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Limiting Conflicts of Interest Arising from Physician Investment in Specialty Hospitals

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LIMITING CONFLICTS OF INTEREST ARISING FROM PHYSICIAN INVESTMENT IN SPECIALTY HOSPITALS

I. INTRODUCTION

Legislative, regulatory, and ethical standards that seek to limit conflicts of interest exist in a variety of professional settings.[1] For example, executive officers of banking corporations are prohibited from owning stock in private banking houses or agencies that underwrite securities.[2] Public servants and their families cannot own stock in savings and loan associations or other financial institutions doing business with state government.[3] Insurance adjusters are prohibited from having ownership interest in fire repair contracting firms, and life insurance agents cannot own funeral homes, mortuaries, or cemeteries.[4]

Over the past century, changes in the health care market have given rise to new ethical conflicts for physicians, sparking initiatives to limit the effect of such conflicts.[5] Arrangements that exacerbate the worrisome tension between the financial interests of physicians and the best interests of patients arise in a number of contexts.[6] For example, while physician ownership in commercial

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1. A conflict of interest may be defined as a condition in which an individual's professional judgment is unduly influenced by personal gain. *See* Dennis F. Thompson, *Understanding Financial Conflicts of Interest*, 329 NEW ENG. J. MED. 573, 573 (1993).

2. *See, e.g.*, MISS. CODE ANN. § 81-5-1(2) (1996 & Supp. 1999); *see also* 12 U.S.C. § 244 (2003) (providing that members of the Federal Reserve Board of Governors cannot hold stock in any bank, banking institution, or trust company). Employees of the Federal Reserve and their families also are prohibited from owning financial interests in banks or in mutual funds that concentrate on financial services. *See* BD. OF GOVERNORS OF THE FED. RESERVE SYS., *Conflict of Interest Rules for Reserve Bank Personnel with Supervision Responsibilities*, http://www.federalreserve.gov/boarddocs/SRLETTERS/1995/sr9506a2.pdf (last visited Jan. 17, 2004).

3. *See, e.g.*, MISS. CODE ANN. § 25-4-105(4)(a) (2003).

4. *See, e.g.*, MICH. COMP. LAWS ANN. § 500.1224(4) (West 2002); MICH. COMP. LAWS ANN. §§ 500.2080(1–3) (West 2002).

5. *See infra* Part V.

6. For example, pharmaceutical and biotechnological corporations support many, if not most, clinical research trials. Such firms often provide significant economic incentives to physicians who prescribe or investigate their products. The financial advantages created for physician-researchers may create a desire to skew research methodology in order to increase patient participation or produce favorable results. *See* TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 440 (4th ed. 1990). Other sources of incentives include: (1) monetary kickbacks for directed referrals, (2) income earned by doctors for selling medical products or equipment, and (3) gifts given to physicians by medical suppliers. *See* MARC A. RODWIN,

ventures can provide important benefits for patient care, a conflict of interest arises when physicians refer patients to facilities in which they have a financial interest.[7] Critics contend that this practice, commonly called "self-referral,"[8] inappropriately affects physicians' clinical and referral behavior, resulting in over-utilization of services.[9] Numerous studies have confirmed the assertions of critics, demonstrating a dramatic increase in the frequency and expense of services when self-referral arrangements exist.[10]

Consistent and costly[11] increases in utilization led the United States Congress to enact laws restricting physician self-referral.[12] Such laws contain a number of exceptions, including a provision that permits physician self-referral if the physician's investment interest is in a whole hospital.[13] The "whole hospital exception" reflects the belief among lawmakers that a physician is unlikely to be influenced by the potential for profit when referring to a general acute-care hospital due to three factors: size, scope, and stake.[14] However, in drafting the exception, lawmakers did not anticipate the evolution and proliferation of a new kind of hospital, characterized by a relatively small size, a limited scope of services, and a greater stake in profitability for physicians: the specialty hospital.

The recent proliferation of specialty hospitals has revived concerns regarding physicians' conflicts of interest and potential changes in the referral

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MEDICINE, MONEY, AND MORALS: PHYSICIANS' CONFLICTS OF INTEREST 56 (1993). Physician risk-sharing with health maintenance organizations (HMOs) and hospital purchasing and bonding practices are also areas of concern. *See* Thompson, *supra* note 1, at 573.

7. *See* Council on Ethical and Judicial Affairs, American Medical Association, *Conflicts of Interest: Physician Ownership of Medical Facilities*, 267 JAMA 2366, 2366 (1992).

8. HEALTH LAW: CASES, MATERIALS AND PROBLEMS 993 (Furrow et al. eds, 4th ed. 2001).

9. In addition to staggering increases in costs, the referral of patients for unnecessary diagnostic or therapeutic procedures exposes individual patients to unnecessary risks and may adversely affect an individual patient's health. *See* FLA. STAT. ANN. § 456.053(2) (West 2001 & Supp. 2004) (noting that, "[t]he Legislature finds these referral practices may limit or eliminate competitive alternatives in the health care services market, may result in overutilization of health care services, may increase costs to the health care system, and may adversely affect the quality of health care").

10. *See infra* notes 42–50 and accompanying text.

11. The difference in utilization cost the Medicare program $28 million in 1987. *See* RICHARD P. KUSSEROW, *Financial Arrangements Between Physicians and Healthcare Businesses*, No. OAI-12-88-01411 (May 1989) (US Dept. of Health and Human Services Report to Congress) [hereinafter HHS Report, May 1989].

12. 42 U.S.C. § 1395nn (2000).

13. *See id.* § 1395nn(d)(3).

14. *Hearing on Ohio H.B. 71 Before the Ohio House Health and Family Services Comm.*, 125th General Assembly (2003) (statement of Theresa Brooks, on behalf of the Ohio Hospital Association), http://www.ohanet.org/advocacy/state/issues/testimony/conflict081203brooks.pdf (last visited Jan. 17, 2004); *see also* U.S. GENERAL ACCOUNTING OFFICE, *Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance*, GAO-04-167, at 6–7 (Oct. 2003) [hereinafter GAO REPORT, Oct. 2003].

behavior of physician investors. Critics have focused public attention on two prominent issues: the increase of troublesome physician self-referral arrangements and the ability of physician-owned specialty hospitals to steer the most profitable patients away from general acute-care hospitals. Commentators have pressed for limitations on self-referral by physician investors in specialty hospitals. In contrast, advocates of specialty hospitals assert that there is no evidence that self-referral by physician investors in specialty hospitals results in increased utilization and that efforts to restrict self-referral are merely an attempt by general hospitals to quash the competition.

Concern over physician self-referral at specialty hospitals has triggered a range of responses from federal and state legislatures, regulatory agencies, and competing general acute-care hospitals.[15] In 2003, two federal bills were introduced to amend the whole hospital exception and restrict self-referral by physician investors in specialty hospitals.[16] In November 2003, in lieu of enacting self-referral prohibitions via these bills, the 108th U.S. Congress imposed an eighteen-month moratorium on physician self-referral at newly developed specialty hospitals and mandated extensive studies of self-referral practices at specialty hospitals.[17] The reports generated by the congressionally mandated studies, which are due approximately three months before the moratorium expires, will provide critical information regarding self-referral patterns and the extent to which these practices affect local health

15. For example, in May 2003, the Centers for Medicare and Medicaid Services ("CMS") announced its plan to propose a regulation that would prohibit physician investment in surgical and other specialty hospitals by revising the whole hospital exception. However, in anticipation of congressional action, CMS subsequently withdrew the proposal. *See* Physician Ownership in Specialty Hospitals, 68 Fed. Reg. 30214 (2003). Other legislative proposals include: "requiring specialty hospitals to accept Medicaid and indigent patients, requiring the same quality and patient-safety standards for specialty and general hospitals, requiring specialty hospitals to have full-service emergency departments, and enacting certificate-of-need laws aimed at curbing excess capacity." *Specialty Hospital Building Boom Threatens General Hospitals—Health Care Construction in Focus,* HEALTHCARE REV., Sept. 16, 2003, *available at* http://articles.findarticles.com/p/articles/mi_m0HSV/is_8_16/ai_108195480 (last visited June 30, 2004). Administrators of general hospitals have undertaken a variety of initiatives to discourage physician investment in specialized facilities, including: building their own specialty facilities, forming joint ventures with local physicians, or attempting to offer physicians some of the advantages of a freestanding facility, such as improved scheduling and staffing. *See id.* In a more controversial effort, some general hospitals have sought to discourage physician investment in competing specialized facilities by denying admission privileges to new physicians who have a financial interest in a competing facility. *See* Mahan v. Avera St. Luke's Hospital, 621 N.W.2d 150, 153 (S.D. 2001).

