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The Specialty Hospital Debate: Beyond the Medicare Moratorium

Executive Summary

- On June 8, an 18-month moratorium imposed on certain specialty hospitals that serve Medicare patients will expire.
- The rationale for the moratorium was to address concerns voiced by traditional community hospitals that the competition posed by physician-owned specialty hospitals would hurt their ability to offer quality care to all of their patients.
- Specifically, the moratorium is on the referral of Medicare patients to new, physician-owned specialty hospitals (particularly those specializing in cardiac, orthopedic, and surgical care).
- To help it determine the impact specialty hospitals have on overall patient care, Congress mandated studies by the Medicare Payment Advisory Commission (MedPAC) and the Department of Health and Human Services (HHS). Both studies were due March 8, 2005.
- In its report to Congress, MedPAC recommended reforms to the payment system used to reimburse hospitals for Medicare patients in order to make the system more fair. MedPAC estimated that its reforms would substantially benefit many community hospitals. MedPAC also suggested that the moratorium be extended for an additional 18 months.
- Importantly, the MedPAC report did not base its moratorium extension recommendation on a finding of financial harm to the community hospitals as a result of competition from the specialty hospitals. Indeed, it produced no evidence of such harm. Rather, it suggested that the moratorium be extended only for the purpose of allowing both Congress and the Secretary of HHS time to consider and implement its payment-reform recommendations.
- In its report, CMS also recommended reform of the Medicare payment system and called for a six-month study period to allow time to begin implementation of the reforms.
- Based on the current lack of evidence of harm from specialty hospitals, extension of the moratorium is not warranted. However, it would be beneficial to the community hospitals, in particular, for Congress to implement payment reforms along the lines of those recommended by MedPAC and CMS. This is the more appropriate response to the concerns raised by the community hospitals than an extension of the moratorium, and is more likely to result in achieving the paramount goal of assuring quality health care for all Americans.

Introduction

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), well known for its historic reforms to the Medicare program, contained a little-known provision imposing an 18-month moratorium on the referral of Medicare patients to new, physician-owned “specialty hospitals.” That moratorium is set to expire on June 8, 2005.¹

Specialized, targeted-care facilities, like women’s and children’s hospitals, are not new to medicine. However, the recent, rapid growth of certain specialized facilities owned by physicians represents a relatively new trend. What the MMA identified for scrutiny were those specialty hospitals that primarily provide care to Medicare patients in one of three areas: cardiac care, orthopedics, or surgery.² Concerns about how the success of these facilities might affect the financial well-being of community hospitals prompted Congress to impose the moratorium. The intent of the Congress was to determine whether additional legislative or administrative restrictions on specialty hospitals were necessary, pending a review of the issue by the Medicare Payment Advisory Commission (MedPAC) and the Department of Health and Human Services (HHS).³

As the June 8 expiration date approaches, Congress must decide whether to extend the moratorium or allow it to expire. This paper examines the information available to Congress in making its decision, and compares the arguments for and against extending the moratorium.

Meanwhile, there is justification for the Senate to work on a related matter: reform of the Medicare payment system for hospitals. Improving the fairness in the way that Medicare pays hospitals will ensure that both community hospitals and specialty hospitals receive adequate and appropriate payment for their services, which is key to preserving quality care for Medicare patients. This in turn will assure that hospitals can continue to adequately serve the entire community.

Background

Proponents of physician-owned specialty hospitals argue that the recent increase in the number of such facilities grew out of physicians’ frustrations with community hospital administration and the physicians’ desire to provide better care for their patients, increase predictability in scheduling of patient procedures, and have greater administrative control over

¹Section 507 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Public Law 108-173, H.R. 1, 108th Congress, 1st Session, December 8, 2003 (hereafter referred to as MMA).

²MMA, Section 507(a)(1)(B).

