

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**PHYSICIAN-OWNED  
SPECIALTY HOSPITALS' ABILITY  
TO MANAGE MEDICAL  
EMERGENCIES**



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# *Office of Inspector General*

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## OBJECTIVE

To assess physician-owned specialty hospitals' ability to manage medical emergencies.

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## BACKGROUND

Physician-owned specialty hospitals are hospitals that primarily perform cardiac, orthopedic, or surgical procedures and are partially or fully owned by physician investors. Two recent deaths of specialty hospital patients have raised concerns about the ability of these hospitals to manage medical emergencies. In both instances, a patient experienced complications following elective surgery. Neither hospital had a physician on duty at the time the emergency occurred, and both hospitals called 9-1-1. The patients were then transferred to community hospitals, where they were both pronounced dead.

All hospitals that participate in the Medicare program must demonstrate to the Centers for Medicare & Medicaid Services (CMS) their initial and ongoing ability to meet a set of health and safety standards, referred to as the Conditions of Participation (CoP). The CoPs require that all hospitals have a physician on duty or on call at all times. Hospitals are also required to provide 24-hour nursing services, furnished or supervised by a registered nurse. In addition, the CoPs require that hospitals have written policies and procedures in place for addressing individuals' emergency care needs, regardless of whether the hospital has an emergency department. Finally, according to CMS, a hospital is not in compliance with the CoPs if it relies on 9-1-1 services as a substitute for its own emergency services. However, there is no specific Medicare prohibition on a hospital calling 9-1-1 to arrange for the transfer of a patient to another hospital.

The Senate Finance Committee requested that the Office of Inspector General (OIG) conduct an evaluation of patient care and safety in physician-owned specialty hospitals. This study focuses on hospitals' emergency departments, staffing patterns, and written policies for managing medical emergencies. It is based on data from 109 physician-owned specialty hospitals that we identified from a list provided by CMS. CMS currently does not have a system in place to track physician-owned specialty hospitals or to identify newly enrolled physician-owned specialty hospitals.

The study relies on four primary sources of data: (1) a review of physician and nurse staffing schedules for 8 sampled days, (2) a review of hospitals' staffing policies, (3) a review of hospitals' policies for managing medical emergencies, and (4) structured interviews with administrators at each hospital.

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## FINDINGS

**About half of all physician-owned specialty hospitals have emergency departments, the majority of which have only one emergency bed.** Fifty-five percent of all physician-owned specialty hospitals have an emergency department. More than half of these hospitals have only one emergency bed. Another 17 percent of these hospitals have between 2 and 5 emergency beds, 15 percent have between 6 and 8 emergency beds, and 8 percent have 9 or 10 emergency beds. Medicare does not require that hospitals have emergency departments, but some States do have this requirement.

**Not all physician-owned specialty hospitals had nurses on duty and physicians on call during the 8 sampled days.** Based on our review of hospitals' staffing schedules, 93 percent of physician-owned specialty hospitals met these two requirements during our 8 sampled days. The remaining 7 percent of hospitals did not meet these requirements. Specifically, seven hospitals failed to have a registered nurse on duty and one hospital failed to have a physician on call or on duty during at least 1 of the 8 sampled days. Hospitals were least likely to meet these staffing requirements on weekends.

**Administrators report that less than one-third of physician-owned specialty hospitals have physicians onsite at all times.** According to administrators, 28 percent of hospitals have a physician onsite 24 hours a day, 7 days a week. Additionally, 45 percent of the hospitals with emergency departments have a physician onsite at all times, compared to 8 percent of the hospitals without emergency departments. Medicare does not require that hospitals have physicians onsite at all times.

**Two-thirds of physician-owned specialty hospitals use 9-1-1 as part of their emergency response procedures.** According to administrators and our review of hospital policies, 66 percent of hospitals instruct staff to call 9-1-1 as part of their medical emergency response procedures. Most notably, 34 percent of hospitals use 9-1-1 to obtain medical assistance to stabilize a patient, a practice that may

violate Medicare requirements. Almost half of all hospitals (46 percent) use 9-1-1 to transfer patients, a practice that is permitted by Medicare.

**Some physician-owned specialty hospitals lack basic information in their written policies about managing medical emergencies.** Almost a quarter of all physician-owned specialty hospitals have policies that do not address appraisal of emergencies, initial treatment of emergencies, or referral and transfer of patients. In addition, some policies lack certain information about managing medical emergencies, such as the type of emergency response equipment to be used or the life-saving protocols to be followed.

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## RECOMMENDATIONS

Based on these findings, we recommend that CMS take the following actions to improve the ability of physician-owned specialty hospitals to manage medical emergencies. We recognize that although the scope of this study includes physician-owned specialty hospitals, some of the recommendations apply to all hospitals. Specifically, we recommend that CMS:

- Develop a system to identify and regularly track physician-owned specialty hospitals.
- Ensure that hospitals meet the current Medicare CoPs that require a registered nurse to be on duty 24 hours a day, 7 days a week and a physician to be on call if one is not onsite.
- Ensure that hospitals have the capabilities to provide for the appraisal and initial treatment of emergencies and that they are not relying on 9-1-1 as a substitute for their own ability to provide these services.
- Require hospitals to include necessary information in their written policies for managing a medical emergency, such as the use of emergency response equipment and the life-saving protocols to be followed.

In addition to making these recommendations, we will forward to CMS for appropriate action information on the 8 hospitals that did not meet the two staffing CoPs reviewed in the study and the 37 hospitals that use 9-1-1 to obtain medical assistance.

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## AGENCY COMMENTS

CMS concurred with all four of our recommendations.

In response to our first recommendation, CMS stated that it will add information to CMS's provider enrollment form and the new Provider Enrollment and Chain-Operated System.

In response to our second recommendation, CMS indicated that it currently examines hospital compliance with all Medicare CoPs through its routine hospital surveys. CMS does not conduct these surveys for the 42 percent of hospitals that are accredited by either the Joint Commission or the American Osteopathic Association. However, CMS investigates all credible complaints, including complaints against accredited hospitals. CMS stated that it will ensure that both accreditation organizations are aware of our findings.

In response to our third recommendation, CMS stated that it issued a program memorandum to State Survey Agencies during the period that we were conducting the study that reiterates its requirements for hospitals and addresses medical emergency requirements. CMS circulated this memorandum to the national accreditation organizations and made it available to the public through its Web site.

Finally, CMS concurred in principle with our fourth recommendation. CMS stated that it will consider whether regulatory changes to create more specific requirements for equipment and staff qualifications would be appropriate.