16. *See* Hospital Investment Act of 2003, H.R. 1539, 108th Cong. §§ 1–2 (2003); The Prescription Drug and Medicare Improvement Act of 2003, H.R. 1, 108th Cong. § 453 (2003).

17. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 § 507 (2003).

care markets.[18]

As the self-referral moratorium edges closer to its mandated expiration date, policymakers should examine the role that self-referral plays in the development and operation of local specialty hospitals and carefully review the upcoming self-referral studies. In addition, policymakers should anticipate a return to the debate regarding the enactment of self-referral limitations and a renewed discussion of the previously proposed federal restrictions. However, certain aspects of the proposed federal self-referral legislation may diminish the restrictions' effectiveness in limiting physician self-referral, particularly in areas where physician-owned specialty hospitals have an established presence. Therefore, lawmakers must familiarize themselves with the complex issues that surround physician self-referral at specialty hospitals and closely examine the previously proposed statutory limitations. This Comment will provide an overview of the issues and highlight potential problems with proposed self-referral limitations.

Part II of this Comment provides background concerning specialty hospitals, including what types of facilities are considered specialty hospitals and data regarding prevalence, proliferation, and physician ownership. Part III provides an overview of the debate concerning the enactment of self-referral limitations for physician investors in specialty hospitals. Included in this section is a more detailed description of concerns regarding physician self-referral and patient selection by physician investors in specialty hospitals. The contentions of commentators who oppose self-referral restrictions are discussed and criticized. Part IV describes ethical standards promulgated by professional organizations, provides a brief overview of existing federal and state self-referral legislation, and addresses the applicability of existing legislation to physician investors in specialty hospitals. Part V reviews the proposed federal legislation and the moratorium imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Part VI provides a discussion of potential flaws in the self-referral proposals and concludes with some recommendations for legislators.

II. SPECIALTY HOSPITALS

A. Definition

Generally, specialty hospitals are health care facilities that focus on performing certain procedures or on treating patients with particular diseases

18. *See id.*

or conditions.[19] In 2003, the U.S. General Accounting Office ("GAO") completed two major studies regarding specialty hospitals.[20] GAO researchers classified a hospital as a specialty hospital if more than two-thirds of its Medicare patients fell into no more than two major diagnosis categories, such as cardiac or surgical patients.[21] This group of hospitals was further classified into five specialization categories: cardiac, orthopedic, surgical, women's, and other specialty hospitals.[22]

B. Prevalence and Proliferation

Specialty hospitals represent a small but burgeoning presence in the national health care market.[23] In an April 2003 GAO report, researchers identified ninety-two existing cardiac, orthopedic, surgical, and women's specialty hospitals in operation as of February 2003.[24] GAO researchers also noted a rapid increase in the number of specialized facilities in the recent past; the number has tripled since 1990,[25] with at least another twenty specialty hospitals under development.[26] According to a study released by the Center for Studying Health System Change,[27] a Washington, D.C. health policy research organization, there are three factors that appear to be driving the specialty hospital boom: (1) relatively high private and government insurer reimbursements for certain procedures; (2) physicians' desire for greater control over working conditions and management decisions; and (3) physicians' desire to increase their income in the face of reduced

19. *See* U.S. GENERAL ACCOUNTING OFFICE, *Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served*, GAO-03-683R, at 1 (Apr. 2003) [hereinafter GAO REPORT, Apr. 2003].

20. *See id.*; *see also* GAO REPORT, Oct. 2003, *supra* note 14.

21. *See* GAO REPORT, Oct. 2003, *supra* note 14, at 2.

22. *See id.*

23. *See* GAO REPORT, Apr. 2003, *supra* note 19, at 3.

24. *See id.* In addition to its examination of prevalence, the April study compared the patients served by specialty hospitals with those treated in general hospitals in terms of severity of illness and the extent to which physicians have investment interests in such facilities. *See id.* at 1.

25. *Id.* at 3.

26. *Id.* Recent legislative action has dramatically altered the number of facilities "under development." In September 2003, after the Ohio House of Representatives passed a two-year moratorium on the construction of specialty hospitals, at least fifty-six notices of intent to build new specialty hospitals were filed with the state in order to qualify under the bill's grandfather clause. *See* Mark Taylor, *Deadline Dash in Ohio: Legislative Limit on Specialty Hospitals May Backfire*, MOD. HEALTHCARE, Oct. 6, 2003, at 12.

27. The Center for Studying Health System Change is a nonpartisan policy research organization located in Washington, D.C. that designs and conducts studies focused on the U.S. health care system. For HSC information, see http://www.hschange.com/index.cgi?file=about (last visited June 27, 2004).

reimbursement for professional services by capturing a portion of facility profits.[28]

C. Geographic Concentration

In October 2003, GAO researchers reported that the distribution of specialized hospitals is concentrated in states where state policy is least restrictive of hospital growth.[29] While twenty-eight states have at least one specialty hospital, the vast majority of these facilities—two-thirds of the identified specialty hospitals—are located in seven states where hospitals are permitted to expand capacity or build new facilities without seeking state approval or demonstrating a community need.[30] In addition, the October GAO report indicated that the twenty-six specialty hospitals under development in 2003 reflected the existing pattern of geographic concentration, with one hundred percent of developing facilities located in states without health care capacity controls.[31]

D. Physician Ownership

While specialty hospitals, such as children's and rehabilitation hospitals, have existed for generations, the recent proliferation of specialized facilities involves a new genre of hospitals: for-profit facilities that are owned entirely or in part by physician investors.[32] The April 2003 GAO report found that more than ninety percent of the specialty hospitals opened since 1990 were for-profit facilities.[33] The GAO also noted that "seventy percent of the specialty hospitals in existence or under development had [at least] some physician owners," with physicians averaging slightly more than fifty percent ownership.[34] Approximately twenty percent of specialty hospitals were

28. *See* Kelly J. Devers et al., *Specialty Hospitals: Focused Factories or Cream Skimmers?* Issue Brief No. 62, CENTER FOR STUDYING HEALTH SYSTEM CHANGE (Apr. 2003), http://www.hschange.com/CONTENT/552/; *see also* Reed Abelson, *Generous Medicare Payments Spur Specialty Hospital Boom,* N.Y. TIMES, Oct. 26, 2003, at A1, A20.

29. *See* GAO REPORT, Oct. 2003, *supra* note 14, at 3–4. Approximately half of the states did not have such regulations at the time of the study. *Id.* at 4 n.6. In addition to research regarding geographic concentration, the GAO examined how specialty hospitals compare to general hospitals in providing emergency care and other community needs and how specialty and general hospitals compare in terms of market share and financial health. *Id.* at 2.

30. *See id.* at 11. The seven states are Arizona, California, Kansas, Louisiana, Oklahoma, South Dakota, and Texas. *Id.*

31. *See id.*

32. *See* GAO REPORT, Apr. 2003, *supra* note 19, at 1.

33. *See id.* at 2. Overall, 74% of specialty hospitals are for-profit, as compared to about 20% of all general Medicare service hospitals. *See id.*

34. *See* GAO REPORT, Apr. 2003, *supra* note 19, at 4. Nearly all the specialized hospitals with physician owners reported that some of the physicians were members of a single group practice, and

owned almost entirely by physicians.[35] In addition, while GAO researchers reported that individual physicians owned relatively small shares of their hospitals—the average individual share being less than two percent at half the specialty hospitals—"nearly all [of the identified] specialty hospitals with physician owners reported that some of the owners were members of a single group practice."[36] In fact, "[i]n about 1 in 10 specialty hospitals, physicians in a single group practice owned 80 percent or more of the hospital."[37]

III. THE DEBATE REGARDING LIMITATIONS ON SELF-REFERRAL BY PHYSICIAN INVESTORS IN SPECIALTY HOSPITALS

A. Supporters of Self-Referral Restrictions

Many assert that physician ownership of specialty hospitals is problematic and have advocated limitations on self-referral by physicians with financial interests in specialty hospitals.[38] These commentators generally focus on two prominent concerns: physician self-referral and patient credentialing and selection.[39]

1. Physician Self-Referral

According to many commentators, past empirical research strongly suggests that the self-referral arrangements between physicians and specialty hospitals will result in increased utilization of medical services, creating unnecessary inflations in cost and exposing patients to avoidable risks.[40] In the early 1980s, concern regarding the referral practices of physicians with investment or ownership interests in nonhospital facilities, such as clinical laboratories, outpatient surgery centers, diagnostic and imaging centers, and durable medical equipment companies, motivated a number of studies.[41] In 1981, the Michigan Department of Social Services examined the difference

single group practices owned 80% or more in one out of ten specialty hospitals. *Id.* at 10.

35. *Id.* at 8. In the April GAO report, only 5% of specialty hospitals had physician ownership of less than 20%. *Id.* at 8–9. Physicians tended to own smaller percentages of cardiac specialty hospitals (31%), while physicians owned 70% of surgical specialty hospitals. *Id.* at 9.

