American Hospital Association

PROTECTING THE HEALTH CARE SAFETY NET

Limited-Service Hospitals

Issue

A loophole in the federal law allows doctors to own limited-service hospitals where they then refer their carefully selected patients to perform highly reimbursed procedures – a practice known as self-referral. This practice raises serious concerns about conflict of interest, fair competition, and whether the best interests of patients and communities are being served.

Federal Law Prohibiting Physician Self-Referrals. "Self-referral" – the practice of physicians referring patients to a facility they own – has been of concern to the Congress for many years. Federal laws to regulate these referrals grew out of a rapidly changing health care environment and growing concern about the potential for conflict of interest and inappropriate use of services. Research by the Department of Health and Human Services' Office of the Inspector General found that physicians ordered more services when they owned the facility that provided the service.

As a result, Congress passed the Ethics in Patient Referrals Act of 1989, which created a strict prohibition on physician conflicts of interest and self-referral to clinical laboratories – the area studied in 1989. Additional research found that self-referral increases the use and cost of imaging services, physical therapy, and services covered by workers' compensation. In 1993, Congress expanded the law to apply to inpatient and outpatient hospital services; physical, occupational and radiation therapy services; most imaging services; and home health services.

However, exceptions were created in the law to allow what Congress thought, at the time, to be a narrow set of arrangements that would be free from conflict of interest. One is the so-called "whole hospital" exception for self-referrals for inpatient and outpatient hospital services when a physician has an ownership stake in a "whole hospital." This exception was created based on the reasoning that a single physician's ownership in and referral to a whole hospital was diffused across so many different departments in the hospital that it would limit any financial gain that might result to the physician. And Congress expressly prohibited the use of this exception for physician self-referral to individual departments or subdivisions within a hospital to protect against conflicts of interest. But at the time the self-referral laws were passed, policy makers did not foresee that specific departments or specialties within a hospital (e.g., cardiac care, orthopedics, surgery) would become standalone hospitals.

Because of concerns with this practice, the Medicare Modernization Act of 2003 (MMA) imposed a temporary moratorium on physician self-referrals under Medicare to new limited-service hospitals. The moratorium is set to expire June 8, 2005. The MMA also required government studies in the meantime.

AHA View

In order to preserve care in communities, prevent conflict of interest and promote fair competition, the AHA strongly urges Congress to act quickly to close the loophole in federal law by permanently banning physicians from referring patients to new limited-service hospitals they own.

(Over)

This is about Fair Competition. Some wrongly suggest that full service community hospitals are just afraid of competition from these limited-service hospitals. Some also have suggested that consumer choice might somehow be limited without these facilities. Not so. Full service community hospitals welcome competition and patient choice – as long as it is free from the physician ownership and self-referral that create an un-level competitive playing field.

When physician owners of limited-service hospitals can pick and choose the services they provide, and when they can pick and choose the patients – often the healthier, well-insured patients – they refer to the facilities they own, physician owners have unfair advantages. And that's anti-competitive.

As to patient choice, most patients rely almost exclusively on the advice of their physicians when deciding where to have a procedure performed. Real choice means not having to worry that the motivation for referring a patient to a limited-service hospital is anything other than what is in the best interest of the patient.

The Facts. In October 2003, the Government Accountability Office found that, when compared to full service hospitals, physician-owned limited-service hospitals:

- treated patients that tended to be less sick;
- treated smaller percentages of Medicaid patients;
- are much less likely to have emergency departments;
- have higher margins; and
- had physician ownership that averaged slightly more than 50 percent.

In March 2005, the Medicare Payment Advisory Commission (MedPAC) issued its report to Congress on the topic. They found, when compared to full service hospitals, physician-owned limited-service hospitals:

- tend to treat lower shares of Medicaid patients;
- concentrate on certain diagnoses – high-paying diagnostic related groups (DRGs);
- treat relatively low-severity patients within those DRGs; and
- do not have lower Medicare costs per case.

In March 2005, the Centers for Medicare & Medicaid Services (CMS) shared with Congress preliminary findings from their research on this topic. Their work showed that, when compared to full service hospitals, physician-owned limited service hospitals generally treat less severe cases and provide less uncompensated care.

These findings, from all three sources, describe some of the ways in which physician ownership and self-referral create unfair competition in the health care market place.

