


TO: Senator Tim Gay, Chair
Members of the Health and Human Services Committee

FROM: Bruce R. Rieker, Vice President, Advocacy 

DATE: February 24, 2010

SUBJECT: LB 999 – Provide a two-year moratorium on new hospital licenses

On behalf of our 85 member hospitals in Nebraska and the more than 42,000 people they employ, the Nebraska Hospital Association (NHA) **supports LB 999.**

LB 999 establishes a moratorium from September 1, 2010 to August 31, 2012 on the issuance of a license for any new hospital, excepting critical access hospitals (CAHs). This moratorium would provide time for the Nebraska legislature to review the myriad of issues involved when a specialty or physician-owned hospital seeks to open in any Nebraska community.

How many specialty or physician-owned hospitals are there in the U.S.?

According to research conducted in 2008 by the American Hospital Association (AHA), the number of physician-owned limited service hospitals has risen dramatically since the early 1990s. The number of those facilities tripled between January 1990 and March, 2003, and nearly doubled from 46 to 89 between 2002 and 2004¹. Their growth was largely on hold from 2004 to 2006 due to a federal government imposed moratorium on physician self-referral to new specialty hospitals. But since the moratorium ended, rapid growth has resumed. As of 2007, AHA estimates that there are about 180 such hospitals in the country, with an additional 85 facilities currently in development².

Where are specialty or physician-owned hospitals located?

The location of physician-owned limited service hospitals strongly correlates to states' Certificate of Need (CON) laws or requirements, which govern construction of new and expansion of existing health care facilities. CON rules require evidence that a community need exists for the additional capacity before it can be built. Ninety-six percent of physician-owned, limited service hospitals that opened between 1990 and 2003 are located in states without CON laws⁴. The distribution of physician-owned, limited service hospitals is uneven—with most located in the South and Southwest. Texas has the highest number of these facilities by far—approximately 70 as of 2007⁵.

What is the impact of a specialty or physician-owned hospital on an existing community hospital?

Most physician-owned specialty hospitals are new facilities with attractive amenities. Physicians enjoy the lifestyle benefits afforded by limited service

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hospitals, such as the ability to perform more procedures in a shorter amount of time, freedom from emergency department/on-call responsibilities, a more predictable schedule, free from interruption from emergency cases, and the opportunity to share in facility profits⁶.

Physician owners have both the ability and financial incentive to direct patients to or away from the facilities in which they have an ownership interest. As such, these facilities tend to specialize in well reimbursed services, serve fewer patients with other health complications, and treat fewer low-income and uninsured patients. In addition to limiting their services to the more lucrative specialties, physician-owned hospitals tend to treat patients who are healthier and have less severe illnesses.

Those selection practices place full service community hospitals at a disadvantage because they depend on a balance of services and patients to support the broader needs of the community. The current payment system does not explicitly fund standby capacity for emergency, trauma and burn services nor does it fully reimburse hospitals for care provided to Medicaid and uninsured patients. Community hospitals rely on cross-subsidies from the well reimbursed services targeted by physician-owned hospitals to support these and other essential but under-reimbursed health services⁷. Revenue lost to specialty hospitals can lead to staff cuts and reduction in subsidized services such as inpatient psychiatric care, as well as lower operating room utilization, which decreases efficiency, strains resources and increases costs⁸.

Do physician-owned or specialty hospitals provide emergency care?

Many physician-owned hospitals lack the ability to deal appropriately with patient complications or emergencies that arise during the course of care⁹. A 2008 study by the Department of Health and Human Services' Office of the Inspector General (OIG) found most physician-owned limited service hospitals are not equipped to handle medical emergencies. Two-thirds of physician-owned hospitals use 9-1-1 as a part of their emergency response procedure, including 34 percent that use 9-1-1 for medical assistance to stabilize a patient. According to Medicare regulations, 9-1-1 may not be used as a substitute for the hospital's own ability to provide an adequate initial response to the emergency needs of their patients. About one-quarter of physician-owned hospitals lack policies regarding the management of medical emergencies, while less than one third have physicians on site 24 hours a day, seven days a week¹⁰.

The majority of physician-owned, limited service hospitals do not have emergency departments (EDs). Hospitals lacking EDs have more control over the types of cases admitted because they do not have the obligation under the Emergency Medical Treatment and Active Labor Act (EMTALA) to medically screen and stabilize all patients regardless of their ability to pay. About half of all physician-owned hospitals have EDs but more than half of those EDs have only one emergency bed. While a single ED bed may meet state requirements, there are doubts about whether these EDs can safely provide emergency care¹¹.

What types of patients do physician-owned or specialty hospitals treat?

Unlike community hospitals, which typically treat diverse groups of patients, specialty hospitals tend to treat only a small share of Medicaid patients and rarely treat patients who cannot pay for their care. Medicaid beneficiaries comprise 13 percent of a community hospital's patients, nationally (14.5 percent of Nebraska discharges), but only 2-3 percent of limited service hospitals' patients. Physician-owned limited service hospitals are also less likely to treat racial and ethnic minorities^{12/13}.

What is the impact of physician ownership on referrals?