36. *See id.* at 10.

37. *Id.*

38. *See* GAO REPORT, Oct. 2003, *supra* note 14, at 1–2.

39. *See id.* at 1.

40. *See, e.g.*, Medicare Physician Self-Referral—A Bill to Keep Specialty Hospitals From Skirting the Intent of the Law, U.S. House of Representatives, 107th Cong., (July 12, 2001) (statement of Congressman Pete Stark), http://www.house.gov/stark/documents/107th/hospital investstate.html (last visited Jan 17, 2004); GAO REPORT, Oct. 2003, *supra* note 14, at 1.

41. Theodore N. McDowell, Jr., *Physician Self Referral Arrangements: Legitimate Business or Unethical "Entrepreneurialism,"* 15 AM. J.L. & MED. 61, 62–63 (1989).

between patient referrals to clinical laboratories by physician-owners and referrals by nonowners.[42] Researchers found that patients referred by physician-owners had forty-one percent more tests than those referred by nonowners.[43] In April 1989, the Office of the Inspector General of the U.S. Department of Health and Human Services ("HHS"), reported that physicians who owned or invested in independent clinical laboratories referred Medicare patients for forty-five percent more laboratory services than physicians without such interest.[44]

Researchers in California analyzed the effects of physician self-referral on physical therapy, psychiatric evaluation, and magnetic resonance imaging (MRI) services covered under California's workers' compensation law in 1992.[45] The study compared self-referral patterns of physician investors to referral patterns of physicians who directed patients to independent facilities.[46] Researchers found patients were referred for physical therapy twice as often by physician investors.[47] In addition, the costs of psychiatric evaluation services were significantly higher in the self-referral group.[48] Finally, the study noted that of all the MRI scans requested by the self-referring physicians, thirty-eight percent were found to be medically inappropriate, as compared to twenty-eight percent of those requested by physicians in the independent-referral group.[49]

By the mid-1990s, multiple private, state, and federally funded studies confirmed previous findings, demonstrating a dramatic increase in the frequency and expense of medical services provided when self-referral arrangements exist.[50] The increases in utilization and expense caused

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42. *See* HHS Report, May 1989, *supra* note 11, at 3.

43. *See id.*

44. *See id.* at 18.

45. *See* Alex Swedlow et al., *Increased Costs and Rates of Use in the California Workers' Compensation System as a Result of Self-Referral by Physicians*, 327 NEW ENG. J. MED. 1502 (1992).

46. *Id.* at 1503.

47. *Id.*

48. *Id.* at 1504.

49. *Id.*

50. *See* D. Hemenway et al., *Physicians' Responses to Financial Incentives-Evidence From a For-profit Ambulatory Care Center*, 322 NEW ENG. J. MED. 1059 (1990) (finding that physicians increased the number of laboratory tests performed per patient visit by 23% when their compensation was linked to the gross income they generated individually); Bruce J. Hillman et al., *Physicians' Utilization and Charges for Outpatient Diagnostic Imaging in a Medicare Population*, 268 JAMA 2050 (1992) (finding that physicians who own imaging technology order diagnostic imaging in the evaluation of their patients significantly more often than physicians who refer imaging examinations to radiologists); B.J. Hillman et al., *Frequency and Costs of Diagnostic Imaging in Office Practice—A Comparison of Self-Referring and Radiologist-Referring Physicians*, 323 NEW ENG. J. MED. 1604

significant escalations in costs.[51] For example, a study in Florida concluded that Medicare costs in 1990 would have been approximately ten million dollars less if physicians with a financial interest in imaging centers ordered imaging services at the same rates as other Florida physicians.[52]

2. Patient Credentialing and Selection

The ability of physician investors to self-refer patients to specialty hospitals forms the basis of another prominent concern: the tendency of specialty hospitals and individual physician investors to select the most profitable patients. The financial value of patient selection requires an understanding of the Medicare Prospective Payment System ("PPS"). Before the system was in place, physicians and hospitals were reimbursed by third-party payers based on the actual costs incurred in caring for a particular patient.[53] Hospitals, physicians, and patients had no incentive to contain the number or expense of services utilized in the course of treatment.[54] Indeed, hospitals and physicians, who were compensated for each service provided, had incentives to expand services and extend the patient's length of stay.[55] In an effort to combat these incentives and stem rapidly rising costs, Medicare implemented the PPS in 1983.[56]

The PPS was designed to give providers cost-cutting incentives by

(1990) (finding that physicians who used imaging equipment located in their offices (self-referring) ordered imaging examinations at least four times more often than physicians who referred their patients to radiologists for imaging services); Jean M. Mitchell & Elton Scott, *Physician Ownership of Physical Therapy Services: Effects on Charges, Utilization, Profits, and Service Characteristics,* 268 JAMA 2055 (1992) (finding that per patient visits were 39% to 45% higher at freestanding physical therapy and rehabilitation facilities owned by referring physicians and that gross and net revenue per patient were 30% to 40% higher in such facilities; also finding that joint ventures involving physicians generate more of their revenues from patients with well-paying insurance); Jean M. Mitchell & Jonathon H. Sunshine, *Consequences of Physicians' Ownership of Health Care Facilities—Joint Ventures in Radiation Therapy,* 327 NEW ENG. J. MED. 1497 (1992) (finding that the frequency and costs of radiation therapy treatments at free-standing centers in Florida were 40% to 60% higher than in the rest of the United States; 44% of the centers in Florida were joint ventures with physician owners, compared to 7% of centers located elsewhere.).

51. *See* Mitchell & Sunshine, *supra* note 50, at 1499.

52. *See id.* In addition to staggering increases in costs, the referral of patients for unnecessary diagnostic or therapeutic procedures exposes individual patients to unnecessary risks and may adversely affect an individual patient's health. *See Medicare "Self-Referral" Law: Hearing Before the Subcommittee on Health of the House Committee on Ways and Means,* 106th Cong. (May 13, 1999) (statement of D. McCarty Thornton, Chief Counsel to the Inspector General, Office of the Inspector General, U.S. Department of Health and Human Services), http://waysandmeans.house.gov/hearings.asp?formmode=archive&hearing=191 (last visited Jan. 17, 2004).

53. *See* RODWIN, *supra* note 6, at 15.

54. *Id.*

55. *Id.*

56. *Id.*

providing reimbursement at a fixed amount irrespective of the actual costs of caring for a patient.[57] The Medicare PPS assumes that treating patients with the same diagnosis should cost roughly the same amount; therefore, Medicare will pay a predetermined amount based upon the "Diagnosis Related Group" into which a Medicare patient's condition falls.[58] Because the actual cost incurred is not a factor in determining reimbursement, the PPS provides a strong financial incentive to decrease the cost of patient care.[59] Likewise, because Medicare payments are not reduced if fewer services are needed, providers can benefit financially if they select patients who are less medically complicated.[60]

Specialty hospitals may indirectly select profitable patients by limiting the scope of services they provide.[61] While this strategy may be troublesome, clearly the more concerning aspect of profitable patient selection at physician-owned specialty hospitals is that physician self-referral at specialty hospitals may promote "patient credentialing" by physician investors.[62] Patient credentialing[63] is the physician's use of an individual patient's medical or

57. *See generally* James F. Blumstein, *The Fraud and Abuse Statute in an Evolving Health Care Marketplace: Life in the Health Care Speakeasy*, 22 AM. J. L. & MED. 205, 208 (1996).

58. Diagnostic Related Groups are the basis for Medicare Part A payments under the prospective inpatient payment system. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., *Acute Inpatient Prospective Payment System*, *available at* http://www.cms.hhs.gov/providers/hipps/background.asp (last visited Jan. 24, 2004).

59. *See* GAO REPORT, Oct. 2003, *supra* note 14, at 6.

60. In a March 2000 report, the Medicare Payment Review Advisory Commission ("MedPAC") noted the costs incurred providing care for patients who are more seriously ill may be substantially higher. *See* GAO REPORT, Apr. 2003, *supra* note 19, at 12 n.11. MedPAC recommends that the DRG system be refined to reflect illness severity more accurately. Specifically, MedPAC recommends that the number of DRG categories be expanded to reflect more fully coexisting conditions and complications, and that the calculation of the DRG's relative weights be modified to reflect better the relative costliness of cases across DRGs. MEDICARE PAYMENT ADVISORY COMMISSION, *Report to the Congress: Rethinking Medicare's Payment Policies for Graduate Medical Education and Teaching Hospitals*, at 9 (Aug. 1999), http://www.medpac.gov/publications/congressional_reports/august99.pdf (last visited Jan. 17, 2004).

61. Critics contend specialty hospitals concentrate on services that are subject to better rates of reimbursement. *See* GAO REPORT, Oct. 2003, *supra* note 14, at 1.

