STRUCTURE AND COMPETITIVE BEHAVIOR
OF PHYSICIAN-OWNED HOSPITALS
Testimony Submitted to the Senate Finance Committee by
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Good morning. Mr. Chairman, Senator Baucus and Members of the Committee, my name is Dan Mulholland. I am an attorney based in Pittsburgh, Pennsylvania. Both my firm and I practice exclusively in the area of health care law. Among other things, I provide advice and counseling on federal laws governing financial relationships between health care facilities and physicians, and their many exceptions, "safe harbors" and loopholes. I also often litigate issues arising under these laws, and speak and write on the same topics. It is an honor to be here today and to provide this testimony, which I hope will assist the Committee in its own analysis and policy development on issues and concerns created by physician ownership of health care facilities.

Overview

In my testimony, I set out some examples of unfair economic incentives that promote physician investment in health care facilities; discuss that investment's impact on service utilization, patient care, competition, and on full-service community hospitals; and discuss how the policy goals of both the federal Medicare Anti-kickback statute and the Physician Self-referral law are subverted by the same. Finally, I recommend that this Committee and the larger Congress consider repealing the broadly abused "whole hospital" exception to the Physician Self-referral law in order to promote level competition in health care, fair and reasonable utilization, and high quality patient care.

Brief History of Physician-Hospital Relations

Traditionally, physicians and hospitals have peacefully co-existed with one another and have enjoyed a mutually beneficial relationship. Physicians derived most of their income from providing professional services, while hospitals relied on "technical revenue" to be reimbursed for the space, equipment, supplies and personnel used by the physicians to treat their patients in the facility. In the traditional setting, most physicians are not

employed by a hospital, but instead are appointed to the hospital's medical staff and granted clinical privileges to treat patients at the hospital. Unless the physician performs some other unique service for the hospital, no money changes hands and both the doctor and the hospital look to their own separate revenue streams for reimbursement.

In recent years, however, a variety of factors and trends have blurred this traditional relationship. In some situations, in order to assure adequate access to medical services in the community, hospitals have provided physicians recruited to their service area with income guarantees. In other instances, hospitals or related organizations have employed physicians to provide medical services to patients. But doctors too have begun to offer services that were historically only offered by hospitals. As a result of payment policies and technological advances, there has been a significant increase in investment by physicians in health care facilities, including imaging facilities, ambulatory surgery centers and even hospitals. This allows the physician-investor to supplement his or her professional income with revenue from the facility services that he or she orders. Many of these opportunities are quite lucrative for physician-investors and their joint venture partners.

Impact on Full-Service Community Hospitals

While this trend has provided an attractive supplemental revenue stream to the physician-investors, sometimes bordering on a windfall,[2] it has had a significant negative impact on their full-service community hospital competitors that are not physician-owned. Aside from reduced revenue resulting from the shift in referrals to the physician-owned hospital by the investors, community hospitals also experience considerable turmoil resulting from physician competitors remaining on the community hospital's medical staff. There have been numerous instances where physicians who compete with hospitals fail to properly handle conflicts that stem from their investment interest, refuse to accept community service obligations such as indigent care and emergency room call coverage, and "free ride" on the community hospital by cherry-picking more profitable patients while admitting or transferring uninsured, Medicaid or more acutely ill patients to the

community hospital. These trends have been especially dramatic when the physician-owned hospital is a specialty hospital.[3]

Many of these problems flow from the fact that when physicians have an ownership interest in a hospital or other health care facility, they have a financial incentive to refer patients to that facility and will, absent extraordinary circumstances, do so.[4]

The Federal Fraud and Abuse Laws and Medical Ethical Standards

Such an incentive has consistently been recognized as suspect from a public policy and ethical perspective. On two occasions, Congress has significantly restricted physician ownership in certain kinds of health care facilities and services. One is a criminal statute, while the other is civil. These laws carry penalties ranging from prison time, fines, civil money penalties and exclusion from participation in Medicare and Medicaid. Physician investment and ownership in limited-service or specialty hospitals, can, through creative lawyering and financial arrangements, navigate around these legal restrictions. In other cases, physician-investors and their equity partners employ outright secrecy and nondisclosure to strain Congress's intent.

The Medicare Anti-kickback statute,[5] which prohibits the payment, receipt, offering or solicitation of remuneration in return for the referral of Medicare or Medicaid patients, was enacted to address three fundamental concerns with economic incentives to refer patients: (1) overutilization; (2) potential harm to patients that can flow from not being referred to the facility that provides the best care; and (3) the undercutting of fair competition that occurs when competition is based on paying for referrals, and not price or quality.[6] All three of these concerns are present when physicians have an ownership or investment interest in hospitals.

