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COMMUNITY HOSPITALS OPPOSE LEGISLATION (H.R. 977/S. 470) TO ALLOW UNFETTERED GROWTH OF SELF-REFERRAL TO PHYSICIAN-OWNED HOSPITALS

New Analysis Shows Physician-owned Hospitals Cherry-pick Patients, Provide Less Uncompensated and Emergency Care

The Federation of American Hospitals (FAH) and the American Hospital Association (AHA), representing more than 5,000 hospitals nationwide, urge Congress to oppose the Patient Access to Higher Quality Health Care Act (H.R. 977/S. 470), and any other proposals that would repeal current law limiting self-referral to physician-owned hospitals (POHs).

A new analysis by the health care economics consulting firm Dobson | DaVanzo makes clear the harmful impact of POHs on patients and communities and reinforces why current law must be maintained. The 2023 Dobson | DaVanzo analysis compares the financial, operating, and patient characteristics of full-service community hospitals with a list of POHs based on a June 2016 Physician Hospitals of America roster and subsequent FAH/AHA review. The data paints a grim picture very similar to that which led Congress to enact the 2010 law restricting physician self-referral to facilities they own. Specifically, the new study shows that:

- POHs cherry-pick patients by avoiding Medicaid beneficiaries and uninsured patients;
- POHs treat fewer medically complex cases;
- POHs enjoy patient care margins 15 times those of community hospitals;
- POHs provide fewer emergency services—an essential community benefit; and
- POHs, despite their claims of higher quality, are penalized the maximum amount by CMS for unnecessary readmissions at five times the rate of community hospitals.

Background

For the past two decades, community hospitals, policymakers, the business community, and governmental advisory bodies have grappled with overutilization and higher health care costs caused by physician self-referral to POHs. Conflicts of interest are inherent in these arrangements, through which physicians selectively refer their healthy, better-insured patients to hospitals where they have an ownership interest.

Thirteen years ago, after a decade of studies and Congressional hearings demonstrating the harmful effects of these arrangements, Congress acted to protect the Medicare and Medicaid programs and taxpayers, who fund these programs, by enacting a ban on physician self-referral to new POHs, and limits on the growth of existing POHs.

- The 2010 law represents a compromise that allows existing POHs to continue operating.

- As of December 31, 2010, no new POHs can bill Medicare or Medicaid for services.
- POHs in operation as of December 31, 2010 can continue to admit and bill for Medicare and Medicaid patients.
- POHs can expand if they meet community needs.

Data Continues to Strongly Support the Need to Maintain Current Law

A substantial history of congressional policy development and underlying research exists on the impact of physician self-referral to facilities they own. The data are clear that these conflict-of-interest arrangements of hospital ownership and self-referral by physicians result in cherry-picking of the healthiest and best insured patients, excessive utilization of services, and patient safety concerns. This policy development includes a decade of work by Congress involving numerous hearings and analyses by the U.S. Department of Health and Human Services Office of Inspector General, the Government Accountability Office (GAO), and the Medicare Payment Advisory Commission (MedPAC).

And now, using the most recent publicly available data, a new analysis by Dobson | DaVanzo reinforces those findings.

Exhibit 1: Summary Statistics for Physician Owned Hospitals (POHs) and All Other Medicare IPPS Hospitals (Non-POHs)

	POHs	Non-POHs
Number of Hospitals	163	3,020
Hospital Financial and Operating Characteristics		
Percentage of Hospitals with Medicare Maximum Readmission Penalty of 3%	5.6%	1.0%
Percentage of Hospitals Located in Rural Areas	6.8%	24.0%
Patient Care Margin[6]	15.3%	-1.4%
Overall Medicare Margin[6]	-0.3%	-8.3%
Total Unreimbursed and Uncompensated Care Cost as a Percent of Net Patient Revenue[7]	3.1%	6.7%
Hospital Patient Characteristics[8]		
Medicaid Discharges as a Percent of Total	3.5%	8.4%
Percentage of Medicare Inpatient Claims with Emergency Room Services	39.1%	79.0%
Percentage of Medicare Inpatient Claims for Patients with Dual Eligibility	15.6%	26.3%
Mean Number of CC/MCCs per Medicare Claim	2.3	3.7
Percentages of Medicare Inpatient Claims for Patients who are 85 Years or Older	12.1%	19.7%
Percentage of Medicare Inpatient Claims for Patients who are Non-White	17.5%	22.3%
Percentage of Medicare Inpatient Claims for Patients with a Diagnosis of COVID-19 (Primary or Secondary)	4.1%	8.6%

Source: Dobson | DaVanzo analysis of FY 2020-2021 Medicare Hospital Cost Report data, FY 2022 Medicare RIF claims data, MBSF data, and FY 2023 Medicare IPPS Impact File data.

As demonstrated by this analysis, the dangers of unfettered physician self-referral are as significant as ever, and current law must be maintained, not weakened. Yet, some groups, including the newly branded Physician-Led Healthcare for America (formerly Physician Hospitals of America) want to repeal current law.

Repealing the Ban Would Not Increase Competition in Health Care

Supporters of H.R. 977 / S. 470 say that repealing current law would promote competition; in fact, physician self-referral is the antithesis of competition. America's community hospitals welcome the opportunity to compete based on quality, price and patient satisfaction. But the repeal bills set an unlevel playing field and would instead allow physicians to select the healthiest patients with the most profitable insurance arrangements to reap large profits for themselves.

The unfettered growth of cherry-picking POHs would jeopardize the financial stability of community hospitals, which must rely on a balance of services and patients to support the broader needs of the communities they serve. 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.

Current law, in effect now for 13 years, is working as Congress intended to protect taxpayers and ensure a more level playing field—one that promotes fair competition. It is a carefully crafted policy that includes important safeguards to permit limited expansion of grandfathered hospitals to meet demonstrated community needs. Since its implementation, several POHs have met the established requirements and have been permitted to expand.

The law as it stands protects patients, public health and taxpayers. It helps ensure that community hospitals can continue to fulfill their mission to provide quality care to all patients in their communities. We urge you to stand with America's community hospitals and oppose any and all attempts to weaken it.

Sincerely,

Federation of American Hospitals and American Hospital Association