62. The author has not observed the use of the term "patient credentialing" in the literature. The term "economic credentialing" has been used in the context of the physician-hospital relationship to describe a hospital's use of economic criteria in determining a physician's qualifications for medical staff membership or privileges. *See* COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AM. MED. ASS'N, Policy Statement H-230.975, *available at* http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/H-230.975.HTM (last visited Oct. 1, 2004).

63. The practice of patient credentialing can be considered analogous to the process of ratemaking by health insurers. A health insurer attempts to achieve an accurate estimate of future losses based upon the characteristics and historical data of a certain population. *See* CONGRESSIONAL RESEARCH SERVICE, INSURING THE UNINSURED: OPTIONS AND ANALYSIS, House

financial information to determine the relative financial risk of caring for that patient.[64]

Physician investors in specialty hospitals are uniquely positioned to engage in patient credentialing and selection because they have largely unrestricted access to their patients' medical, insurance, and employment information, as well as the ability to refer patients to the facility of their choosing (within the constraints of health insurers). Riskier patients, both medically and financially, can be referred to facilities in which the physician does not have a financial interest.[65]

Patient credentialing may have a significant negative impact on competing community hospitals.[66] Unlike physicians, general hospitals have limited access to information and generally do not restrict or control patient admissions based upon severity of illness. Federal legislation also prohibits some general hospitals from turning away patients based upon their ability to pay.[67] Numerous commentators assert that drawing away profitable patients frustrates the ability of general hospitals to fulfill the broader needs of the community, such as the need for charity care, emergency services, and

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Comm. On Education & Labor, Comm. Print (1988), *excerpted in* HEALTH LAW: CAES, MATERIALS AND PROBLEMS, *supra* note 8, at 512–15. It is distinguished from the ratemaking process, however, in that insurers generally use historical or experience ratings based upon a segment of the population, whereas patient credentialing focuses on an individual patient's medical and financial status. *Id.*

64. In recent literature, this process is referred to as "cherry-picking" or "cream-skimming." *See* Joe Manning, *GAO Hospital Report Finds Disparities*, MILW. J. SENTINEL, Oct. 23, 2003, at 3D (reporting that U.S. Rep. Jerry Kleczka (D-Wis.) asserted that "specialty hospitals 'cherry pick'" healthier patients, leaving sicker, costlier patients for the general, not-for-profit hospitals); *see also* Leigh Page, *Battle Lines: Acute Care and Specialty Hospitals Square Off in Turf Wars Over Lucrative Medical Procedures,* MOD. PHYSICIAN, Mar. 1, 2003, at 14 (noting that acute-care hospitals complain that physician investors send the more lucrative cases to the specialty hospital in which they have a financial interest, leaving less profitable patients for local general hospitals). The term "patient credentialing" is used here as synonymous with, but more descriptive than, "cherry-picking." The author notes that most health care consumers, particularly those in need of intense services, such as angioplasty or cardiac bypass surgery, do not regard themselves as "cherries." *Id.*

65. *See* Page, *supra* note 64, at 14.

66. Trudi L. Matthews, *The Debate Over Specialty Hospitals,* 46 STATE GOV'T NEWS 28 (2003).

67. In 1986, Congress enacted EMTALA to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act requires Medicare-participating hospitals that offer emergency services to provide a medical screening examination for an emergency medical condition regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for all patients with EMCs. *See* Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. §§ 1395dd (implementing regulations at 42 C.F.R. § 489.24). Many specialty hospitals do not offer emergency services, and therefore are not subject to EMTALA requirements. *See* GAO REPORT, Oct. 2003, *supra* note 14, at 17. In 2003, GAO researchers noted that only 45% of specialty hospitals in existence had emergency departments, compared with 92% of general hospitals. *See id.* Notably, less than half of the emergency departments at specialty hospitals were staffed by physicians twenty-four hours per day. *Id.* at 20.

standby capacity to respond to community-wide disasters.[68]

There is empirical evidence that physician-owned specialty hospitals tend to select less medically complicated, and therefore more profitable, patients.[69] In 2003, the GAO compared the inpatient discharge data from twenty-five urban specialty hospitals to the discharge data from local general hospitals.[70] Researchers used a widely recognized system to assign an illness severity level to each patient.[71] The analysis revealed that eighty percent of the specialty hospitals examined[72] treated fewer severely ill patients than local general hospitals.[73] For example, GAO researchers noted that three percent of the patients at one Texas orthopedic hospital were classified as severely ill, while eight percent of patients with similar diagnoses were classified as severely ill at the fifty-one general hospitals in the same urban area.[74] Researchers also noted that "[f]or all four specialty hospital categories—cardiac, orthopedic, surgical and women's—the median share of severely ill patients treated was lower than the median share of severely ill patients in the same diagnostic categories treated at corresponding general hospitals."[75]

There is also evidence that specialty hospitals tend to select more profitable patients based on public program participation.[76] In the October 2003 GAO report, researchers noted that specialty hospitals tended to treat a lower percentage of Medicaid participants than general hospitals across all four specialization classifications.[77] For example, while approximately five percent of surgical patients served at general hospitals were Medicaid participants, such patients comprised only one percent at specialty hospitals.[78]

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68. *See id.* at 1; *See also* Tony Fong, *Competitive Risks: Specialty Hospitals Criticized at Justice, FTC Hearings for Endangering Community Facilities*, MOD. HEALTHCARE, Mar. 31, 2003, at 6; S.B. 828 §§ 1(c)–(f), 2003–04 Reg. Sess. (Cal. 2003) (finding that "[t]he ability of a hospital to continue to provide emergency services to California's insured and uninsured patients is threatened by so-called 'boutique hospitals'"). This drawing away of profitable patients has also created significant tension between physicians and some general hospitals, particularly when general hospitals seek to stop their losses by denying privileges to physician investors in competing facilities. *See* Reed Abelson, *Barred as Rivals, Doctors See Some Hospitals in Court*, N.Y. TIMES, Apr. 13, 2004, at C1.

69. *See* GAO REPORT, Apr. 2003, *supra* note 19, at 11.

70. *Id.*

71. *Id.* The system is referred to as the All Payer Refined Diagnosis Related Groups. *Id.*

72. *Id.* The specialty hospitals were located in eighteen urban areas in six states: Arizona, North Carolina, New Jersey, New York, California, and Texas. *Id.*

73. *Id.* at 12.

74. *Id.*

75. *Id.*

76. *See* GAO REPORT, Oct. 2003, *supra* note 14, at 20.

77. *See id.*

78. *Id.*

Similarly, while six percent of patients receiving cardiac services at general hospitals were Medicaid participants, such patients accounted for only three percent of those treated at cardiac specialty hospitals.[79]

B. Opponents of Self-Referral Restrictions

Opponents of prohibitions on physician self-referral at specialty hospitals contend that initiatives to restrict self-referral are premature and have been pursued without clear evidence of a linkage between increased utilization and physician ownership of specialty hospitals.[80] However, past research regarding physician self-referral has demonstrated a significant increase in utilization when physicians self-refer patients to imaging facilities, laboratory facilities, freestanding physical therapy and rehabilitation facilities, radiation therapy treatment centers, and psychiatric treatment centers.[81] Critics of self-referral prohibitions often neglect these studies or fail to offer a rationale for asserting that physician self-referral at specialty hospitals is unlikely to result in similar outcomes.[82]

Other opponents of self-referral restrictions assert that such limitations are anticompetitive and are not intended to address the conflict of interest confronted by physician investors, but rather represent "a misguided attempt to keep free-market forces from working some magic in the woefully inefficient health care services sector" by curbing the growth of specialty hospitals.[83] Indeed, although the 2003 moratorium merely prohibits self-referral by physician investors in newly developed specialty hospitals, a fact widely misunderstood and misreported by the popular press, the self-referral moratorium is generally regarded as a significant impediment to the

79. *Id.* See also Heidi R. Centrella, *General Acute-Care Hospitals Compete With Specialty Hospitals For Profitable Patients*, J. REC. (Oklahoma City), June 21, 2004, for a report that a local general hospital showed a net profit of nearly $39 million, (about $71,000 profitability per bed) with 41% of patients in Medicare and 19% in Medicaid. On the other hand, a neighboring orthopedic specialty hospital showed a net profit of about $17.6 million (nearly $1 million profitability per bed), with only 11% of patients in Medicare and 0% of patients in Medicaid. *See id.*

80. *See* Clark Bell, *Legal Interference: When It Comes to Specialty Hospitals, Let the Market Decide*, MOD. HEALTHCARE, Mar. 29, 2004, at 20; *see also* Sarah Swartzmeyer & Carrie Norbin Killoran, *Specialty Hospital Ban was Premature; Studies Would Have Shown Whether Those Facilities Help or Harm Healthcare*, MOD. HEALTHCARE, Jan. 12, 2004, at 21.