³MMA, Section 507(c).

the management of their cases.⁴ Opponents of specialty hospitals counter that physicians' true motivation is "self-interest and profit."⁵

During the 2003 debate on Medicare reform, representatives of the nation's traditional community hospitals voiced concerns about increased competition from physician-owned specialty hospitals, asserting that physicians could refer the most profitable cases to facilities in which they have an ownership interest. Community hospitals, of course, treat all kinds of patients at all levels of care, not all of them highly profitable. As such, they have employed the practice of "cross-subsidizing" – allowing the use of higher-profit services to offset the costs of less profitable but necessary services, like burn units and trauma centers.⁶ They contended that the loss of some of the more profitable services to specialty hospitals would substantially affect their ability to maintain critical but unprofitable services. As a result, Congress imposed the 18-month moratorium on referral of Medicare patients to physician-owned cardiac, orthopedic, and surgical hospitals that were not in existence as of November 18, 2003.⁷

To help it determine what, if any, detrimental effects these specialty hospitals have on the traditional hospitals operating in the same communities, Congress also mandated reports from two federal agencies, MedPAC and HHS.⁸ MedPAC was ordered to primarily study the financial impact, while HHS was ordered to study the issue primarily from a quality-of-care perspective. MedPAC is an independent federal body permanently charged with the task of making Medicare payment-policy recommendations to Congress twice each year (in addition to issuing special reports, such as the one mandated by MMA). The HHS study was conducted by the Centers for Medicare and Medicaid Services (CMS), which under the direction of the Secretary of HHS, is charged with administering both the Medicare and Medicaid programs.

In its efforts to discover whether specialty hospitals threaten the viability of community hospitals, Congress mandated that each agency report to Congress on certain specified topics. For example, MedPAC was directed to focus its efforts on examining the current system used to reimburse hospitals for inpatient stays. CMS was directed to focus on patient referral patterns, quality of care, and differences in uncompensated care. Both studies, including each group's recommendations for legislation or administrative changes, were due to Congress by March 8, 2005. This was meant to provide Congress with ample time to consider the findings and make a fair determination as to the best way to respond to the concerns of both hospital groups prior to the expiration of the moratorium.

⁴Jamie Harris, Executive Vice President and Chief Financial Officer, MedCath Corporation, in testimony before the House Committee on Ways and Means, March 8, 2005 - <http://waysandmeans.house.gov/hearings.asp?formmode=view&id=2533>, and MedPAC, "MedPAC Report to the Congress: Physician-Owned Specialty Hospitals," March 2005, p.vii.

⁵Dick Davidson, "Hospitals Competing for Patients," op-ed, *The Washington Times*, January 28, 2005, p.A18.

⁶American Hospital Association, *TrendWatch*, September 2004, p.7.

⁷MMA, Section 507(a)(1)(B).

⁸Although CMS was asked to look primarily at quality of care issues, the MMA did give CMS the task of "assess[ing] the differences in uncompensated care ... and the relative value of any tax exemption available to such hospitals," MMA, Section 507(c)(2)(D).

Study Results Form the Core of the Issue

What the Studies Found

With expiration of the moratorium on Medicare referrals imminent, traditional hospitals are asking Congress to extend it. Specialty hospitals, on the other hand, claim that their ability to grow in the marketplace and, therefore, better serve Medicare patients, has been stifled long enough, and are asking Congress to allow the moratorium to expire.

In keeping with its intent to determine if restrictions in the hospital marketplace are appropriate, Congress should study the reports to consider whether there is evidence of harm and analyze the accompanying recommendations. MedPAC submitted its report to Congress on time, on March 8, while the CMS report was only made available on May 12. It is important to note from the outset that neither report provides evidence that the operations of specialty hospitals pose harm to community hospitals.⁹

MedPAC's Findings on Harm

In preparation to study whether specialty hospitals are harming the financial health of community hospitals, MedPAC articulated four criteria for determining which specialty hospitals to include in its study in order to produce reliable results.¹⁰ To be included, MedPAC required that the hospital be physician-owned, specialize in a particular category of services (for example, cardiac) and offer at least two major procedures in that category as part of its menu of services, have a minimum of at least 25 Medicare cases during 2002, and have submitted Medicare cost reports and claims for 2002.¹¹ Of the nearly 100 specialty hospitals operating nationwide, 48 met all of the MedPAC criteria. The remaining specialty hospitals, according to MedPAC, could not provide sufficient data because they opened after 2002 or were still under construction.¹²

To supplement its review of the cost reports and claims data for the 48 selected specialty hospitals, the agency made site visits to three markets, where it conducted interviews with representatives from eight specialty hospitals and nine community hospitals. Additional information was obtained through conversations with an additional group of 14 specialty hospitals and seven community hospitals.¹³

After analysis, MedPAC put forward no conclusive data that there is any financial harm to community hospitals as a result of the operation of specialty hospitals. The report states, "The financial impact on community hospitals in the markets in which physician-owned specialty

⁹See Footnote 4 and CMS, "Centers for Medicare & Medicaid Services Study of Physician-owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003," May 2005.

