



American Hospital  
Association

# PHYSICIAN-OWNED AMBULATORY CARE SETTINGS

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Agenda Item 8B—For Action

October 31, 2006

## Background

In the spring of 2004, the Task Force on Delivery System Fragmentation was appointed with a two-part charge: 1) to revisit the issue of limited-service hospitals picking up where the first task force left off; and 2) to evaluate models for strengthening physician and hospital relationships. The Board later asked that the task force also examine an issue of growing importance—physician owned ambulatory settings.

Previous work of the task force centered on developing policy on physician self-referral in limited-service hospitals and policy on modernizing federal laws to facilitate financial incentive arrangements between physicians and hospitals, which were approved by the Board in November 2004 and November 2005, respectively.

The task force has met several times this year and has obtained member input on the ambulatory settings issue twice through governing council, Committee on Governance, and RPB meetings. At the summer 2006 round of meetings, members were asked to provide a more current assessment of the nature and pace of growth in physician ownership of ambulatory settings in their communities, how hospitals are responding, and the issues that members believe the task force should be addressing. A *TrendWatch* on the migration of care to ambulatory settings was produced. At the fall round of meetings, a paper summarizing member views and presenting draft recommendations was discussed. Task force members participated in each of the RPB meetings. The task force met by conference call on October 13 to review member input from the fall round of meetings and revise its recommendations.

The attached revised paper presents the final set of recommendations for consideration by the Board. In order of the priority assigned by the majority of RPBs and governing councils, the three areas of recommendations cover:

1. Applying comparable standards for comparable services across ambulatory settings.
2. Sharing social responsibility among all health care providers.
3. Ensuring conflict-of-interest safeguards in ambulatory settings.

Each area includes recommendations for federal, state, and private sector actions, recognizing that state laws and private payer policies are part of the problem and the solution.

**Requested Disposition**

The recommendations in the attached paper are presented for approval by the Board. In addition, the Board is asked to discharge the task force with its thanks.

William Petasnick  
Chairman  
Task Force on Delivery System Fragmentation

**Modernizing the Regulation of  
Ambulatory Care Settings  
Public Policy Recommendations of the  
Task Force on Delivery System Fragmentation  
October 2006**

**Background**

Relationships between physicians and hospitals are challenged and, in many cases, not functioning as well as needed by our patients. Acute care is especially dependent on the ability of hospital leaders and physicians to work together—to improve the efficiency of patient care and to get patients the right care, at the right time, and in the right setting.

But there are many forces today driving hospitals and physicians apart—economics, changes in health care delivery, and outdated payment and regulatory requirements among them. Hospitals are undertaking improvements in their operations to address issues important to physician productivity and to patients, but physicians today are less dependent on hospitals as a place to practice, and obligations traditionally accepted by physicians as a member of the organized medical staff are no longer consistent with their expectations. And the traditional organized medical staff model may no longer provide a viable structure for resolving today's issues.

Several aspects of the health care environment complicate physician-hospital relationships:

- Payment to physicians for their professional services continues to decline, especially under Medicare and Medicaid, and the gap between payment and practice expenses is rapidly widening. As a result, physicians will likely continue to pursue new income opportunities. This will continue to put physicians and hospitals in competition with one another.
- Care is changing—both where and how delivered. More care can be provided in non-hospital settings, further distancing physicians and hospitals.
- Growth in non-hospital settings, which have no EMTALA requirements, means Medicaid and uninsured patients find their primary care access limited to hospitals and community health centers.
- Legal and regulatory barriers prevent hospitals and physicians from coming together in financial relationships that are beneficial to physicians, hospitals, and communities.

The solution is to find new, acceptable ways of working together. Both hospitals and physicians need to thrive and succeed in order to ensure that communities have the care they want and need. Strengthening these relationships is a long-term imperative and one that will be challenging to achieve. But in the short-term, the rapid proliferation of physician ownership needs to be slowed in order to maintain safety net services and the continued viability of full-service hospitals in many communities, while longer-term federal and state public policy solutions are pursued.