81. *See supra* note 50 and accompanying text.

82. *See* Swartzmeyer & Norbin Killoran, *supra* note 80, at 21. These critics also overlook the possibility that while pending research may not demonstrate an increase in utilization, such research may conclude that self-referral practices of physician investors at specialty hospitals results in the questionable practice of patient credentialing and selection.

83. *See* Bell, *supra* note 80, at 20; *See also* Julie Piotrowski, *Niche Facilities Hit; Moratorium Raises New Self-Referral Issues For Docs*, MOD. HEALTHCARE, Dec. 22, 2003, at 28.

development of specialty hospitals.[84] This supposition underscores the extent to which physician self-referral is the linchpin of specialty hospitals' financial success and begs the question: If specialty hospitals provide superior care, why is the financial viability of specialty hospitals threatened when physician self-referral is restricted or eliminated?

In addition, these "let-the-market-decide" commentators appear to rely on free-market principles in an industry that is so heavily and extensively regulated it is difficult to conceive of it as a competitive free market.[85] Ideally, a free-market system produces the most efficient allocation of resources.[86] However, market failures occur when the essential characteristics of a free market, including a competitive environment in which no one buyer or seller is large enough to influence price, do not exist.[87] As the authors of a Congressional Budget Report on rising health care costs noted,

> To achieve such efficiencies . . . free markets must operate under certain conditions. They work best when the consumer has good information about the characteristics of products and their prices . . . . In addition, market efficiency requires that a large number of sellers compete with each other over prices that reflect true resource costs. With a large number of sellers, no single vendor has the power to control prices, and price competition among sellers lowers prices to the point that they reflect the marginal costs of production. The

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84. Bruce Jaspen, *Medicare Law a Brake on Specialty Hospitals*, CHI. TRIB., Jan. 8, 2004, BUSINESS ZONE C, at 3 (stating that "[t]he Medicare reform package . . . put an 18-month moratorium on the development of new specialty hospitals"); Marsha Austin, *Bill Targets Specialty Hospitals by Barring Referrals*, DENVER POST, Jan. 28, 2004, BUSINESS, at C1 (stating that "[l]ate last year Congress put an 18-month moratorium on payments to new specialty hospitals"); Amy Goldstein, *Medicare Law Stunts Hospital Rival; Growth of Specialty Care Centers Slowed While Impact Studied*, WASH. POST, Dec. 16, 2003, at A35 (claiming the Medicare law will "slow the development of [specialty] hospitals by forbidding physicians to make new investments in them for the next 18 months").

85. Others argue that a *laissez faire* approach does not recognize the public service responsibilities of hospitals. *See* Bill Walsh, *Breaux Targets Doctors' Specialty Hospitals; Advocates Contend Care There is Superior*, TIMES-PICAYUNE (New Orleans), Oct. 20, 2003, at 1.

86. *See* CONG. BUDGET OFFICE, ECON. IMPLICATIONS OF RISING HEALTH CARE COSTS (1992), *excerpted in* HEALTH LAW: CASES, MATERIALS AND PROBLEMS, *supra* note 8, at 478. In the ideal free market, "[s]ellers' behavior, expressed as supply, interacts with buyers' behavior, expressed as demand, at the point of equilibrium which determines market price. This price reflects the point at which the amount of goods buyers want to purchase equals the amount of goods sellers wish to sell. At any other price, buyers and sellers would have incentives to change their behavior until the quantities supplied and demanded become mutually consistent." Julie E. Mathews, The Physician Self-Referral Dilemma: Enforcing Antitrust Law as a Solution, 19 AM. J. L. & MED. 523, 529–530 (1993) (citations and footnotes omitted).

87. James L. Huffman, The Impact of Regulation on Small and Emerging Business, 4 J. SMALL & EMERGING BUS. L. 307, 312 (2000).

market for health care, however, does not meet many of these conditions.[88]

In the present health care system, market failure occurs because, among other reasons, the federal government fixes the price for services.[89] Under an economic theory of regulation, when market failures occur, regulations such as the proposed self-referral restrictions are necessary in order to promote social welfare.[90]

Furthermore, these same free-market proponents abandon their *laissez faire* assertions and seek government intervention when community hospitals react competitively and deny or withdraw the privileges of physicians who invest in and refer to competing specialized facilities.[91] This seems to result in the untenable position that a physician should be permitted to engage in economic credentialing of his or her patients, but legislation should be enacted (or existing legislation interpreted) to prevent hospitals from the economic credentialing of physicians.

However, the contention that specialty hospitals should not be targeted by self-referral legislation is not without merit. If the growth and development of specialty hospitals is detrimental to local health care markets, initiatives should be undertaken to address this problem by legislative or administrative initiatives that are separate from those intended to address physician conflicts of interest.

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88. *See* CONG. BUDGET OFFICE, *supra* note 86, at 478.

89. According to one author:

> [T]he health care market [in the U.S.] "departs substantially from competitive conditions." Due to the nature of the health care industry, market failures prevent competition from achieving its potential. Such failures endemic to the health care market include payment by insurance companies for most of patients' health care expenses without regard to cost and appropriateness of care, thus increasing patients' incentives to demand all of the care the doctor recommends, and increasing physicians' incentives to render more care than patients may truly need. Provider influence over the market through collusive behavior reflects another health care market failure. This influence reduces the benefits of competition which occur when providers act independently.

Mathews, *supra* note 86, at 530 (citations and footnotes omitted).

90. *See id.*

91. *See* Leigh Page, *Battle Lines: Acute Care and Specialty Hospitals Square Off in Turf Wars Over Lucrative Medical Procedures*, MOD. PHYSICIAN, Mar. 1, 2003, at 14 (noting that while physician investors in specialty hospitals deny they are skimming away the most profitable patients, acute-care facilities are denying or threatening to deny physicians privileges in an attempt to reduce their losses). Meanwhile, attorneys opposed to these measures suggest that physicians employ federal antikickback laws to prohibit the denial of privileges. *Id.*; *see also* Mark Taylor, *Striking Back at Doc Investors: OhioHealth Pulls Hospital Privileges for Physicians in Largest Revocation to Date*, MOD. HEALTHCARE, Jan. 26, 2004, at 10.

IV. EXISTING SELF-REFERRAL RESTRICTIONS

A. Ethical Considerations

In response to concerns regarding the integrity of the physician-patient relationship, various professional medical associations have established ethical guidelines that either permit self-referral within certain parameters, or prohibit the practice entirely.[92] The American Medical Association Council on Ethical and Judicial Affairs has developed guidelines that discourage, but do not prohibit, self-referral.[93]

In contrast, the American College of Radiology ("ACR") has assumed a more stringent position, prohibiting physician self-referral.[94] According to the ACR:

> The practice of physicians referring patients to health care facilities in which they have a financial interest is not in the best interest of patients. Self-referral may improperly influence the professional judgments of those physicians referring patients to such facilities. When such an arrangement exists, radiologists . . . should make efforts to restructure the ownership of the facility.[95]

Interestingly, the current position of the American College of Radiology regarding physician self-referral differs significantly from its original position.[96] In the early 1980s, the ACR debated the merits and disadvantages

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92. *See U.S. House of Representatives, Ways and Means Comm., Subcomm. on Health*, 106th Cong. (May 13, 1999) (prepared testimony of J. Bruce Hauser, M.D., FACR of the American College of Radiology), *available at* http://www.waysandmeans.house.gov/legacy.asp?file=legacy/health/106Cong/5-13-99/5-13haus.htm (last visited June 27, 2004).

93. *See* "Conflicts of Interest: Physician Ownership of Medical Facilities," adopted Dec. 1991 (JAMA. 1992; 267: 2366-69) and Updated June 1994 ("In general, physicians should not refer patients to a health care facility outside their office practice at which they do not directly provide care or services when they have an investment interest in the facility. . . . 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."). For the updated policy, see AMERICAN MEDICAL ASSOCIATION, E-8.032 Conflicts of Interest: Health Facility Ownership by a Physician, http://www.ama-assn.org/ama/pub/category/8472.html.

94. *See* American College of Radiology Article XIII, § 2, note 4. Code of Ethics 2003–2004 ACR Bylaws (Incorporating ACR Council Changes Approved at the 2003 Annual Meeting), http://www.ama-assn.org/ama/pub/article/7665-4674.html (last visited June 27, 2004).