¹⁰MedPAC, p.4.

¹¹MedPAC, p.4. Note that 2002 was the most recent set of complete Medicare costs and claims data available for review at the time that MedPAC undertook its study.

¹²MedPAC, p.4.

¹³MedPAC, p.5.

hospitals are located has been limited, thus far. Those community hospitals competing with specialty hospitals have demonstrated financial performance comparable to other community hospitals.”¹⁴ The report underscored this in noting that there had been “little impact on community-hospital profitability” during the period studied by MedPAC.¹⁵ Moreover, it suggests that “specialty hospitals may be an important competitive force that promotes innovation.”¹⁶

CMS’s Findings on Harm

CMS used similar criteria to define its sample of study hospitals, although it required that, to be included, the hospital offer five major procedures in its category of specialization.¹⁷ The agency further required that the hospitals be geographically diverse (i.e., include both urban and rural hospitals), include both mature hospitals and recent start-ups (to understand the evolution of the industry), and have adequate caseloads to facilitate analysis and the use of patient focus groups.¹⁸ Applying the criteria, CMS reached a study sample of 11 specialty hospitals in six markets to which site visits were made. CMS also made visits to competing community hospitals in each of the six markets.¹⁹ Data from the site visits was supplemented with analysis of cost reports and claims data for all specialty hospitals and their competitors through 2003.²⁰

In contrast to a finding of harm, Dr. Mark McClellan, Administrator of CMS, remarked on findings of high quality of care at the specialty hospitals studied by CMS when he presented his agency’s report to Congress. With regard to patient care, he noted that “specialty hospitals generally provide a more uniform set of services and have fewer competing pressures than community hospitals, and thus are able to provide more predictable scheduling and patient care.”²¹ The CMS report also found fewer complications and lower mortality rates at cardiac hospitals, even when adjusted for severity, and remarked that “cardiac hospitals delivered high quality of care that was as good as or better than their competitor hospitals.”²² As for surgical and orthopedic hospitals, CMS remarked that, although smaller sample sizes precluded the agency from drawing statistically significant conclusions on the quality of care in these facilities, patient satisfaction was extremely high.²³

The Question of the Moratorium

Despite having found no evidence of harm, MedPAC recommended that Congress extend the moratorium for an additional 18 months. This recommendation seems to be based on a new

¹⁴MedPAC, p.vii.

¹⁵MedPAC, p.23.

¹⁶MedPAC, p.43.

¹⁷CMS, p.5.

¹⁸CMS, p.6.

¹⁹CMS, p.6.

²⁰CMS, p.8.

²¹Mark McClellan, M.D., Administrator, Centers for Medicare & Medicaid Services (CMS), in testimony before the House Committee on Energy and Commerce, May 12, 2005 - <http://www.cms.hhs.gov/media/press/testimony.asp?Counter=1459>.

²²CMS, p.42 and p.iii.

²³CMS, p.iii

argument, that implementation of payment reforms – which MedPAC, in this same report, recommends – should begin before specialty hospitals are allowed to re-enter the marketplace. MedPAC’s suggested reforms would significantly change the way that hospitals are reimbursed for Medicare inpatients. (These recommended reforms are detailed in the next section of this paper.) The report states that an extension is needed to allow additional time for gathering information, and to provide Congress time to consider the complex payment reform recommendations that it details and give HHS time to implement them.²⁴ It is unclear why, as MedPAC seems to say, it is justifiable to penalize the specialty hospitals while payment reforms for all hospitals are being implemented. In any event, this rationale for extension is not consistent with the original intent of Congress, which was to impose a temporary moratorium while awaiting MedPAC’s and CMS’s reports on harm.

Further, MedPAC suggests that, in order to spare hospitals from incurring drastic, one-time changes in reimbursement rates that might result if its payment reform recommendations were implemented, the reform process should be conducted incrementally over a transitional period. The report, however, gives no clear indication of how long a period would be needed.²⁵ It is unlikely that Congress and HHS can design and implement large-scale reforms in only 18 months. If it adhered to its new rationale, in January 2007, MedPAC presumably would again advocate extension of the moratorium until payment reforms are complete. Thus, instead of resolving Congress’ questions about the effect of specialty hospitals, this recommendation leaves Congress with an indefinite timeline, and precludes further study of this fledgling sector of the hospital industry.

