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Statement
of the
American Hospital Association
before the
United States Senate
Committee on Finance
on
Physician-owned Specialty Hospitals: Profits before Patients?

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On behalf of the American Hospital Association (AHA), our 4,800 member hospitals and health care systems, and our 35,000 individual members, we are pleased to present our views on the critically important issue of physician-owned, limited-service hospitals and their impact on health care in our society.

A loophole in federal law allows physicians to own limited-service hospitals, such as cardiac, orthopedic and surgical facilities, where they then refer patients – a practice known as self-referral. Self-referral 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. The AHA commends the committee for focusing squarely on the conflict of interest caused by self-referral.

Risks of Conflict of Interest vs. Benefits of "Competition"
The question facing lawmakers is: Do the risks posed by self-referral outweigh the benefits of adding physician-owned, limited-service hospitals to the competitive landscape? The risk of self-referral is that the financial incentives inherent in a self-referral model will influence physician behavior in ways that may not be in the best interests of patients and the system as a whole. Potential benefits touted by the physician-owned, limited-service hospital community include enhanced quality and greater efficiency.

This question can be answered by an examination of the evidence. The research to date has found strong evidence that financial incentives are influencing physician behavior. Behaviors documented include patient selection and steering, service selection and increased utilization. On the other hand, two benefits of competition claimed by these facilities have not been borne out – they are not more efficient and quality results have been mixed.

Patient selection and steering. Evidence shows that physician-owners respond to financial incentives by "cherry picking" patients in three ways. First, they simply avoid treating uninsured, Medicaid and other patients for whom reimbursement is low. Second, they 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 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. Central to this concern is whether the patient's best interest is being served by the physician's selection of where the procedure will be provided.

These behaviors were documented by the Medicare Payment Advisory Commission's (MedPAC) March 2005 report to Congress. MedPAC found that physician-owned hospitals treat, on average, a lower share of Medicaid patients. Since Medicaid pays less than the cost of care – in 2004, Medicaid paid less than 90 cents for every dollar spent treating Medicaid patients – the financial burden of treating more than 57 million Medicaid beneficiaries falls to the full-service community hospital. MedPAC also found that physician-owned, limited-service facilities treat relatively low severity patients within profitable diagnoses-related groups. Government Accountability Office (GAO) reports and other peer review literature also support these findings.

A March 2005 Centers for Medicare & Medicaid Services' (CMS) report to Congress studied physician-owned, limited-service facilities and also found that all but one hospital treated patients with a lower severity of illness than full-service community hospitals. In addition to this evidence of patient selection, CMS documented patient steering: In two out of three cardiac facilities, owners had a clear preference for referring inpatients to their owned facility. CMS also found that surgical and orthopedic hospitals resemble ambulatory surgery centers, lack active emergency departments and focus on outpatient services.

Service selection. Physician-owned, limited-service hospitals, by definition, limit the care they provide to a select group of services. As research from 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.

Increased utilization. Even more troubling, growth in these facilities leads to increased use of health care services. MedPAC found in its April 2006 study that when physician-owned heart hospitals entered a community, cardiac surgeries per 1,000 Medicare beneficiaries increased by about 6 percent. As one commissioner stated, "That's not a sustainable rate of growth." These results represent an update of the prior report, including data from 43 additional physician-owned, limited-service hospitals – nearly double the number with available data in the original study. The finding of increased utilization is statistically significant based on two additional years of experience with physician-owned cardiac hospitals.

Meanwhile, the research to date does not support claims that these facilities provide the desired benefits of competition, efficiency and quality.

Efficiency claims unfounded. The April 2006 MedPAC data found that physician-owned surgical and orthopedic hospitals have costs that are 20 to 30 percent **higher** than competing community hospitals, while physician-owned heart hospitals have about the same cost per case as competing community hospitals. This finding refutes the claim from physician-owned, limited-service hospitals that they are more efficient – no competitive benefits were found. A recent GAO report, which questioned whether physician-owned, limited-service hospitals enhance the competitive landscape, instead found that hospitals in markets with and without limited-service hospitals already face a high level of competition. The study found no evidence that physician-owned, limited-service hospitals enhance competition.

Improved quality claims unproven. The March 2005 CMS report to Congress also found that when physician-owned cardiac hospitals were compared to full-service hospitals for quality, readmission rates were higher for physician-owned hospitals while mortality rates were lower.

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.

Moratorium Recognized Congressional Concerns

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. After the moratorium expired June 8, 2005, CMS put in place a "defacto" moratorium – barring self-referral under Medicare to new limited-service facilities while they

undertook a careful review of Medicare policies related to these entities. In the Deficit Reduction Act of 2005 (DRA), enacted in early 2006, Congress required that CMS continue its prohibition against self-referral in 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.

