

# Ensuring Fair Marketplace Conditions for Providers

## *A look at limited-service hospitals, ASCs, physician relationships and health plan consolidation*

### Issue

The landscape of health care delivery and financing is evolving rapidly. As medical care becomes more specialized and advanced, some patient care is moving increasingly from general hospitals to limited-service hospitals, from the inpatient to outpatient settings, and from hospital-based settings to physicians' offices, freestanding ambulatory surgical centers (ASCs) or diagnostic facilities. Some physicians increasingly refer their patients to hospitals, freestanding ASCs or diagnostic facilities that they own, partially stimulated by new income opportunities to compensate for declines in payment for their professional services. The rapid increase in physician ownership of such facilities is fueling the issue of physician referral.

As more complex procedures shift to freestanding ambulatory facilities and physicians' offices, regulatory standards for monitoring quality, patient safety, equal access and patient rights have lagged behind. With less demanding rules and oversight in freestanding ambulatory settings, those settings are now preferred by many physicians and other investors in health care services. In addition, private and public payers have implemented or are developing new payment approaches that often have the effect of pitting one provider against another or providing competitive advantages to some types of providers. These payment policies can discourage care coordination across providers, causing care to fragment at a time when the aging population requires more integrated care.

Meanwhile, intense consolidation in the health insurance industry is causing a small number of large insurers to dominate at the community, regional, state and national levels. This consolidation makes it more difficult to address provider and consumer needs and concerns about how health insurers conduct business.

These market changes profoundly affect full-service community hospitals and how they operate. Both physicians and hospitals need to succeed in order to ensure that communities have the care they want and need. However, physicians and hospitals need to find new, acceptable ways of working together. Strengthening these relationships is a long-term imperative. But in the short-term, the rapid proliferation of physician ownership must be slowed to ensure that safety-net services and the continued viability of full-service hospitals in communities are maintained. In addition, the field needs to address several other marketplace challenges that threaten the provision of essential health care services.

### AHA View

**Physician-owned, Limited-service Providers.** Although a congressional moratorium and subsequent Department of Health and Human Services administrative action from late 2003 to mid-2006 generally held physician-

owned, limited service hospitals in check, their growth is once again on the rise. Many public and private studies conducted during the moratorium found that physician-owned, limited-service hospitals:

- Reduce patient access to specialty and trauma care at community hospitals;
- Damage the financial health of full-service hospitals and lead to cutbacks in services;
- Reduce efficiency of full-service hospitals that must maintain stand-by capacity for emergencies, even as they lose elective cases;
- Increase utilization rates and costs;
- Are not more efficient and do not provide better quality;
- Use physician-owners to steer patients;
- Provide limited or no emergency services;
- Make exceptionally high profits; and
- Cherry-pick the most profitable patients by:
  - Avoiding low-income populations, both uninsured and Medicaid;
  - Offering the most profitable services; and
  - Serving less sick patients within case types.

Moreover, many physicians are opening ambulatory surgical and diagnostic centers that compete with the hospitals at which they have medical staff privileges and on whose boards they sit. The proliferation of physician ownership of limited-service providers in both the inpatient and ambulatory settings is stimulated by opportunities to earn additional income and gain greater control over their operating environment. However, the effect on health care delivery and costs in communities can be devastating, especially when self-referral is involved.

**The AHA supports a permanent congressional ban on physician self-referrals to limited-service hospitals, with limited exceptions for existing facilities that meet strict investment and disclosure rules.** Congress must act this year to avoid the damage of further proliferation of new physician-owned, limited-service hospitals.

The AHA has developed policy recommendations for addressing similar concerns raised in ambulatory settings.

**Comparable Standards for Comparable Services.** As complex procedures move into multiple settings, patients – especially Medicare beneficiaries – incorrectly assume that they will be equally protected by patient safety standards and quality monitoring. However, ambulatory surgical centers are subject to less demanding federal standards than hospital outpatient departments, and physician offices are not subject to any federal standards. Standards and oversight must be comparable for comparable services to protect patients and communities. All



providers of surgical services should meet comparable quality monitoring, operating room equipment, staffing, infection control, anesthesiology and other relevant standards.

