PROMISES UNDER PRESSURE

Safeguarding Community Access to Health Care Services

AHA
Advancing Health in America

The Trend Toward "Niche" Providers

Issue

The delivery of health care in America is changing rapidly. In the midst of this change, one thing has remained constant – communities across America rely on hospitals to provide access to basic health care services. They look to the mission of hospitals and the physicians who serve with them to provide care to all, including those who are uninsured or underinsured. Community hospitals serve as the medical safety net for those in need.

Physician-owned specialty care providers, also known as "niche providers" – those that focus on a specific set of medical services, conditions or populations – are not new, but the nature and pace of their growth is. They include heart hospitals, cancer hospitals and clinics, ambulatory surgery centers (ASC), dialysis clinics, pain centers, imaging centers, mammography centers, and a host of other narrowly focused providers, generally owned, at least in part, by the physicians who refer patients to them.

AHA View

The AHA is very concerned that the growth of niche providers, if left solely to market forces, will undermine access to health care services for communities across this country. That concern is based on several factors.

Niche providers often do not serve the broader community. The rapid growth of niche providers threatens community access to basic health services and jeopardizes patient safety and quality of care. The trend among these providers is to carve out the more profitable services and to serve the well insured patients. They leave the community hospital to provide unprofitable services, such as trauma, and to care for all, regardless of their ability to pay.

Most niche providers have little or no obligations under the Emergency Medical Treatment and Labor Act (EMTALA), either because they operate on an ambulatory basis or because they do not have emergency departments (ED). Instead, niche providers rely on the ED capacity of local community hospitals. Many specialty care providers do not participate in Medicare and/or Medicaid or limit their participation when they do, and many provide little uncompensated care. These business decisions allow some niche providers to produce services less expensively, while often being paid the same or more than community hospitals that carry the social obligation to provide care to all 24 hours a day, 365 days a year.

Niche providers are undercutting the ability of community hospitals to meet the needs of the broader community. As profitable services are drawn away from general community hospitals, it becomes more difficult to support services needed by the community that are unprofitable. Trauma centers, burn units and EDs are seldom self-supporting. Caring for the uninsured, Medicaid patients and others who have limited coverage can only be accomplished if the hospital can rely on revenues from services with a positive margin. If the profitable services and well-covered patients are removed from the community hospital, its ability to

AHA View *(con't)*

continue meeting the needs of the entire community deteriorates. The result: The community loses access to specific services or ultimately to all the hospital's services as the general hospital closes.

Communities are also losing access to specialty physicians because the growth of specialty providers reduces the physicians' willingness to care for ED patients. The consequences for emergency patients can be life threatening. Many communities are already experiencing this problem as hospital EDs go on diversion for all or certain types of cases. A primary reason: lack of specialty physicians willing to serve on-call and treat patients in need.

At the same time niche providers are drawing profitable services and specialty physicians away from community hospitals, they expect those same hospitals to be their back-up. Consider the safety of a patient admitted to a specialty hospital for a routine surgical procedure, who then develops complications beyond the capacity of that facility. This surgical patient has to be transferred to a general acute care hospital for needed care. Or consider the nearby resident out for a jog, who experiences chest pain outside a specialty orthopedic hospital, goes inside to seek assistance, and is told to call 911.

Niche providers are increasingly owned by the same physicians who make decisions about when and where patients should receive care. Specialty physicians are making decisions about care for their patients that will also have an effect on the physician's personal financial interest. Caring for sick people transcends the simple buyer/seller relationship. Patients need to be able to trust that decisions about their care will be made on the basis of what is in their best interest, not the provider's. Left to market forces alone, the incentives in a competitive market may lead some providers to make business decisions that raise issues for the patients and communities they serve. Current federal regulations intended to tightly control physician self-referral are inconsistent in today's environment – they prohibit specialty physician referrals to a specialty program within the hospital if the physicians have any ownership interest, but allow unfettered referrals by those same physicians to a specific niche hospital they own outside the community hospital.

The incentives and business practices associated with increased reliance on market forces in the health care field must be integrated with basic ground rules that recognize that the public's expectations of health care providers are different than those of other sectors of the economy. Failure to do so would tear asunder, rather than refine, the social contract between health care practitioners and providers and the public. To preserve community access and safeguard patients' safety in this rapidly changing delivery environment, those ground rules must:

Restrict Conflict of Interest. Regulatory requirements should effectively limit physician self-referral and investment to tightly managed, group practice arrangements that are integral to their own practice.

Ensure Fairness in Regulation. Regulatory requirements should be comparable for competing health care practitioners and providers offering similar services, with respect to:

AHA View
(con't)

- Providing community access to essential services, including participation in Medicare and Medicaid, providing emergency services for all, and providing care to the uninsured;
- Quality standards and their enforcement;
- Disclosure of financial and ownership interests and conflicts of interest; and
- Payment for comparable services.

Compensate for Variations. Variations in regulatory obligations among competing providers (such as required provision of free care) should not create a disadvantage for affected providers. The market cannot operate effectively or appropriately if payment levels are the same for competing providers, but community obligations are not. To protect community access until necessary changes are made to regulatory requirements, certain compensating measures should be established, such as payment differentials to offset the costs of under- or uncompensated care.

The most critical changes to current federal law and regulations that are needed include:

Physician Ownership and Self-Referral. With the marked increase in physician-owned niche providers, the AHA supports revising the Stark law to eliminate or severely curtail the rural and "whole hospital" exceptions currently being used as loopholes. Under the current Stark exceptions, physicians may refer patients to a hospital in which they are an owner, so long as their ownership is in the whole hospital, not just a program or department. Unfortunately, many physician-owned niche hospitals have seized on this loophole by offering services that were once a specific department or specialty in a community hospital (e.g., cardiology, orthopedics, etc.) and turning them into a stand-alone niche hospital. As a result, the Stark "whole hospital" exception perversely allows referrals to niche hospitals while prohibiting referrals to the same specialty program or department if it remains within the community hospital.

Public Disclosure. Physicians should be required to disclose the nature of any financial interest they have in a health care-related entity to which they refer patients. The disclosure should be made in a manner that would inform individual patients for whom the physician is making referrals, as well as the larger community in which the physician practices.

Quality Standards and Monitoring. Where there are similar or exact clinical practices occurring in inpatient, outpatient and specialty service settings (e.g., ASCs or physician offices), federal quality standards and the mechanisms for enforcing them should be comparable, and in many areas, the same.

Transfer Agreements. Every ASC and specialty hospital that does not have a full-time ED should be required to have a formal transfer agreement with the community hospital(s) it intends to rely on for emergency back-up services. These transfer agreements should address support (whether in the form of serving on-call or providing financial support) for maintaining emergency capacity in the community, including specialty on-call coverage, and a full range of transfer and continuity of care procedures comparable to those required by EMTALA.