CMS does not recommend a moratorium, but does suggest a review period, during which the agency will review its Medicare participant approval procedures for hospitals.²⁶ The agency suggests that its review of participant approval procedures could take up to six months, during which time CMS “will instruct [its] fiscal intermediaries to refrain from processing further participation applications from specialty hospitals.”²⁷ When questioned by members of the Energy and Commerce Committee about whether this six-month review constitutes a moratorium, Dr. McClellan was emphatic in stating that CMS does not support extension of the current moratorium.²⁸

Beyond the Moratorium: Medicare Payment Reforms

MedPAC’s Recommendations

MedPAC’s remaining recommendations in its report to Congress relate to improving payment accuracy in the Medicare Inpatient Prospective Payment System (IPPS). Thus, MedPAC is clearly focusing much more on the proactive – payment reforms – than on the

²⁴MedPAC, p.43.

²⁵MedPAC, p.viii.

²⁶McClellan, p.10.

²⁷McClellan, p.20.

²⁸Mark McClellan, M.D., Administrator, Centers for Medicare & Medicaid Services (CMS), during questioning by the House Committee on Energy and Commerce, May 12, 2005.

punitive – extension of the moratorium. This is an appropriate focus because payment reforms will affect all types of hospitals. As MedPAC Chairman Glenn Hackbarth commented, “What’s striking to me is that ... 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.”²⁹

Specifically, MedPAC focuses on a reform that can eliminate disparities and equalize payments to all inpatient hospitals: refining the current diagnosis-related groups, known as DRGs, which are used in determining payment to hospitals for inpatient stays.³⁰ DRGs are used to classify Medicare hospital inpatients for payment purposes, based on their medical diagnosis and the procedures that will be performed during their stay; the DRGs are then used as part of a complex, multi-factor payment formula to determine how much a hospital will be reimbursed for care of a particular patient. One of the problems identified by MedPAC is that some DRGs are defined very broadly and often include patients who receive the same general diagnosis but whose conditions differ greatly in terms of severity. Thus, although admission of a very sick patient requires that a hospital spend more money during the course of treatment than for the admission of a healthier patient, the hospital currently receives the same reimbursement from Medicare if the two patients’ general diagnosis is the same.

MedPAC revealed a critical fault with the current system that is at the heart of the moratorium debate. That is, that the current payment system encourages “cherry-picking” (i.e., patient selection based on profitability). According to MedPAC, “Discrepancies between Medicare’s payment rates and hospitals’ average costs per discharge across DRGs result in differences in profitability. These profitability differences create financial incentives – for all hospitals, *specialty and nonspecialty alike* – to specialize in treating relatively profitable DRGs.”³¹ MedPAC further notes that “when DRGs are defined too broadly they fail to isolate differences in severity of illness that substantially affect the cost of hospital inpatient care. The resulting differences in profitability *within* DRGs create financial incentives for hospitals to select relatively low-cost patients, such as those who have the same diagnosis but are less severely ill.”³²

Part of the reason that this fault is critical is that the hospital inpatient payment system is prospective, meaning that hospitals receive a predetermined amount per patient, based on the DRG formulation described above. The reimbursement amount is intended to cover the *expected* costs of treating that patient; however, some providers will be paid somewhat more than their actual costs and many will be paid somewhat less.

MedPAC wants to address this critical fault by refining the DRGs to reflect more accurately differences in the severity of patient illnesses, thereby reducing the opportunity for adverse patient selection. In the current system, a single DRG encompasses several degrees of

²⁹Glenn M. Hackbarth, in comments made during the MedPAC public meeting, October 29, 2004, p.331 - http://www.medpac.gov/public_meetings/transcripts/1004_allcombined_transcript.pdf.

³⁰MedPAC, p.viii.

³¹MedPAC, p.25 (emphasis added).

³²MedPAC, p.26 (emphasis added).

patient severity, but what MedPAC recommends is a refined DRG system that would have multiple DRGs for a single diagnosis, with each DRG representing a different level of patient severity. Hospital reimbursements would reflect these refinements, with hospitals receiving increased payments for more severe cases. As MedPAC notes, refinements in the DRG system will certainly mean that some providers will see an increase in payments, while others will see a decrease in payments, depending on the patients they see. Overall, however, MedPAC argues that the refinements will result in a more equitable reimbursement system that will not require additional federal spending and will not affect patient access to care.³³

