

# Virtual Mentor

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## HEALTH LAW

### Physician-Owned Hospitals and Self-Referral

Cristie M. Cole, JD

By 2010, approximately 265 hospitals in the United States were owned, in whole or in part, by physicians [1]. Commonly known as physician-owned hospitals (POH), many have an outstanding reputation for providing quality care, maintaining high patient satisfaction ratings, and allowing physician-investors to gain more control over their clinical practice [2]. Proponents of POHs argue that they not only enhance patient care but function as a necessary competitive force in the medical marketplace, promoting patient choice [3]. Critics of POHs, however, caution that conflicts of interest inherent in the model have the potential to compromise patient care at both the POH and surrounding hospitals [3]. Strict legal restrictions are in place to prohibit physician self-referrals, but POHs have been exempt from these laws, which has allowed them to thrive [4]. Now, the Patient Protection and Affordable Care Act (ACA) seeks to limit exemptions for POHs substantially, raising questions about their future status and viability [5].

### Physician Self-Referrals and Physician-Owned Hospitals

Financial gain from self-referrals—referrals for health care services or to facilities in which a physician has a financial interest—can improperly influence a physician’s medical judgment [2]. Risks of unregulated self-referrals include overutilization of the services in which physicians have investments, increased health care costs, and decreased quality of care [2].

POHs raise similar concerns—for example, a physician who shares ownership in a POH may have a financial incentive to refer patients for unnecessary services if he or she receives a percentage of the revenue generated [2]. While medicine as a profession has historically been unwelcoming to commercial practices that place the financial interests of physicians above the best interest of a patient, in the twentieth century physician entrepreneurship (including self-referral to POHs) was generally embraced [2].

Concerned by the growing number of self-referrals in the late 1980s, Congress ordered the Office of the Inspector General (OIG) in the Department of Health and Human Services (HHS) to investigate them [3]. The OIG’s 1989 report substantiated many of Congress’s concerns regarding the sizable presence of self-referrals in the medical market, despite existing anti-kickback laws [3]. There was substantial debate, however, over the systemic effect self-referrals had on patient care and the medical marketplace and the need for government regulation [3]. Proponents of government regulation believed that self-referrals decreased competition, increased

health care costs, and compromised quality of care [3]. Critics of regulation, however, believed that self-referrals strengthened the marketplace by giving patients more choices for health care services and, thus, providing an incentive to physicians to maintain high quality of care [3].

### **Stark Law, the “Whole Hospital Exception,” and the Rise of Physician-Owned Hospitals**

The 1989 OIG report prompted Congress to push forward legislation, commonly known as the Stark law, which prohibits physician self-referrals for eleven designated health services paid for by Medicare or Medicaid [2]. Physicians who violate the law face denial of Medicare payment for services rendered or mandated refunds of payments and civil monetary penalties [6-9]. The Stark law allowed certain safe harbors (or exemptions from the law) for activities that, as is commonly said, accommodate a legitimate business relationship [10].

Included among the safe harbor provisions was the “whole hospital exception.” Under this exception, a physician could refer Medicare or Medicaid patients to a hospital in which he or she had a financial interest if (1) the referring physician was authorized to perform services at that hospital and (2) the physician’s financial interest was in the *whole* hospital as opposed to a specific department or subdivision [4]. Savvy physician entrepreneurs used this provision to invest in and refer patients to POHs, which satisfied the “whole hospital exception” because POHs are freestanding facilities [2, 11]. However, many POHs closely resemble divisions within general hospitals. Most specialize in specific services, such as cardiac or orthopedic surgery, and many of their patients are referred from general hospitals by the POH’s physician-investors [11]. As such, the “whole hospital exception” allowed the growth of an industry that profited from the very type of self-referral scheme it was clearly intended to prevent [1].

### **Government Investigation of the Impact of POHs**

In 2003, Congress ordered an 18-month moratorium on further development of POHs while the Department of Health and Human Services (HHS) and the Medicare Payment Advisory Commission (MedPac) investigated their impact on care, patient safety, and the medical marketplace [12]. Overall, the reports painted POHs as less of a threat than originally believed. While they confirmed that POHs increased overutilization of services, treated patients whose care was less costly, and provided less uncompensated care than nonphysician-owned hospitals, the feared decreased in competition was found to be negligible [13, 14]. Moreover, the data showed that physician-investor referral patterns to POHs and other facilities were similar to those of physicians without an investment interest [13, 14]. The HHS report did, however, substantiate concerns about patient safety arising from inadequate emergency services [15].

Ultimately, neither MedPac nor HHS recommended the elimination of the “whole hospital exception” [13-15]. In fact, MedPac stated that POHs “may be an important competitive force” and “an appropriate response to physician frustration with

community hospitals' lack of responsiveness and physicians' desire for control" [13]. Instead, they recommended modification of the Medicare payment system [13] and "that hospitals...require a registered nurse to be on duty 24 hours a day, 7 days a week, and a physician to be on duty or on call if one is not onsite" [15].

Despite the relatively benign picture painted by these reports, Congress proposed several measures in 2007 and 2008 that would have, in varying degrees, eliminated the "whole hospital exception" for new and expanded POHs [16-18]. While none of these measures was enacted, they demonstrated a continuing effort by some to continue to limit or eliminate POHs [16-18].

