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March 22, 2013

Chairman Parks and Members of the Council
State Health Coordinating Council
North Carolina Division of Health Service Regulation
Medical Facilities Planning Branch
809 Ruggles Dr.
Raleigh, NC 27603

Re: Novant Health, Inc.'s Comments Regarding the March 6, 2013 Petition of
MedCapital Advisors, LLC for a Change in Basic Policies and Methodologies of the
State Medical Facilities Plan

Dear Chairman Parks, SHCC Members, and DHSR Medical Facilities Planning Branch
Staff:

Enclosed are Novant Health's comments regarding the 3/6/2013 Petition of MedCapital
Advisors. If you have questions please do not hesitate to contact me at:

Barbara L. Freedy, Director
Certificate of Need
Novant Health, Inc.
2085 Frontis Plaza Blvd.
Winston-Salem, NC 27103
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E-Mail: blfreedy@novanthealth.org

Sincerely,

A handwritten signature in cursive script that reads "Barbara L. Freedy".

Barbara L. Freedy, Director
Certificate of Need
Novant Health, Inc.

March 22, 2013

Via Electronic Mail

Chairman Parks and Members of the Council
State Health Coordinating Council
North Carolina Division of Health Service Regulation
Medical Facilities Planning Branch
809 Ruggles Dr.
Raleigh, NC 27603

Re: Novant Health, Inc.'s Comments Regarding the March 6, 2013 Petition of MedCapital¹ Advisors, LLC for a Change in Basic Policies and Methodologies of the State Medical Facilities Plan

Pursuant to the process specified in the 2013 State Medical Facilities Plan at pages 10-11 and 15, Novant Health submits the comments below regarding the MedCapital petition proposing the unlimited expansion of single specialty surgery centers.

The Petition for “Changes in Basic Policies and Methodologies” Lacks Key Elements Specified by the 2013 SMFP

The State Medical Facilities Plan is North Carolina's annual health plan document prepared pursuant to a process and timeline defined in Chapter 2 of the SMFP. The development of the annual state health plan is supported and overseen by staff from the NC Department of Health and Human Services, NC Division of Health Service Regulation, Medical Facilities Planning Branch and the State Health Coordinating Council (“SHCC”), an advisory body, whose members are appointed by the Governor. The SMFP states that “the major objective of the plan is to provide individuals, institutions, state and local government agencies, and community leadership with policies and projections of need to guide local health planning for specific health care facilities and services. See the 2013 SMFP at page 1.

The 2013 State Medical Facilities Plan, as well as prior years' SMFPs, provides very specific matters which the petitioner must address in its petition. These five steps include:

1. *Petitioner's name, address, e-mail address, and phone number.*
2. *A statement of the requested change, including identification of the SMFP Policy or planning methodology which is proposed for change.*

¹MedCapital Advisors is a North Carolina Limited Liability Company (LLC) located at 944 19th Ave. N.W. in Hickory, NC with a Registered Agent and Member/Manager identified as Robert H. Blake, III. Mr. Blake prepared and the MedCapital petition and presented it at SHCC's public hearing in Raleigh on 3/6/2013. The web site www.zoominfo.com indicates that Mr. Blake is the President of MedCapital Advisors, LLC and is an Advisor to Alex Lee, Inc. (a large grocery distributor in Hickory, NC) on health plan performance; has over 20 years of direct experience in health plan management; and is assisting in the development of a community health plan with employers and physicians in Charleston, SC and pay for performance programs (P4P).

3. *Petitioner's reasons for the proposed change to include: (a) a statement of the adverse effects on providers or consumer of health services if the change is not made; and (b) a statement of alternatives to the proposed change that were considered and found not feasible.*
4. *Evidence that the proposed change would not result in unnecessary duplication of health resources*
5. *Evidence that the change requested is consistent with the three Basic Principles governing the development of the NC State Medical Facilities Plan: (a) Safety & Quality; (b) Access; and (c) Value (aka "QAV").²*

The MedCapital Petition fails to address several of the above requirements.

First, the MedCapital Petition fails to identify an SMFP Policy for which the petitioner proposes a change. The SMFP Policies are listed in Chapter 4 of the 2013 SMFP, pages 23-43, and cover acute care hospitals, nursing care facilities, adult care homes, ESRD services, mental health, substance abuse and developmental disabilities, psychiatric inpatient services, ICFMRs, and all health services. In addition, the MedCapital petition does not specify an SMFP planning methodology for which the petitioner proposes a change. Rather the petition seeks Certificate of Need and Licensure changes, which are outside the scope of the State Medical Facilities Plan.

Second, the MedCapital petition does not include either "a statement of the adverse effects on providers or consumer of health services if the change is not made" or "a statement of alternatives to the proposed change that were considered and found not feasible," as outlined in the instructions to the petitioner for this type of petition³. None of the headings, text or attachments in the MedCapital petition speaks to these important and necessary petition elements.

Third, the MedCapital petition fails to include "evidence" regarding whether "the proposed change would not result in the unnecessary duplication of health resources..." The requirement for this information is articulated in Step #4 of the "Instructions for Writing Petitions for Changes in the Basic Policies and Methodologies" at page 10 of the 2013 SMFP. Instead, on page 3 of the MedCapital petition the petitioner states: "the demand for ambulatory surgery is increasing...and single-specialty ambulatory surgery centers are recognized as a highly effective means of expanding access and achieving cost savings, regardless of the availability and potential underutilization of hospital-based operating rooms." The underlined phrase may suggest that the petitioner's position is that it is not essential to provide "evidence" that the change proposed in the petition "would not result in unnecessary duplication of health resources." Nor does the petitioner provide any outside sources (journal articles, Dartmouth Health Atlas data, etc.) to support the assertion that "single-specialty ambulatory surgery centers are recognized as a highly effective means of expanding access and achieving cost savings."

²The 2013 SMFP contains an extensive discussion of these three "Basic Principles Governing the Development of this Plan [SMFP] at pages 2-4 of the 2013 SMFP.

³See Step #3 of the "Instructions for Writing Petitions for Changes in the Basic Policies and Methodologies" at page 9 of the 2013 SMFP.

Fourth, the MedCapital petition does not contain sufficient “evidence” showing how the change proposed is “consistent with the three Basic Principles governing the development of the North Carolina SMFP: Safety and Quality, Access, and Value.” Petition pages 3-4 appear to discuss briefly the petitioner’s interpretation of the “Value” Principle of the SMFP. However, the SMFP Basic Principles pertaining to Safety and Quality are not discussed on pages 3-4 of the petition. Page 4 of the petition includes a discussion of the “Certificate of Public Advantage” which is governed by a separate North Carolina statute from the CON law.