Why Physician Conflict of Interest is a Serious Problem. When physicians own, even in part, the facilities to which they refer patients, their decisions are subject to competing interests. Self-referral to a limited-service hospital that depends on physician ownership and self-referral raises the following concerns:

Patient selection. Physician owners have at least three ways in which they can financially reward themselves by selectively referring or "cherry picking" patients. First, they can simply avoid treating uninsured, Medicaid and other patients for whom reimbursement is low. Second, they can selectively refer patients to different facilities, sending well-insured patients to the facilities they own and poorly insured or uninsured patients elsewhere, often to the local full service community hospital. And third, they can selectively refer healthier, lower cost, lower risk patients to facilities they own, leaving more severely ill patients to be treated by local full service community hospitals.

Service selection. Physician-owned limited-service hospitals, by definition, limit the care they provide to a select group of services. As MedPAC research has shown, physician-owners target only profitable diagnoses and procedures – cardiac care, orthopedic surgery and other surgical procedures. There are no limited-service burn hospitals, limited-service neonatal care hospitals, or limited-service pneumonia hospitals.

Quality oversight concerns. Physician ownership and self-referral can also lead to serious conflict of interest in the area of quality oversight. Oversight for the quality of care in America is performed through a "peer review" process – groups of physicians who review, evaluate and oversee the quality of the care provided by their physician colleagues and specialists. Quality oversight is fraught with conflict of interest when the physician doing the review is an owner/partner with the physician being reviewed. The arrangement raises concerns about whether quality could be compromised because of financial interests.

The Impact on Care. The conflict-of-interest practices of physician-owned limited-service hospitals put at risk community hospitals' ability to fully serve their communities. As physician-owned limited-service hospitals pull out from the community hospitals profitable services and healthier elective patients, full service community hospitals are challenged to:

- Continue providing essential services that are seldom self-supporting, such as emergency departments (EDs), burn units, trauma care, and care for the uninsured.

- Maintain specialty "on-call" coverage in their EDs, as physician-owners of limited-service hospitals may no longer want to participate in this broader community commitment. Lack of specialty coverage in our nation's EDs can jeopardize a hospital's trauma level status and cause emergency patients to be transported much farther to access needed specialty care.

- Overcome growing inefficiencies, such as more downtime and less predictable staffing needs, that result from a higher proportion of emergency admissions at full service hospitals. These result as physician-owners move elective admissions to their own limited-service hospitals.

- Coordinate care for patients in their community when increasing numbers are being treated for a single condition by a limited-service hospital. Also, complications unrelated to the condition being treated (for example, a heart attack or a blood clot during or following surgery) result in last-minute emergency transfers to full-service hospitals, increasing the risk to patients.

These are serious implications for all patients served – for everyone who relies on an ED when they are in need of urgent care or a hospital to be there to meet a wide range of health care community needs.

The Solution – Ban Self-Referral to Limited-Service Hospitals. To protect patients and the health care safety net in America, Congress should close the current loophole in federal law and permanently ban physician self-referral to new limited-service hospitals.

There may be a role for "focused facilities" within our health care system. The problem is not physician ownership. If a physician in California wants to invest in a limited-service hospital in Kentucky, conflict of interest wouldn't exist. The problem is self-referral – physician-owners who refer patients to facilities they own. Self-referral is a federal issue, and Congress has acted, beginning in 1989 and in years since, to limit self-referral at the federal level.

Payment Changes Alone are Not Enough. MedPAC has recommended a number of changes to the Medicare hospital inpatient payment system designed to rebalance payments and remove financial incentives for physicians to target certain, more-financially-rewarding Medicare services. But these changes alone will not solve the problem. Even if Medicare inpatient payments were revised, it would do nothing to address incentives for physician-owners of limited-service hospitals to increase use of outpatient care and ancillary services (e.g., lab and imaging services) for which self-referral under the whole hospital exception loophole is currently permitted. And changing Medicare inpatient payments does nothing to change physician-owners' incentives to select the most well-insured patients and avoid Medicaid and uninsured patients.

Many Others are Concerned. Hospitals are not alone in their concern. As a result of its study, MedPAC has recommended that Congress extend the moratorium. The American Academy of Family Physicians, the National Rural Health Association and the U.S. Chamber of Commerce support extension of the current moratorium.

Congress should close the loophole in federal law by permanently banning physician self-referral to new limited-service hospitals. By doing so, Congress can help to prevent conflict of interest between physicians and patients, preserve care for everyone's emergent and urgent health care needs, and promote fair competition in today's market place.