Additional MedPAC recommendations touch on another element of the complex hospital payment formula: DRG relative weights. MedPAC suggests that these weights, or payment factors, be based on the *estimated cost of care* rather than on the average of national *charges*. Under the current system, “CMS assigns a relative weight to each DRG that is intended to reflect the relative costliness of typical patients in that [DRG] compared with the cost of treating the average Medicare patient.”³⁴ To compute the relative costliness of the patient, CMS looks at the national average of charges that hospitals bill to Medicare for each DRG. However, due to differences in hospital charges, this number may not reflect the actual cost of care. There are several factors that may influence the way a hospital bills Medicare for its patients’ care. One example cited by MedPAC is that hospital markups for ancillary services, like access to the operating room or imaging services, tend to be higher than markups for routine services like room and board. Thus, weights for DRGs that typically require significant use of ancillary services will, over time, become higher in comparison to the actual cost of care. Conversely, weights for DRGs using primarily routine services may not be high enough.³⁵

MedPAC recommends that the relative weights be based on the estimated cost of care, so that hospital markups on services would equalize in order to prevent under-reimbursement. As with refinement of DRGs, MedPAC contends that changes in the relative weights that more accurately reflect the cost of care within each DRG will lead to more equitable reimbursement and will not require additional federal spending and will not affect patient access to care.³⁶

CMS’s Recommendations

Three of CMS’s four recommendations, which provide for payment reforms as well as administrative changes to the Medicare program, are based on a distinction that CMS draws between the average cardiac hospital and its surgical and orthopedic counterparts.

This distinction is important because, although many of CMS’s findings applied generally to all specialty hospitals, the CMS report notes that cardiac hospitals differ substantially from surgical and orthopedic hospitals in that “cardiac hospitals tend to have a higher average daily census, an emergency department, and other features, such as community outreach programs, while surgery and orthopedic hospitals more closely resemble ambulatory surgery centers,

³³MedPAC, p.40.

³⁴MedPAC, p.28.

³⁵MedPAC, p.26.

³⁶MedPAC, p.40.

focusing primarily on outpatient services.”³⁷ Thus, CMS drew upon information it gathered in response to a separate mandate related to ambulatory surgery centers (ASCs) in formulating a response on the issue of specialty hospitals.³⁸ CMS concludes that reforms are needed for both inpatient hospital stays and for ASC services.

In the two months since MedPAC issued its report to Congress, CMS has begun the process of analyzing MedPAC’s recommendations to assess the feasibility of implementing the suggested payment reforms and determine how the reforms might impact hospitals.³⁹ Using the MedPAC report as a guide, CMS plans to implement significant reforms to the Medicare inpatient payment system; however, CMS suggests that other irregularities in hospital payment policy may exist, and that refinement of the inpatient payment system is only the first step in assuring that all hospitals are paid accurately for the services they provide. Through its research, CMS determined that, while cardiac hospitals tend to be similar to community hospitals, orthopedic and surgical hospitals more closely resemble ASCs. Thus, CMS suggested, “physicians may be participating in the ownership of small orthopedic or surgical hospitals rather than in ASCs in part to take advantage of payment differences between hospital outpatient departments and ASCs.”⁴⁰ Because the current ASC payment system is badly outdated, “the payments for particular services are [often] significantly higher in hospital outpatient departments” than in ASCs.⁴¹ These differences, CMS reasons, create incentives for physicians to develop orthopedic and surgical hospitals where services are reimbursed at higher rates. Reforming the ASC payment system will eliminate these payment differences.

In order to complement the above-mentioned payment reforms, CMS recommends “closer scrutiny of whether entities meet the definition of a hospital” under Section 1861(e) of the Social Security Act.⁴² One of the key requirements for a hospital under Section 1861(e) is that it be primarily engaged in treating patients in an inpatient setting. If CMS implements its recommendation, any entity that does not meet the Section 1861(e) definition of “hospital” will be ineligible for a Medicare hospital provider agreement.⁴³ CMS makes it clear that this requirement will apply to both new applications and existing provider agreements; if a hospital ceases to be engaged primarily in inpatient care, the hospital’s provider agreement may be terminated. Thus, those specialty hospitals whose patient populations consist primarily of outpatients will not be granted Medicare hospital provider agreements but will likely be categorized instead as ASCs and will be reimbursed accordingly.

Effects of the Recommendations

The MedPAC report provided an analysis of how the agency anticipated that its suggested payment reforms might affect community and specialty hospitals. According to the report, both

³⁷McClellan, p.6.