### **Section 6001 of the Patient Protection and Affordable Care Act (ACA)**

The movement against POHs gained substantial ground in May 2010 when President Obama signed the ACA into law, substantially restricting POHs [5]. Section 6001 of the ACA modified the "whole hospital exception" of the Stark law in three key ways, adding (a) limits on the growth of POHs in the medical marketplace, (b) requirements to disclose investment terms and investor identities, and (c) requirements to provide emergency services [5]. Notably, the ACA measures are somewhat narrow in their impact and scope—they apply only to facilities seeking reimbursement for Medicare services that were Medicare certified after December 31, 2010. They do not affect POHs' ability to seek reimbursement from self-pay patients or private insurance [19-21]. To the extent that POHs rely on Medicare reimbursements, however, their growth and development are substantially curtailed.

*(a) Prohibitions expanding existing or establishing new POHs.* Section 6001 prohibits expanding the capacity of existing Medicare-certified POHs as of March 23, 2010, unless they meet one of two exceptions. The law also placed a moratorium on the establishment of new Medicare-certified POHs after March 23, 2010. For the 60-65 POHs that were already being developed in March 2010, the ACA set a deadline of December 31, 2010 to obtain Medicare certification [22, 23].

*(b) Disclosure requirements.* The ACA imposes reporting requirements and restrictions on physician investments. POHs must report to HHS and disclose to their patients the identity of their investors and investment terms and post their POH status on websites and in public advertising. Moreover, the percentage of the aggregate value of investments owned by physicians (as opposed to nonphysicians) in a given POH was capped at its March 23, 2010, level. The act also limits the terms of physician investment to prevent inappropriate behavior, prohibiting, for example, lending money to finance physician investment in POHs or requiring physician-investors to meet referral quotas [24].

*(c) Emergency services.* Also included in the ACA are regulations addressing patient safety concerns regarding insufficient emergency services in POHs. POHs that lack 24-hour physician availability are required not only to disclose this fact to their patients but also to obtain written acknowledgment that the patient understands. Moreover, POHs must "provide assessment and initial treatment for medical

emergencies and have the capacity to refer and transfer patients to full-service hospitals, if necessary to treat a patient’s emergent condition” [20].

### ***Physician Hospitals of America v. Sebelius***

The new measures of the ACA that restrict POH growth and development have recently come under legal challenge. Physician Hospitals of America (PHA), an advocacy group for POHs, and one specialty POH, Texas Spine and Joint Hospital (TSJH), filed suit against the secretary of HHS in the U.S. District Court for the Eastern District of Texas challenging the constitutionality of section 6001 [20]. TSJH was in the process of expanding but was unable to complete its efforts before the ACA restricted it [20]. PHA and TSJH argued that the restrictions (1) violated due process and equal protection rights, (2) constituted an unjustified governmental taking because it deprived the owners of their real property and capital investment, “including their anticipated revenue source of Medicare,” and (3) were unconstitutionally vague [20].

The district court dismissed the suit, upholding the constitutionality of the restrictions and finding in favor of the secretary (and the Obama administration), a victory for the ACA [20]. At the same time, it recognized that PHA and TSJH may have identified a “wiser legislative approach” to achieving the underlying purposes of the statute—primarily limiting financial incentives for unnecessary referrals [20]. The district court’s opinion implied that sufficient evidence was presented to support the position that POHs are a valuable element of the medical marketplace and less restrictive means would be “wiser” [20].

PHA and TSJH appealed to the Fifth Circuit Court of Appeals, which also dismissed the suit [20]. Unlike the district court, the appellate court did not address the constitutional arguments [20]. Instead, it determined that the court lacked subject matter jurisdiction because PHA and TSJH needed to pursue their claims directly through HHS before bringing a lawsuit [20]. In order to bring a claim directly to HHS, though, TSJH would have to complete its \$30 million expansion, treat patients, and file a claim with Medicare for reimbursement [20]. Only after its claims for Medicare reimbursement were denied could TSJH then pursue its claim through HHS directly [20]. This is a substantial financial risk for any institution.

### **Conclusion**

In sum, the long-term impact of section 6001 of the ACA on the POH industry and patient care is unknown. The dismissal of *Physician Hospitals of America v. Sebelius*, the only challenge to section 6001 thus far, does not preclude future suits in other federal jurisdictions or challenges to HHS—in fact, because the appellate court did not address the constitutionality of the law, more claims are likely, either through HHS or in other federal courts. Neither does the Supreme Court’s June 2012 decision upholding the constitutionality of the ACA preclude challenges to section 6001 [25]. Even with legal challenges looming, though, section 6001 is a regulatory reality for POHs. While critics of section 6001 warn that it will debilitate an important competitive force in the marketplace, it does not categorically eliminate further

development of the POH industry. It only eliminates Medicare as a source of income for affected POHs. Even though most POHs' financial stability has relied on Medicare, new or expanding POHs could alter their business models. Moreover, it is questionable whether section 6001 will fulfill its stated intent, particularly given the fact that the 2003 MedPac and HHS reports showed the POHs were not, or at least not yet, the grave threat to patient care that many feared.

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Cristie M. Cole, JD, is a 2012-2014 fellow in the Cleveland Fellowship in Advanced Bioethics affiliated with Cleveland Clinic, Case Western Reserve University, MetroHealth Medical Center, University Hospitals Case Medical Center, and the Louis Stokes Cleveland VA Medical Hospital in Ohio. She received her JD from the University of Arizona's James E. Rogers College of Law. Her current research focuses on the legal and ethical limits of procreative liberty in clinical practice, particularly in the context of vulnerable patient populations, emerging reproductive technologies, and disease management, as well as the legal and ethical issues in treating adolescent patients and direct-to-consumer genetic testing.

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