American Hospital Association

800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100 Phone
www.aha.org

Testimony

of the

American Hospital Association

before the

Health Subcommittee

of the

Committee on Ways and Means

of the

U.S. House of Representatives

"Improving Competition in Medicare: Removing Moratoria and Expanding Access"

May 19, 2015

I am Rich Umbdenstock, president and CEO of the American Hospital Association (AHA). On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, I thank you for the opportunity to testify.

Community hospitals embrace fair competition where facilities compete over quality, price and patient satisfaction. However, we are strongly opposed to the practice of self-referral, which skews the marketplace in favor of physician owners who self-refer the healthiest and wealthiest patients to their own facilities. Therefore, the AHA urges Congress to maintain current law preserving the ban on physician self-referral to new physician-owned hospitals, and retaining restrictions on the growth of existing physician-owned hospitals.

Our specific objections to changing current law on physician-owned hospitals follow, along with our ideas for how the government can help foster true competition while improving care for patients and preserving the health care safety net for our communities.

BACKGROUND

For decades, the Ethics in Patient Referrals Act ("Stark law") has shielded 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 stake. But the Stark law's "whole hospital" exception permitted physicians to refer patients to those hospitals where they had an ownership interest in the entire facility rather than just in a subdivision, such as imaging or surgery.

In 2010, Congress limited the use of the "whole hospital" exception to existing physician-owned hospitals that had a Medicare provider number as of Dec. 31, 2010. The law imposed growth restrictions on "grandfathered" hospitals but allowed for limited exceptions if such hospitals can demonstrate that their communities need additional capacity. For example, if a physician-owned hospital can show that it has the average or a higher number of Medicaid inpatient admissions and is located in an area with significant population growth and high bed occupancy rates, it may apply to increase its number of beds. Congress added the need criteria because the proliferation of physician-owned hospitals was focused in those states without certificate-of-need laws and restricted physician self-referral to new physician-owned hospitals.

THE WRONG PRESCRIPTION FOR COMPETITION

Physician self-referral represents the antithesis of competition. Instead it allows physicians to steer the most profitable patients to facilities in which they have an ownership interest, potentially devastating the health care safety net invulnerable communities. Changing current law would not foster competition. Instead it would only allow these physicians to increase their profits.

Current law represents a compromise that protects current physician ownership of hospital arrangements and allows these arrangements to grow where increased hospital capacity is needed. However, some members of Congress propose to weaken significantly Medicare's prohibition on physician self-referral to new physician-owned hospitals and loosen restrictions on the growth of grandfathered hospitals. The so-called Patient Access to Higher Quality Care Act (H.R. 976) would allow many more physician-owned hospitals to open and permit unfettered growth in all grandfathered hospitals.

The AHA opposes any changes that would expand use of the whole hospital exception beyond grandfathered hospitals or that allow grandfathered hospitals to expand or increase their capacity beyond what is allowed in current law. We oppose such changes for three primary reasons. First, physician-owned hospitals provide limited or no emergency services, relying instead on publicly funded 911 services when their patients need emergency care. The Department of Health and Human Services' (HHS) Office of Inspector General reported that "[t]wo-thirds of physician-owned specialty hospitals use 911 as part of their emergency response procedures," and "[m]ost notably, 34 percent of [specialty] hospitals use 911 to obtain medical assistance to stabilize patients, a practice that may violate Medicare requirements."

Second, physician self-referral leads to greater utilization of services and higher costs. The Congressional Budget Office (CBO), the Medicare Payment Advisory Commission (MedPAC) and independent researchers all have concluded that physician self-referral leads to greater per capita utilization of services and higher costs for the Medicare program.

And third, physician-owned hospitals tend to cherry-pick the most profitable patients and services, jeopardizing communities' access to full-service care. The Government Accountability Office (GAO), the Centers for Medicare & Medicaid Services and MedPAC have all found that physician-owned hospitals' patients tend to be healthier than patients with the same diagnoses at general hospitals. Further, MedPAC and GAO found that physician-owned hospitals treat fewer Medicaid patients. This trend creates a destabilizing environment that leaves sicker and less-affluent patients to community hospitals. These selection practices place full-service hospitals at a disadvantage because they depend on a balance of services and patients to support the broader needs of the community. The current payment system does not explicitly fund standby capacity for emergency, trauma and burn services, nor does it fully reimburse hospitals for care provided to Medicaid and uninsured patients.

Community hospitals rely on cross-subsidies from the well-reimbursed services targeted by physician-owned hospitals to support these and other essential but under-reimbursed health services. Revenue lost to specialty hospitals can lead to staff cuts and reductions in subsidized services such as inpatient psychiatric care, as well as lower operating room utilization, which decreases efficiency, strains resources and increases costs. In addition, many of the physicians profiting from limited-service hospitals will not serve "on call" in the community's emergency department or participate in wider quality improvement projects that benefit the community. Furthermore, the nation is experiencing shortages in many physician and other allied health professions. These facilities duplicate services, further exacerbating these shortages. Siphoning off the most financially rewarding services and patients threatens the ability of community hospitals to offer comprehensive care – and serve as the health care safety net for all patients.

Furthermore, closing the "whole hospital" exception loophole to the Stark law reduced the federal deficit by $500 million over 10 years, according to the CBO. The ill-advised Patient Access to Higher Quality Care Act would erase those savings and raise the deficit at a time when our nation is trying to control increases in health care costs. We strongly oppose any attempt to expand the number of physician-owned hospitals and support tight restrictions on the growth of existing facilities.

