Legal Opinion Letter

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HOSPITALS & PHYSICIAN OWNERSHIP: LEGAL AND HEALTH CARE ISSUES WARRANT CAREFUL SCRUTINY

by
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Last year's death of a 44-year-old father of three creates a real-life context for the legal and policy issues surrounding physician-owned hospitals. Following a truck accident, the father was recovering from an elective spinal surgery at such a hospital when he began having breathing problems. The limited-service facility had no doctor on duty at the time and no emergency room. Nurses had to call 911 in order to transfer him to the emergency room at a full-service hospital where he was pronounced dead. His family was reported to be considering a lawsuit for wrongful death.[1]

The proliferation of physician-owned hospitals could make such lawsuits more prevalent. More than 140 such physician-owned hospitals operate across the country, and another 85 facilities are currently in development.[2] These smaller hospitals, which specialize in specific procedures, have come under criticism. A report[3] released in January by the Department of Health and Human Services' Office of the Inspector General highlights a number of concerns with such hospitals. Just 55 percent of the 109 physician-owned hospitals reviewed had emergency departments, and the majority of those had only one bed. 34 percent of the physician-owned hospitals rely on 911 for medical assistance to stabilize a patient. And less than one-third of these facilities have physicians on-site 24 hours a day, seven days a week.

Those facts suggest a significant liability exposure if practices are not changed. Wrongful death actions will begin to establish the courts' standards for negligence as related to limited-service hospitals. Intuitively we assume hospitals can handle emergencies; yet it is unclear how the size and scope of a hospital may determine its legal obligations in such instances.

Perhaps the key complicating factor is the ownership of these facilities, not their size. 57 percent of physician-owned, limited-service hospitals had profit margins at or above ten percent, compared with just 17 percent profit margins for other acute-care facilities.[4] Such profit margins are achievable through careful selection of patients. Specialty hospitals are also exempt from some regulatory requirements which apply to community hospitals. For instance, specialty hospitals are not subject to the provisions of the *Emergency Medical Treatment and Labor Act* requiring them to stabilize patients regardless of ability to pay.

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[1]CNN's July 4, 2007 coverage of this case indicated that "the family, no later than next week, will file the initial papers they need to file the lawsuit." http://transcripts.cnn.com/TRANSCRIPTS/0707/04/acd.02.html; *see also*, Reed Abelson, *Some Hospitals Have to Call 911 to Save Their Patients*, N.Y. TIMES, Apr. 2, 2007.

[2]American Hospital Association, *Trendwatch,* Apr. 2008, at 1.

[3]HHS OIG, Physician-Owned Specialty Hospitals Ability to Manage Medical Emergencies, Jan. 2008, OEI-02-06-00310.

[4]*Supra* note 2, at 4.

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Indeed, patient selection and the control of a more profitable caseload is the heart of the matter in terms of many legal issues beyond liability. Physician-owned hospitals' major advantage over their competition is self-referral. Doctors are able to refer their patients to whichever facilities they choose, including those in which they have ownership interest. This allows them to grab three levels of compensation: for the procedure; a share of the facility fee; and also as the value of their investment in the hospital increases as a direct result of self-referral.

Many physician-owners leverage this by directing better compensated, less complicated cases to their own hospitals. Not surprisingly, research demonstrates that there is a relationship between the physician's proportion of ownership in the hospital and the likelihood of physician's referring patients to that facility.[5] This sort of economic motivation is also revealed in ratios of Medicaid patients served by physician-owned hospitals. For example, as the Medicare Payment Advisory Commission (MedPAC) found, just 2 percent of orthopedic/surgical hospitals' patients are Medicaid beneficiaries, compared with 13 percent of full-service hospitals' patients.[6] In response to an inquiry by the leaders of the Senate Finance Committee, MedPAC also found that specialty hospitals are also less likely to treat racial and ethnic minorities,[7] which could implicate discrimination issues and inspire class-action lawsuits depending on how self-referral and physician-ownership spreads.

In fact, estimates have the costs of self-referral to Medicare checking in at $2.5 billion over the next decade. A 6 percent market-wide increase in the rate of cardiac surgeries per 1,000 Medicare beneficiaries was observed upon market entry of physician-owned cardiac hospitals.[8] Another study revealed a doubling of the rate of coronary revascularization.[9] Certificate of Need laws have been imposed in many states to address the concern that the construction of excess hospital capacity would cause competitors in an oversaturated field to cover the costs of a diluted patient pool by over-charging, or by convincing patients to accept hospitalization unnecessarily.[10]

Most types of physician self-referral have been banned in the past three decades because of the inherent conflict of interest.[11] Self-referrals by physicians to hospitals in which they have an ownership stake places their professional and personal business interests into conflict. There are two roles to be served — one as a doctor and one as an owner. As the doctor, he or she has an interest in making sure patients have all the information they need to make an informed consent to procedures. This would include information about the hospital and its possible limitations (i.e. lack of emergency department), so patients can be sure that that particular facility is the best choice for them.

Physician ownership of hospitals raise numerous legal and policy questions, the most important of which was asked by Senator Charles Grassley at a May 17, 2006 Senate Finance Committee hearing: whether "[physician-owned hospitals] serve the best interest of the patients being treated by them, or if they are serving the best interests of the physicians who own and operate them." The public interest is certainly served by careful scrutiny of how these types of care facilities impact patients and the expenditure of increasingly scarce personal and government health care resources.

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[5]Greenwald, L. et al. (2006), *Specialty versus Community Hospitals: Referrals, Quality and Community Benefits*, HEALTH AFFAIRS, 5(1), 106-118.

[6]Medicare Payment Advisory Commission, *Physician-owned Specialty Hospitals Revisited* (Aug. 2006), at 7.

[7]Medicare Payment Advisory Commission, *Medicare admission by type of hospital and race* (May 2005).

[8]*Supra* note 6, at 19.

[9]Brahmajee K. Nallamothu, MD, MPH, et al., *Opening of Specialty Cardiac Hospitals and Use of Coronary Revascularization in Medicare Beneficiaries*, JAMA, 297:962-968 (Mar. 2007).

[10]Robert James Cimasi, *The U.S. Healthcare Certificate of Need Sourcebook* (2005), at 2.

[11]*See*, *e.g.*, 42 U.S.C. § 1395nn (the "Stark Law").

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