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Physician self-referral and physician-owned specialty facilities

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SUMMARY OF KEY FINDINGS

- The number of physician-owned facilities has increased substantially in the last decade, as have the number of imaging procedures performed in physician offices and IDTFs.
- Self-referral has resulted in higher utilization of services, particularly imaging services.
- Specialty hospitals and ASCs treat more profitable patients—those less likely to have complications or to be on Medicaid—than general hospitals.
- For the types of patients treated, the quality of care provided by specialty hospitals and ASCs is comparable to that of general hospitals; less is known about the quality in IDTFs and physician offices.
- Though they are losing some profitable cases to specialty hospitals and ASCs, general hospitals overall are maintaining their profit margins.

Why is this issue important to policy-makers?

- Self-referral occurs each time a physician refers a patient to a facility in which the physician has an ownership interest. Self-referral is not inherently bad and may be good practice of medicine. Because of the financial gain to physicians, however, there is a potential conflict of interest every time self-referral occurs.
- Interest in physician self-referral has heightened primarily because of the rapid growth of physician-owned specialty hospitals and ambulatory surgical centers (ASCs) and of imaging services performed in physician offices and independent diagnostic testing facilities (IDTFs).

The growth of self-referral and physician-owned specialty facilities

The number of self-referrals has grown significantly over the last decade.

This policy brief focuses on self-referral to physician-owned specialty hospitals and ASCs, as well as imaging services performed in physician offices and IDTFs.

The number of physician-owned specialty hospitals more than doubled between 2002 and 2007 and this number is expected to increase (Figure 1).

The increase is most likely to be seen in new surgical hospitals or ASCs converting to surgical hospitals. Surgical hospitals are relatively inexpensive to create and receive higher payments than ASCs for the same types of cases.

Figure 1. Growth in physician-owned specialty hospitals

	2002	2004	2007
Total	46	89	109
Cardiac	12	25	20
Orthopedic/Surgical	34	64	89

Source: 2002 and 2004 data from MedPAC (Reference 1); 2007 data from OIG (Reference 2).

Surgery is increasingly being done in physician offices and in ASCs, 80 percent of which have at least some physician ownership.

Between 1999 and 2005, the volume of services performed in ASCs grew at seven times the rate of comparable services performed at hospital outpatient departments (Reference 3).

In recent years, the volume of diagnostic imaging services has grown far more rapidly than other physician services (Figure 2).

Physician self-referral is influenced by financial, regulatory and clinical incentives.

WHAT HAS LED TO THE EMERGENCE OF SELF-REFERRAL?

Physician decisions to self-refer are affected by financial, regulatory and clinical incentives.

Financial incentives:

Dual fees: Physicians who perform services in physician-owned facilities are able to bill both for their services and for the facility fee.

Cost containment policies: As Medicare and private health plans constrain physician payment rates, physicians can compensate by referring patients to facilities they own.

Disparities in payment policies: Private health plans usually pay more than Medicare, which pays more than Medicaid. Physicians can refer patients in private health plans to their own facilities while referring Medicaid patients to other facilities in order to maximize revenues.

Regulatory incentives:

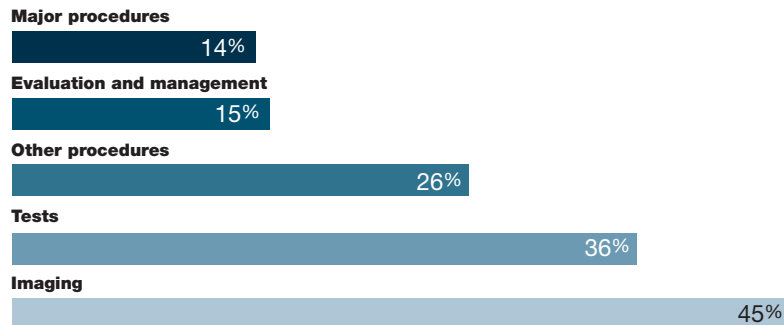
Anti-self-referral legislation: The Stark anti-self-referral laws have eliminated certain forms of self-referral, but allow exceptions for specialty hospitals, ASCs, and for office-based surgical or imaging procedures.

Certificate of need (CON) laws: Ninety-six percent of specialty hospitals created since 1990 are located in states without CON laws (Reference 10).

Clinical incentives:

Patient convenience and timeliness of care: In-office imaging eliminates the need for patients to travel between a physician's office and a separate imaging facility and makes immediate diagnosis and treatment possible.

Figure 2. Cumulative growth rate of physician services, 1999–2003 (Reference 4).



What types of patients do physicians most commonly self-refer?

Patients referred to specialty hospitals are significantly healthier than those referred to general hospitals for the same procedures (References 5, 6). Patients referred to ASCs are only slightly healthier than those referred to hospital outpatient departments for the same procedures (Reference 7).

Specialty hospitals and ASCs treat a much lower percentage of Medicaid patients than general hospitals (References 5, 8). Specialty hospitals also treat patients with higher incomes and fewer minorities than general hospitals (Reference 6, 9).

What are the effects of physician self-referral on quality, costs and access?

Quality

Quality of care at specialty hospitals—as measured by risk adjusted mortality and complication rates—is similar to that of general hospitals (References 5, 6). Orthopedic and surgical hospitals are less likely than general hospitals to have an emergency department or a physician on-site at all times (Reference 2). While transfers out of orthopedic and surgical hospitals are rare, they are higher than for general hospitals (Reference 6).