During the 2012 petition cycle for the then draft 2013 SMFP, the SHCC and DHSR Medical Facilities Planning Branch staff were presented with a petition in a similar posture as the MedCapital petition. In that situation, the petitioner was seeking to adjust a need determination for a new PET scanner in the draft 2013 SMFP. During summer and fall 2012, the full SHCC and the SHCC’s Medical Equipment and Technology Committee along with DHSR MFPB staff recommended and determined that the format, form and content of the “petition” which was styled as a “comment letter” did not meet the SMFP petition requirements for “Petitions for Adjustments to Need Determinations,” as described on pages 11-12 of the 2012 SMFP⁴. Thus, the SHCC’s decision was that the petition be denied. This same analysis and outcome is relevant to the consideration of the current MedCapital petition.

The Change Sought in the Petition is Not Within the Scope of Authority or Responsibility of the SHCC

As discussed above, the MedCapital petition does not explicitly set forth the policy or need methodology change for which it is seeking approval by the SHCC. Rather, the petitioner generally advocates for changes that would make it simpler for surgeons other than plastic surgeons, maxillofacial surgeons, and otolaryngology surgeons to provide outpatient surgical procedures without North Carolina certificate of need and licensure regulation. In pertinent part the petition states on page 1, Item #2:

“It is requested that CON and licensure exceptions be applied equally to all ambulatory surgical facilities, regardless of medical/surgical specialty. The request is that orthopedic surgery, ophthalmology, urology, OB/GYN, general surgery, and other medical/surgical specialties be allowed to develop and operate single specialty ambulatory surgical facilities, not subject to requirements of CON and state licensure, equally as plastic surgery⁵, oral maxillofacial surgery, and otolaryngology (ENT) do presently.”

The petitioner’s requested change would require the SHCC to go beyond its statutorily-defined role in the North Carolina annual state health planning process. As set forth in North Carolina General Statute Section 131E-176(17) the SHCC’s role and responsibility is to “prepare with the [NC] Department of Health and Human Services, the State Medical Facilities Plan.” And North

⁴ See DHSR Medical Facilities Planning Branch meeting minutes for the 9/18/2012 meeting of the SHCC’s Medical Equipment and Technology Meeting and the meeting minutes for the 10/3/2012 meeting of the SHCC.

⁵ In Appendix A (page 3) of the MedCapital petition, the Plastic Surgery Center of North Carolina in Winston-Salem, NC is erroneously identified as an unlicensed surgery center. PSNC has been a licensed surgery center in Forsyth County for many years and has on file with the DHSR Licensure Section in Raleigh a 2013 annual Surgery Center Licensure Renewal Application.

Carolina General Statute Section 131E-176(25) further states: “the State Medical Facilities Plan means the plan prepared by the [NC] Department of Health and Human Services and the North Carolina State Health Coordinating Council, and approved by the Governor....The Department shall hold at least one public hearing prior to the adoption of the proposed Plan and at least six public hearings after the adoption of the proposed Plan by the State Health Coordinating Council. The Council shall accept oral and written comments.” Moreover, on the first page of the 2013 SMFP it also states: “the major objective of the Plan is to provide individuals, institutions, state and local government agencies, and community leadership with policies and projections of need to guide local planning for specific health care facilities and services.”

Based on the above statutory and SMFP language, it is the SHCC’s role and responsibility to determine the number of licensed operating rooms that need to be developed and not whether certain outpatient surgical procedures may or may not be provided in unlicensed facilities. It is the North Carolina CON statute, rather than the SHCC, which determines the facilities, services and equipment which are subject to CON regulation. By existing North Carolina statute “an ambulatory surgical facility may be operated as part of a physician or dentist’s office, provided the facility is licensed under NC General Statutes Chapter 131E, Article 6, Part D, but the performance of incidental, limited ambulatory surgical procedures which do not constitute an ambulatory surgical program as defined in subdivision (1c) of this section and which are performed in a physician’s office does not make that office an ambulatory surgical facility.” See NC General Statutes at Section 131E-176(1b). Therefore, the ability to provide limited ambulatory surgical procedures in unlicensed physician office settings is not restricted to a particular specialty. Nothing in the current CON statutes restricts surgeons other than plastic surgeons, oral maxillofacial surgeons, or otolaryngology surgeons from doing so. Enforcement measures for providers offering new institutional health services without a certificate of need are found in N.C.G.S. 131-190. It should be noted that the SHCC plays no role in the enforcement process.

Practically speaking, questions or changes regarding the applicable standard of care and payor requirements may provide direction or even dictate which specialties are best equipped to offer procedures in unlicensed settings. For example, the North Carolina Medical Board has promulgated a Position Statement on “Office-based procedures,” laying out factors to be considered in offering such procedures.⁶

Likewise, government payors regulate the conditions for payment of “technical” or “facility” fees and generally pay such fees only for procedures performed in licensed facilities. Managed care payors can impose similar provider reimbursement requirements for their insured lives. This may serve as a deterrent for surgeons who primarily care for Medicare, Medicaid, or commercially insured patients and keep them from performing surgical procedures in unlicensed facilities. However, surgeons who provide procedures on a self-pay basis may have more flexibility and therefore a greater incentive to offer procedures in unlicensed settings. This is purely a function of payor requirements and well outside the health planning purview of the SHCC.

⁶See N.C. Medical Board Position Statement: “Office-Based Procedures” (http://www.ncmedboard.org/position_statements/detail/office-based_procedures).

The SHCC cannot address the relief or changes requested in the MedCapital petition and thus should deny the petition.

Unlimited Expansion of Single Specialty Ambulatory Surgery Centers in North Carolina Would Create an Incomplete and Irrational Annual State Health Planning Process for New Operating Rooms

The Petitioner's Proposal Creates an Unwieldy Bi-furcated Network of Operating Rooms Assets in NC

Operating Rooms are among the most sophisticated and complex health assets regulated by need determinations in the North Carolina State Medical Facilities Plan. Operating rooms, whether developed in the inpatient or outpatient setting are costly to construct and equip and costly to maintain. Both inpatient and outpatient ORs require numerous highly trained and skill personnel, including physicians and surgeons, to operate in a safe, effective, and high quality manner.

