detailed manner, studied the approximately 350 APR-DRGs and the severity of cases within the APR-DRGs. Here, they calculated for each DRG the overall payment of a DRG compared to the overall cost of the service for the DRG. For example, a more profitable case would involve a higher payment-to-cost ratio. Based on the detailed study, MedPac made two general conclusions:

1. Surgical DRGs are generally more profitable than medical DRGs.
2. Moderate and minor severity patients are generally more profitable than major and extreme severity patients.

The focus of the discussion and report then turned to the issue of physician-owned specialty hospitals.

Next we turn from the relatively [sic] profitability of the DRGs in the APR-DRGs at the national level to what physician-owned specialty hospitals do. We have two questions on patient selection. Do physician-owned specialty hospitals focus on DRGs with above average relative profitability under Medicare? Within DRGs, do they treat groups of patients that are expected to be relatively more profitable than the average? That is, do they treat groups of patients that are expected to be relatively more profitable than the average? That is, do they treat a favorable selection of Medicare patients across and within DRGs?

Here, in simple terms, the study concluded that specialty hospitals had a patient mix advantage. In short, the specific DRGs and the lower severity of patients led to approximately a 5 to 10% profit advantage.

For heart hospitals, however, the 1.06 in the first column means that, on average, physician-owned hospitals treat Medicare patients in DRGs that are relatively more profitable than the national average. They also treat a favorable selection of patients within DRGs. This is the 1.03 in the middle column. So that overall their expected relative profitability is 1.09 or 9 percent above the relative profitability of the average Medicare patient.

Peer heart hospitals also have a favorable selection of DRGs, but not as favorable as the physician-owned hospitals. But peer hospitals also have a slightly unfavorable selection within DRGs, at 0.99, so they end up with an expected relative profitability value of 1.03. It's still above average, but it's not as high as for physician-owned hospitals.

The physician-owned orthopedic hospitals, in contrast, have a definitely unfavorable selection of DRGs but that's more than counterbalanced by their favorable selection within them. So that overall they end up above average.

Peer orthopedic hospitals have an equally unfavorable selection of DRGs but their selection within DRGs is only slightly favorable, so they end up still below average.

Physician-owned surgical hospitals start with an average selection of DRGs but they have a very favorable selection within DRGs and therefore end up well above average. The peer surgical hospitals start with the same roughly average selection across DRGs and they have a slightly favorable selection, a somewhat favorable selection with the DRGs as well, so they end up overall above average.

The Commissioners engaged in discussions as to solutions or policy changes as to this issue. Here, it was interesting to note that the Commissioners realized that the profit differential may very well not be based on improper incentives. In fact, in many situations such specialty hospitals recognize that they do not have the appropriate resources to treat very severe patients or certain types of patients. Rather, they treat, in a higher quality, lower cost manner, certain types of patients. Here, for example, the dialogue was as follows:

DR. REISCHAUER: There is a tendency in these kinds of discussions to look at the evidence and draw motivational conclusions. And within DRG selection it is perfectly possible that more complex cases are, in a sense, "better served" in a full-service facility and the "selection" is occurring for that reason. And so I think we want to be careful that we don't overinterpret the evidence that we have in front of us. The system clearly is flawed in the sense of the payment incentives and that is causing behavior which should be expected if we think we have an efficient economy here. And there are other explanations for some of this behavior, as well.

DR. HACKBRATH: What's striking me is that both Nick [Wolter] and Ralph [Muller], if I understand them correctly, are saying this is an issue not just in specialty hospitals but really across the hospital sector, not-for-profit, for-profit, specialty, general hospital. This is a more fundamental issue.

I agree with you. You create the incentives. The whole principle of the system is that people are going to respond to incentives.

MR. MULLER: My point is that the issue is somewhat mitigated when you take care of a broad range of patients. And therefore the ones where you're at 0.9 on payment-to-cost balance out the ones where you're at 1.5. Not perfectly and maybe not...in every last hospital in the country. But by and large, if you have a fuller range, some of that is mitigated.

DR. STENSLAND: Just to echo what Bob said, on our site visits we found pretty much what you said. Many of the surgical hospitals and the orthopedic hospitals specifically told us we don't think it is appropriate for us to treat these higher severity patients and they had explicit criteria not to. The heart hospitals give a different statement, that they were more wide-open in terms of who they would treat. I guess you can see some of that reflected in the data we have up there. It just really matches up with what we saw in our site visits.

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Overall, this part of the study presents findings that are not unexpected. In short, surgical patients are more profitable than medical patients and lower severity patients are more profitable than higher severity patients. These findings will be touted by opponents of physician ownership as reason to prohibit such ownership. In contrast, advocates of the development of cost effective alternatives to full service hospitals will assert that changes are needed in the DRG system as a whole and that reductions in costs which are driven by specialty hospitals should help to improve the viability and cost effectiveness of the entire health care system.