FACTSHEET

Physician Self-Referral to Physician-Owned Hospitals

THE ISSUE

A group of lawmakers want to significantly weaken the current law and prohibition on physician self-referral to new physician-owned hospitals, and loosen the restrictions for growth on grandfathered facilities. *The Middle Class Tax Relief and Job Creation Act of 2011*, passed by the House of Representatives on December 13, 2011, included an ill-advised provision that would allow a significant expansion of physician self-referral to hospitals by grandfathering many more new physician-owned hospitals and allowing unfettered growth in all grandfathered hospitals. This provision would drive up costs at a time when our nation is trying to control health spending and actually adds $300 million to the deficit. The Patient Protection and Affordable Care Act (ACA) closed the loophole which allowed physicians to self-refer patients to hospitals in which they have an ownership stake. For decades, The Ethics in Patient Referrals Act (the "Stark" law) has protected the Medicare program from the inherent conflict of interest created when physicians self-refer their patients to facilities and services in which they have a financial interest. Physician self-referral is especially damaging for full-service community hospitals. Self-referral creates a destabilizing environment that leaves less-profitable patients and services to community hospitals, thereby threatening their ability to continue to meet the needs of the community as a whole.

AHA POSITION

Maintain current law and support the prospective ban on physician self-referral for new physician-owned hospitals and restrictions on growth for existing physician-owned hospitals.

WHY?

- **Closing the "whole-hospital" exception loophole to the Stark law reduced the deficit. When enacted,** the Congressional Budget Office (CBO) estimated this provision would save $500 million over 10 years.
- **Numerous studies have associated physician self-referral with higher utilization of health care services and costs.** The Congressional Budget Office (CBO), Medicare Payment Advisory Commission (MedPAC), and independent researchers found self-referral resulted in higher per person utilization of services and higher costs for the Medicare program at a time when rising health care costs is an issue of critical importance. This is especially the case when there is no evidence of the need for more capacity.
- **Most physician-owned hospitals tend to cherry-pick the most profitable patients.** Studies conducted by the Government Accountability Office (GAO), Centers for Medicare and Medicaid Services (CMS), and MedPAC all found that physician-owned specialty hospitals treat healthier patients with the same diagnosis. In addition, MedPAC and GAO further found that physician-owned hospitals treat fewer Medicaid patients.
- **Physician-owned hospitals provide limited or no emergency services.** Many physician-owned, limited-service hospitals do not have emergency departments. In fact, the Department of Health and Human Services Office of Inspector General issued a report regarding the ability of physician-owned specialty hospitals to manage medical emergencies, finding in part, that "[t]wo-thirds of physician-owned specialty hospitals use 9-1-1 as part of their emergency response procedures," and "[m]ost notably, 34 percent of [specialty] hospitals use 9-1-1 to obtain medical assistance to stabilize patients, a practice that may violate Medicare requirements."
- **Overall, the data clearly showed physician self-referral was creating an un-level, anti-competitive playing field, and threatened the health care safety net.**

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KEY FACTS

The number of physician-owned hospitals increased rapidly throughout the country during the 1990s and 2000s, especially in states with no Certificate of Need (CON) laws. From December 2003 to August 2006, temporary congressional or regulatory actions were taken to prohibit self-referral to new physician-owned hospitals or to suspend the issuance of Medicare provider numbers to these hospitals, thereby limiting the impact on Medicare of the growth in physician-owned hospitals. Between August 2006 and January 2011 no such constraints existed and growth in such facilities accelerated, along with the physician-owner's ability to self-refer.

The ACA limited use of the exception for physician-owned hospitals under the Stark law to existing physician-owned hospitals that had a Medicare provider number on December 31, 2010. Those grandfathered facilities are also required to comply with disclosure, patient safety, bona fide investment, and growth restriction rules. The ACA allows limited exceptions to the prohibition on growth for grandfathered physician-owned hospitals when there is some evidence of the need for additional capacity. For example, growth is allowed when the hospital provides the highest level of Medicaid inpatient admissions in its county and is not the sole hospital in its county. Or, a physician-owned hospital can show it has average or higher Medicaid inpatient admissions, and is located in an area with significant population growth and high bed occupancy rates.