Quality of care at ASCs—as measured by risk adjusted mortality and complication rates—is similar to that of general hospitals (References 9, 11, 12). Limited data suggest quality of care, especially for procedures requiring sedation or anesthesia, may be lower for surgery performed in physician offices than for surgery performed in hospital outpatient departments or ASCs (References 13, 14).

Little is known about the quality of care of imaging services performed in physician offices and IDTFs. Limited data suggest quality may be poor (Reference 15). In most states there is little oversight of procedures done in physician offices and one-third of physicians practice in one- or two-physician offices where there is no supervision from other physicians (Reference 16).

To date, general hospitals' profit margins have not been affected by specialty hospitals.

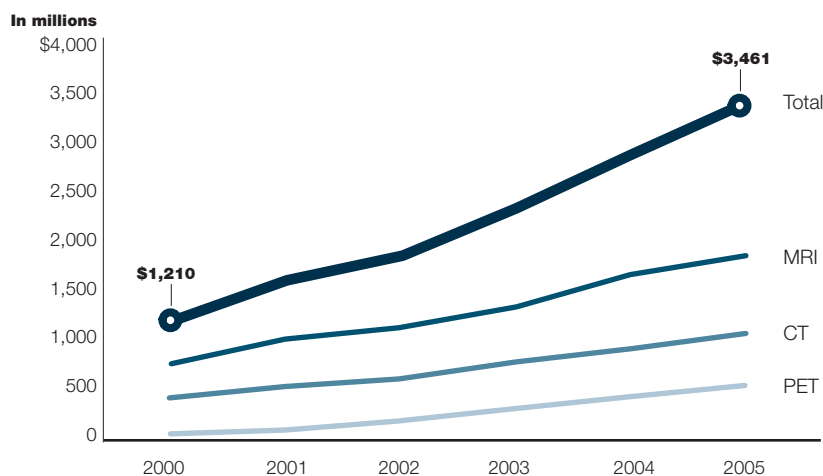
Costs

Rates of cardiac surgery are moderately higher in markets with cardiac hospitals and spinal surgical rates are significantly higher in markets with orthopedic hospitals (References 17, 18). There is no data to determine whether the increased utilization is clinically appropriate or inappropriate.

Physician ownership is related to referral patterns. The higher the percentage of physician ownership, the more likely a physician is to refer patients to a specialty hospital rather than a general hospital (Reference 5).

Between 2000 and 2005 total Medicare charges for advanced imaging—CT, MRI and PET scans—nearly tripled (Reference 19) (Figure 3). Much of the increase in imaging involves physician self-referral (Reference 19). The increase has been driven primarily by imaging performed in physician offices, IDTFs, and through lease, time-share and “pay-per-click” arrangements between physicians and separately owned imaging facilities (Reference 19).

Figure 3. Medicare physicians' fee schedule allowed charges for advanced imaging (Reference 19)



Access

Research is scarce on whether increased utilization resulting from self-referral is clinically appropriate or inappropriate. If increased utilization is medically indicated, the growth of physician-owned facilities and in-office procedures may be fulfilling an unmet need. One of the few studies to look at medical appropriateness by reviewing medical records found that nearly one-third of imaging performed at IDTFs was unnecessary (Reference 15).

Medicare beneficiaries' coinsurance is generally lower for surgeries performed in ASCs than in hospital outpatient departments (Reference 3), though the Centers for Medicare and Medicaid Services (CMS) is gradually narrowing the difference. ASCs may give beneficiaries a lower cost alternative to general hospitals while still providing the same quality care.

THE EFFECT OF SELF-REFERRAL ON GENERAL HOSPITALS

General hospitals argue that physician-owned specialty hospitals and ASCs have unfair competitive advantages: specialty hospitals limit their focus to the most profitable services and care for fewer Medicaid patients (Reference 6), more high income patients (Reference 7), and fewer patients likely to have costly complications.

General hospitals rely on profitable services to subsidize unprofitable areas, such as emergency departments and psychiatric units. Losing more profitable services to physician-owned facilities may affect general hospitals ability to cross-subsidize.

However, the limited evidence available to date suggests that overall, general hospitals' profit margins have not been affected by specialty hospitals. General hospitals appear to have adapted by entering into joint ventures with physicians, by employing physicians who might otherwise compete with the hospital and by expanding their own focus on profitable service lines.

Conclusions and Policy Implications

- > **There is strong evidence that self-referral increases the utilization of health care services.** Indirect evidence suggests that at least some of the increased utilization is not medically appropriate.
- > **The benefits and costs may differ substantially depending on the type of self-referral.** For example, leasing and pay-per-click imaging arrangements appear to have little potential for improving quality or controlling costs. Increased competition from physician-owned facilities could result in lower prices and improved quality, but there is currently no evidence on this issue.
- > **Policy-makers could adopt policies to increase the quality of the services provided by facilities to which physicians self-refer.** For example, Medicare, state regulators and health plans could strengthen their conditions of participation and oversight of ASCs and IDTFs and of physician offices that want to provide imaging services and in-office surgery.
- > **The rapid growth of key forms of physician self-referral is fueled by payment policies that make it much more profitable to provide some services than others.** Policies that make likely profit margins more equal across different types of services and sites of care would encourage the creation of facilities only when they are able to provide high-quality, cost-efficient care.

THE SYNTHESIS PROJECT (Synthesis) is an initiative of the Robert Wood Johnson Foundation to produce relevant, concise, and thought-provoking briefs and reports on today's important health policy issues.

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