IMPLEMENTING HEALTH REFORM

The Ban on Physician-Owned Specialty Hospitals

The criticisms of physician-owned specialty hospitals are chiefly that they receive the same tax breaks and insurance payments as do traditional hospitals but don't provide the same breadth of care, and that they are rife with conflicts of interest. Periodically, the federal government has imposed moratoriums on physician ownership, but even so, the number of facilities has grown. Now, a provision of the Affordable Care Act bans the construction of new physician-owned hospitals that do not receive Medicare certification before Dec. 31; existing physician-owned facilities have been prohibited from expanding since the law was enacted on March 23.

Dr. Jack Lewin, CEO of the American College of Cardiology, talks about the upcoming ban on physician-owned specialty hospitals.

RHEUMATOLOGY NEWS: What finally moved Congress to approve permanent restrictions on physician ownership?

DR. LEWIN: Strong opposition from hospitals was effective in protecting their interest. There are legitimate concerns in some communities – for example, where services for low-income patients may be jeopardized by the shifting of high-revenue patients from public and community hospitals to specialty hospitals – but this is not a phenomenon everywhere specialty hospitals exist.

The contrary position is that specialty hospitals provide services at a higher quality and competitive cost. If legitimate problems were caused by the introduction of a hospital into a community, it would be better to address the concern when approving the new facility rather than to create an outright ban.

Regardless of the ban, the way care is provided in the United States will change due to public and market pressures.

DR. LEWIN

RN: Critics claim improper referrals and higher procedure rates among their reasons to ban physician-owned hospitals. The ACC is against a ban. What is the argument for physician ownership?

DR. LEWIN: The ACC supports a policy that promotes better medical and clinical quality outcomes and patient satisfaction. There are a number of ways to protect against physician self-interest, self-referral, and overuse of services. The use of ACC registries could readily identify such problems. In many instances, physician investors in these facilities are limited to less than 1% of overall ownership. It is hard to argue that this in itself is an unfair self-interest, in particular when there is no source of funding available to improve the situation in communities where operating rooms are overbooked, understaffed, and ill equipped. In other words, the ACC supports assurances that physician self-interest is not the key factor behind a specialty hospital, but rather that the central issues are the best interests of the patient and community, and the quality of care.

RN: How can physicians ensure that appropriate, high-quality care is being delivered at specialty hospitals?

DR. LEWIN: More than 2,400 hospitals participate in the ACC's NCDR (National Cardiovascular Data Registry) programs, but by using just a few specialty-hospital registries, we could provide objective feedback and comparisons based on clinical data, rather than on claims data that insurance companies and the government use. Our registries provide most of the U.S. hospitals that offer cardiac care access to data and feedback on quality outcomes, system problems, and rates of complications. If specialty hospitals were required to participate in these registries, most of the concerns could be mediated.

RN: Does the ACC support legal challenges to the coming ban?

DR. LEWIN: The ACC believes that the ban should be lifted and replaced with thoughtful policies that allow for specialty hospitals to improve access, quality, patient satisfaction, and efficiency. These policies could address concerns about self-referral, self-interest, or adverse impacts on other needed community-based hospital services.

RN: What would the ACC propose as an alternative to the ban?

DR. LEWIN: The ban notwithstanding, the way care is provided in the United States will change due to public and market pressures. Community hospitals will continue to need to provide emergency surgeries, general intensive care, and other services as currently provided in the traditional model, but the ACC believes that the best care and services will evolve into specialty units that focus on increased volume and increased quality in cardiology, orthopedics, gynecology, trauma, neurosciences, oncology, and other specialized areas. This will include pediatric as well as inpatient services. If we are serious about promoting the best outcomes, best quality, and patient and physician satisfaction, then this is where we are headed, regardless of the politically inspired ban. ■

DR. LEWIN is CEO of the American College of Cardiology.