If the approach proposed in the petition were adopted, there would be no licensure of those future single specialty ORs, which would mean no OR inventory and no OR case volume data for these centers would be reported on the state's annual surgery center licensure renewal application forms. This boutique, specialty outpatient ORs would operate outside the licensure framework, which is the most basic layer of assuring patient safety and quality for payors and patients. A surgery center license is sort of akin to a baseline "Good Housekeeping Seal of Approval." The OR data reported by both the surgery centers and hospitals each year on the state's annual licensure renewal application forms captures the data that drives NC's annual state health planning process for ORs. Under the framework proposed in the petition, the unlicensed single specialty ORs would operate in a parallel, unreported, unregulated universe for outpatient surgery. A North Carolina ambulatory surgery center delivery system with that much surgical care being delivered outside the basic framework of health planning-CON-and licensure will make it impossible for either providers, patients, or payors to have a comprehensive picture of ambulatory surgical care delivery in North Carolina and it would essentially have the potential to make the health planning process for ORs in North Carolina a bi-furcated system at best and a superfluous system at worst.

Data on the Current North Carolina OR Inventory Shows Significant Underutilized OR Capacity in NC Today

As proposed in MedCapital's petition, there would be no health plan need determination limits based on statewide OR case volume data or third party frameworks to ensure patient safety, quality, access, and affordability, through CON, Licensure or otherwise for the future expansion of surgeon-owned operating rooms in single specialty surgery centers in North Carolina. Contrary to the assertions of the petitioner, the creation of additional single specialty surgery centers without regard to the need for those facilities and new operating rooms could increase overall spending for those services in North Carolina.

A review of the inventory of North Carolina operating rooms, based on SMFP Chapter 6/Operating Rooms, Table 6B, Column T/OR Deficit or Surplus shows the following for NC State Medical Facility Plan Years 2010-2011-2012-2013⁷:

- In the 2010 SMFP (FFY 2008 data), there were ~1,226 existing and CON-approved ORs in North Carolina and 207.7 (or 17%) of those ORs were identified as “surplus” or under-utilized ORs.
- In the 2011 SMFP (FFY 2009 data), there were ~1,224 existing and CON-approved ORs in North Carolina and 233.7 (or 19%) of those ORs were identified as “surplus” or under-utilized ORs.
- In the 2012 SMFP (FFY 2010 data), there were ~1,223 existing and CON-approved ORs in NC and 233.7 (or 19%) of those ORs were identified as “surplus” or under-utilized ORs.
- In the 2012 SMFP (FFY 2011 data), there were ~1,242 existing and CON-approved ORs in NC and 262.8 (or 21%) of those ORs were identified as “surplus” or under-utilized ORs.

These under-utilized ORs are found in both ambulatory surgery center and in hospital settings. The unlimited expansion of unlicensed specialty surgery centers, as proposed in the petition would clearly exacerbate the existing excess capacity in the North Carolina OR inventory. Excess capacity is not free. There is a carrying cost for excess capacity.

These ORs also provide an opportunity for providers to work together rather than permitting only an exclusive group of providers to unilaterally develop future single specialty surgery centers.⁸ The legislature’s Findings of Fact below recognize the cost impact of excess capacity of health resources, including ORs.

The legislature’s Findings of Fact for the NC CON statute at NC General Statutes Section 131E-175 state in part:

*“(1) The financing of healthcare, particularly the reimbursement of health services rendered by Health service facilities, limits the effect of free market competition and government regulation and is therefore necessary to control costs, utilization, and distribution of new health service facilities.”*⁹ ...

(4) “...the proliferation of unnecessary health service facilities results in costly duplication and underuse of facilities, with the availability of excess capacity leading to the unnecessary use of expensive resources and overutilization of health care services.” ...

(6) Excess capacity of health service facilities places an enormous economic burden on the public who pay for the construction and operation of these facilities as patients, health insurance subscribers, health plan contributors, and taxpayers.”

⁷The 2010-2011-2012-2013 SMFP years cover OR inventory data for the time periods of FFY 2008-FFY2009-FFY2010 and FFY 2011 and is the most current data that is publicly available.

⁸ Novant Health currently jointly owns and operates two specialty surgery centers with affiliated surgeons: Matthews Surgery Center (orthopedics) and South Park Surgery Center (ENT & Ophthalmology).

⁹In the CON law at NCGS Section 131E-176(9b) “health service facility” is defined to include ambulatory surgery facility and hospital, as well as several other types of health-related facilities.

Increasing Single Specialty Ambulatory Surgery Centers Would Very Likely Increase Utilization and Spending

The unlimited expansion of single specialty ambulatory surgery facilities without regard to the quantitative and qualitative need for such facilities could increase overall spending for those services. Even assuming that the costs of certain individual outpatient surgical procedures might come down, studies have shown that with the development of additional or excess facilities leads to increased utilization. The increased outpatient surgical procedure volume can increase total spending for such services overall and thus, the costs that all payors – and insured patients and taxpayers – must bear. For example, research has shown that the expansion of ambulatory surgery centers in Florida led to increased procedure use beyond the simple addition of capacity to the market. The new ASCs did not merely shift volumes from hospitals, but also led to “volume growth . . . in the marginal patient,” reflecting increased procedures and lowered treatment thresholds. J.M. Hollingsworth et al., *Opening of Ambulatory Surgery Centers and Procedure Use in Elderly Patients*, *Arch/Surg* 146, no.2 (February 2011): 187-2267. That is, when ASCs are built, overall utilization increases.

A study of Idaho ASCs similarly found that the frequency of three common outpatient orthopedic procedures was significantly higher for physician owners of ASCs than for non-physician owners, including arthroscopic knee surgery, a treatment that has been found to yield no improvement in outcomes compared with physical and medical therapy, which costs half as much. J.M. Mitchell, *Effect of Physician Ownership of Specialty Hospitals and Ambulatory Surgery Centers on Frequency of Use of Outpatient Orthopedic Surgery*, *Arch/Surg*, 145, no. 8 (August 2010): 732-38.

