February 24, 2017

Dear Member of Congress:

On behalf of the Federation of American Hospitals (FAH) and the American Hospital Association (AHA), we write to you today to express our **strong opposition to H.R. 1156, the ‘‘Patient Access to Higher Quality Health Care Act of 2017,” and any other legislation that would repeal or modify current law to expand self-referral to physician-owned hospitals.**

For more than 15 years, community hospitals, policymakers, the business community and governmental advisory bodies have grappled with overutilization and higher health care costs caused by self-referral to physician-owned hospitals. Conflicts of interest are inherent in these arrangements, whereby physicians refer their patients to hospitals in which they have an ownership interest. Seven years ago, after a decade of studies and congressional hearings showing the adverse impact of these arrangements, Congress acted to protect the Medicare and Medicaid programs and the taxpayers that fund them by imposing a prospective ban on self-referral to new physician-owned hospitals.

Nevertheless, some groups like the Physician Hospitals of America (PHA) continue to attempt to unwind the law. Their proposals would harm patients, community hospitals and local businesses. Proponents of weakening the law contend that the underlying data that fueled congressional action is out-of-date and current data no longer supports the earlier findings.

To the contrary, a recent analysis conducted by the health care economics consulting firm Dobson | DaVanzo refutes their argument and presents new findings that reinforce the reasons why Congress acted.

What the Data Show

The Dobson | DaVanzo analysis compares the performance of non-physician owned full-service community hospitals with physician-owned hospitals identified on PHA’s public-facing website. It provides a clear picture that the characteristics of these PHA hospitals virtually mirror the findings and data collected in the early-to-mid 2000s that drove Congress to enact the law prospectively banning self-referral to new facilities. Among those findings, physician-owned hospitals:

- cherry-pick patients by avoiding Medicaid and uninsured patients;
- treat fewer medically complex patients;
- enjoy all-payer margins nearly three times those of non-physician owned hospitals;
- provide few emergency services – an important community benefit; and

- are penalized for unnecessary readmissions at 10 times the rate of non-physician owned hospitals.

Exhibit 1: Summary Statistics for Physician Owned Hospitals (POH) and All Other Medicare IPPS Hospitals (Non-POH)[2] from the 2014 Medicare Cost Reports, 2014 CMS 100% Standard Analytic File Limited Data Set, and 2016 Hospital IPPS Final Rule and Correction Notice Public Use File

	POH	Non-POH
Number of Hospitals	68	3,116
Hospital Operating Characteristics		
Medicaid Discharges as a Percent of Total	2.2%	12.4%
Percentage of Hospitals in Hospital Group with Medicare Maximum Readmission Penalty of 3%	10.3%	0.9%
Percentage of Medicare Inpatient Claims with Emergency Department Services	21.1%	72.4%
Percentage of Medicare Inpatient Claims for Patients with Dual Eligibility	12.2%	27.6%
Mean Number of CC/MCCs[3] per Medicare Claim	1.3	2.4
Hospital Financial Characteristics		
Total All-Payer Margin (Average)	21.0%	8.0%
Uncompensated Care Costs as Percent of Total Hospital Expense	1.6%	3.9%

[1] This study was commissioned by the Federation of American Hospitals and the American Hospital Association.

[2] Physician owned hospitals were identified using the Physician Hospital of America member hospital list as of March 30, 2016. We note that four hospitals on this list were not included in the analysis because Medicare provider numbers could not be found. Non-physician owned hospitals were identified using the FY 2016 Hospital IPPS Final Rule and Correction Notice Impact Public Use File and FY 2014 Medicare Cost Reports.

[3] CC is defined as complicating or comorbid condition. MCC is defined as a major complicating or comorbid condition.

Legislative History

- In 2003, responding to the Government Accountability Office's (GAO) concerns about cherry-picking and rapid growth in this sector, the Medicare Modernization Act imposed an 18-month ban on referrals to new physician-owned specialty hospitals.
- In 2005, the Deficit Reduction Act extended through August 2006 an administrative suspension of admitting new physician-owned specialty hospitals into the Medicare program.
- In 2010, with the support of the business and hospital communities, Congress enacted legislation that prospectively banned physician-self referral, required grandfathered arrangements to provide greater financial and patient safety transparency, and permitted such grandfathered arrangements to expand only if they meet certain conditions.

Since the enactment of this ban, the system has stabilized. The instability created by the proliferation of self-referral has calmed. Patients can choose the appropriate facility for the procedures and treatments they need, and health care spending has been kept in check. In those instances where grandfathered arrangements have met the law's conditions, they have been permitted to grow.

Data Continues to Strongly Support the Need to Maintain Current Law

There is a substantial history of congressional policy development and underlying research on the impact of self-referral to physician-owned hospitals. The empirical record is clear that these conflict-of-interest arrangements of hospital ownership and self-referral by physicians result in ***cherry-picking of the healthiest and wealthiest patients, excessive utilization of care, and patient safety concerns***. This policy development includes 15 years of work by Congress, involving numerous hearings, as well as analyses by the Health and Human Services Office of Inspector General, the GAO, and the Medicare Payment Advisory Commission. ***And now, using the most recent publicly available data, Dobson | DaVanzo has reinforced those findings.***

In short, the dangers of self-referral remain, and the foundation for current law must be fortified, not weakened. Despite recent assertions by the PHA, Congressional Budget Office scoring of proposals to modify existing law consistently demonstrate that self-referral to physician-owned hospitals increases utilization, which increases Medicare costs and health care costs generally. This is a key reason why the U.S. Chamber of Commerce has long supported the ban on self-referral to physician-owned hospitals.

In November 2014, the U.S. Chamber wrote to congressional leadership describing the devastating effects of self-referral to physician-owned hospitals. The letter explains:

> "Unbridled, spiraling health care costs is one of the most important challenges facing our health care system today. One legal protection that currently helps combat unnecessary cost increases is a safeguard against certain self-referral practices. When the most profitable patient cases are referred to hospitals where physicians have a financial interest, "cherry-picking" occurs. While this referral practice increases profits for these physician-owned hospitals, such cherry-picking also has the negative impact of leaving the more complicated and poorly reimbursed cases to be treated by neighboring community hospitals.
>
> The Chamber urges Congress to not take a step backward on this policy which has historically enjoyed strong bipartisan support dating back over a decade. Although the Chamber and many lawmakers strongly opposed the Affordable Care Act (ACA) generally in 2010, the Chamber and many bipartisan lawmakers have for years supported the protections and safeguards codified in §6001 of the ACA. This provision is working by appropriately limiting the practice of self-referral to physician-owned hospitals, which increases utilization and costs to businesses and taxpayers, as well as distorting health care markets. The Chamber supports the current self-referral law and opposes any effort to unwind or weaken it."

The 2010 law is working exactly as planned to protect taxpayers and ensure a more level playing field – one that promotes fair competition. It is a carefully crafted policy with an important safeguard that permits limited expansion of grandfathered hospitals to meet demonstrated community need. Several physician-owned hospitals, in fact, have met the requirements and are currently on the path to expand.

The FAH and AHA stand with the U.S. Chamber of Commerce in supporting current law on self-referral to physician-owned hospitals. We agree with the Chamber that – "Balancing entrepreneurial spirit and sound public policy is no easy feat, but Congress achieved the right balance when it prohibited self-referral prospectively while grandfathering current arrangements…."

The law as it stands protects patients, businesses and taxpayers. It also helps ensure that full-service hospitals can continue to meet their mission to provide quality care to all the patients in their communities. We urge you to oppose any and all attempts to weaken it.

Sincerely,

Federation of American Hospitals

American Hospital Association