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## OBJECTIVE

To assess physician-owned specialty hospitals' ability to manage medical emergencies.

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## BACKGROUND

Physician-owned specialty hospitals are hospitals that primarily perform cardiac, orthopedic, or surgical procedures and are partially or fully owned by physician investors.

There is an ongoing debate about the value of physician-owned specialty hospitals. Proponents of these facilities state that by narrowing services to a select group of procedures, specialty hospitals can deliver a higher level of care to their patients, compared to that delivered by community hospitals. Critics note that because these facilities are physician-owned, they create incentives for physician owners to refer their more profitable and healthier patients to their specialty hospitals. They argue that this creates a financial problem for community hospitals, by depriving them of an important revenue stream without alleviating the burden of providing uncompensated care. They also believe safety is an issue for specialty hospital patients, because they are being treated in a facility that may be less prepared to handle postoperative emergencies compared to a community hospital.<sup>1</sup>

Two recent deaths of specialty hospital patients have raised concerns about the ability of physician-owned specialty hospitals to manage medical emergencies. In both instances, a patient experienced complications following elective surgery. Neither hospital had a physician on duty at the time the emergency occurred, and both hospitals called 9-1-1. The patients were then transferred to community hospitals, where they were both pronounced dead.

The Senate Finance Committee requested that the Office of Inspector General (OIG) conduct an evaluation of patient care and safety in physician-owned specialty hospitals. This study focuses on hospitals' emergency departments, staffing patterns, and written policies for managing medical emergencies.

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<sup>1</sup> "Physician-Owned Specialty Hospitals: In the Interest of Patients or a Conflict of Interest?" Hearing Before the Committee on Finance, United States Senate, 109<sup>th</sup> Congress, First Session, March 8, 2005.



**Medicare Enrollment of Physician-Owned Specialty Hospitals**

Congress and the Centers for Medicare & Medicaid Services (CMS) imposed several restrictions on physician-owned specialty hospitals between 2003 and 2006. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) imposed a temporary moratorium on new physician-owned specialty hospitals to provide time to study the impact they have on patients, community hospitals, and the Medicare and Medicaid programs.<sup>2</sup> The moratorium limited physician owners' ability to refer patients to their own specialty hospitals and specialty hospitals' ability to bill any individual, third-party payer, or other entity for these self-referrals. The moratorium began on December 8, 2003; it expired on June 8, 2005.<sup>3</sup>

The day after the moratorium expired, CMS temporarily suspended the Medicare enrollment of new physician-owned specialty hospitals pending CMS review of the procedures used to qualify specialty hospitals for participation in the Medicare program.<sup>4</sup> Under section 5006(c) of the Deficit Reduction Act of 2005 (DRA), Congress continued CMS's suspension until the earlier of August 8, 2006, or the date that the Department of Health and Human Services (HHS) could submit a plan to address issues relating to physician ownership of specialty hospitals.<sup>5</sup> HHS submitted its plan to Congress on August 8, 2006, thereby ending the suspension.<sup>6</sup> The plan included action items for HHS to undertake, such as reforming the payment system for inpatient hospital services and ambulatory surgical centers and promoting transparency of physician investments in hospitals.

Currently, the exact number of physician-owned specialty hospitals is unknown. CMS compiled a list of 130 physician-owned specialty hospitals for a study required by the MMA and for its plan to Congress.<sup>7</sup>

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<sup>2</sup> P.L. No. 108-173, § 507(a) (2003) (codified at 42 U.S.C. §§ 1395nn(d)(2), (d)(3), and (h)(7)).

<sup>3</sup> The moratorium did not apply to grandfathered specialty hospitals that met the requirements of 42 U.S.C. § 1395nn(h)(7)(B).

<sup>4</sup> CMS memorandum to State Survey Agency Directors, "Hospitals – Suspension of Processing New Provider Enrollment Applications (CMS-855A) for Specialty Hospitals," S&C-05-35, June 9, 2005.

<sup>5</sup> P.L. No. 109-171, § 5006(c) (2006).

<sup>6</sup> HHS, "Final Report to the Congress and Strategic and Implementing Plan Required Under Section 5006 of the Deficit Reduction Act of 2005," August 2006.

<sup>7</sup> HHS, "Study of Physician-Owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003," 2005.

However, CMS does not have a system in place to identify newly enrolled physician-owned specialty hospitals and does not track hospitals that are no longer physician-owned specialty hospitals.

### **Regulations Governing the Management of Medical Emergencies**

All hospitals that participate in the Medicare program must demonstrate to CMS their initial and ongoing ability to meet a set of health and safety standards, referred to as the Conditions of Participation (CoPs). CoPs define the minimum standards for all hospitals participating in the Medicare program.

Generally, the CoPs require that a physician be responsible for the care of each Medicare patient with respect to any medical problem that is present on admission or that develops during hospitalization.<sup>8</sup> The CoPs also require that all hospitals have a physician on duty or on call at all times.<sup>9</sup> Hospitals are also required to provide 24-hour nursing services, furnished or supervised by a registered nurse.<sup>10</sup>

Hospitals must have written policies and procedures in place for addressing individuals' emergency care needs, regardless of whether the hospitals have emergency departments.<sup>11</sup> The CoPs require that if a hospital has an emergency department, there must be adequate medical and nursing personnel who are qualified to manage medical emergencies and who are able to meet "the written emergency procedures and needs anticipated by the facility."<sup>12</sup> The CoPs also require that if a hospital does not have an emergency department, the hospital must ensure that the medical staff have "written policies and procedures for the appraisal of emergencies, initial treatment, and referral when appropriate."<sup>13</sup> Finally, if the hospital has an emergency department, but also has off-campus departments that do not have an emergency department, such as imaging facilities or physical therapy clinics, the hospital must ensure that the medical staff have "written policies and procedures in effect with respect to the off-campus

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<sup>8</sup> 42 CFR § 482.12(c)(4)(i).

<sup>9</sup> 42 CFR § 482.12(c)(3).

<sup>10</sup> 42 CFR § 482.23(b)(1).

<sup>11</sup> CMS memorandum to State Survey Agency Directors, "Provision of Emergency Services - Important Requirements for Hospitals," S&C-07-19 (April 26, 2007).

<sup>12</sup> 42 CFR § 482.55(b)(2).