95. *Id.*

96. *See Medicare "Self-Referral" Law, Hearing Before the Subcomm. on Health of the House Comm. on Ways and Means*, 106th Cong. (May 13, 1999) (statement by J. Bruce Hauser, M.D., FACR, American College of Radiology), http://waysandmeans.house.gov/legacy.asp?file=legacy/health/106cong/5-13-99/5-13haus.htm (last visited Oct. 1, 2004).

of self-referral arrangements and initially adopted a position that radiologists could ethically participate in such ventures, with a warning that financial arrangements should be carefully structured to avoid conflicts of interest.[97] However, in 1988 the ACR policymaking council revised this position after finding that "the potential for, and actual abuse and exploitation of patients by unethical practices, and the flagrant disregard of physicians' ethical responsibilities to the patient to be so great and so pervasive."[98]

B. Legal Restrictions on Physician Self-Referral

1. Federal Legislation

Restrictions on the practice of self-referral exist at both the state and federal levels. In the late 1980s, concern over the consistent and costly increases in utilization that resulted from physician self-referral arrangements led the U.S. Congress to consider legislation directed at physician self-referral. In August 1988, Representative Fortney "Pete" Stark (D-Cal.) introduced H.R. 5198, a bill intended "to provide civil monetary penalties and other remedies for certain improper referral arrangements for services provided under the Medicare program."[99] In 1989, the U.S. Congress passed the Ethics in Patient Referrals Act ("Stark I"),[100] establishing some restrictions on physician self-referral.[101]

Stark I prohibits physicians from referring Medicare patients for clinical laboratory services to entities in which they, or members of their immediate family, have an ownership or investment interest, unless an exception

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97. *See id.*

98. *Id.* The revised ACR policy states:

> The practice of physicians referring patients to health care facilities in which they have a financial interest is not in the best interest of patients. This practice of self-referral may also serve as an improper economic incentive for the provision of unnecessary treatment of services. Even the appearance of such conflicts or incentives can compromise professional integrity. Disclosing referring physicians' investment interests to patients or implementing other affirmative procedures to reduce, but not completely eliminate, the potential for abuse created by self-referral is not sufficient.... The American College of Radiology believes that radiologists and radiation oncologists should make efforts to restructure the ownership interests in existing imaging or radiation therapy facilities because self-referral may improperly influence the professional judgments of those physicians referring patients to such facilities.

Id.

99. Ethics in Patient Referrals Act of 1988, H.R. 5198, 100th Cong. (1988).

100. So-called for the bill's principal sponsor, Rep. Fortney "Pete" Stark.

101. 42 U.S.C. § 1395nn (2000).

applies.[102] In addition, the Act prohibits entities from making a claim for payment under the Medicare program for clinical laboratory services furnished pursuant to a prohibited referral.[103] In 1993, Stark I was expanded by the Omnibus Budget and Reconciliation Act ("Stark II").[104] Stark II extends the prohibitions contained in Stark I to Medicaid programs and expands restrictions to ten additional categories of Designated Health Services.[105]

2. State Legislation

Following the promulgation of the Stark laws and regulations, almost all states enacted self-referral statutes; however, the content of such legislation varies widely.[106] For example, a North Carolina statute provides, "[a] health care provider shall not make any referral of any patient to any entity in which the health care provider or group practice or any member of the group practice is an investor."[107] Other states prohibit self-referral unless the investment interest was established prior to a certain date and the interest is disclosed to patients.[108] In Florida, a health care provider may not self-refer, unless the self-referral relationship meets a number of requirements and the interest is disclosed to patients.[109] Still others permit self-referral, requiring only that

102. An "ownership or investment interest" is defined to include "equity, debt, or other means and includes an interest in an entity that holds an ownership or investment interest in any entity providing the designated health service." *Id.* § 1395nn(a).

103. *Id.* § 1395nn(a)(1)(B).

104. Omnibus Budget Reconciliation Act of 1993 (Stark II), Pub. L. No. 103-66, §13562, 107 Stat. 312 (1993).

105. The ten affected services include the following: physical therapy services; occupational therapy services, radiology services and supplies; radiation therapy services and supplies; durable media equipment and supplies; parenteral and enteral nutrients, equipment, and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services. 42 U.S.C. § 1395nn(h)(6). In 1993, Rep. Pete Stark was unsuccessful in his attempt to expand the self-referral ban to all payers. *See* Comprehensive Physician Ownership and Referral Act of 1993, H.R. 345, 103rd Cong. (1993).

106. For a thorough discussion of various state laws, see Jennifer Herndon Puryear, Comment, *The Physician as Entrepreneur: State and Federal Restrictions on Physician Joint Ventures*, 73 N.C. L. REV. 293 (1994).

107. *See* N.C. GEN. STAT. § 90-406(a) (2003). The statute further provides that any entity that collects payment for services rendered as a result of a prohibited referral must refund such amount to the payor or the individual within ten days. *See* § 90-406(c). Interestingly, as of June 2004, MedCath, Inc., a developer of cardiovascular specialty hospitals incorporated in North Carolina, which operates at least thirteen such facilities across the nation, does not have a specialty hospital located in North Carolina. *See* MedCath Inc. Facilities, http://www.medcath.com/index.aspx?CORE_ElementID=corp_Facilities (last visited June 28, 2004).

108. *See, e.g.*, N.J. STAT. ANN. § 45:9-22.5 (West 1991).

109. *See* FLA. STAT. ANN. § 456.053(5) (West 2001 & Supp. 2004). In the October 2003 GAO report, Florida, which has certificate-of-need legislation and a more developed self-referral statute,

physicians disclose their investment interests to patients.[110]

Interestingly, the seven states in which specialty hospitals are concentrated[111] also have relatively permissive physician self-referral provisions. For example, Arizona, Kansas, Louisiana, Oklahoma, and South Dakota permit physician self-referral arrangements, requiring only that physicians disclose financial interests to patients.[112] Texas allows self-referral unless the referral is for home or community support services and the arrangement violates federal self-referral prohibitions (Stark laws).[113] California prohibits physician self-referral for patients seeking services under California's workers' compensation laws,[114] but allows all other self-referral as long as the physician's return on the investment is not a function of the number of patients referred and the interest is disclosed to patients.[115]

C. Applicability of Legislative Self-Referral Restrictions on Physician Investors in Specialty Hospitals.

While most state provisions simply do not address the self-referral practices of physician investors in specialty hospitals,[116] the Stark self-referral restrictions contain a loophole that permits self-referral by physician investors in specialty hospitals.[117] Under Stark's "whole hospital exception," a referral by a physician with a financial interest in a hospital is not subject to the Stark self-referral prohibition if (1) "the referring physician is authorized to perform services at the hospital" and (2) "the ownership or investment interest is in the entire hospital itself (and not merely in a subdivision of the hospital)."[118] The

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had only one to two specialty hospitals. *See* GAO REPORT Oct. 2003, *supra* note 14, at 12 fig.2.

110. LA. REV. STAT. ANN. § 37:1744(B) (West 2000 & Supp. 2004).

111. *See* GAO REPORT, Oct. 2003, supra note 14, at 11. The seven states are: Arizona, California, Kansas, Louisiana, Oklahoma, South Dakota, and Texas. *Id.*

112. *See* ARIZ. REV. STAT. ANN. § 32-1854(35) (West 2002 & Supp. 2003); KAN. STAT. ANN. § 65-2837(29) (2002); LA. REV. STAT. ANN. 37:1744 (West 2000 & Supp. 2004); OKLA. STAT. ANN. TIT. 59, § 725.4 (West 2000); S.D. CODIFIED LAWS § 36-2-19 (Michie 1999).

113. *See* TEX. HEALTH & SAFETY CODE ANN. § 142.019 (Vernon 2001).

114. *See* CAL. LAB. CODE § 139.3(a) (West 2003 & Supp. 2004).

115. *See* CAL. BUS. & PROF. CODE § 650 (West 2003); *see also* CAL. BUS. & PROF. CODE § 654.1–654.2 (West 2003).

116. *See* Puryear, *supra* note 106.

117. *See* 42 U.S.C. § 1395nn(d)(3) (2003).

118. *See id.* Other Stark exceptions permit physician investment in health care facilities when patient referrals to such entities would result in minimal financial gain or when alternative financing for the development of such entities is not available. *See id.* § 1395nn(c)–(d). For example, a physician is not subject to the referral prohibition if the physician's ownership is in a publicly traded company with $75 million in stockholder equity or by the ownership of mutual funds with total assets exceeding $75 million. *Id.* § 1395nn(c)(1)(B)(2). Additional provisions exclude ownership and investment interests in hospitals in Puerto Rico and rural areas. *Id.* § 1395nn(d)(1)–(2).

term "hospital" is not defined within the statute. Although specialty hospitals tend to resemble a subdivision or subpart of a general hospital because they are relatively small,[119] offer a limited range of services, and may provide a significant stake in profitability, such facilities have been considered "whole hospitals" and fall within the exception. Therefore, physicians who invest in specialty hospitals are currently not subject to Stark self-referral restrictions.