### **Issues Created by Physician Ownership**

Many hospitals face an immediate problem: an increasing number of physicians are investing in ambulatory care facilities and services to which they, themselves refer patients. Self-referral creates the potential for conflict of interest for those involved and raises serious risk for patients. The risk of self-referral is that the financial incentives inherent in a self-referral model have the potential to influence physician behavior in ways that may not be in the best interests of patients and the system as a whole.

Research shows that physicians order more services when they have an ownership interest in the entity that is going to provide those services. According to this research, patients of physicians referring to entities in which they had an investment interest:

- Received 34 percent more laboratory services than the general Medicare population (OIG, 1989).
- Received physical therapy at rates 39 to 45 percent higher than patients referred to independent practitioners (Mitchell and Scott, 1992).
- Had higher overall costs for medical care covered by workers' compensation (Swedlow et al, 1992).
- Were substantially more likely to receive referrals for imaging services. Relative to non-owners, owners ordered 54 percent more MRIs, 27 percent more CT scans, 37 percent more nuclear medicine scans, 27 percent more echo cardiograms, 22 percent more ultrasounds, and 22 percent more complex x-rays (GAO, 1994)
- Were more likely—by an increase of about 6 percent per 1,000 Medicare beneficiaries—to receive cardiac surgery when a physician-owned heart hospital entered their community (MedPAC, 2006).

However, banning physician self-referral in ambulatory settings is complex. Expanding federal prohibitions on physician self-referral under the Medicare and Medicaid programs would be a difficult task—both technically and politically. It would require a complete overhaul of the Ethics in Patient Referrals Act—known as the Stark law—including the construction of a bright line between what physicians can and cannot do in their office practice settings. It is unlikely that such changes would be successful.

The current environment also presents a variety of practical problems and issues for hospitals.

- Physician-owned ambulatory facilities often are perceived as being more convenient. Because full-service hospitals are designed to meet the need of the entire community, including emergency needs, they cannot always organize their operations to maximize physician productivity or patient convenience.
- Staffing is increasingly difficult. As more physicians own and operate their own ambulatory surgical and diagnostic centers, hospitals lose access to physician services for ED on-call coverage and specialty care, in particular.

- Any service or technology requires a certain level of reimbursable use to support its capital and operating costs. As more volume of services moves to non-hospital settings, maintaining a broad range of services to serve the needs of the community at large at the hospital, especially in rural areas, is putting upward pressure on hospital charges.
- Hospitals today have too few options to address these challenges, each with its own limitations. Direct competition with members of their own medical staff leads to a further deterioration of relationships, unwillingness on the part of some physicians to perform medical staff functions such as emergency department on-call coverage and financially weakens the hospital. Joint ventures, which are not practical for all types of physicians, can lead to allegations of favoritism among segments of the medical staff as well as a reduction in revenue for the hospital, at least in the initial years.
- Hospitals are frustrated by government's outdated application of regulation to different care settings, which creates uneven standards for patient safety, access, and quality, and stimulates excess capacity and utilization. It also can put hospitals at a competitive disadvantage relative to other ambulatory settings.

### **Task Force Recommendations**

Much work can and must be done by physicians and hospitals together to create stronger, more functional relationships. That work will be long and hard. What is clear is that public policy changes can be made in the interim to stop the unintended consequences of this change in the health care environment. The American Hospital Association's Task Force on Delivery System Fragmentation has been working to map appropriate public policy changes to protect America's health care safety net.

The recommendations below would modernize the regulation of ambulatory settings to apply comparable standards for comparable services, encourage the sharing of our social responsibility for health care delivery among all practitioners and providers, and better manage opportunities for provider conflict of interest. The recommendations are for federal, state, and private sector action, recognizing that state laws and private payer policies are part of the problem and the solution. When combined with the policies adopted in 2005 by the AHA Board to broaden opportunities for hospital-physician financial incentive arrangements, the task force believes this package of changes can help to limit unintended consequences and expand the opportunities for hospitals and physicians to work together, strengthen relationships, and meet our collective health care delivery challenges.

