

# STAT: TACKLING TODAY'S CHALLENGES

## *Strengthening the Health Care Delivery System*

### **Limited-service Providers**

#### **Issue**

The delivery of health care in America is changing rapidly. But in the midst of this change, one thing has remained constant: Communities across America rely on hospitals and the physicians who serve with them to provide care to all, including those who are uninsured or underinsured. Full-service community hospitals serve as the health care safety net, providing basic health care services for those in need.

Limited-service providers, also known as “niche” or specialty providers, are not new, but the nature and pace of their growth is. They include heart hospitals, orthopedic hospitals, surgical hospitals and ambulatory surgery centers (ASCs), cancer hospitals and centers, dialysis clinics, pain centers, imaging centers, mammography centers, and a host of other narrowly focused providers. The last decade has seen explosive growth in both inpatient and ambulatory limited-service providers, increasingly owned, at least in part, by the physicians who refer patients to them.

In its March 2003 report, the Medicare Payment Advisory Commission (MedPAC) found that the number of Medicare-certified ASCs doubled between 1991 and 2001 (from 1,460 to 3,371) with a 60 percent growth in the number of procedures performed on Medicare beneficiaries. And in its April 2003 report, *Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served*, the General Accounting Office (GAO) reported a tripling of specialty hospitals since 1990.

Congress took action last year to stop, at least temporarily, some of this growth. Provisions of the Medicare Modernization Act of 2003 (MMA) called for an 18-month moratorium on physician self-referral under Medicare for new specialty hospitals, while the Department of Health and Human Services (HHS) and MedPAC study the issues related to limited-service providers. This action is a step in the right direction; however, more needs to be done.

#### **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:

**Limited-service providers often do not serve the broader community.** The trend among these providers is to carve out the more profitable services and to serve the well-insured patients. They leave the full-service community hospital to provide unprofitable services such as trauma and to care for all, regardless of their ability to pay.

Most limited-service 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, they rely on the ED capacity of local community hospitals, and they generally operate normal business hours, not the 24/7 hours of hospitals. In its October 2003 report, *Specialty Hospitals: Geographic Location*,



*Services Provided, and Financial Performance*, GAO found that only 45 percent of specialty hospitals (compared to 92 percent of general hospitals) have EDs.

Many specialty care providers do not participate in Medicaid or limit their participation when they do, and many provide little uncompensated care. In its October 2003 report, GAO found that specialty hospitals treated significantly fewer Medicaid patients than the community hospitals in their area. These business decisions allow some niche providers to produce services less expensively, while often being paid the same as 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 continue to meet the needs of the broader community:**

- **They are eroding support for unprofitable services, access for patients with limited or no coverage, and ultimately access for the community as a whole.** 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 other services with a positive margin.
- **They are drawing away specialty physicians and hospital staff, jeopardizing emergency department coverage, while at the same time relying on the community hospital for free backup.** Communities also are 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 already are 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. While limited-service providers are drawing profitable services and specialty physicians away from community hospitals, they expect those same hospitals to be their backup when one of their patients develops complications beyond the capacity of that facility or when their facility is closed at night and on weekends.

**Limited-service providers are increasingly owned by the same physicians who make decisions about when and where patients should receive care.** Some specialty physicians are making decisions about care for their patients that also will have an effect on their 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. 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 freestanding limited-service hospital they own.



The incentives and business practices of health care providers must be grounded by the public's expectations. Those ground rules must:

- **Restrict Conflict of Interest.** Regulatory requirements should limit physician self-referral and investment.
- **Ensure Fairness in Regulation.** Regulatory requirements should be comparable for hospitals and niche providers offering similar services, with respect to:
  - 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 providers (such as required provision of free care) should not create a disadvantage for some. The market cannot operate effectively or appropriately if payment levels are the same for hospitals and niche providers, but community obligations are not. To protect community access until necessary changes are made to regulatory requirements, measures should be established to offset the costs of under- or uncompensated care borne by community hospitals.

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

- **Extend the Moratorium.** The 18-month moratorium on the use of the "whole-hospital" exception by certain specialty hospitals (cardiac, orthopedic, and surgical) should be extended to ensure adequate time for Congress to consider and act on the HHS and MedPAC studies on the operations and impact of limited-service providers. The MMA provides only a few months from the scheduled completion of the reports to the end of the moratorium, and one of the studies has not yet begun.
- **Limit Further Physician Self-Referral.** With the marked increase in physician-owned limited-service providers, the AHA supports revising the Stark law to curtail the rural exception that has been used as a loophole.
- **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. The final physician self-referral (Stark II) regulations published by CMS on March 26, 2003 fall far short of the change needed. The rules only require reporting to HHS of physician financial interests when requested by federal regulators. No baseline or regular reporting will be required. Without reporting, the public has no access to the information.



- **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. Reports of significant patient safety and quality issues are emerging, such as the findings reported to MedPAC on March 18 regarding the safety of imaging services provided in some physician offices.
- **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 backup services. These transfer agreements should address 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.

The AHA has appointed a task force to assess the current environment and consider how these recommended actions should be expanded to address the escalating growth in limited-service providers and ways in which community hospitals and physicians can work together to meet all the needs of their communities.