<sup>13</sup> 42 CFR § 482.12(f)(2).

department(s) for appraisal of emergencies and referral when appropriate.”<sup>14</sup>

In addition, in April 2007, CMS issued a program memorandum to State Survey Agency Directors addressing specific requirements for the management of medical emergencies.<sup>15</sup> In this memorandum, CMS clarified the use of 9-1-1, stating that: “A hospital is not in compliance with the Medicare CoPs if it relies on 9-1-1 services as a substitute for the hospital’s own ability to provide services otherwise required in the CoPs. This means, among other things, that a hospital may not rely on 9-1-1 services to provide appraisal or initial treatment of individuals in lieu of its own capability to do so.” However, CMS notes that there is no specific Medicare prohibition on a hospital calling 9-1-1 to arrange for the transfer of a patient to another hospital.

In August 2007, CMS adopted a final rule requiring hospitals to inform all patients in writing, at the beginning of their hospital stay or outpatient visit, if a physician is not present in the hospital 24 hours a day, 7 days a week. The hospital must also inform patients how the hospital would meet the medical needs of any patient who develops an emergency medical condition when no physician is present.<sup>16</sup>

### **Prior Studies**

In 2006, the Government Accountability Office (GAO) examined community hospitals’ competitive response to physician-owned specialty hospitals in their market areas.<sup>17</sup> It found that community hospitals in markets with and without specialty hospitals did not differ substantially in the changes they made to their operations and clinical services.

As mandated by the MMA, the Medicare Payment Advisory Commission (MedPAC) and the Secretary of HHS also conducted studies on physician-owned specialty hospitals. MedPAC looked at the financial

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<sup>14</sup> 42 CFR § 482.12(f)(3).

<sup>15</sup> CMS memorandum to State Survey Agency Directors, “Provision of Emergency Services - Important Requirements for Hospitals,” S&C-07-19 (April 26, 2007).

<sup>16</sup> Medicare Program, Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates, 72 FR 47130, 47413 (August 22, 2007) (to be codified at 42 CFR § 489.20(v)).

<sup>17</sup> GAO, “General Hospitals: Operational and Clinical Changes Largely Unaffected by Presence of Competing Specialty Hospitals,” GAO-06-520, April 2006.

impact of specialty hospitals on full-service community hospitals.<sup>18</sup> MedPAC found no statistically significant difference in the cost of providing care to patients at physician-owned specialty hospitals, compared to the cost at other area hospitals. However, it found that physician-owned specialty hospitals were less likely to treat Medicaid patients than community hospitals in the same areas and that physician-owned specialty hospitals tended to treat healthier patients.

HHS reviewed patterns of physician referral to specialty hospitals, as well as quality of care and patient satisfaction at these hospitals.<sup>19</sup> It found that physician owners did not exhibit clear and consistent patterns of hospital preference in their referrals, compared to physicians with no hospital ownership. However, similar to the MedPAC study, HHS found that cardiac hospitals treated healthier patients than community hospitals in the same geographic area. HHS also found indications that patients at specialty hospitals receive a high quality of care, similar to that received by patients at competitor hospitals. Additionally, it found that patient satisfaction was very high in specialty hospitals and high in competitor community hospitals.

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## METHODOLOGY

### Scope

This study assesses physician-owned specialty hospitals' ability to manage medical emergencies. It focuses on hospitals' emergency departments, staffing patterns, and written policies for managing medical emergencies.

This study is based on data from 109 physician-owned specialty hospitals that we identified from a list provided by CMS. The study relies on four primary sources of data: (1) a review of physician and nurse staffing schedules for 8 sampled days, (2) a review of hospitals' staffing policies, (3) a review of hospitals' policies for managing medical emergencies, and (4) structured interviews with administrators at each hospital.

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<sup>18</sup> MedPAC, "Physician-Owned Specialty Hospitals," March 2005.

<sup>19</sup> HHS, "Study of Physician-Owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003," 2005.

### Identification of Physician-Owned Specialty Hospitals

For the purposes of its MMA-mandated study, CMS defined a “physician-owned hospital” as a hospital that has at least one physician owner. It defined a specialty hospital as a “surgical” hospital if at least 45 percent of Medicare discharges involve a surgical procedure. It defined a specialty hospital as “cardiac” or “orthopedic” if at least 45 percent of its Medicare discharges are classified under the Medical Diagnostic Categories for cardiac or orthopedic conditions. Cardiac hospitals must also have at least five major heart surgery discharges a year; orthopedic hospitals must have at least five major orthopedic surgery discharges a year.<sup>20</sup>

Currently, CMS does not have a system to identify all physician-owned specialty hospitals. It originally compiled a list for the MMA study and added to the list for the plan that HHS submitted to Congress as required by the DRA.<sup>21</sup> The list included a total of 130 physician-owned specialty hospitals. CMS surveyed the hospitals it identified, but did not fully verify that all of them were physician-owned specialty hospitals because some of the hospitals did not respond to the survey.

Between December 2006 and March 2007, we contacted each hospital on the list to verify whether it currently met CMS’s definition of physician-owned specialty hospital. We verified that a total of 109 of the 130 hospitals met this definition. Of the 21 remaining hospitals, 14 were not physician owned; 3 hospitals no longer met CMS’s definition of a cardiac, orthopedic, or surgical specialty hospital; 3 hospitals were terminated by CMS in 2006 and 2007; and 1 hospital was converted to a critical access hospital in 2004.

The remaining 109 hospitals that met CMS’s definition have the following characteristics: 66 hospitals are surgical hospitals, 23 are orthopedic hospitals, and 20 are cardiac hospitals. They are located in a total of 20 States. The five States with the highest concentration of these hospitals are Texas (33 hospitals), Louisiana (15 hospitals), Oklahoma (9 hospitals), Kansas (9 hospitals), and South Dakota (8 hospitals). Appendix A provides a map of the distribution of these hospitals. In addition, 42 percent of the hospitals were accredited by

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<sup>20</sup> HHS, “Study of Physician-Owned Specialty Hospitals Required in Section 507(e)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003,” 2005.

<sup>21</sup> HHS, “Final Report to the Congress and Strategic and Implementing Plan Required Under Section 5006 of the Deficit Reduction Act of 2005,” August 2006: Appendix I.

the Joint Commission and the American Osteopathic Association as of 2006.<sup>22</sup>

### **Review of Staffing Schedules**

We collected and reviewed staffing schedules from each of the 109 specialty hospitals for 8 sampled days. We selected a sample of 8 days between July 1, 2006, and December 31, 2006, using a two-stage sampling method. First, we divided all the days during our study timeframe into eight strata representing each of the 7 days of the week, plus one stratum for holidays. Second, we randomly selected 1 day from each stratum. Our findings based on these data are limited to the sampled days.