Congress also recognized this fact when it enacted the Physician Self-referral law.[7] That statute renders any financial relationship, including ownership and investment interests by physicians in hospitals to which they refer presumptively illegal, unless they fit within a number of statutory or regulatory exceptions. There is an exception allowing physician

ownership in a "whole hospital."[8] That exception states that, in the case of designated health services provided by a hospital, a financial relationship shall not be considered to be an ownership or investment interest if: "the referring physician is authorized to perform services at the hospital;… and the ownership or investment interest is in the hospital itself (and not merely in a subdivision of the hospital)."

In its final regulation implementing the Physician Self-referral statute, the Centers for Medicare & Medicaid Services ("CMS") specifically acknowledged that physician-owned hospitals could possess a competitive advantage over those with no physician ownership.[9] CMS also recognized that notwithstanding the whole hospital exception in the statute, physician ownership of hospitals, particularly specialty hospitals, could implicate the Anti-kickback statute.[10]

The American Medical Association has also recognized that physician referrals to facilities in which they have an ownership interest can create conflicts of interest, and thus should be allowed only in limited circumstances. Among other things, the AMA's Council on Ethical and Judicial Affairs has stated that: "Physicians may invest in and refer to an outside facility, whether or not they provide direct care or services at the facility, if there is a demonstrated need in the community for the facility and alternative financing is not available."[11] Unfortunately, this ethical rule is honored more in the breach rather than the observance where many physician-owned specialty hospitals compete head-to-head with existing community hospitals which provide more than adequate services to the community.

Recent Developments Affecting Physician-Owned Hospitals

As part of the Medicare Modernization Act of 2003, Congress amended the Physician Self-referral law to enact an 18-month moratorium on physician ownership of specialty hospitals pending further study of this issue by CMS and the Medicare Payment Advisory Commission (MedPAC).[12] The moratorium has since expired, but pursuant to the Deficit Reduction Act of 2005, CMS has been directed to prepare a Strategic and Implementing Plan relative to physician-owned specialty hospitals and, in the interim, refrain from

enrolling any physician-owned specialty hospitals in Medicare.[13] There is also legislation pending to permanently reinstate the moratorium's prohibition on physician ownership of hospitals.

Regardless of the outcome of the CMS plan or proposed legislation, the structure and activities of physician-owned hospitals bear witness to the concerns that were voiced by CMS and others that physician ownership of hospitals can lead to exactly the kinds of abuses that the Anti-kickback statute, Physician Self-referral law and AMA Code of Ethics were designed to address.

Analysis of Physician Investing Patterns

A close analysis of how these hospitals are set up, what they represent to potential investors, and how they often try to conceal the identities of the physician-investors bears this out.

In a number of cases, physician-owned hospitals have been quite bold in touting the value of the investment as being tied to the fact that physician ownership will drive and improve the financial performance of the hospital. For example, in the Prospectus for the Canadian securities offering for three South Dakota surgical hospitals, the following statement appeared:

> Physician loyalty is a key to the success of the MFC Hospitals. Physician ownership and operation of each MFC Hospital has been a key factor in attracting physicians to the medical staffs of the MFC Hospitals. Physicians prefer practicing at the MFC Hospitals because they are able to increase the number of procedures they perform in a given period relative to the traditional hospital setting, thereby maximizing their efficiency and increasing professional fee potential. Managerial control of the MFC Hospitals and ownership interests therein, also provide participating physicians with operational freedom and administrative control over their practices.[14]

That offering statement went on to admit that physician ownership could possibly be found to violate the Anti-kickback statute.[15] A more recent newspaper article about a proposed physician-owned hospital in Lancaster, Pennsylvania was even more explicit.

According to the article: "Doctors buy into a hospital, becoming part owners. Doctors direct their patients to the hospital. Hospital thrives."[16] Individuals connected to this venture who were quoted in the article made no attempt to refute this premise.

Maximizing Referrals

The way in which physician-owned hospitals are organized also suggests that the sole reason for investment is the physicians' incentive to refer patients to the hospital and maximize revenue by maximizing referrals. In many cases, physicians are given more favorable investment positions than non-physician investors and/or enter into other arrangements with their investment partners that effectively underwrite the cost of the physicians' investment. For example, investment companies not controlled by physicians or occasionally full-service hospitals which are looking to joint venture with the physicians will occasionally purchase real estate or services from the physicians at amounts that appear to be above market value as a way of providing funds for the physicians to invest in the operating entity that will run the hospital. In other situations, physicians are not required to guarantee the debt of the hospital-operating entity even though their investment company and hospital joint venture partners provide guarantees. Some physician-investors also are given the right to sell their shares back to the joint venture at any time for a pre-determined price that may or may not reflect the true fair market value of those shares.

