

Niche (Limited-service) Hospital Providers

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National Rural Health Association

The delivery of health care in rural America is changing rapidly. Within this change, one thing remains constant: Rural communities across America rely on hospitals and physicians who serve them to provide care to all, including those who are uninsured or underinsured. Often, full-service community hospitals in rural areas serve as the healthcare safety net, providing basic health services for those in need.

Limited-service providers, also known as “niche” or specialty providers, are not new, but the nature and place of their growth is. Examples include heart hospitals, orthopedic hospitals, surgical hospitals and ambulatory surgery centers (ASCs), cancer hospitals and centers, dialysis clinics, pain centers, imaging center, mammography centers, and many other narrowly focused providers. This policy brief shall use the terms *limited-service providers* and *niche hospitals* interchangeably.

In its March 2003 report, the Medicare Payment Advisory Commission (MedPAC) found that the number of Medicare-certified ASCs doubled between 1991 and 2001 (from 1,460 to 3,371) with a 60 percent growth in the number of procedures performed on Medicare beneficiaries. The General Accounting Office (GAO) reported a tripling of specialty hospitals since 1990, in an April 2003 report.

Congress took action to stop, at least temporarily, some of this growth in 2003. Provisions of the Medicare Modernization Act (MMA) of 2003 called for an 18-month moratorium on physician self-referral under Medicare for new specialty hospitals, while the Department of Health and Human Services (HHS) and MedPAC study the issues related to limited-service providers. This Congressionally imposed moratorium is set to expire on June 8, 2005.

The NRHA is very concerned that the growth of niche providers, if left solely to market forces, will undermine access to health care services for rural communities across this country. Our concern is based on several factors:

Niche Hospital providers often do not serve the broader community. The trend among these providers is to “carve-out” the more profitable services and to serve well-insured patients. They leave the full-service rural community hospital to provide unprofitable services such as Emergency Services and to care for all, regardless of their ability to pay.

Most limited-service providers have little or no obligations under the Emergency Medical Treatment and Labor Act (EMTALA), either

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because they operate on an ambulatory basis or because they do not have emergency departments (ED). Instead, they rely on the ED capacity of local rural community hospitals, and they generally operate normal business hours, not the 24/7 hours of hospitals. Many limited-service providers either do not participate or limit their participation in Medicaid, and many provide little uncompensated care.

In a rural community, the healthcare infrastructure is very fragile and the advance of these alternative delivery models will serve to threaten the existence of the full-service community hospital in a rural environment.

NRHA RECOMMENDATIONS

- 1) **Ban Physician Self-Referral to Limited-Service Providers.** The conflict of interest created by physician ownership and self-referral is easily addressed. The NRHA, in order to protect the healthcare safety net in rural America, recommends that Congress close the current loophole in federal law and amend the Ethics in Patient Referral Act of 1989 to permanently ban physician self-referral to new limited-service hospitals.
- 2) **Public Disclosure.** Physicians should be required to disclose the nature of any financial interest they have in a health care-related entity to which they refer patients. The final physician self-referral (Stark II) regulations, published by CMS on March 26, 2003, fall short of the change needed. The rules only require reporting physician financial interests to HHS when requested by federal regulators.
- 3) **Quality Standards and Monitoring.** Where there are similar or exact clinical practices occurring in inpatient, outpatient and specialty service settings, federal quality standards and the mechanisms for enforcing them should be the same. Reports of significant safety and quality issues are emerging, such as recent MedPAC findings regarding the safety of imaging services provided in some physician offices.
- 4) **Transfer Agreements.** Every ASC and specialty hospital that does not have a full-time ED should be required to have a formal transfer agreement with the community hospital(s) it intends to rely on for emergency backup services. These transfer agreements should address support for maintaining emergency capacity in the community, including specialty on-call coverage, and a full range of transfer and continuity of care procedures comparable to those required by EMTALA.

Questions in regard to this policy brief should be directed to the NRHA Government Affairs Office at 703/519-7910

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