ENCOURAGING COMPETITION TO BENEFIT PATIENTS AND COMMUNITIES

The health care field is rapidly changing, moving toward new payment and delivery system models that emphasize value over volume. As part of this change, hospitals are actively exploring clinical integration – a move away from working in silos toward emphasizing teamwork to coordinate care. Increasingly, public and private payers are holding hospitals accountable for reducing costs and improving quality in ways that can be accomplished only through teamwork with physicians and other health care professionals within and across sites of

care, including the alignment of financial incentives. This is opening up new opportunities for partnership, joint ventures and new types of health care organizations.

However, hospitals attempting to seize these opportunities to improve care and care coordination for Medicare beneficiaries and other patients face significant legal barriers. Chief among these are outdated rules governing compensation relationships between hospitals, physicians and other caregivers – portions of the Anti-kickback Statute, the Stark law and the Civil Monetary Penalty (CMP) law.

Congress recently acknowledged the need for change to the CMP law through the work of this committee to remove impediments to improving care for beneficiaries and other patients and remedy the government's problematic interpretation of the law. The recently passed Medicare Access and CHIP Reauthorization Act of 2015 limits the scope of this prohibition, which had prevented hospitals from offering physicians incentives to follow evidence-based care guidelines, so that a hospital or critical access hospital is only subject to CMPs for making payments to reduce or limit *medically necessary* care. The AHA advocated for this change and is pleased that the Congress has lifted this significant barrier to hospital "gainsharing" arrangements with physicians. Additional commonsense changes like this would allow hospitals and other caregivers, including physicians, to work together to better coordinate care for beneficiaries and other patients and would spur increased competition for the benefit of patients and payers, chief among them Medicare.

Congress itself has promoted change by fostering new care delivery models through the Center for Medicare and Medicaid Innovation and the Medicare Shared Savings Program (MSSP). However, it too recognizes the barriers currently in place. For example, when crafting the MSSP, Congress expressly granted the HHS Secretary authority to waive provisions of the Anti-kickback, Stark and CMP laws to remove these impediments to the successful implementation of Medicare accountable care organizations (ACOs). It did the same to enable new models to be tested under the Innovation Center.

All federal health program beneficiaries should have the same opportunity to benefit from the quality and care coordination improvements that clinically integrated organizations can provide. Specifically, the AHA recommends three statutory changes to enhance hospitals' ability to improve health and health care: creating an Anti-kickback safe harbor for clinical integration programs; refocusing the Stark law on ownership arrangements; and standardizing the merger and review process between the two federal antitrust agencies.

Creating an Anti-kickback Safe Harbor for Clinical Integration Programs. The Anti-kickback law's main purpose is to protect patients and federal health programs from fraud and abuse. The law states that anyone who knowingly and willfully receives or pays anything of value to influence the referral of federal health program business – including Medicare and Medicaid – can be held accountable for a felony. Today, the law has been stretched to cover any financial relationship between hospitals and doctors. For example, if a hospital rewards a physician for following evidence-based clinical protocols, the reward could be construed as violating the Anti-kickback law, since technically such a reward could influence a physician's order for treatment or services. In acknowledgement that there are cases where the Anti-kickback

statute thwarts good medical practices, Congress has periodically created "safe harbors" to protect those practices. Congress should create a safe harbor for clinical integration programs. The safe harbor should allow all types of hospitals to participate, establish core requirements to ensure the program's protection from Anti-kickback charges, and allow flexibility in meeting those requirements so the programs can achieve their health goals.

Refocusing the Stark Law on Ownership. The Stark law was originally enacted to ban physicians from referring patients to facilities in which they have a financial stake (i.e., self-referral). However, prohibitions that have grown around the law now prevent arrangements that encourage hospitals and physicians to work together to improve patient care. Specifically, they prohibit hospitals from making payments to physicians that are tied to achievements in quality and efficiency – rather, payments must be for hours worked only. For example, if a hospital pays a physician to help patients manage their diabetes according to a well-designed medical protocol, both the hospital and physician risk being in violation of the Stark law. Congress should return the Stark law to its original focus of regulating self-referral to physician-owned entities by removing compensation arrangements from the definition of "financial relationships" subject to the law.

Standardizing the Merger and Review Process between the Two Federal Antitrust Agencies. The Department of Justice's Antitrust Division (DOJ) and the Federal Trade Commission (FTC) are the two federal agencies with antitrust oversight. FTC has frequently used its own internal administrative process to challenge a hospital transaction, an option not available to DOJ, which increases the time and expense of defending a transaction and the likelihood of an outcome that favors the agency. The Standard Merger and Acquisition Reviews through Equal Rules (SMARTER) Act of 2014 sought to eliminate FTC's ability to challenge a transaction without going to court and to require FTC to meet the same preliminary injunction standards as DOJ. The bill was approved by the House Judiciary Committee. The AHA urges Congress to reintroduce and pass the SMARTER Act. Hospital integration and realignment is essential if the field is to be successful in its drive to build an efficient and effective continuum of care that delivers care to communities in innovative ways and in new, more convenient settings. Both antitrust agencies should be required to prove their case before a neutral judge in the federal courts and not just internal proceedings in which the agency has a decided advantage.

CONCLUSION

Conflict of interest is inherent in self-referral. To again allow for the proliferation of self-referral to physician-owned facilities would prove to be a giant step backward for both health care consumers and taxpayers. We urge you to reject efforts to change the carefully crafted compromise contained in law and help protect community hospitals and access to care for all who need it. Common sense changes in current law to allow providers to work more closely together would go much further toward fostering competition and improving health and health care.