Moreover, not all patients appear to get the benefits promised by the advocates of ASCs. One study found that physician owners of ASCs directed 92% of their commercially covered patients, 91% of Medicare patients, 98% of “self pay” patients (who primarily received cosmetic surgery not covered by their health plan) to their ASCs – but only 55% of their Medicaid patients, referring the remaining 45% of Medicaid patients to hospital outpatient departments. J.R. Gabel et. al., *Where Do I Send Thee? Does Physician-Ownership Affect Referral Patterns to Ambulatory Surgery Centers?*, *Health Affairs*, 27, no. 3 (March 18, 2008): w165-w174. The March 2008 article from Health Affairs also notes:

“This study asks the question: Are physicians who are leading referrers to physician-owned ambulatory surgery centers (ASCs) more likely to send Medicaid patients to hospital outpatient clinics than other patients? The comparison group is physicians who are leading referrers to non-physician owned ASCs, using data from two metropolitan areas. Findings indicate that physicians at physician-owned facilities are more likely than other physicians to refer well-insured patients to their facilities and route Medicaid patients to hospital outpatient clinics.... Previous studies by the GAO (Government Accountability Office) and MedPAC (Medicare Payment Advisory Commission) have measured differences in patient mix between physician-owned and non-physician owned facilities based on diagnostic mix, severity of illness, payor mix, and co-morbidities. The consensus of these studies is that patients treated in physician-owned specialty hospitals are not as severely ill as patients cared for in general hospitals and that specialty hospitals tend to treat fewer Medicaid patients.... There is reason for concern that physician-owned facilities will contribute to further unraveling of the fragile [hospital] safety net.”

Similarly, a study found that in Pennsylvania, 8% of hospital outpatients were Medicaid patients, compared to only 1% of physician owned ASC patients. *Critical Condition: The State of Health Care in Pennsylvania*, p. 18 (*Critical Condition: The State of Health Care in Pennsylvania, Pennsylvania Health Care Cost Containment Council* (October 2007)). “Just as 11 a.m. on a Sunday morning might be the most segregated hour of the week in the United States, perhaps ASCs are the most payer-segregated component of our health care system.” *Gabel et al.*, w173-174.

Single Specialty Boutique Surgery Centers and Licensed GI Endoscopy Centers are Not Analogous

There have been suggestions that single specialty ambulatory surgery facilities should be treated like outpatient endoscopy facilities. The differences between the two are meaningful. First, the change in the regulation of endoscopy rooms in 2005 was the result of a statutory amendment, not merely a change in the SMFP. Moreover, in enacting that change the legislature specifically found “*That demand for gastrointestinal endoscopy services is increasing at a substantially faster rate than the general population given the procedure is recognized as a highly effective means to diagnose and prevent cancer.*” N.C.G.S. 131E-175 (12). Expanding access and procedure volumes to this potentially life-saving service was the specific goal of this statutory change.

We are not aware of any such preventative health need associated with the expansion of single specialty boutique surgery centers. There is no similar need to expand access and volumes for single specialty outpatient surgical procedures. North Carolina currently has significant excess capacity in ambulatory surgery facilities. Out of the 42 licensed ambulatory surgery centers reporting any volume in the 2013 SMFP (excluding those who reported 0 procedures):

- only 22 ASCs had procedures sufficient to exceed 1000 hours per procedure per room (assuming 1.5 hours per ambulatory procedure assumed in the SMFP OR Need Methodology)
- Only 5 of those exceeded 1872 hours per year per room (to be considered at or above 80% of capacity based on the 1.5 hours per procedure assumption); however, five of these ASCs had average surgical procedure times ranging from 15 to 60 minutes and none actually would have exceeded 1,872 hours of outpatient surgical procedures, based on their reported procedure times in their annual surgery center licensure renewal applications
- 14 were designated as “chronically underutilized” and excluded from the need determinations (while only 2 hospitals were chronically underutilized).

Alternatives to the Petitioner’s Proposal Exist

Where a need may exist for additional single specialty OR capacity, CON current law and regulations provide the opportunity. Ambulatory surgery centers can and do obtain file CON Applications and gain CON approval from the state. In the last two competitive OR reviews in

Wake County, the first¹⁰ resulted in a CON for a 4-OR orthopedics specialty ambulatory surgery center (which is under development). The second decision approved an application¹¹ for an ambulatory surgery center in Holly Springs (recently affirmed in fall 2012 by the North Carolina Court of Appeals).

In addition, the SHCC has been willing to entertain and thoroughly assess petitions for adjustments to need determinations for new ORs as part of the annual process for developing the State Medical Facilities Plan. The one new Catawba County OR identified as needed in the 2011 SMFP is the result of a successful petition by the provider in that county.

In addition, the SHCC has created three demonstration projects for single-specialty demonstration project ambulatory surgery centers, subject to carefully crafted reporting requirements to enable the SHCC to determine the effect of such facilities on patients and other providers. The 2010 SMFP the SHCC created need determinations for three new single specialty demonstration project surgery centers with 2 new ORs for each ASC:

- One in the Triangle Area (including Wake, Durham and Orange Counties)
- One in the Triad Area (including Forsyth and Guilford Counties) and
- One in the Charlotte Area (including Union, Cabarrus, and Mecklenburg Counties)

Almost 20 applicants filed CON Applications in 2010 to seek approval for these projects. All Three single specialty ASC projects were approved and one is currently operational (an ENT demonstration project ASC in Forsyth County) and two are under development (one orthopedic ASC in Wake County and one orthopedic ASC in Mecklenburg County). Those projects are only just now coming on line, and have not yet provided the information on each center's patient safety, quality of care, access to medically underserved population needed to evaluate them.

Further increasing the number of single specialty ambulatory surgery facilities without regard to quantitative and qualitative need in individual health service areas would lead to the unnecessary duplication of services. As set forth above, it can lead to unnecessary increases in volume. It can also lead to the shift of well-insured patients away from hospitals to physician-owned facilities.

File: CommentsNovantMedCapitalPetition.03.22.2013FINAL.docx

¹⁰Based on a CON Application filed in 2008.

¹¹Based on a CON Application filed in 2010.

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Where Do I Send Thee? Does Physician-Ownership Affect Referral Patterns To Ambulatory Surgery Centers?

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Where Do I Send Thee? Does Physician-Ownership Affect Referral Patterns To Ambulatory Surgery Centers?

