American Hospital Association

Protecting and Improving Care for Patients and Communities

Limited-Service Hospitals

Issue

A loophole in federal law allows physicians to own limited-service hospitals, such as cardiac, orthopedic and surgical facilities, where they then refer their carefully selected patients for 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.

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. This practice of 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. 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 research from the Medicare Payment Advisory Commission (MedPAC) 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 also can 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.

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, MedPAC issued its report to Congress on the topic, which found that 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 diagnosis-related groups (DRGs);
- treat relatively low-severity patients within those DRGs; and
- do not have lower Medicare costs per case.

Because of concerns with the rapid increase in physician-owned limited-service hospitals, the Medicare Modernization Act of 2003 (MMA) imposed a temporary moratorium on physician self-referrals under Medicare to new limited-service hospitals. While the moratorium expired June 8, 2005, CMS put in place a "defacto" moratorium – barring new limited-service facilities from coming into the Medicare program while they undertook a careful review Medicare policies related to these entities. That review was expected to be completed by the end of 2005, but is still underway. In the Deficit Reduction Act of 2005, enacted in early 2006, Congress required that CMS continue its suspension of new limited-service hospitals entering Medicare until the agency develops and submits to Congress a strategic implementation plan that includes legislative and regulatory recommendations for regulating physician investment in limited-service hospitals, participation in Medicaid, and provision of uncompensated care. CMS has six to eight months to submit the report.

AHA View

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 – 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 new 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.