For the 8 sampled days, we requested and received the staffing schedules of the physicians and nurses who were on duty or on call for each unit of the main hospital and for each off-campus department or satellite office operated by the hospital, if applicable. We reviewed the staffing schedules for the 8 sampled days from each of the 109 hospitals. We identified any instances when a hospital did not meet the Medicare staffing CoPs that require at least one physician to be on duty or on call at all times and at least one registered nurse to be on duty at all times. We also reviewed the number of nurses per shift in the inpatient unit for a randomly selected weekday and weekend day from our 8 sampled days.

### **Review of Hospital Staffing and Emergency Management Policies**

We collected and reviewed each hospital's staffing policies. We received these policies from all but two hospitals.<sup>23</sup> In reviewing these documents, we specifically looked for how hospitals determine the number of staff who are on duty for different shifts and whether they designate a certain response time for on-call staff.

We also collected and reviewed each hospital's policies for managing medical emergencies. We received these policies from all 109 hospitals. We also requested any documents that the hospital provides to patients describing their emergency care policies and procedures. In reviewing these documents, we specifically looked for how the hospital instructs staff to respond to medical emergencies, the procedures that should be

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<sup>22</sup> The Joint Commission and the Healthcare Facilities Accreditation Program of the American Osteopathic Association are two accrediting organizations that have deeming authority to certify hospitals as meeting Medicare requirements.

<sup>23</sup> Two hospitals did not submit staffing policies.

followed, and any guidance about the transfer of patients to other hospitals.

### **Interviews With Hospital Administrators**

We conducted structured telephone interviews with the hospital administrator at each of the 109 hospitals. In some instances, other staff, such as the medical director, director of nursing, or risk manager, were present at the interview. We asked each administrator about procedures for the management of medical emergencies at their hospital and at any off-campus departments. In addition, we discussed staffing patterns for their inpatient, outpatient, and emergency departments, if applicable. We conducted these interviews between January and March 2007.

### **Limitations**

We based this study on 109 physician-owned specialty hospitals that we identified from a list of 130 hospitals that CMS updated in 2006. This list may not have included all physician-owned specialty hospitals. In addition, the 109 hospitals that we verified do not include any physician-owned specialty hospitals that may have enrolled in Medicare since the suspension ended in August 2006. The information from our interviews with the hospital administrators is self-reported; we did not independently verify their responses. Also, we did not collect information from other short-term acute care hospitals and therefore cannot make relevant comparisons.

### **Standards**

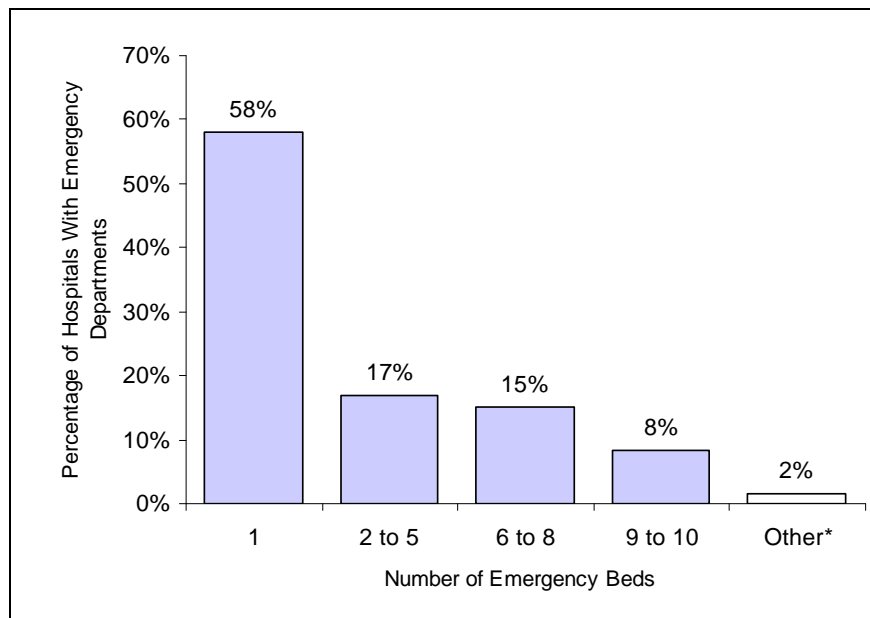
This study was conducted in accordance with the “Quality Standards for Inspections” issued by the President’s Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency.

**About half of all physician-owned specialty hospitals have emergency departments, the majority of which have only one emergency bed**

Fifty-five percent of all physician-owned specialty hospitals have an emergency department. There is no Federal requirement that all hospitals have emergency

departments, but some States do require emergency departments in hospitals. As shown in Chart 1, many of these emergency departments are relatively small. More than half of hospitals with emergency departments have only one emergency bed. Another 17 percent of these hospitals have between 2 and 5 emergency beds, 15 percent have between 6 and 8 emergency beds, and 8 percent have 9 or 10 emergency beds. According to administrators, the hours of operation for all of these emergency departments are 24 hours a day, 7 days a week.

CHART 1:  
Physician-Owned Specialty  
Hospitals With Emergency  
Departments by the Number of  
Emergency Beds (N=60)



\* One hospital with an emergency department shares the emergency beds of an adjacent hospital.

Source: OIG analysis of interview data, 2007.

Among physician-owned specialty hospitals, cardiac hospitals are twice as likely as orthopedic and surgical hospitals to have an emergency department. Ninety percent of cardiac hospitals have an emergency department, compared to 48 percent of orthopedic hospitals and 47 percent of surgical hospitals. See Appendix B for the number of each type of hospital that has an emergency department. Cardiac hospitals have a median of seven beds in their emergency departments, compared



to a median of one bed for surgical and orthopedic hospitals. In addition, 72 percent of the hospitals with emergency departments are located in three States that require hospitals to have emergency departments.<sup>24</sup> Seventy-six percent of these hospitals have only one bed in their emergency department.

Several administrators at hospitals without emergency departments note that as a safety precaution, their hospital will not admit patients with certain conditions. They explain that they will not admit patients needing intensive care or a higher level of care than the hospital can provide. Additionally, 13 administrators at hospitals without emergency departments report that they are located adjacent to or across from or are connected to a hospital with an emergency department.

**Not all physician-owned specialty hospitals had nurses on duty and physicians on call during the 8 sampled days**

The Medicare CoPs state that hospitals must have, at a minimum, a registered nurse on duty 24 hours a day, 7 days a

week, and a physician on call if one is not on duty at the hospital.<sup>25</sup> Based on our review of hospitals' staffing schedules, 93 percent of physician-owned specialty hospitals met these two requirements for our 8 sampled days. The remaining 7 percent of hospitals did not meet these requirements.