³⁸MMA, Section 626.

³⁹McClellan, p.10.

⁴⁰McClellan, p.17.

⁴¹McClellan, p.17.

⁴²McClellan, p.18. See also 42 U.S.C. 1395x.

⁴³McClellan, p.18.

types of hospitals would see payment increases in some areas and payment decreases in others, if all of the MedPAC payment reforms were implemented. It is important to note MedPAC's conclusion that, while some community hospitals would see a decline in payment amounts, many more would see payment increases.⁴⁴ Moreover, MedPAC found that nearly all specialty hospitals would see decreases in their payments, and that no specialty hospitals are projected to receive increased payments. Even so, specialty hospital proponents continue to support payment reform as a means of allaying the concerns of specialty hospital detractors.⁴⁵

In its recommendations, CMS concurs with MedPAC's recommendation that improving the accuracy of IPPS payment rates would be worthwhile. CMS finds that, while "the emergence of specialty hospitals makes pointed the need for such improvement, we believe such changes should be desirable in any case."⁴⁶ The agency cautions that, while payment reforms are needed, it is still conducting a detailed analysis of MedPAC's recommended reforms and their possible effects on patient care. CMS further cautions that, even with reforms, any reimbursement system "that groups cases and provides a standard payment for cases in the group – that is, the IPPS among other Medicare payment systems – will always present some opportunities for providers to specialize in cases where they believe margins are better."⁴⁷ The report concludes that improving payment accuracy should reduce opportunities and incentives for achieving profitability through adverse patient selection.⁴⁸

Senate Response

In anticipation of the moratorium's expiration, Senator Charles Grassley, Chairman of the Senate Committee on Finance, recently introduced legislation that would implement MedPAC's recommended payment reforms.⁴⁹ However, the legislation would also make *permanent* the moratorium on new specialty hospitals, while the operations of existing specialty hospitals would essentially be frozen.⁵⁰ In short, the bill would foreclose any possibility of further growth of the physician-owned specialty hospital industry.

Neither MedPAC nor CMS has advocated a permanent moratorium. To the contrary, both agencies have indicated that specialty hospitals represent a desirable, alternative form of

⁴⁴MedPAC, p.39.

⁴⁵Alan Pierrot, M.D., Past President, American Surgical Hospital Association, in testimony before the Senate Committee on Finance, March 8, 2005 - <http://finance.senate.gov/hearings/testimony/2005test/030805aptest.pdf>, and Michael Maves, M.D., Executive Vice President, American Medical Association, in a letter to Senate Majority Leader Bill Frist, April 22, 2005.

⁴⁶CMS, Recommendations Regarding Physician-Owned Specialty Hospitals, May 2005 - <http://www.cms.hhs.gov/media/press/files/052005/RecommendationsRegardingPhysicianOwnedSpecialtyHospitals.pdf>.

⁴⁷CMS Recommendations.

⁴⁸CMS Recommendations.

⁴⁹"Hospital Fair Competition Act of 2005," S. 1002, 109th Congress, 1st Session.

⁵⁰Current Law and Section-by-Section Analysis of the "Hospital Fair Competition Act of 2005," distributed by the Senate Committee on Finance. According to the document, existing specialty hospitals "would be prohibited from increasing their number of physician investors, increasing the percent of individual investment and aggregate physician investment in the facility, expanding their scope of services, and increasing their number of beds or operating rooms."

care for many Medicare patients and agree that specialty hospitals should be permitted to operate, provided that concerns about payment inequalities are alleviated.

Taken together, the payment recommendations of MedPAC and CMS provide a road map for reform of the Medicare payment system and suggest administrative action that would enhance the effectiveness of such reforms, making extension of the current moratorium unnecessary.

Conclusion

Congress' asserted power to legislate that certain businesses cannot participate in federal health programs must be exercised carefully. In determining whether to extend the specialty hospital moratorium or allow it to expire, Congress should consider the evidence it has before it. General hospitals continue to argue that they are disadvantaged by the operation of specialty hospitals. Specialty hospitals respond that there is insufficient data to conclude that their operations are having a detrimental effect on traditional community hospitals or on inpatient care, and that, based on the reports of MedPAC and CMS, extension of the moratorium is unwarranted.

Medicare payment reform provides a possible solution that will address the concerns that prompted the moratorium, ensuring that, whatever the past impacts, both community and specialty hospitals can be paid fairly for the services they provide.