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NEW INSIGHTS FROM RESEARCH RESULTS

Physician Self-Referral and Physician-Owned Specialty Facilities

Lawrence P. Casalino, M.D., Ph.D.
University of Chicago

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Why is this issue important?

- Self-referral to physician-owned facilities may affect both the costs and the quality of care
- Certain forms of self-referral are increasing rapidly
 - specialty cardiac and surgical hospitals
 - ambulatory surgery centers
 - diagnostic imaging centers
 - in-office imaging and procedures
- Physician-owned specialty facilities could potentially reduce general hospitals' ability to cross-subsidize unprofitable patients and services



Self-referral to physician-owned facilities might:

- Increase quality, decrease costs, and be more convenient for patients

because . . .

- The facilities may function as “focused factories”
- that physician owners will make as efficient and high quality as possible
- and that will enable physicians to use their time more efficiently



Self-referral also might lead to:

- Growth in unnecessary services
- Lower quality and/or higher cost per service
- Physician cherry-picking of the healthiest and best-insured patients



The Synthesis focuses on three questions:

- How common is self-referral to physician-owned facilities and how rapidly is it growing?
- Why is self-referral increasing?
- What are the effects of self-referral on quality, costs, access to care, and the organization of health care?



How common is self-referral to physician-owned facilities and how rapidly is it growing?

Growth of physician-owned specialty hospitals

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

Source: 2002/2004 data from MedPAC; 2007 data from OIG



Growth of ambulatory surgery centers (ASCs)



Source: MedPAC and CMS, 2007



Growth of diagnostic imaging

- In recent years, imaging (especially CT, MRI, PET) has grown more rapidly than other physician services
- Most of the growth is due to self-referral:
 - By 2005, radiologists were receiving only 40% of Medicare payments for imaging services
 - Orthopedists performed 33 times more advanced imaging procedures in 2005 than in 1995; cardiologists 29 times more
- Independent Diagnostic Testing Facilities (IDTF) share of advanced imaging: 3% in 1995, 23% in 2005.



Why is self-referral increasing?

- Financial incentives
- Clinical incentives
- Regulatory policies
- New technologies



Financial Incentives

- Gain both professional fee AND facility fee
- Increase the volume of services
 - some of which (e.g. imaging) require little MD time
- Use MD time more efficiently
- Select most profitable services and patients
- Compensate for perceived low payment rates/discounts from Medicare and managed care
- If medical care is a market, then why shouldn't doctors be market players?



Clinical incentives

- Narrow focus and MD control → increased quality?
- Patient convenience and amenities
- Timeliness and coordination of care



Regulatory policies

- Stark does not ban self-referral to specialty hospitals, ASCs, or for office-based surgery or imaging services
- Certificate of Need regulation blocks specialty hospitals in many states (and, to a lesser extent, ASCs)
- Medicare oversight of IDTFs and of office-based imaging and surgery is not strong



What are the effects of self-referral on quality, costs, access and the organization of health care?



Effects on quality: Specialty hospitals

- Care for healthier patients than general hospitals
- Slightly lower risk-adjusted mortality rates
- Orthopedic/surgical hospitals have slightly higher transfer rates
- Orthopedic/surgical hospitals are often poorly prepared to deal with post-operative emergencies
- Confirmatory research needed for all these findings



Effects on quality: ASCs

- Care for healthier patients than hospital outpatient departments (OPDs)
- Rates of death and serious complications are similar in ASCs and OPDs



Effects on quality: Office-based surgery

- Very limited data suggest increased risk of death and serious injury, particularly for procedures that require intravenous sedation, general anesthesia, or large amounts of local anesthetic
- Most states (and Medicare) have little oversight of office-based procedures



Effects on quality: Diagnostic imaging

- Little data available
- Equipment, staff, MD skill in interpreting images likely lower in primary care offices
- GAO study of IDTFs found 43% of facilities not complying with Medicare requirements



Self-referral and costs: Four ways to think about self-referral and costs

1. Cost of providing the service
2. Price paid for the service
3. Overall price paid for the service in a given geographic area for a given time period (price times volume across all providers)
4. Overall price paid for all services for a population of patients in a given geographic area for a given time period



Effects on costs: MUCH more data needed

- Cost per discharge similar between cardiac and general hospitals; higher for orthopedic/surgical hospitals
- Volume of services in an area increases when specialty hospitals appear
- Cost per case lower in ASCs than OPDs
- Some evidence that some of the increased volume of imaging services is discretionary, at best



Effects on access and patient selection

- Patients in specialty hospitals and ASCs are:
 - healthier
 - less likely to be covered by Medicaid
 - more likely to be white and to have higher income (data for specialty hospitals only)



Effects on the organization of care

- New types of organization (specialty hospitals, ASCs, IDTFs)
- Increasing formation of single specialty medical groups
- Threat to general hospitals
 - clearly lose some profitable patients/cases
 - overall, so far have managed to sustain net revenues
 - no systematic evidence of how this has been done (increased efficiency? increased provision of high profit services/reduced cross-subsidization?)



Conclusions and Implications

- Benefits and costs of self-referral may differ substantially, depending on the service and setting
 - one-size-fits-all approach may not be appropriate
- Self-referral does increase the volume of services provided; little evidence on appropriateness, but some reason for concern
 - need labor-intensive research re appropriateness of care
- Data available is still quite limited, particularly for imaging and for office-based surgery



Conclusions and implications, cont.

- Self-referral/MD-owned specialty facilities may affect the behavior of general hospitals
 - need research on effects within a market, not just on costs and quality of the specialty facilities themselves
- Overall, no disastrous effect on general hospitals at this time, though this could change with proliferation of specialty facilities
- Specialty facilities care for healthier and wealthier patients; quality appears comparable to general hospitals



Project Information

Web site: www.policysynthesis.org

E-mail: synthesisproject@rwjf.org

Contacts

RWJF: Brian Quinn

Synthesis Project: Sarah Goodell