Specifically, seven hospitals failed to have a registered nurse on duty and one hospital failed to have a physician on call or on duty during at least 1 of the 8 sampled days. Most notably, three hospitals did not have a registered nurse on duty for any shift during 1 of the sampled days. Another hospital did not have a registered nurse on duty for any shift during 3 of the sampled days, as well as for the night shift on a 4<sup>th</sup> day. Hospitals were least likely to meet these staffing requirements on weekends.

Most physician-owned specialty hospitals (60 percent) have policies that specify coverage requirements for physicians on call. Many of these policies state that physicians must be on call around the clock. Forty-two percent of the hospitals with on-call policies require specific

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<sup>24</sup> These States are Texas, Oklahoma, and Colorado. See 25 Tex. Admin. Code § 133.41(e); Okla. Admin. Code § 310:667-49-9; and 6 Colo. Code Regs. § 1011-1, Chapter IV, para. 11.1.

<sup>25</sup> 42 CFR § 482.23(b)(1); 42 CFR § 482.12(c)(3).

response times; these policies typically state that on-call physicians need to respond within 30 minutes.

Almost all of the hospitals have policies governing nurse staffing requirements. These policies commonly set certain nurse-to-patient ratios, factor into account patients' needs, and/or set a minimum number of nurses that a hospital is required to have on duty.

In addition, according to our review of hospitals' staffing schedules, hospitals typically have between one and three registered nurses on duty per shift in their inpatient units. During the day, they have a median of three registered nurses during the week and during the weekend, they have a median of two registered nurses.<sup>26</sup> At night, they have a median of two registered nurses on duty during both the week and the weekend. See Appendix C for the number of registered nurses on duty in the inpatient units during the day and night.

According to our review of 8 sampled days, the patient census for the hospitals varied greatly depending upon whether it was a weekday, weekend, or holiday. The median number of patients ranged from four to nine during the week and from one to two patients during the weekend. During the holiday, the median number of patients was two. Most hospitals had patients during the week; however, 46 percent of hospitals did not have any patients during one of the weekend days, and 25 percent did not have any patients during the holiday.

**Administrators report that less than one-third of physician-owned specialty hospitals have physicians onsite at all times**

According to information provided by administrators, 28 percent of physician-owned specialty hospitals have a physician onsite 24 hours a day, 7 days a week.

Medicare does not require that hospitals have physicians onsite at all times. Administrators at hospitals that do not have a physician onsite at all times commonly explain that their hospital does not employ physicians directly. Physicians typically have privileges at the hospital and are generally on duty during business hours to perform surgeries and/or check on their patients, but the hospital does not manage the physicians' schedules.<sup>27</sup>

<sup>26</sup> This analysis is based on a randomly selected weekday and weekend day from our 8 sampled days.

<sup>27</sup> According to the hospitals' policies, business hours typically include daytime hours.

Additionally, not all physician-owned specialty hospitals with emergency departments have a physician onsite at all times. According to administrators, 45 percent of the hospitals with emergency departments have a physician onsite at all times, compared to 8 percent of the hospitals without emergency departments. Cardiac hospitals are more likely than orthopedic and surgical hospitals to have a physician present around the clock. Ninety-five percent of cardiac hospitals have a physician onsite at all times, compared to 17 percent of orthopedic hospitals and 12 percent of surgical hospitals.

Administrators report that hospitals with emergency departments that do not have a physician on duty at all times use on-call physicians to staff their emergency department. As one administrator stated, her hospital does not have a dedicated physician for the emergency department; if an emergency occurs, staff would need to call in the appropriate physician.

**Two-thirds of physician-owned specialty hospitals use 9-1-1 as part of their emergency response procedures**

Based on information provided by administrators and our review of hospital policies, 66 percent of physician-owned hospitals instruct staff to call 9-1-1 as part

of their medical emergency response procedures; however, hospitals differ in their usage of 9-1-1. See Chart 2 on the next page.

About one-third of physician-owned specialty hospitals (34 percent) use 9-1-1 to obtain medical assistance to stabilize a patient. As noted earlier, a hospital is not in compliance with Medicare CoPs if it relies on 9-1-1 services to provide appraisal or initial treatment in lieu of its own capabilities. For example, one hospital’s emergency policy states, “9-1-1 will be called to the scene to attempt resuscitation.” Another hospital has a policy that states, “After hours, call 911 for a Code Blue. Upon arrival, [county] EMS will assume responsibility for the patient.” Additionally, another hospital’s policy states, “If conditions are such that staff should require additional assistance, 911 will be contacted.”

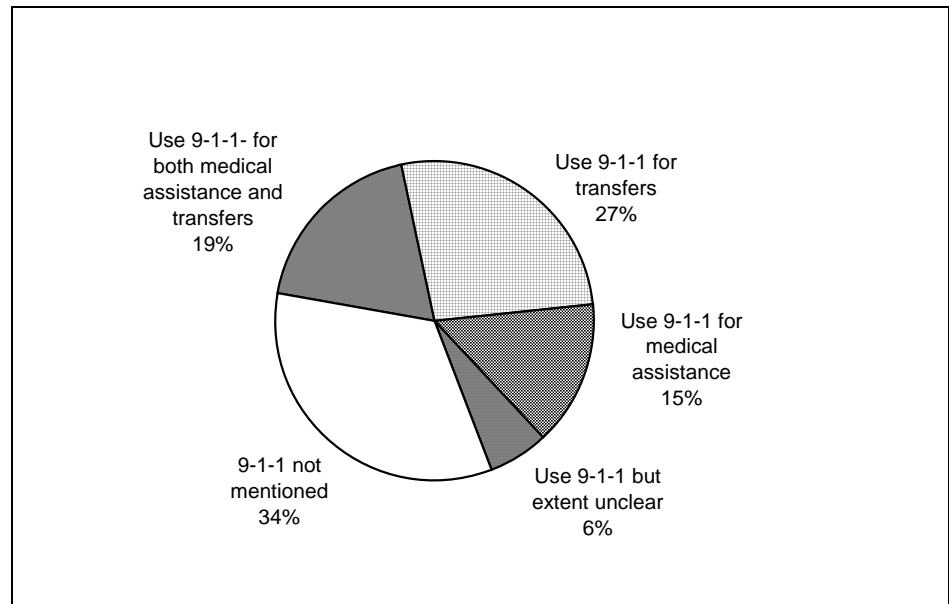
Almost half (46 percent) of physician-owned specialty hospitals use 9-1-1 to transfer patients to other hospitals. Medicare CoPs do not prohibit using 9-1-1 for transfers. One administrator reports that it is a city requirement to use 9-1-1 for transfers because there are no other ambulance services available.