Physicians significantly influence a patient's course of treatment, often including where they receive care. When physicians have a financial stake in a health care facility, there is potential for the medical needs of the patient to be in conflict with the financial interests of the physician. When physicians refer patients to hospitals they own, they not only receive professional fees for providing the services, they share in the earnings of the facility, and typically see the value of their ownership share in the facility increase over time. Physician ownership influences where physicians direct their patients for services and may drive up the referral rates for those services. Research has found that the likelihood of physicians referring patients to a physician owned hospital increases with the proportion of the physician's ownership in the hospital¹⁴.

Why does the NHA support LB 999?

NHA member hospitals support the two-year moratorium included in LB 999 because there are many unanswered questions about the impact of physician-owned hospitals that should be answered before such a hospital is allowed to open in any Nebraska community. In addition to the two-year moratorium, Nebraska's community hospitals urge the Legislature to conduct an extensive interim study that examines all issues related to this matter and develop recommendations for the Legislature's consideration before the expiration of the moratorium.

NHA member hospitals support a level playing field; if community hospitals must have a fully functioning emergency room with coverage available 24 hours per day, seven days per week, so should any physician-owned entity. Nebraska hospitals contend that the EMTALA requirement that community hospitals must medically screen and stabilize all patients must also apply to any physician-owned hospital. Additionally, NHA member hospitals contend that physicians must be required to provide on call support for all hospitals and that any physician-owned hospital must treat an appropriate number of Medicaid and Medicare beneficiaries, and must also treat an appropriate percentage of uninsured and underinsured patients, just as community hospitals do.

NHA member hospitals do not support physician self-referral. The ability to refer patients to an entity owned by any individual or group of physicians results in financial incentives for physicians to steer more complex and costly patients to community

hospitals while referring less complex, well insured patients to their own facilities. Those selection practices compromise community hospitals' ability to offer essential services such as emergency, trauma, neonatal, burn, behavioral health and uncompensated care. If physician-owned hospitals are allowed to siphon off the profitable cases, leaving the community hospital with unprofitable cases, in time the community hospital may be forced to discontinue certain services, causing access to care issues for residents in various parts of the state.

NHA member hospitals are also concerned that the agreements between the state's 65 CAHs and their hub hospitals may be at risk should another physician-owned hospital enter Nebraska. CAHs rely on the hub hospital to provide physicians to offer specialty clinics in rural Nebraska. If physicians develop their own hospital, they may not be willing to offer clinic services, jeopardizing access to health care in rural Nebraska.

Nebraska's hospitals **urge you to support and advance LB 999** and to conduct a study that examines the myriad of issues related to this matter before allowing any new physician-owned hospital to be licensed in this state. Thank you for your consideration of the NHA's perspective on this important matter.

Endnotes for NHA Testimony for LB 999

1. Medicare Payment Advisory Commission. (August 2006). *Physician-owned Specialty Hospitals Revisited*. Washington, DC, and Government Accountability Office. (April 2003). *Specialty Hospitals: Information on National Market Share, Physician Ownership and Patients Served*. Washington, DC.
2. AHA estimates are derived from state surveys and the Centers for Medicare & Medicaid Services data.
3. Government Accountability Office. (October 2003). *Specialty Hospitals: Geographic Location, Services Provided, and Financials Performance*. Washington, DC. and Mitchell, J.M. (2007). Utilization Changes Following Market Entry by Physician-owned Specialty Hospitals. *Medical Care Research and Review*, 64(4), 395-415.
4. Government Accountability Office. (April 2003). *Specialty Hospitals: Information on National Market Share, Physician Ownership and Patients Served*. Washington, DC.
5. AHA estimates are derived from state surveys and the Centers for Medicare & Medicaid Services data.
6. Casalino, L.P., Devers, K.J., & Brewster, L.R. (2003). Focused Factories? Physician-owned Specialty Facilities. *Health Affairs*, 22(6), 56-67., and Greenwald, L., et al. (2006). Specialty versus Community Hospitals: Referrals, Quality and Community Benefits. *Health Affairs*, 25(1), 106-118.
7. Lesser, C.S., Ginsburg, P.B., & Felland, L.E. (2005). *Initial Findings From HSC's 2005 Visits: Stage Set for Growing Health Care Cost and Access Problems*. Washington, DC: Center for Studying Health Systems Change, and Mitchell, J.M. (2005). Effects of Physician-owned Limited Service Hospitals: Evidence from Arizona. *Health Affairs*, Web Exclusive.
8. McManis Consulting. (2004-2005). *Impact of Physician-owned Limited-service Hospitals*. Greenwood Village, CO.
9. Government Accountability Office. (October 2003). *Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance*. Washington, DC, and Office of Inspector General. (January 2008).
10. Office of Inspector General. (January 2008). *Physician-owned Specialty Hospitals' Ability to Manage Medical Emergencies*. Washington, DC.
11. Ibid.
12. Medicare Payment Advisory Commission. (August 2006). *Physician-owned Specialty Hospital Revisited*. Washington, DC.
13. Medicare Payment Advisory Commission. (May 2005). *Medicare Admissions by Type of Hospital and Race*. Washington, DC.
14. Greenwald, L., et al. (2006). Specialty versus Community Hospitals: Referrals, Quality and Community Benefits. *Health Affairs*, 25(1), 106-118