There is reason for concern that physician-owned facilities will contribute to a further unraveling of the fragile safety net.

by Jon R. Gabel, Cheryl Fahlman, Ray Kang, Gregory Wozniak, Phil Kletke, and Joel W. Hay

ABSTRACT: For more than three decades, Congress has struggled with potential financial conflicts of interest when physicians share in financial gain from nonprofessional services. This study asks the question: Are physicians who are leading referrers to physician-owned ambulatory surgery centers (ASCs) more likely to send Medicaid patients to hospital outpatient clinics than other patients? The comparison group is physicians who are leading referrers to non-physician-owned ASCs, using data from two metropolitan areas. Findings indicate that physicians at physician-owned facilities are more likely than other physicians to refer well-insured patients to their facilities and route Medicaid patients to hospital outpatient clinics. [*Health Affairs* 27, no. 3 (2008): w165-w174 (published online 18 March 2008; 10.1377/hlthaff.27.3.w165)]

THE DEFICIT REDUCTION ACT (DRA), passed by Congress in January 2006, represents another chapter in the thirty-plus-year history of congressional concern and involvement about potential financial conflicts of interest when physicians receive payment for nonprofessional services. Among the DRA's provisions was a continued suspension of participation of new physician-owned specialty hospitals in Medicare. On 8 August 2006, the Centers for Medicare and Medicaid Services (CMS) allowed the suspension to expire.

■ **Background.** Recent congressional unease about physician financial conflict

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of interest has focused on specialty hospitals, but historically, Congress has also turned its attention to physicians' ownership of laboratories, imaging centers, pharmacies, and other facilities. One concern is whether physician-ownership leads to unfair competitive advantages relative to non-physician-owned facilities.¹ At issue is whether physician-owners refer more-lucrative patients to their own facilities and less-lucrative patients to their competitors. A second issue is that when physicians receive payment for nonprofessional services, they have added incentives to induce demand for these services, without the constraint of their own time as they would when they provide services in their own offices.² Proponents of physician ownership see direct ownership of facilities leading to more-efficient management and scheduling.

This paper examines the first of these concerns: physicians' referral patterns when physicians own health care facilities. Current law prohibits physicians from referring their patients to facilities that they own in ten different categories. One exception to current law is the "whole hospital" exception, which allows physicians who have ownership interest in an entire hospital to refer patients there.³ Another exception is ambulatory surgery centers (ASCs), where the rationale for the exemption is that ASCs deliver services at a lower cost than hospitals.⁴

ASCs play an important and growing role in the U.S. health care delivery system. An estimated 3,800 ASCs were operational in 2003, with more than 40 percent of them owned by physicians and another 40 percent owned in joint physician-hospital or physician-corporate ventures.⁵ These ASCs competed with 3,998 hospital outpatient departments.⁶ From 2000 to 2006, the number of ASCs grew 55 percent, and total Medicare payments to ASCs rose 13.3 percent per year.⁷

This paper explores how physician-ownership of ASCs affects referral patterns to ASCs. For a set of Pennsylvania physicians and ASCs, we analyzed whether physicians who are leading referrers to ASCs are more likely to send Medicaid and uninsured patients to hospital outpatient departments and refer privately insured patients to physician-owned facilities. We compared the referral patterns of "high referrers" to physician-owned ASCs, a proxy for physician-ownership, with patterns for physicians who are "high referrers" to non-physician-owned ASCs.

■ **Previous studies.** In recent years, several researchers and organizations have assessed differences in patients treated among physician-owned specialty hospitals and general hospitals. Studies by the Government Accountability Office (GAO), the Medicare Payment Advisory Commission (MedPAC), the CMS, Jean Mitchell, and Leslie Greenwald and colleagues have measured differences in patient mix in numerous ways: (1) diagnostic mix, (2) severity of illness, (3) payer mix, and (4) comorbidities. The consensus of these studies is that patients treated in physician-owned specialty hospitals are not as severely ill as patients cared for in general hospitals and that specialty hospitals treat fewer Medicaid patients.⁸

One previous study examined referral patterns of physicians, but it only analyzed data on Medicare patients. Greenwald and her colleagues found that "own-

ership by physicians is positively related to the likelihood of referring patients to a specialty hospital.⁹ This probability increased as the ownership share of the physician rose.

■ **Expansion on previous work.** This paper expands on previous work in two ways. First, to our knowledge, this is the first study to compare ASCs' selection of patients for physician-owned ASCs with that of non-physician-owned ASCs in the same medical marketplace. Second, we analyze the actual referral patterns by payer status. Thus, the paper presents a more direct measurement how physician-ownership affects where a patient is sent for ambulatory surgery.

Study Data And Methods

The study sought a state with both large numbers of physician-owned ASCs and a requirement that all ASCs and hospital outpatient departments submit discharge abstracts. Pennsylvania was one of the few states that met this requirement. The Pennsylvania Health Care Cost Containment Commission provides discharge abstracts for all ambulatory/outpatient hospital surgeries in Pennsylvania through a public use file.

The commission divides the state into nine regions and sells data for each region separately. Because of budgetary limitations, we restricted our analysis to regions 1, 8, and 9—which roughly correspond to the Pittsburgh and Philadelphia metropolitan areas. We chose these areas because of the concentration of the state population and ASCs within these regions. Study data are for calendar year 2003.

■ **Types of facilities.** Pennsylvania discharges entailed 1,008,034 discharges from twenty-eight physician-owned ASCs, eighty hospital outpatient departments, six for-profit ASCs, and nine nonprofit ASCs. We aimed to examine facilities providing services to all patients at different types of ASCs, regardless of age or sex, thereby eliminating pediatric and women's hospitals. We also wanted ASCs that provided a broad range of services. Therefore, facilities that provided only cancer therapy, cosmetic, or eye surgery were not included in the analysis.

■ **Physician-ownership.** Identifying physician-ownership proved to be one of the most resource-intensive tasks of the study. Pennsylvania files do not indicate whether a hospital or facility is physician-owned. We worked with the Hospital Association of Pennsylvania, Highmark Blue Cross Blue Shield, and Independence Blue Cross Blue Shield to identify physician ownership. In addition, we made telephone calls to individual hospitals and ASCs and conducted Web searches to determine the ownership of facilities.

■ **Patients' characteristics.** The patient constitutes the unit of observation throughout the study. The discharge files include data on race and ethnicity, primary payer, diagnosis, procedure codes, source of admission, and referring physician ID. The database does not include measures of severity of illness or mortality risk.

■ **Study and comparison physician groups.** The study experimental group was physicians who accounted for the top 50 percent of referrals to physician-

owned ASCs. The comparison groups are physicians who accounted, respectively, for the top 50 percent of referrals to outpatient departments, the top 50 percent of referrals to nonprofit ASCs, and the top 50 percent of referrals to for-profit ASCs.