**Recommendation 1: Apply Comparable Standards for Comparable Services.** In the short term, comparable standards and oversight should apply to providers of comparable services. That is, health care standards should be service-specific, not setting-specific. Achieving comparability should be driven by what is reasonably needed, regardless of setting, to ensure patient safety and quality.

- **Federal:**
  - *Ensure appropriate, comparable requirements in all settings for comparable services by modifying national private accreditation standards and Medicare conditions of*

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*participation regarding patient safety, patient rights, quality assurance, and operating standards.* For example, all providers of surgical services should meet comparable quality monitoring, operating room equipment, staffing, infection control, anesthesiology and other relevant standards. Similarly, all providers of imaging services should meet comparable requirements for patient and staff radiation safety protocols, equipment calibration, staff training, and image analysis proficiency whether the services are provided in hospital outpatient departments, ambulatory surgical centers, imaging centers, or physician offices. This can be done by either increasing or decreasing standards to achieve comparability.

- *Require cost and quality data reporting for all Medicare providers.* There is a great deal of unevenness in Medicare cost and quality reporting requirements. Hospitals, including their outpatient operations, must provide needed cost information to the Centers for Medicare and Medicaid Services (CMS) every year. Ambulatory surgical centers (ASCs) do not. CMS has just proposed that hospital outpatient departments be required to submit quality measure data or face a significant reduction in their outpatient payments. Similar quality reporting requirements have not been proposed for ASCs. All Medicare providers should be subject to a comparable level of accountability.
- *Ensure that Medicare payment levels for different settings reflect underlying costs and the type of patients served.* Hospital outpatient departments (HOPDs) care for more complex patients who have more comorbidities and higher anesthesia risks, are often fragile, and often are lower income requiring greater social service support. In addition, HOPDs maintain longer hours, are subject to more expensive hospital-level regulatory requirements, support standby capacity for emergency services, etc. Such factors yield higher costs of providing care.
- **State:**
  - *Modernize state licensure law definitions of various providers to reflect changes in clinical practice.* Hybrid providers have been emerging that blur the lines between different provider categories and the standards that must be met for licensure. For example, extended-stay recuperative centers located next to ambulatory surgical centers often provide inpatient recuperation for up to 72 hours but generally are not subject to hospital inpatient requirements. Similarly, patients receiving ambulatory surgery in physician offices are reportedly now being kept in recuperation beds for extended periods of time.
  - *Revise state licensure laws to ensure comparable requirements in all settings for comparable services and accomplish the same ends as described above for federal and national accreditation standards.*
  - *To the extent that states require reporting of cost or quality data by some providers, those requirements should apply to all providers of similar services.*
  - *In states with certificate-of-need (CON) laws in place or under consideration, requirements for review and approval of new or revised services or facilities should*

*apply evenhandedly to all providers of similar services. Applying capacity constraints to one type of provider but not others who are delivering comparable services favors some and penalizes others in their ability to effectively compete.*

- **Private:**

- *The hospital field, in conjunction with national and state hospital associations, should work with insurers and employers so that when they adopt “buy right” strategies, their purchasing decisions are based on more than unit prices. Decisions should be based on both cost and quality and should consider both short-term and long-term effects.*

**Recommendation 2: Share Social Responsibility Among All Health Care Providers.** Health care practitioners and providers have always been looked to by Americans as unique members of our society because they heal the sick, comfort the dying, and, increasingly, help people avoid disease and disability so that they can live longer, more productive lives. That is made more difficult, given growing numbers of uninsured (now about 46 million) and underinsured individuals. Society looks to practitioners and providers to care for those who are in need, without regard to whether they are insured or can pay for all or part of their care.

Yet, the only legal requirement to provide care regardless of ability to pay or any other limitations is on hospitals that have emergency departments—whether public, private not-for-profit, or private investor-owned. As more care moves from the hospital setting to other ambulatory settings, the safety net is unraveling. Other practitioners and providers, faced with inadequate Medicaid payments and growing numbers of uninsured, are increasingly avoiding these members of our society. Until and unless we are prepared to implement comprehensive coverage for all, all health care providers need to help maintain the safety net of care in our communities.