For 6 percent of physician-owned specialty hospitals, it is not clear to what extent staff rely on 9-1-1 services. In these cases, the hospitals’

## FINDINGS

emergency response procedures typically state that staff should call 9-1-1 but the policies do not indicate whether it is for medical assistance or patient transfer.

CHART 2:  
Percentage of  
Hospitals,  
by 9-1-1 Usage



Note: Percentages do not total 100 because of rounding.

Source: OIG analysis of interview data and hospitals' policies, 2007.

Orthopedic and surgical hospitals are more than twice as likely to include 9-1-1 as part of their medical emergency response procedures compared to cardiac hospitals. In addition, hospitals that do not have emergency departments and hospitals that do not have physicians on duty around the clock are more likely to use 9-1-1 as part of their emergency response procedures.

### **Some physician-owned specialty hospitals lack basic information in their written policies about managing medical emergencies**

All physician-owned specialty hospitals have written policies governing the management of medical emergencies. However, some hospitals' policies lack basic

information about how they would manage such emergencies.

Most physician-owned specialty hospitals have policies that address the appraisal of emergencies, initial treatment of emergencies, and the referral and transfer of patients. Such policies may identify which staff should respond to an emergency to appraise a patient's condition or may

## F I N D I N G S

contain detailed procedures for using life-support equipment. However, almost a quarter of physician-owned specialty hospitals (22 percent) have policies that do not address appraisal of emergencies, initial treatment of emergencies, or referral and transfer of patients.

Moreover, some of the policies for the 109 hospitals lack certain information about managing medical emergencies. Specifically:

- Twenty-four percent of hospitals do not have policies that mention the use of emergency response equipment, such as defibrillators.
- Twenty-one percent of hospitals in which administrators do not report having a physician on duty at all times do not have policies that provide guidelines for managing medical emergencies when a physician is not on duty.
- Fifteen percent of hospitals do not have policies that mention the use of cardiopulmonary resuscitation or Advanced Cardiac Life Support (ACLS) protocols.<sup>28</sup>
- Six percent of hospitals do not have policies that indicate who should respond to medical emergencies.

In addition, 2 of the 10 hospitals with off-campus departments do not have emergency policies that apply to these departments. One hospital does not have a policy. The other hospital has a policy for its main campus, but the policy is not applicable to its off-campus department because it does not take into account the absence of physicians and nurses at the off-campus department.

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<sup>28</sup> The ACLS refers to a set of medical interventions used to treat people experiencing respiratory and/or cardiac emergencies and stroke, including invasive techniques, such as intubation and administration of drugs. Available online at <http://www.americanheart.org/presenter.jhtml?identifier=3012127>. Accessed July 18, 2007.

## ► R E C O M M E N D A T I O N S

Our findings raise some concerns about physician-owned specialty hospitals' ability to manage medical emergencies. During the 8 sampled days we reviewed, not all physician-owned specialty hospitals met the Medicare CoP requirements to have a registered nurse on duty at all times and a physician on call if one is not onsite at all times. Over one-third of physician-owned specialty hospitals also rely on 9-1-1 to provide medical assistance, and some hospitals lack basic information in their written policies about how to manage medical emergencies. In addition, CMS does not have a system to identify or track the number of physician-owned specialty hospitals.

Based on these findings, we recommend that CMS take the following actions to improve the ability of physician-owned specialty hospitals to manage medical emergencies. We recognize that although the scope of this study includes physician-owned specialty hospitals, some of the recommendations apply to all hospitals. Specifically, we recommend that CMS:

- Develop a system to identify and regularly track physician-owned specialty hospitals.
- Ensure that hospitals meet the current Medicare CoPs that require a registered nurse to be on duty 24 hours a day, 7 days a week, and a physician to be on call if one is not onsite.
- Ensure that hospitals have the capabilities to provide for the appraisal and initial treatment of emergencies and that they are not relying on 9-1-1 as a substitute for their own ability to provide these services.
- Require hospitals to include necessary information in their written policies for managing a medical emergency, such as the use of emergency response equipment and the life-saving protocols to be followed.

In addition to making these recommendations, we will forward to CMS for appropriate action information on the 8 hospitals that did not meet the two staffing CoPs reviewed in the study and the 37 hospitals that use 9-1-1 to obtain medical assistance.

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## AGENCY COMMENTS

CMS concurred with all four of our recommendations.

In response to our first recommendation, CMS stated that it will track physician-owned specialty hospitals by adding information to CMS's provider enrollment form and the new Provider Enrollment and Chain-Operated System.

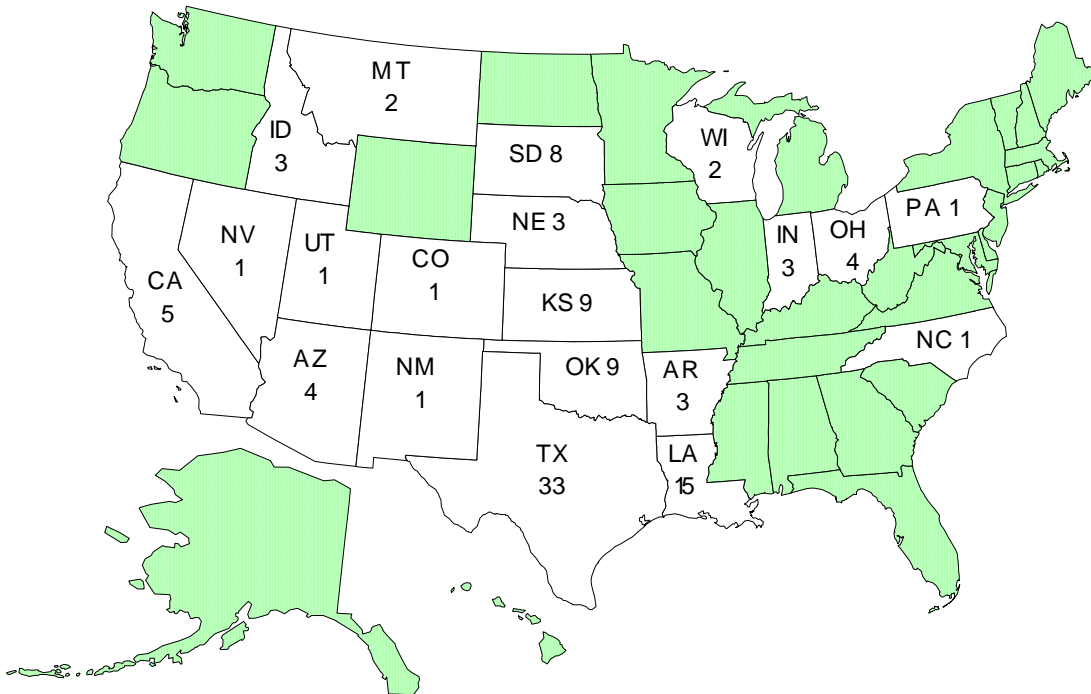
In response to our second recommendation, CMS indicated that it currently examines hospital compliance with all Medicare CoPs through its unannounced initial certification and recertification hospital surveys. CMS does not conduct these surveys for the 42 percent of hospitals that are accredited by either the Joint Commission or the American Osteopathic Association. However, CMS investigates all credible complaints, including complaints against accredited hospitals. CMS stated that it will ensure that both accreditation organizations are aware of our findings.