V. PROPOSED LEGISLATION AND THE MORATORIUM

In 2003, two federal bills were proposed to limit self-referral by physician investors in specialty hospitals: the Hospital Investment Act of 2003[120] and the Breaux-Nickles-Lincoln Amendment ("Breaux Amendment") to the Medicare prescription drug bill.[121]

A. The Hospital Investment Act

On April 1, 2003, Representatives Pete Stark (D-Cal.) and Gerald D. Kleczka (D-Wis.) introduced the Hospital Investment Act of 2003.[122] According to Representative Stark, self-referral arrangements with specialty hospitals may induce physician investors to base treatment decisions on financial factors, rather than on the best interests of the patient, the precise behavior the Stark laws were written to prevent.[123] Under the bill, physicians would be prohibited from referring Medicare and Medicaid patients to a specialty hospital in which they have an investment interest unless the interest was purchased on terms generally available to the public.[124] The Act would have applied only to ownership and investment interests purchased on or after July 12, 2001.[125]

B. The Breaux Amendment

A similar amendment, jointly sponsored by Senators John Breaux (D-La.),

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119. GAO REPORT, Apr. 2003, *supra* note 19, at 7. Specialty hospitals are relatively small when compared to general hospitals. While the average short-term general hospital has approximately 170 beds, cardiac specialty hospitals average fifty-nine beds, orthopedic hospitals average twenty-one, surgical hospitals average sixteen, and women's care hospitals average sixty. *Id.* at 8 fig.4.

120. Hospital Investment Act of 2003, H.R. 1539, 108th Cong. §§ 1–2 (2003).

121. Prescription Drug and Medicare Improvement Act of 2003, H.R. 1, 108th Cong. § 453 (2003).

122. Hospital Investment Act of 2003, H.R. 1539, 108th Cong. (2003).

123. *See* Introduction of The Hospital Investment Act, Apr. 1, 2003 Congressman Pete Stark (D-Cal.), http://www.house.gov/stark/news/108th/hospitalinvestmentstate.htm (last visited June 28, 2004).

124. Hospital Investment Act of 2003, H.R. 1539, 108th Cong. § 2(a) (2003).

125. *Id.* § 2(b).

Don Nickles (R-Okla.), and Blanche Lincoln (D-Ark.) was included in the Medicare prescription drug bill.[126] The Breaux Amendment provided that specialty hospitals be specifically excluded from Stark's whole-hospital exemption.[127] A specialty hospital was narrowly defined within the amendment to include only those hospitals that primarily or exclusively provide services to cardiac, orthopedic, surgical, or other specialized categories of patients. In addition, a grandfather clause in the Breaux Amendment provided that a specialized facility in operation or development prior to June 2003 would not be classified as a specialty hospital.[128] However, in order to maintain the exception, such specialized facilities may not increase the number of physician investors or the total number of beds in their facilities.[129]

C. Medicare Prescription Drug, Improvement, and Modernization Act of 2003

In lieu of enacting self-referral prohibitions via the Hospital Investment Act or the Breaux Amendment, the 108th U.S. Congress imposed an eighteen-month self-referral moratorium that mirrors the Breaux Amendment.[130] Under § 507 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the Act),[131] physician investors are prohibited from self-referral if their investment interest is in a specialty hospital not in operation or development as of November 18, 2003.[132] Physician investors are also subject to the self-referral ban if the hospital in which they have a vested interest increases the number of physician investors, changes or expands its field of specialization, expands beyond the main campus, increases the total number of beds, or fails to meet other requirements.[133]

Under the new legislation, "specialty hospitals" include cardiac care and orthopedic hospitals, surgical hospitals, and any other facility that provides specialized services as designated by the Department of Health and Human

126. *See* Patrick Reilly, *Lobbying Offensive: Congress Asked to Limit Physician Investments*, MOD. HEALTHCARE, Sept. 29, 2003, at 8. Prescription Drug and Medicare Improvment Act of 2003, H.R. 1, 108th Cong. § 453 (2003).

127. A specialty hospital was defined within the amendment as a hospital that primarily or exclusively provides services to cardiac, orthopedic, surgical, or other specialized category of patients. *Id.* § 453(a)(7)(A)(i)–(iv).

128. *See id.* § 453(a)(7)(B)(i)(I).

129. *See id.* § 453(a)(7)(B).

130. *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 § 507(a)(I)(B) (2003).

131. *See id.*

132. *See id.* § 507(a)(1).

133. *See id.* § 507(a)(7)(B)(ii)–(v).

Services.[134] Certain hospitals that provide specialized services are not considered specialty hospitals for the purpose of the moratorium, including: psychiatric hospitals, rehabilitation hospitals, children's hospitals, long-term care hospitals, and certain cancer hospitals.[135]

It is important to note what the Act does *not* prohibit. The Act does not restrict or impede the development of, or investment in, specialty hospitals by physicians or other investors.[136] Nor does the Act deny payment for services rendered to a patient referred to an existing specialty hospital, even if a physician investor referred the patient.[137] The Act does not discourage the referral of patients to specialty hospitals by noninvestor physicians.[138] Finally, the Act does not provide that specialty hospitals cannot expand, but merely that if they do so, physician investors may no longer self-refer.[139]

The new legislation also provides that the Medicare Payment Advisory Commission ("MedPAC") must conduct a study comparing specialty hospitals with other similar general acute-care hospitals regarding the number and extent of patients referred by physician investors, the quality of care provided, and the impact of the specialty hospital on the acute-care general hospital.[140] MedPAC must also examine differences between specialty and general hospitals concerning the scope of services furnished, Medicaid utilization, and the amount of uncompensated care provided.[141]

In addition, the Secretary of Health and Human Services (HHS) must provide a report describing "the percentage of patients admitted to physician-owned specialty hospitals who are referred by physicians with an ownership interest, the referral patterns of physician owners, including the percentage of patients they referred to physician-owned specialty hospitals, and the percentage of patients they referred to local full-service community hospitals for the same condition."[142] The HHS study must also investigate differences in quality of care and patient satisfaction and provide data regarding differences in the provision of uncompensated care.[143] Both the MedPAC and

134. *See id.* § 507(a)(7)(A)(i)–(iv).

135. *See* DHHS, CTRS. FOR MEDICARE & MEDICAID SERVS., *CMS Manual System, Pub. 100-20 One-Time Notification*, (Mar. 19, 2004), http://www.cms.hhs.gov/manuals/pm_trans/R62OTN.pdf (last visited June 28, 2004).

136. *See id.* § 507.

137. *See supra* note 133 and accompanying text.

138. *See* § 507.

139. *See id.*

140. *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 § 507(c)(1) (2003).

141. *See id.*

142. *See id.* § 507(c)(2).

143. *See id.*

HHS reports and any recommendations for legislative or administrative changes are expected in the spring of 2005.[144]

VI. RECOMMENDATIONS FOR LEGISLATORS

A. Self-Referral Restrictions Should Focus on Limiting Physician Conflicts of Interest

The congressionally mandated studies will provide critical information with regard to self-referral patterns and will return the attention of policymakers to the previously proposed self-referral restrictions. Certain aspects of the proposed restrictions may discourage the proliferation and expansion of specialty hospitals, but do not effectively limit self-referral and patient credentialing, particularly in states where physicians and specialty hospitals have established relationships. If lawmakers conclude that the growth and development of specialty hospitals is detrimental to local health care markets, legislation should be directed at this issue, but self-referral limitations should be focused exclusively on limiting the conflict of interest that arises for physician investors. In order to effectively limit these conflicts, legislators need to take action.

B. Lawmakers Should Press for Expanded Federal Restrictions on Physician Self-Referral

Because federally enacted legislation enjoys the existence of an effective mechanism of enforcement, specifically the threat of exclusion from Medicare and Medicaid programs,[145] legislators seeking to limit physician self-referral and patient credentialing at specialty hospitals should press for expanded federal restrictions.

1. Lawmakers Should Eliminate Grandfather Clauses Based on Date of Investment

Lawmakers should consider self-referral provisions that are applicable regardless of when or how the financial interest was obtained. When the original physician self-referral laws (Stark laws) were enacted, the U.S. Congress did not include grandfather provisions to allow certain physician investors to continue to self-refer if his or her interest was obtained prior to a

144. The new legislation mandates that the reports are due fifteen months after the date of enactment and are therefore expected sometime during March 2005. *See id.* § 507(c)(3).