In the DRA, Congress again signaled its concern with these facilities – which the AHA shares – by requesting a study of investment structures of physician-owned, limited-service hospitals. On May 9, CMS submitted its interim report to Congress. The report provided lawmakers with an update on CMS' development of a plan to determine whether physician investments in limited-service hospitals are bona fide and proportional to their investment returns, and whether physician-owned, limited-service hospitals should be required to annually furnish investment information. The AHA supports the collection of new data in order to conduct a rigorous examination of these issues.

The report also includes a summary of steps CMS has taken since June 2005 to respond to recommendations from MedPAC and the Department of Health and Human Services (HHS). Many of these recommendations fall short of dealing with the real issue – physician self-referral and conflict of interest.

Troubling Recent Events

Some physicians who have a financial interest in and practice medicine at physician-owned, limited-service hospitals focus on well-paying elective procedures, increase the number of these procedures they perform per day, and avoid emergency department coverage. For these physicians, profit – and not patient care – has become a strong motive for practicing medicine.

The AHA also is concerned that more than 40 physician-owned, limited-service hospitals opened and participated in Medicare during the moratorium and subsequent suspensions, even though 13 appear to have been grandfathered under the MMA. We are concerned that self-referral may have occurred in these facilities and that CMS has not scrutinized such arrangements. In a November 21, 2005 Freedom of Information Act request to CMS, the AHA asked for information on specialty hospitals which had requested advisory opinions as to the validity of their operation as a limited-service hospital during the moratorium, information on those entities that requested Medicare provider numbers and other related documentation and information. As of May 17, 2006, we are still waiting for CMS to provide the documentation.

According to local news reports from Willamette, Ore., one hospital which opened during the moratorium, Northeast Portland's Physicians' Hospital, was unable to provide critical medical attention to a post-operative patient. No physicians were present at the hospital when an 88-year old patient who had undergone back surgery that day went into cardiac and respiratory distress. Hospital staff instead called 911 – emergency services – and requested an ambulance to transport the patient to a local community hospital.

Unfortunately, the patient died as a result of delayed medical treatment for her complications. Was the patient or her family aware of just how limited the capabilities were at this hospital and that complications would require being transported to a full-service community hospital?

No matter how routine a surgical procedure may be, complications can – and do – arise. Physicians have a professional obligation to be available to their patients when these situations occur, whether it is at 3:00 p.m. or 3:00 a.m. In the case of the Oregon woman, she went into cardiac and respiratory distress just before 6 p.m. on Wednesday, July 27, 2005, yet no physicians were on site at the specialty surgery facility and none responded to pages.

Impact on Care

Mr. Chairman, the AHA and its members are concerned about the impact that these limited-service facilities will have on community health care services. The behavior of physician owners in response to financial incentives puts at risk a community hospital's ability to fully serve their communities. You and Senator Baucus recently requested examinations of these facilities and their practices from the HHS Office of Inspector General and the GAO, and how these practices affect our communities and health care system.

Through studies and evidence that the AHA has conducted and collected in communities in which a number of physician-owned, limited-service hospitals operate, we can tell you they do affect the community health care infrastructure. In general, as these facilities pull out from the community hospitals profitable services and healthier elective procedures, full-service community hospitals are challenged to:

- Continue supporting essential services that are seldom self-supporting, such as EDs, burn units, trauma care, and care for uninsured patients.
- Maintain specialty "on-call" coverage in the ED, 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.

So far most community hospitals have been able to sustain services, despite the financial impact of physician-owned, limited-service hospitals, but at what cost and for how long? Given full rein, physician-ownership and self-referral will erode the ability of community hospitals to recover and maintain access to essential – and for some unprofitable – services for their communities.

The solution – ban self-referral to new limited-service hospitals. Self-referral is a federal issue and Congress has acted since 1989 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 prospective 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 non-Medicare patients, incentives for physician-owners of limited-service hospitals to steer patients to their owned facilities, to increase utilization and select the most well-insured patients and avoid Medicaid and uninsured patients.

Self-referral and conflict of interest are serious threats to our nation's health care system, and endanger the overall health of communities. We strongly urge Congress to close the loophole in the federal law by permanently banning physician self-referral to new limited-service hospitals. By doing so, Congress can help prevent conflict of interest between physician financial incentives and patient need, preserve care for everyone's emergent and urgent health care needs, and promote fair competition in today's marketplace.