It is important to understand that when parties to a transaction such as a physician-owned hospital are in a position to refer to one another, the concept of "fair market value" – that is, what a willing buyer and willing seller in an arms-length transaction where both are free from compulsion – takes on a different dimension. Both the Physician Self-referral law and regulations and the Anti-kickback statute state that fair market value in such situations may not take into account the volume or value of services that one party may refer to the other.[17]

Limited Capital Investment

The effect of these "sweetheart" deals is that physicians often have to put very little of their own capital at risk. The only plausible explanation for such arrangements is that they are designed to induce the physicians to invest in a facility to which they will refer and thus provide a sufficient revenue stream to guarantee high returns for all the investors. The Office of Inspector General for the Department of Health and Human Services ("OIG") recently warned that providing physicians who are expected to make a large number of referrals with more favorable investment opportunities in joint ventures suggests that there may be an improper nexus between selection of joint venture participants and the volume or value of their referrals.[18]

Many physician-owned facilities are highly leveraged, with large debt-to-equity ratios. This allows physicians to have little up front capital at risk. But financing can come from still other sources. In one instance, $15,000,000 in bonds issued by a Louisiana economic development authority on behalf of a physician-owned specialty hospital were purchased by GE Commercial Finance Business Property Corporation, an affiliate of General Electric, a major vendor of medical equipment.[19]

Masquerading Act: General Hospital or Specialty Hospital?

Physician-owned specialty facilities have on occasion attempted to disguise themselves as general hospitals, either to avoid the prior moratorium or for other purposes. In one case, the Louisiana State Bond Commission approved the issuance of bonds for a proposed hospital project while the moratorium was in place, in spite of the fact that the facility clearly met the MedPAC definition of a specialty heart hospital. The promoters refused to concede that the facility was a specialty hospital. The matter is now being litigated in the state courts.[20] In another, one of the parties to a dispute over a non-compete covenant involving physician-investors in a heart hospital in Kansas (who happens to be one of the promoters in the Louisiana transaction mentioned above) tried to claim that a new facility in which he and others were going to invest was a general hospital despite the fact that 66% of the revenue from the new hospital was projected to come from the performance of heart procedures.[21] It is quite possible that a number of

new facilities which opened during the specialty moratorium took a similar position to avoid compliance with the moratorium.

Secrecy and Nondisclosure

The physician-owners of specialty hospitals have been especially reluctant to reveal their identity as well. For example, in the Louisiana litigation mentioned above, the Economic Development District refused to answer an interrogatory asking for the identities of all persons having an ownership interest in the proposed hospital, ostensibly because they feared retaliation by the community hospital with which they are planning to compete.[22] This consistent lack of transparency on the part of physician-owned facilities suggests that they may be unwilling to allow their patients to make a fully informed choice of where they would like to have their procedures performed.[23]

Impact on Full-Service Community Hospitals

Far from being in a position to "retaliate" against physicians who invest in facilities that compete with them, full-service community hospitals are often hampered in their ability to effectively compete when physicians have an economic incentive to direct patients to another facility. An uneven competitive playing field results. To the extent that such physicians are also on the medical staff of the community hospital, they are in a position to "cherry pick" the most favorably insured patients and the most profitable procedures and refer them to their own facility, while continuing to send Medicaid, underinsured and uninsured patients, and low-margin procedures to the community hospital. Hospitals that attempt to rein in this egregious "free-riding" by the physician-owners of their competitors by restricting their clinical privileges or establishing conflict of interest rules that prevent their competitors from serving in leadership positions are accused of "economic credentialing," which is a pejorative term coined by certain medical trade associations. A significant amount of litigation involving this issue has arisen in recent years, and courts throughout the country are split on whether hospitals can restrict or deny medical staff appointment to physicians who are direct competitors.[24]

The challenges associated with taking on competing physicians on an uneven playing field, and the prospect of having large amounts of revenue diverted as a result of that competition, have led many community hospitals to pursue joint ventures with physicians on their medical staffs to construct and operate specialty hospitals. In such cases, the majority of the financing, usually in the form of debt, is borne by the community hospital, and, as stated above, the physician-investors have relatively little at risk. The community hospital in this situation will suffer since most of its revenue will be diverted to the joint venture facility, while less financially attractive patients are still treated at the community hospital. To recover the lost revenue that is now shared with the physician-investors (as well as to protect the community hospital's investment, be it debt or equity), the volume and revenue at the joint venture facility must double, which is difficult to do without questionable utilization practices on the part of the physicians.

Conclusions and Recommendations

To address these issues of improper financial incentives, nondisclosure and deception, and free-riding on community hospitals, and the mischief that can result from them, the following public policy suggestions are offered.