In response to our third recommendation, CMS stated that it issued a program memorandum to State Survey Agencies during the period that we were conducting the study that reiterates its requirements for hospitals and addresses medical emergency requirements. CMS circulated this memorandum to the national accreditation organizations and made it available to the public through its Web site.

Finally, CMS concurred in principle with our fourth recommendation. CMS stated that it currently has the authority to require that hospitals have policies and procedures addressing, at a minimum, assessment of a medical emergency, initial treatment, and referral as appropriate. CMS stated that it will consider whether regulatory changes to create more specific requirements for equipment and staff qualifications would be appropriate. Appendix D provides the full text of CMS's comments.

▶ APPENDIX - A

Distribution of Physician-Owned Specialty Hospitals, by State\*

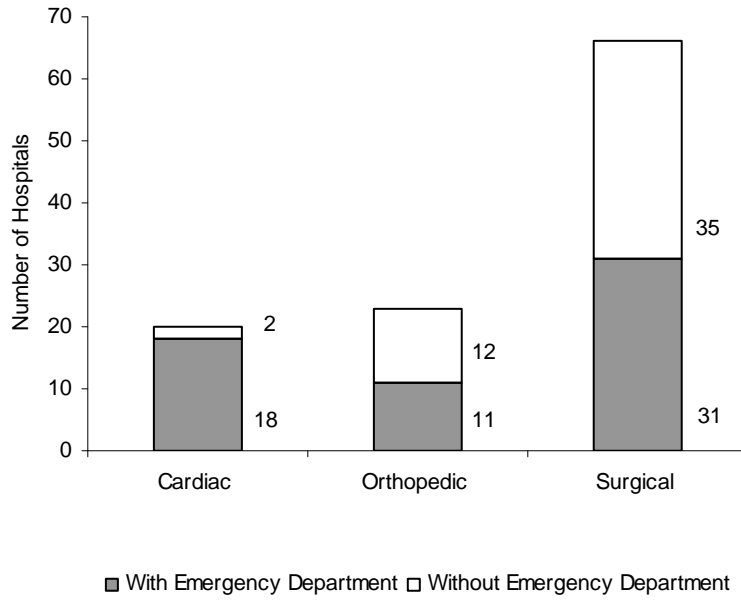


\*States that are shaded do not have any physician-owned specialty hospitals.

Source: Office of Inspector General analysis of interview data, 2007.



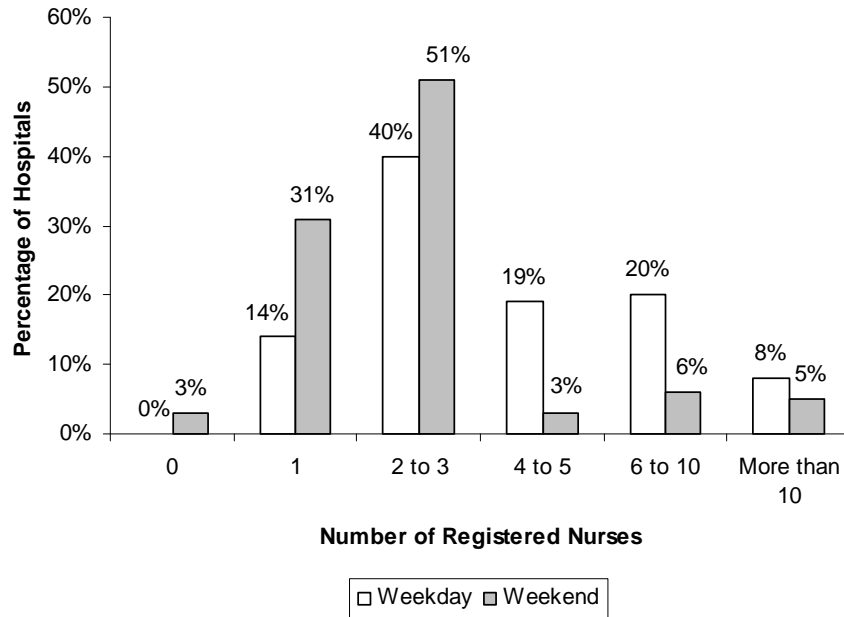
### Number of Physician-Owned Specialty Hospitals That Have an Emergency Department



Source: Office of Inspector General analysis of interview data, 2007.

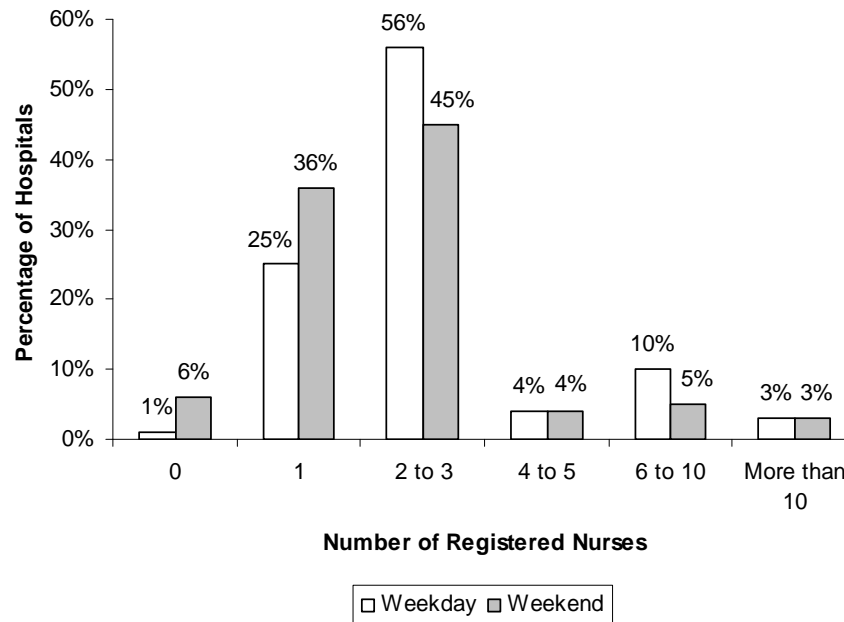
➤ A P P E N D I X ~ C

**Chart 1: Number of Registered Nurses on Duty in the Inpatient Units During the Day**



Source: Office of Inspector General analysis of hospitals' staffing schedules, 2007.