Similarly, all imaging service providers should meet comparable requirements for patient and staff radiation safety protocols, equipment calibration, staff training and image analysis proficiency, regardless of whether the services are provided in hospital outpatient departments, ambulatory surgical centers, imaging centers or physician offices. **Comparable standards and oversight should apply to providers of comparable services. Achieving comparability should be driven by what is reasonably needed, regardless of setting, to ensure patient safety and quality.** Similarly, all Medicare providers should be subject to a comparable level of accountability and transparency with respect to cost and quality data reporting.

#### **EMTALA Responsibilities**

- **Physician On-call Coverage.** When care moves out of the full-service community hospital setting, access to emergency departments (EDs) – a vital community service – becomes threatened. Hospitals are the only providers required under the *Emergency Medical Treatment and Labor Act* (EMTALA) to provide care to anyone who walks through their doors. No requirements exist, however, for physicians to assist hospitals. To the contrary, incentives lead some physicians to concentrate their practices in settings where they do not provide emergency services to improve their productivity, income and lifestyle; reduce medical liability insurance premiums; and limit the number of uninsured and Medicaid patients. These incentives drive some physicians, specialists in particular, away from providing on-call coverage or to demand significant payment for providing on-call coverage and, in the case of the uninsured, payment for their professional services. **To avoid a national crisis in the availability of emergency care, the AHA believes that incentives need to be provided to physicians to provide on-call coverage to the EDs in their specialty.** Such incentives could include payment incentives from insurers, Medicare and Medicaid to provide on-call coverage, physician tax incentives for providing uncompensated care, and targeted liability relief for those physicians treating patients with whom they have no previous relationship when the physicians provide on-call coverage.
- **Patient Transfers.** Freestanding facilities are not subject to the same transfer requirements as full-service hospitals when surgical patients experience complications. If a hospital with an ED has to transfer a patient to another hospital, EMTALA requires hospitals to follow protocols to ensure that the patient is stabilized, the receiving hospital is contacted prior to transfer and the patient's medical information is provided to the receiving hospital. **All freestanding facilities providing surgical or other invasive procedures, but not ED services, should be required to establish transfer agreements with**

**the community hospital(s) they intend to rely on for emergency backup services. These freestanding facilities also should be subject to a full-range of EMTALA-like transfer and continuity of care procedures.**

### **Ambulatory Surgical Centers**

- **Scope of Services.** In a recently proposed overhaul of the ASC payment system, the Centers for Medicare & Medicaid Services (CMS) proposed a broad expansion in the number and types of services performed in ASCs. In essence, CMS would allow ASCs to perform virtually all procedures currently performed in hospital outpatient departments. However, CMS did not update the ASC standards or develop sufficient criteria for determining which services may be performed safely in ASCs. These shortcomings put Medicare beneficiaries' safety and quality of care at risk.

CMS should defer implementing any changes to the list of ASC procedures until the agency can ensure that patients have comparable protections to those treated in the hospital outpatient setting. In addition, CMS should develop criteria by which certain ASCs would be prohibited from performing certain procedures based on patient- and organization-specific factors that reflect increased risk for patients, such as advanced patient age, recent prior hospital admissions, anesthesia risk level, co-morbidities and the ASC's ability to rescue the patient in the event of a life- or limb-threatening complication.

- **Fair Payment for Ambulatory Surgery.** CMS' proposed overhaul of the ASC payment system is based on the hospital outpatient prospective payment system (PPS) payment classifications, weights and policies. The Medicare statute requires that payments under the new ASC payment system be no greater than payments under the old system in its first year. The ASC community strongly criticized CMS' proposal to pay services performed in the ASC setting at 62 percent of hospital outpatient PPS rates, calling the payment inadequate. However, no national ASC cost data are available to evaluate whether that level of payment is adequate for ASCs.