145. 42 U.S.C. § 1395nn(g) (2000). Violators of the Stark self-referral prohibitions are subject to a range of civil sanctions, including nonpayment for the services provided, monetary penalties, and the exclusion from Medicare and Medicaid programs. *Id.*

certain date.[146] Under the existing Stark laws, if a physician self-referral arrangement does not fall within one of the specified exceptions, the self-referral prohibition applies regardless of *when* the physician obtained the ownership or investment interest.[147] In contrast, both the Hospital Investment Act and the Breaux Amendment contain provisions permitting self-referral by physician investors in specialty hospitals if certain criteria are met prior to specified dates.[148] In communities where specialty hospitals already have an established presence in the local market, the grandfather clauses contained in both proposals would allow continued physician self-referral.[149]

2. Lawmakers Should Eliminate Grandfather Clauses Based on Date of Hospital Development

Instead of exempting the ownership interests obtained prior to a certain date, a grandfather clause within the Breaux Amendment provides that the specialty hospital itself, if in operation or development prior to June 2003, is not classified as a specialty hospital.[150] Thus, under the whole hospital exception, original physician investors in these existing facilities can continue to self-refer.[151] However, all physician investors become subject to the moratorium if the specialty hospital adds physician investors or capacity. This provision is troublesome because it stifles the growth and development of existing specialty hospitals, reduces the potential for competing specialty hospitals, provides no limits on the self-referral practices of original physician investors, and creates a situation in which an incoming physician could

146. *See id.* § 1395nn.

147. *See id.*

148. The Breaux Amendment's grandfather clause allows physician self-referral if the specialty hospital meets the following requirements: (1) is in existence or development prior to June 12, 2003, (2) does not increase the number of beds or physician investors, and (3) meets other requirements specified. Prescription Drug and Medicare Improvement Act of 2003, H.R. 1, 108th Cong. § 453(a)(1)(B)(7)(B) (2003). Under the Hospital Investment Act, the self-referral prohibition does not apply to ownership and investment interests purchased before July 12, 2001. Hospital Investment Act of 2003, H.R. 1539, 108th Cong. § 2(b) (2003).

149. MedCath Inc., a national chain of cardiac specialty hospitals, has eleven facilities nationwide, all of which would be exempt under the Breaux Amendment: Arkansas Heart Hospital (1997), Tucson Heart Hospital (1997), Arizona Heart Hospital (1998), Heart Hospital of Austin (1999), Dayton Heart Hospital (1999), Bakersfield Heart Hospital (1999), Heart Hospital of New Mexico (1999), Heart Hospital of South Dakota (Mar. 2001), Harlingen Medical Center (Oct. 2002), Louisiana Heart Hospital (Mar. 2003), Heart Hospital of Milwaukee (Oct. 2003), Heart Hospital of San Antonio (under development); Heart Hospital of Lafayette (Fall 2003). *See* MedCath, Inc. 2002 Annual Report 28, *available at* http://ir.thomsonfn.com/InvestorRelations/IRFiles/5531/MedCath Annual.pdf (last visited June 28, 2004).

150. *See* Prescription Drug and Medicare Improvement Act of 2003, H.R. 1, 108th Cong. § 453 (2003).

151. *See supra* Part IV.B. and accompanying notes.

essentially purchase an interest and the ability to self-refer from an original physician investor. Lawmakers should press to eliminate this type of grandfather clause.

3. Lawmakers Should Provide Specific Limitations on Allowable Investment Interests for Original and Future Investors

Empirical research demonstrates a consistent increase in utilization of services when physicians refer patients to facilities in which they have a financial interest.[152] However, such research has not identified at what threshold the financial interest becomes problematic.[153] Therefore, any statutory limitation on the allowable financial interest is essentially a best-guess estimate. Given this absence of data, legislators should consider self-referral restrictions that prohibit the practice entirely, as do existing Stark laws and other statutes that limit professional conflicts of interest.[154] Alternatively, legislators may attempt to draft legislation that limits self-referral to circumstances in which the extent of the physician's financial interest is unlikely to influence referral and treatment decisions. While the former enjoys the advantage of simplicity in drafting and implementation, the latter preserves some freedom of investment.

Both the Breaux Amendment and the Hospital Investment Act allow for continued self-referral by original physician investors, but neither federal proposal limits the extent to which an individual physician, or a physicians' group, can invest in a particular entity.[155] Under both proposals, an individual physician or physicians' group may have a substantial interest in a specialized facility and yet still be permitted to self-refer.

At least one state has enacted legislation that attempts to address this situation.[156] The Florida self-referral statute places restrictions on the allowable investment interest beyond which self-referral is not permitted.[157] The statute provides that if the health care provider's interest is in an entity other than a publicly held corporation, the provider may not self-refer unless, in addition to other requirements, physicians who refer patients hold no more

152. *See supra* note 50 and accompanying text.

153. *See supra* Part III.

154. *See supra* Part I.

155. The Hospital Investment Act restricts self-referral only if the physician's investment interest was obtained on terms available to the general public. *See* Hospital Investment Act of 2003, H.R. 1539, 108th Cong. § 2(a) (2003). The Breaux Amendment allows self-referral unless the facility was not in existence or under development as of November 2003. *See supra* note 141 and accompanying text.

156. FLA. STAT. ANN. § 456.053(5)(a)–(b) (West 2001 & Supp. 2004).

157. *Id.*

than fifty percent of the total investment interests.[158] However, under this statute, the allowable interest is determined in reference to the extent of investment interest held by referring physicians in the entire entity, rather than a determination based upon the individual physician's percentage of ownership interest.[159] Under this scheme, a single physician could own fifty percent of the investment interests.

If lawmakers decide to allow self-referral under specified circumstances, self-referral statutes should contain provisions similar to the Florida statute that limit the extent of allowable investment interests held by referring physicians in the entire entity. This would effectively limit the amount of interest a single physicians' group could obtain in a single entity. In addition, however, lawmakers should limit the amount of interest any individual physician can obtain in a single entity and still be permitted to self-refer to that facility. As stated earlier, in the absence of data, setting such limitations is difficult. Lawmakers should consider that the U.S. Securities and Exchange Commission considers an investment interest that exceeds ten percent significant and requires investors in public companies to submit additional filings with the agency when their interest exceeds this amount.[160] This could be an effective trigger for individual physician investors in specialty hospitals as well.

C. Lawmakers Should Enact or Expand State Legislation

Existing and proposed federal laws place restrictions only on the referral of Medicare and Medicaid patients, permitting self-referral of patients with private health insurance.[161] Because changes in referral behavior affect all patients, irrespective of the reimbursement source, the benefit of self-referral prohibitions should not be limited to those seeking services under Medicare or Medicaid. State legislation is necessary to enact self-referral restrictions that

158. *Id.* The interest must also meet the following additional requirements: (1) "the terms under which an investment interest is offered to [a referring investor] are no different from the terms offered to [nonreferring investors]," (2) "the terms under which an investment interest is offered to [a referring investor] are not related to the previous or expected volume of referrals from that investor," and (3) "there is no requirement that an investor make referrals or be in a position to make referrals to the entity as a condition for becoming or remaining an investor." *See id.* If the interest is in a publicly held corporation, the Florida statute provides that a health care provider may not self-refer unless the corporation's shares are traded on a national exchange and the "total assets at the end of the corporation's most recent fiscal quarter exceeded $50 million." *Id.* Alternatively, shares may be traded on the over-the-counter market. *Id.* The statute does not limit the amount of investment interest that can be held by referring investors in a publicly held corporation. *Id.*

159. *Id.*

160. *See* 15 U.S.C. § 78p(a)(1) (2000).

161. *See supra* notes 99–104 and accompanying text.

apply to all patient referrals, regardless of the payor.

VII. CONCLUSION

Numerous empirical studies have demonstrated that when physicians refer patients to health care providers in which they have a financial interest, there are significant changes in treatment and referral behavior. The result is overutilization of medical services, a consequence that increases the risk of harm for patients and drives up already staggering health care costs. Self-referral by physician investors in specialty hospitals may also promote patient credentialing and favorable patient selection, creating negative consequences for local hospitals that provide a broad range of services, including charity and emergency care.

In 1989, the U.S. Congress enacted the Stark laws to limit physician self-referral. However, Stark's whole hospital exemption, which was intended to exempt investment interests in large general hospitals, also exempts physician investment in specialty hospitals, facilities that tend to be much smaller in size and scope. In addition, most existing state self-referral laws do not prohibit self-referral by physician investors in specialty hospitals.

Policymakers have recognized the need to address this troublesome conflict of interest, and the U.S. Congress considered proposals to amend the whole hospital exemption in 2003. However, in lieu of enacting self-referral restrictions, an eighteen-month moratorium on self-referral by physician investors of newly developed specialty hospitals was imposed.

While the moratorium and proposed federal restrictions may adequately protect the federal government's interests, legislators should carefully examine whether existing state provisions or the proposed federal legislation will adequately limit physician self-referral and patient credentialing in local markets. In light of the limitations identified in this Comment, legislators should consider provisions or amendments that address these issues and effectively limit the conflict of interest that stems from self-referral by physician investors in specialty hospitals.

MAUREEN KWIECINSKI

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