■ **Identifying peer institutions.** In comparing the performance of physician-owned and non-physician-owned facilities, analysts must be able to identify peer institutions. One method would compare institutions delivering similar services in the same or similar communities. The flaw with this approach is that one common strategy of profit-seeking ASCs is to provide profitable services in affluent, well-insured communities. (Nonprofit as well as for-profit institutions may practice this strategy.) For this reason, our analysis did not define similar institutions in terms of narrow geographic locations, such as ZIP codes.

■ **Diagnostic groupings.** Since ASCs report their procedures as *International Classification of Diseases, Ninth Revision (ICD-9)*, *Healthcare Common Procedure Coding System (HCPCS)*, or *Current Procedure Terminology (CPT)* codes, we evaluated the descriptions and combined procedures into major diagnostic groupings. The ability to identify individual procedures also allowed us to assess if self-pay patients were uninsured or receiving services not covered by their insurance plan, such as cosmetic surgery.

■ **Ownership status and sociodemographic characteristics.** We used descriptive statistics to show the relationship between ASC ownership status and sociodemographic characteristics, diagnostic group, source of referral, and discharge status. All statistical analysis used SAS version 8.02. Because the study database is the universe of claims from ASCs in the Pittsburgh and Philadelphia metropolitan areas, differences between groups cannot be attributed to sampling error.

Study Findings

Physician-owned ASCs constituted a relatively small share of the ambulatory surgery market in 2003—less than 8 percent of ASC discharges in the study areas. Hospital-based facilities accounted for about 80 percent of discharges (Exhibit 1).

■ **ASC patients' coverage status.** In a state where 10 percent of the population is uninsured, all categories of ASCs treated few self-pay/indigent patients in 2003. Nearly 4 percent of patients treated by physician-owned ASCs were self-pay/indigent patients, a figure that is slightly more than for hospital-based facilities (2.9 percent). However, a closer examination of services received by such patients in physician-owned ASCs revealed that most procedures were cosmetic surgery, such as liposuction and breast augmentation. The implication is that these patients were not indigent patients but self-pay patients who paid for services that were not covered by their insurance plans. In Pennsylvania, where Medicaid covers 11 percent of the population, a higher share of patients were Medicaid patients in hospital outpatient departments than in physician-owned ASCs (8 percent versus 1 percent).¹⁰ Medicare patients accounted for roughly equal shares of total patients in the above facilities.

EXHIBIT 1
Comparison Of Physician-Owned Ambulatory Surgery Centers (ASCs) With Hospital Outpatient Departments And Other ASCs, Pennsylvania, 2003

| Category | Hospital outpatient department | Not-for-profit ASC | For-profit ASC ^a | Physician-owned ASC | Total ^b |
|--------------------------|--------------------------------|--------------------|-----------------------------|---------------------|--------------------|
| Number of ASCs | 80 | 9 | 6 | 28 | 138 |
| Number of discharges | 802,959 | 23,153 | 21,009 | 86,387 | 1,008,038 |
| Payer mix (%) | | | | | |
| Self-pay, indigent | 2.9 | 0.4 | 0.9 | 3.5 | 2.8**** |
| Medicare | 31.1 | 33.9 | 45.7 | 30.5 | 30.9**** |
| Medicaid | 8.2 | 5.9 | 2.2 | 1.2 | 7.9**** |
| Blue Cross/commercial | 57.0 | 59.2 | 50.4 | 63.8 | 57.5**** |
| Other ^c | 0.8 | 0.6 | 0.9 | 0.9 | 0.9**** |
| Sex (%) | | | | | |
| Female | 56.5 | 55.6 | 57.1 | 58.0 | 56.1**** |
| Male | 43.5 | 44.4 | 42.8 | 42.0 | 43.9**** |
| Average age (years) | 52.3**** | 46.4**** | 61.7**** | 56.8**** | 52.8**** |
| Race and ethnicity (%) | | | | | |
| African American | 13.3 | 4.8 | 1.3 | 3.6 | 12.0**** |
| White | 81.0 | 90.6 | 50.3 | 84.6 | 79.8**** |
| Other ^d | 5.7 | 4.6 | 48.4 | 11.8 | 8.2**** |
| Hispanic | 2.6 | 0.8 | 0.5 | 0.6 | 2.4**** |
| Source of admission (%) | | | | | |
| Physician referral | 78.5 | 72.3 | 100.0 | 99.7 | 80.5**** |
| Clinic referral | 5.1 | 13.8 | 0.0 | 0.0 | 5.3**** |
| Hospital transfer | 0.1 | 9.1 | 0.0 | 0.0 | 0.3**** |
| Other ^e | 16.3 | 4.8 | 0.0 | 0.7 | 13.9**** |
| Discharge status (%) | | | | | |
| Discharged home | 84.8 | 61.7 | 99.9 | 99.3 | 86.3**** |
| Hospital | 0.1 | 0.0 | 0.0 | 0.0 | 0.1**** |
| Skilled nursing facility | 2.3 | 0.0 | 0.0 | 0.0 | 1.9**** |
| Other ^f | 12.8 | 38.3 | 0.1 | 0.7 | 11.6**** |

SOURCE: Pennsylvania Health Cost Containment Commission, Outpatient File, 2003.

NOTE: Significance derived through chi-square tests.

^a ASCs owned by for-profit corporations with no publicly identified physician ownership.

^b Includes visits to women's hospital outpatient departments, pediatric outpatient departments, cancer ASCs, and eye and cosmetic ASCs.

^c Includes commercial automobile, workers compensation, government, and unknown.

^d Includes Asian/Pacific islander, American Indian/Alaska Native, and unknown.

^e Includes health maintenance organization (HMO) referral, transfer from another type of institution, emergency room, court/law enforcement, and unknown.

^f Includes discharged to another type of institution, discharged to home health, left against medical advice, died, discharged to other outpatient service, and unknown.

****p < 0.001

■ **Other patient characteristics.** African Americans constituted 16 percent of the population in the study regions in 2003. Nearly 4 percent of patients cared for in physician-owned ASCs were African Americans, compared to 13 percent in hospital outpatient departments. Few Hispanics resided in the Pittsburgh and Philadelphia metropolitan areas, and very few Hispanics received care at ASCs. Physician referrals were the source of admissions for virtually all patients in physician-owned and for-profit ASCs. In hospital outpatient departments, nonphysician referrals ac-

counted for about one in five patients. In nonprofit ASCs, nonphysician referrals accounted for nearly one in three patients treated.