- **Federal:**

- *All health care practitioners and providers should be required to participate in the Medicare and Medicaid programs if eligible to do so. Payment rates should be adequate to avoid penalizing providers who do so.*
- *All health care practitioners and providers should have incentives to support the safety net of health care services for the uninsured. Incentives that could be provided at the federal level, for example, are:*
  - *Tax provisions enabling the deductibility of the value or cost of unreimbursed care provided to the uninsured of limited means.*
  - *Public reporting of unreimbursed care provided to the uninsured of limited means on a provider- and practitioner-specific basis.*
- *All free-standing facilities that provide surgical or other invasive procedures but do not provide full-time emergency services (e.g., limited-service hospitals, ASCs, etc.) should be required to have a formal agreement with the community hospital(s) it intends to rely on for emergency backup services. These agreements should address the provision of*

support (e.g., on-call coverage and financial support) for maintaining emergency capacity in the community and a full range of EMTALA-like transfer and continuity of care procedures.

- **State:**
  - *Require participation in the Medicaid program as a condition of licensure.* For example, states could require that providers participate in the Medicaid program at a particular level or, if they do not, to pay into a statewide fund. Such requirements need to be extended into the ambulatory settings to ensure continued access for Medicaid enrollees.
  - *Require that physicians be reasonably available to provide on-call emergency services when called upon by community hospitals as a condition of licensure.* As a matter of national policy, the United States has determined that any person in medical need is entitled to emergency evaluation and stabilization care. That policy was implemented through EMTALA which applies to all hospitals with emergency departments, without regard to their ownership or tax status. As more care has shifted to free-standing ambulatory settings and limited-service hospitals that do not have emergency departments, it is increasingly difficult for community hospitals to obtain on-call coverage, particularly for specialty services. This problem is reaching crisis proportions in many areas, jeopardizing the availability of emergency services to everyone.

**Recommendation 3: Conflict-of-interest safeguards in ambulatory settings.** The rules governing physician ownership should be updated to safeguard against significant opportunities for conflict of interest.

- **Federal:**
  - *Limit individual and aggregate physician ownership of entities that receive fees separate from professional fees (e.g., hospitals, ASCs, imaging centers, etc.) and establish other investment rules for physician ownership to better manage potential conflicts of interest. Investment rules should ensure that investments are bona fide, require proportionality between capital investment and investment returns, and other requirements.* Similar rules are contained in a physician investment safe harbor under the federal anti-kickback law and should be required under the federal Ethics in Patient Referrals law as well.
  - *Require disclosure of individual physician ownership interests and investment returns to patients, communities, and regulatory agencies.* Public reporting of individual physician ownership interests is critical to understanding and analyzing utilization and quality patterns and the degree to which physician self-referral plays a role.
- **State:**
  - *Establish or update state laws regarding physician ownership to ensure that limitations on conflicts of interest similar to those recommended at the federal level (which apply only to Medicare and Medicaid) will apply to the private sector as well.* Some states already have physician conflict of interest statutes on the books. Perhaps the oldest example is state laws that prohibit physicians owning and operating pharmacies whether in their offices or on a free-standing basis or self-referring patients to such pharmacies to

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fill prescriptions. Some states also have broader self-referral prohibitions patterned after the federal laws.

- **Private:**

- *Provider organizations should work with employers and insurers to research and better understand the effects of physician self-referral on utilization and quality of care.*

Studies have well-documented that physician self-referral tends to raise utilization rates and, hence, total health care costs. Many employers and insurers are unaware of the overall cost implications for decisions to steer patients to free-standing ambulatory settings based simply on unit price. As important, the public seems unaware of the implications for ordering marginally beneficial or unnecessary procedures and the risk to patients from such procedures. Updated studies on a broader range of services are needed, along with greater public discussion of the implications for stimulating higher use rates.



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