**The AHA believes that Medicare payment for different settings should reflect the underlying costs and the types of patients served.** Hospitals are more costly settings due to their longer hours of operation, EMTALA obligations, higher indigent-care levels and more medically-complex patients, among other things. Overall payment rates for ASCs should be set significantly below those of the hospital outpatient PPS. Congress should require ASCs to report cost data to allow for future validation of the relative appropriateness of the ASC payment weights and rates. In addition, payments under the new ASC system should be held budget neutral to what payments would be under the current ASC system, as Congress intended – not to total Medicare outpatient payments. Payments to ASCs must be correct to eliminate financial incentives that would inappropriately shift services from the hospital outpatient setting to the ASC setting.



**Incentives for Improving Hospitals and Physician Collaboration.** Hospital care depends on the ability of hospital leaders and physicians to work together to improve the quality and efficiency of patient care and to get patients the right care, at the right time, and in the right setting. Yet, many forces today drive hospitals and physicians apart. Federal laws and regulations that prohibit or limit interactions between hospitals and physicians make the situation worse. For example, the Civil Money Penalties law prohibits hospitals from providing any inducement for physicians to limit care to a Medicare beneficiary, regardless of medical necessity. While these laws are meant to avoid conflicts of interest, they need to be modernized to improve the ability of hospitals and physicians to work together to improve the efficiency of hospital care, improve the quality and safety of care, and better serve patients and communities.

Federal laws also need to be simpler and more consistent. The complexity, inconsistency and sometimes-conflicting interpretations of federal laws and regulations regarding hospital-physician arrangements are a significant barrier to physician and hospital collaboration. Clinical integration is one way that hospitals and physicians can tackle fragmentation of the health care delivery system and improve care for patients. However, integration can be burdensome and expensive, and uncertainties about how federal antitrust agencies will apply the laws to clinical integration programs are having a chilling effect. Clinical integration programs involve independent providers working together to pool infrastructure and resources and to develop, implement and monitor clinical protocols and “best practices” in order to achieve a higher quality of care than they could achieve working independently. Clinical integration programs can provide a vehicle for hospitals to work more closely with their medical staffs and improve quality and efficiency, among other benefits.

**The AHA believes that federal public policy changes are needed to simplify and modernize the laws that govern relationships between hospitals and physicians so that they can work together, using incentives, to not only reduce costs, but also improve access to hospital care, as well as efficiency, quality and safety.** This kind of collaboration will improve care, thereby benefiting patients and the communities we serve.

**Health Plan Consolidation.** Over the past several years, numerous health plans have merged, creating a highly concentrated health insurance industry. The AHA is concerned that additional health plan consolidation would cause competitive harm that would adversely impact hospitals, physicians and patients. Among other harms, consolidation of insurers has the potential to create “must have” payers for hospitals because they represent such a large share of a hospital’s business leaving the hospital with no alternative but to adopt the programs and initiatives of that insurer to the exclusion of others. There also is the risk of reduced flexibility for employers and customers, as well as increased premiums.



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**The AHA will monitor health plan consolidation and take steps to ensure that hospitals are not disadvantaged as a result of health insurers' accumulation of market power.**

**Price Transparency.** People deserve meaningful information about the price of their hospital care, and hospitals are committed to sharing information that will help consumers make important decisions about their health care. However, sharing pricing information is challenging because hospital care is unique. Hospital prices can vary based on patient needs and the services they use; the services needed cannot always be determined ahead of time; prices reflect the added costs of hospitals' public service role to provide care 24 hours a day, seven days a week; and hospitals' prices do not reflect important information from other key players, such as the price of physician care while in the hospital or how much of the bill a patient's insurance company may cover.

But more can, and should, be done to share hospital pricing information with consumers. **To facilitate more meaningful price transparency, the AHA supports the *Health Care Price Transparency Promotion Act (H.R. 1666)*, which would build on existing state efforts to report hospital pricing data and require insurers to disclose estimated out-of-pocket costs to consumers.** The bill, which was introduced by Reps. Michael Burgess (R-TX) and Gene Green (D-TX), also would ask the Agency for Health Care Research and Quality to study what types of price information consumers want.