■ **Major diagnostic groups.** Diagnostic groups ranged from the removal of benign skin lesions to hand and wrist disorders, such as carpal tunnel syndrome (Exhibit 2). The common thread for all of these procedures is that they can be safely performed in a variety of settings. For most ASCs, the largest common diagnostic groupings were cataract surgery and gastrointestinal (GI) disorders and testing, including colonoscopies and endoscopies. For all nonhospital-based facilities, cataract surgery was consistently one of the top procedures performed. Since the CMS limits the procedures performed in an ASC, hospital outpatient departments can perform a much broader range of services, so the major diagnostic groups could vary greatly among the different types of facilities. Yet the largest diagnostic group for hospital outpatient departments remained the same, GI disorders and testing (31 percent). Hospital-based facilities differed in that the second most common type of procedure performed related to skin disorders (13 percent), including suturing,

EXHIBIT 2
Percentage Of Visits For Selected Major Diagnostic Groups, Top 100 Ambulatory Surgery Center (ASC) Services Compared With Hospital Outpatient Surgery Centers And Other ASCs, Pennsylvania, 2003

| Group | Hospital outpatient department (%) | Not-for-profit ASC (%) | For-profit ASC (%) ^a | Physician-owned ASC (%) |
|--|------------------------------------|------------------------|---------------------------------|-------------------------|
| Back disorder | 4.1 | 6.2 | 4.3 | 6.9 |
| Benign neoplasm (skin) | _.b | _.b | _.b | 1.5 |
| Breast surgery | 2.6 | _.b | _.b | 1.7 |
| Cardiac catheterization | 2.8 | _.b | _.b | _.b |
| Cataract surgery | 6.0 | 23.0 | 34.4 | 13.3 |
| Cosmetic surgery ^c | _.b | _.b | _.b | 4.9 |
| Diagnostic procedures | _.b | 3.0 | 9.3 | 11.1 |
| Ear disorder | _.b | 15.1 | _.b | _.b |
| Eye surgery (other than cataract and glaucoma) | _.b | _.b | 2.6 | 2.7 |
| Female reproductive | 4.2 | _.b | _.b | _.b |
| Fetal procedures | 2.6 | _.b | _.b | _.b |
| Gastrointestinal disorder/testing | 31.4 | 30.8 | 33.2 | 46.1 |
| Hand/wrist disorders | _.b | 2.9 | 1.7 | 4.7 |
| Injection/infusion | 10.8 | _.b | _.b | _.b |
| Joint disorder | 3.9 | 2.7 | 4.0 | 2.1 |
| Male reproductive | _.b | _.b | 1.3 | _.b |
| Nasal disorder | _.b | _.b | _.b | _.b |
| Pain control | _.b | 3.5 | _.b | _.b |
| Skin disorder | 13.0 | 4.3 | _.b | _.b |
| Tonsillectomy/adenoidectomy | _.b | 3.2 | _.b | _.b |
| Urinary tract disorder | _.b | _.b | 2.7 | _.b |

SOURCE: Pennsylvania Health Cost Containment Commission, Outpatient File, 2003.

^a ASCs owned by for-profit corporations with no identified physician ownership.

^b Less than 0.5 percent. (For some procedures, the ASC may not be authorized to perform the procedure.)

^c Does not include any type of breast surgery.

wound debridement, and excision of lesions and foreign bodies. For-profit or physician-owned ASCs do not commonly perform these types of procedures.

■ **Physician referral.** We sought evidence that financial rewards from physicians' ownership of ASC facilities might affect patterns of referral of less lucrative patients. An ideal analysis would investigate the referral patterns of physician-owners of ASCs. Unfortunately, no public information identifies physician-owners. Our approach, a second-best one, analyzed referral patterns for physicians who accounted for the top 50 percent of patient referrals to physician-owned ASCs and determined if there was a pattern for these physicians to refer better-insured patients (commercial/Blue Cross and Medicare) to physician-owned facilities, and lower-paying patients (Medicaid and self-pay/indigent) to outpatient departments (Exhibit 3). We then conducted a similar analysis for physicians who were high referrers to hospital outpatient departments, nonprofit ASCs, and other for-profit ASCs.

EXHIBIT 3

Distribution Among Payers, For Physicians Who Accounted For The Top 50 Percent Of Physician Referrals To Hospital Outpatient Departments, Not-For-Profit Ambulatory Surgery Centers (ASCs), For-Profit ASCs, And Physician-Owned ASCs In Pennsylvania, 2003

| Category | Hospital outpatient department (%) | Not-for-profit ASC (%) | For-profit ASC (%) ^a | Physician-owned ASC (%) |
|--|------------------------------------|------------------------|---------------------------------|-------------------------|
| Top 50% of referrals to physician-owned ASCs | | | | |
| Total (n = 26,249) | 8.7 | 0.0 | 0.2 | 91.3 |
| Medicaid (n = 368) | 44.6 | 0.0 | 0.0 | 55.4 |
| Uninsured/self-pay (n = 447) | 1.6 | 0.0 | 0.0 | 98.2 |
| Commercial/Blue Cross (n = 17,321) | 7.9 | 0.0 | 0.0 | 92.1 |
| Medicare (n = 7,969) | 9.1 | 0.0 | 0.0 | 90.8 |
| Top 50% of referrals to hospital outpatient departments | | | | |
| Total (n = 336,527) | 95.5 | 1.7 | 0.5 | 2.0 |
| Medicaid (n = 26,526) | 97.6 | 1.0 | 0.3 | 0.2 |
| Uninsured/self-pay (n = 12,026) | 98.0 | 0.1 | 0.1 | 1.8 |
| Commercial/Blue Cross (n = 191,789) | 95.5 | 1.5 | 0.3 | 2.3 |
| Medicare (n = 103,103) | 94.5 | 2.6 | 0.9 | 1.9 |
| Top 50% of physician referrals to not-for-profit ASCs | | | | |
| Total (n = 17,712) | 27.8 | 54.7 | 4.4 | 1.2 |
| Medicaid (n = 1,578) | 41.5 | 26.4 | 0.4 | 0.1 |
| Uninsured/self-pay (n = 110) | 44.6 | 23.6 | 5.5 | 10.0 |
| Commercial/Blue Cross (n = 9,601) | 23.8 | 56.9 | 1.3 | 1.6 |
| Medicare (n = 6,293) | 30.3 | 59.2 | 9.9 | 0.6 |
| Top 50% of physician referrals to for-profit ASCs | | | | |
| Total (n = 10,148) | 20.0 | 5.7 | 73.9 | 0.3 |
| Medicaid (n = 154) | 38.3 | 0.0 | 61.0 | 0.7 |
| Uninsured/self-pay (n = 19) | 31.6 | 0.0 | 63.2 | 0.0 |
| Commercial/Blue Cross (n = 6,151) | 20.4 | 1.5 | 77.7 | 0.3 |
| Medicare (n = 3,710) | 18.8 | 13.1 | 67.7 | 0.3 |

SOURCE: Pennsylvania Health Cost Containment Commission, Outpatient File, 2003.