First, Congress should consider repealing the whole hospital exception in the Physician Self-referral law, not just for specialty facilities, but for all hospitals, since the same effects can be seen regardless of whether the facility in which physicians invest offers full or limited services.

Second, if the whole hospital exception is not repealed, Congress should require full disclosure of any direct or indirect ownership interests held by physicians in hospitals, both to their patients and to CMS (and thus the public) on the hospital's Medicare cost report and 855 enrollment form. This concept of what constitutes an "indirect" ownership or investment interest is already sufficiently described in the Physician Self-referral regulations,[25] so implementation of such a requirement should be relatively simple.

Third, full-service community hospitals should be fully empowered to effectively compete with physician-owned facilities, by allowing revocation of medical staff appointment and proper handling of conflicts of interest on the part of physicians who have an ownership interest in their competitors.

Thank you again for the opportunity to share this information with the Committee.

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[2] In one instance, three physician-owned surgical hospitals in South Dakota were the subject of a public stock offering in Canada, raising $150,000,000 for a 51% share of their operations. "S.D. Surgical Centers Plan Expansion with Merger" Sioux Falls Argus Leader (April 11, 2004). The 2005 Annual Report for this company, Medical Facilities Corporation, as published on the website of the Canadian Securities Commission, revealed that EBITDA income from one of the facilities equaled 49.3% for the last three months of the calendar year.

[3] The term "specialty hospital" has been defined as a hospital primarily or exclusively engaged in the care or treatment of patients with either cardiac or orthopedic conditions or receiving a surgical procedure. 42 U.S.C. § 1395nn(h)(7). For the purposes of specifically identifying specialty hospitals, CMS requires that at least 45% of a hospital's Medicare cases be in the relevant Major Diagnostic Categories for cardiac, orthopedic or surgical procedures. Testimony of CMS Administrator Mark B. McClellan to the House Committee on Energy and Commerce, May 12, 2005.

[4] For an empirical analysis of this phenomena, see Lynk, William J. and Longley, Carina S, "The Effect of Physician-Owned Surgicenters on Hospital Outpatient Surgery," 21 Health Affairs 215 (July/August 2002). With respect to the relationship between physician ownership of hospitals and overutilization, see Mitchell, Jean M., "Effects of Physician-Owned Limited Service Hospitals," Georgetown University Public Policy Institute (2005).

[5] 42 U.S.C. §1320a-7b(b).

[6] 135 Cong. Rec. H240-01.

[7] 42 U.S.C. §1395nn.

[8] 42 U.S.C. §1395nn(d)(3).

[9] 69 Fed. Reg. 16084 (March 26, 2004).

[10] Id.

[11] AMA Ethical Opinion E-8.032. www.ama-assn.org.

[12] Pub. L. 108-173, §507 (2003).

[13] Pub. L. 109-171, §5006 (2006).

[14] Medical Facilities Corporation Prospectus, p. 30 (March 17, 2004).

[15] Id. at p. 39.

[16] "A New Kind of Hospital Here?" Lancaster New Era (April 27, 2006).

[17] See 66 Fed. Reg. 944; 56 Fed. Reg. 35, 952 et seq.

[18] OIG Supplemental Compliance Program Guidance for Hospitals, 70 Fed. Reg. 4865 (Jan. 31, 2005).

[19] Hammond Area Economic and Industrial Development District Taxable Revenue Bond (Louisiana Hospital Center, L.L.C. Project, (February 2, 2006).

[20] Board of Commissioners of the Hammond Economic and Industrial Development District v. Taxpayers, No. 2005-001527 (21st Judicial District, Tangipahoa Parish, Louisiana 2005).

[21] Kansas Heart Hospital, L.L.C. v. Idbeis, No. 04 CV 4230 (18th Judicial District, Sedgwick County, Kansas 2005).

[22] Answers to Interrogatories by Board of Commissioners of the Hammond Economic and Industrial Development District, June 2, 2005.

[23] AMA Ethical Opinion E-8.032, *supra*, requires disclosure to patients whenever a physician refers to a facility in which he or she has an ownership interest.

[24] Compare Mahan v. Avera St. Lukes, 621 N.W.2d 150 (S.D. 2001) to Murphy v. Baptist Medical Center, No. 04-430 (Ark. 2006).

[25] See 42 C.F.R. § 411.354, stating "An indirect ownership or investment interest exists if – (A) Between the referring physician (or immediate family member) and the entity furnishing DHS there exists an unbroken chain of any number (but no fewer than one) of persons or entities having ownership interests; and (B) The entity furnishing DHS has actual knowledge of, or acts in reckless disregard or deliberate ignorance of, the fact that the referring physician (or immediate family member) has some ownership or investment interest (through any number of intermediary ownership or investment interests) in the entity furnishing the DHS."