**Chart 2: Number of Registered Nurses on Duty in the Inpatient Units During the Night**



Source: Office of Inspector General analysis of hospitals' staffing schedules, 2007.



A P P E N D I X ~ D

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

DEC 7 2007

Office of the Administrator  
Washington, DC 20201

RECEIVED  
2007 DEC -7 PM 12: 02  
OFFICE OF INSPECTION  
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**TO:** Daniel R. Levinson  
Inspector General

**FROM:** Kerry Weems *[Signature]*  
Acting Administrator  
Centers for Medicare & Medicaid Services

**SUBJECT:** OIG Draft Report: "Physician-Owned Specialty Hospitals' Ability to Manage Medical Emergencies," (OEI-02-06-00310)

The Centers for Medicare & Medicaid Services (CMS) appreciates the contributions and valuable insight of the Office of Inspector General (OIG) in assessing the compliance of physician-owned specialty hospitals with Medicare Conditions of Participation related to managing medical emergencies. The purpose of this report was to evaluate patient care and safety in physician-owned specialty hospitals, focusing on the emergency departments in such hospitals, their staffing patterns, and their written policies for managing medical emergencies.

The OIG used a list of 130 hospitals that had been previously identified by CMS as meeting the criteria to be considered a physician-owned specialty hospital. The OIG verified that 109 hospitals continued to meet these criteria and were participating in Medicare at the time of the study. The OIG obtained data from all 109 of these hospitals to inform its study, via four hospital-supplied data sources, including 1) physician and nurse staffing schedules for 8 sampled days; 2) hospital staffing policies; 3) hospital policies for managing medical emergencies; and 4) structured interviews with hospital administrators. Based on the OIG's findings:

- 55% of the physician-owned specialty hospitals have an emergency department (ED), most with only 1 bed. 72% of the hospitals that have EDs are located in 3 States that require all hospitals to have an ED. Medicare does not require a hospital to have an ED.
- 7% failed to comply with the Medicare requirement to have an RN on site at all times, and/or to have a physician either on duty or on call at all times.
- 28% have a physician on site at all times. Medicare does not require a physician be on site 24/7.
- 66% of the hospitals instruct staff to call 9-1-1 as part of their response to a medical emergency. 34% use 9-1-1 to obtain medical assistance to stabilize a patient, a practice that may violate Medicare requirements.

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- Some lack basic information in their written policies about managing medical emergencies.

Our response to their recommendations follows.

**OIG Recommendation**

Develop a system to identify and regularly track physician-owned specialty hospitals.

**CMS Response**

We concur. We are already in the process of adding the identifying information to CMS’ provider enrollment form (the “855” form). We will also add the requisite field to CMS’ new Provider Enrollment and Chain-Operated System (PECOS) that maintains enrollment information in an electronic medium. The PECOS database is in the process of being populated now.

**OIG Recommendation**

Ensure that hospitals meet the current Medicare Conditions of Participation that require a registered nurse to be on duty 24 hours a day, 7 days a week, and a physician to be on call, if one is not onsite, 24 hours a day, 7 days a week.

**CMS Response**

We concur. Through its unannounced initial certification and recertification surveys of hospitals by State Survey Agencies, CMS examines hospital compliance with all conditions of participation, including the above-referenced requirements. For the 42% of physician-owned specialty hospitals that are accredited by either The Joint Commission or the American Osteopathic Association, CMS does not conduct initial or recertification surveys. However, CMS investigates through State Survey Agencies all credible complaints alleging failure of a hospital to have the required physician and RN coverage, including complaints against accredited hospitals. We will ensure that the two recognized hospital accreditation organizations are made aware of the OIG’s findings.

**OIG Recommendation**

Ensure that hospitals have the capabilities to provide for the appraisal and initial treatment of emergencies and that they are not relying on 9-1-1 as a substitute for their own ability to provide these services.

**CMS Response**

We concur. During the period that OIG was conducting this study CMS issued a memorandum to State Survey Agency Directors, “Provision of Emergency Services – Important Requirements for Hospitals,” S&C-07-19 (April 26, 2007) to reiterate CMS’s

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requirements for hospitals. This memorandum was also circulated to the national accreditation organizations and is accessible to hospitals and members of the public through CMS' website, and thus serves as a vehicle to educate the regulated community as well as provide guidance to State Survey Agencies that conduct enforcement activities on CMS's behalf. Among other things, this memorandum makes it clear that every hospital that participates in Medicare, regardless of whether or not it operates an ED, must have basic capacities to address medical emergencies that arise within the hospital. Furthermore, the memorandum articulates explicitly that hospitals may not rely upon 9-1-1 services to substitute for capacities to address a medical emergency that all Medicare-participating hospitals are required to have.

**OIG Recommendation**

Require hospitals to include necessary information in their written policies for managing a medical emergency, such as the use of emergency response equipment and the life-saving protocols to be followed.

**CMS Response:**

We concur in principle. We currently have the authority to require that hospitals have policies and procedures addressing, at a minimum, assessment of a medical emergency, initial treatment and referral as appropriate. We expect that such policies and procedures would address in detail issues such as staff competencies; location, access to and use of equipment; and standard protocols to be followed. We will consider whether regulatory changes to create more specific requirements with respect to equipment and staff qualifications would be appropriate.

Thank you for the opportunity to review and comment on this report.



## A C K N O W L E D G M E N T S

This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York regional office, and Meredith Seife, Deputy Regional Inspector General.

Judy Kellis served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the New York regional office who contributed to this report include Lucia Fort and Iris Lin; central office staff who contributed include Kevin Farber, Doris Jackson, and Barbara Tedesco.