^aASCs owned by for-profit corporations with no identified physician ownership.

Referrals to physician-owned ASCs. For the top 50 percent of physician referrals to physician-owned ASCs, there were strikingly few referrals for Medicaid or self-pay/indigent patients: 1.4 percent and 1.8 percent of all referrals, respectively (percentages are not shown in Exhibit 3). When these proxy physician-owners made referrals, they directed about 45 percent of Medicaid patients to hospital outpatient departments and 55 percent to the physician-owned ASC. Eight percent of commercial patients were referred to a hospital outpatient department. In contrast, these same proxy physician-owners sent 92 percent of commercial/Blue Cross patients, 91 percent of Medicare patients, and 98 percent of self-pay/uninsured patients to a physician-owned ASC. A closer examination of self-pay patients indicates that these patients most often received cosmetic surgery, which suggests that the patients received a service not covered by their health plan and probably had some sort of insurance coverage.

Referrals to hospital outpatient departments. For the top 50 percent of physician referrals to hospital outpatient departments, regardless of payer, patients were virtually all treated in the outpatient department (Exhibit 3). The percentage ranged from 95 percent of Medicare patients to 98 percent of uninsured/self-pay patients. Top-referring physicians at nonprofit ASCs referred 45 percent of their uninsured/self-pay patients and 42 percent of Medicaid patients to an outpatient department. In contrast, 24 percent of commercial/Blue Cross patients and 30 percent of Medicare patients were referred to an outpatient department. Top referrers to for-profit ASCs referred 38 percent of Medicaid and 32 percent of uninsured/self-pay patients to for-profit ASCs. In contrast, 20 percent of commercial patients and 19 percent of Medicare patients were referred to an outpatient department.

■ **Summary.** To summarize, the difference between referring the likely highest-paying payer (commercial/Blue Cross) and the lowest-paying payer (Medicaid) to a hospital outpatient department was thirty-six percentage points for top-referring physicians at physician-owned ASCs. The respective figure for hospital outpatient surgical centers was minus two percentage points, which means that hospital outpatient referrers were actually more likely to send a commercial/Blue Cross patient than a Medicaid patient to a nonhospital facility. For physicians who were top referrers to for-profit ASCs, the difference between commercial/Blue Cross and Medicaid was eighteen percentage points, and that figure was seventeen percentage points at nonprofit ASCs.

Discussion

■ **Role of patients' payer status.** This study analyzed more than one million discharge abstracts from hospital outpatient departments and ASCs located in the Pittsburgh and Philadelphia metropolitan areas. Our most important findings pertain to physicians who referred many patients to physician-owned ASCs. These physicians referred very few Medicaid patients at all—about 1.2 percent of their total

referrals. However, when these physicians referred a Medicaid patient, that patient was referred to the physician-owned ASC about 55 percent of the time and to the outpatient department about 45 percent of the time. In contrast, this same set of physicians referred other patients—commercial/Blue Cross, Medicare, and self-pay/indigent—90–98 percent of the time to the physician-owned facility.

We examined self-pay/indigent patients more closely and found that most surgery obtained at the physician-owned ASCs was for cosmetic surgery. The implication of this finding is that these patients probably had insurance but sought a service not covered by their health plan.

When we examined the top 50 percent of physician referrals to hospital outpatient departments, nonprofit ASCs, and for-profit ASCs, we found much smaller differences in where these physicians referred their patients according to payer status. For example, physicians who were major referrers to hospital outpatient departments referred more than 95 percent of their patients covered by Medicaid, Medicare, and commercial/Blue Cross to a hospital outpatient department.

Some of the referral pattern may reflect the payment structure of Medicaid. Only 70 percent of physicians accept any Medicaid, while almost all accept fee-for-service (FFS) Medicare and private insurance.¹¹ It appears that most referrals of self-pay/indigent patients from high-volume referring physicians were for patients receiving cosmetic surgery.

■ **Study limitations.** There are a number of limitations to the study. First, because there are no publicly available data on which physicians are owners of an ASC, we were unable to directly identify these owners. Our proxy measurement of ownership was the set of physicians who accounted for 50 percent of the referrals to physician-owned ASCs. Second, study data are from just one state (and confined to an area roughly corresponding to the Philadelphia and Pittsburgh metropolitan areas). Third, this study did not analyze the cost or quality of care, nor whether favorable selection by physician-owned facilities actually jeopardizes the financial health of non-physician-owned facilities, and the delivery of safety-net services in those facilities. Fourth, the database does not include any measures of severity of illness or mortality risk. One possible source of risk selection is for doctors to refer sicker patients to hospital outpatient departments and healthier patients to physician-owned ASCs. Nevertheless, this study clearly shows that physicians who were heavy referrers to physician-owned ASCs were far more likely to send their lower-paying Medicaid patients to hospital outpatient clinics, and their higher-paying private and Medicare patients to physician-owned ASCs. This pattern of referrals was more pronounced than for other physicians who were leading referrers to hospital outpatient departments, nonprofit ASCs, and for-profit ASCs.

■ **Segregation by payer status.** It was not the objective of this study to investigate access to care for the uninsured and Medicaid populations. Most striking, however, was the conspicuous absence of these patients in ASC settings. Just as 11 a.m. on a Sunday morning might be the most segregated hour of the week in the United

States, perhaps ASCs are the most payer-segregated component of our health care system.

■ **Congressional concern.** If insurer payments to hospitals and ASCs reflected the actual cost of production, and Medicaid fees and payments for care of the uninsured were equivalent to payments for other insured groups, there would be little debate over physician-ownership.¹² However, this is not the current U.S. health care system. Congressional concern over physician-owned facilities may reflect a belief that continued growth of such facilities will contribute to a further unraveling of an already fragile safety net. The worry is that physician-owned facilities will siphon off profit centers that have traditionally cross-subsidized care for uninsured and Medicaid patients, as well as unprofitable services such as burn treatment. The findings from this paper are consistent with that fear.

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