Self-Referral Bill Stands in the Way of Patient Care

Presented on
June 8, 2010

To
The Pennsylvania House of Representatives
Insurance Committee

By
James A. Goodyear, MD, FACS
President

Pennsylvania
MEDICAL SOCIETY®
Doctors and Patients. Preserve the Relationship.®

Good morning. I'm James Goodyear, MD, a general surgeon in Montgomery County and president of the Pennsylvania Medical Society. The Pennsylvania Medical Society represents physicians from every medical specialty throughout the commonwealth. Our mission is to protect the physician-patient relationship.

While the issue of self-referral is vital to those of us providing direct patient care, I frankly believe it is of greater importance to our patients, whose ability to receive quality, timely, safe, and convenient health care services could be adversely affected if this bill becomes law.

Let me begin by thanking Chairman Deluca and the members of this committee for the opportunity to share our strong opposition to House Bill 2522 and why we believe that it is a solution looking for a problem. We welcome this opportunity as we all strive to provide the best care possible for all Pennsylvanians.

I am not an expert on the complexities of self-referral law. There are attorneys and others who dedicate their entire careers to mastering this complex subject. I would like you and the members of this committee to know that I do not have an ownership interest in any ancillary facility, imaging center, or laboratory service.

Beginning in 1989, and again in 1993, the federal government enacted Stark I and II. These laws were an effort to remove potential conflicts of interest when physicians refer Medicare patients to health care facilities in which they have a financial relationship. It took the federal government more than 10 years to develop regulations to address the many unintended consequences of these laws. Twenty years later, regulators continue to develop new exceptions as they identify "good" self-referral practices that have otherwise been prohibited. Make no mistake, physician self-referral is extremely complex and is the most heavily regulated area of medical practice today.

Some of you may view self-referral with a jaundiced eye, believing that having a financial relationship in a facility drives physicians to perform unnecessary procedures or order unnecessary tests. I believe physicians would not violate their professional ethics or risk harm to their patients for a few extra bucks.

So what motivates physicians to create physician-owned ancillary surgical centers, also known as ASCs? In many cases, physicians join together to establish these facilities out of frustration with hospital administrators. These centers often result in lower cost, better quality, and safer and more patient-friendly medical care.

Let me highlight some examples of how these centers do that.

My first example demonstrates how gastroenterologists stepped in to fill a void. In the early 1980s, hospital administrators often turned down requests for costly colonoscopy equipment in favor of more lucrative procedures.

Then, as now, physicians are frequently frustrated by constraints imposed by hospital administrators, such as inadequate staffing for operating rooms or slow acquisition of new technologies. In the case of colonoscopies, gastroenterologists met their patients' need to access quality care by establishing endoscopy centers in their communities. As a result, these physicians revolutionized colorectal screening and saved countless lives through early cancer detection.

Surgeons who join together to establish an ASC are more freely able to make management decisions that vastly improve quality of care, productivity, and patient satisfaction. The ASC can schedule procedures, maintain appropriate staffing levels, and purchase the needed supplies and equipment. These decisions are made in the best interest of both patients and physicians and are not influenced by the need to redirect financial resources to buy a new helicopter, remodel an emergency room or hospital atrium, or build a new hospital.

Even though I don't have a financial relationship with my local surgery center, when it's appropriate for my patients' individual needs, I prefer to do my cases there for these reasons. Many of my fellow surgeons feel the same. I also should mention that many physicians believe that patient safety is further improved in ancillary facilities given a patient's limited exposure to infections that we all know exist in hospitals.

My second example is a patient seen by an orthopedic surgeon for an ankle injury who needs an X-ray or other diagnostic image to make an accurate diagnosis. If the physician is able to provide the necessary imaging services in-office, the examination, diagnosis, and initiation of treatment can be accomplished in one patient encounter. The alternative is to refer the patient to a diagnostic imaging center or hospital outpatient department. This delays diagnosis and treatment until the orthopedic surgeon receives a report back from the center and the patient is seen for a second time.

Providing ancillary services in physician offices speeds up the diagnosis and treatment of a patient's medical condition. When on-site ancillary services are not available, the patient needs to schedule a new appointment with a different physician at a different facility. Having these services readily available is especially important to the elderly and other patients with limited transportation options or mobility problems.

So far, I've given you examples that show how providing ancillary services in a physicians' office improves access, quality, and safety of care. But cost concerns are an equally compelling reason why physicians oppose restrictive self-referral. "One-stop shopping" can be cost-effective because it can improve efficiency and lower overall costs by reducing the number of office visits required. Hospitals are required to have certain personnel and equipment available at all times regardless of whether they are needed to provide a specific diagnostic imaging or other ancillary service. Those indirect hospital costs contribute to the overall cost of patient care.

At a system-wide level, severe self-referral restrictions potentially pose a barrier to clinical integration. Clinical integration is a key component in new reimbursement models aimed at controlling costs and improving quality. The self-referral restrictions in HB 2522 create an unnecessary maze of barriers that physicians must overcome to clinically integrate with other physicians and health care providers. Federal law gives the secretary of the US Department of Health and Human Services the authority to waive federal self-referral restrictions that impede

new reimbursement models being tested for Medicare and Medicaid. Clearly, the very body that enacted self-referral prohibitions recognizes the inherent flaws and shortcomings caused by these prohibitions when it comes to an efficient health care delivery marketplace.

This is where self-referral gets very confusing and becomes a political football. Let me give you an example. The American Hospital Association is advocating for elimination of the federal self-referral restrictions for compensation relationships that physicians have with hospitals. This is fascinating since today you will likely hear the Hospital and Health System Association of Pennsylvania (HAP) testify in favor of HB 2522 and perhaps even call for more limiting language. This is even more ironic because HB 2522, in our opinion, will affect all self-referral—including self-referral that takes place in ancillary facilities jointly owned by hospitals. It could even affect self-referral within the hospital itself.

Don't get me wrong; we recognize the need to reduce over-utilization. However, additional self-referral restrictions that cause physicians' administrative costs to escalate are not the solution. Defensive medicine is a driving force of over-utilization, particularly in highly litigious areas of our state, like Philadelphia, where liability costs are among the highest in the country. You won't be surprised to hear me say that tort reform is imperative to help reduce health care costs. I also would welcome the opportunity to come back and talk with you about how the state could facilitate other efforts to rein in costs, such as standardizing managed care contracts and physician credentialing procedures.

But without documented evidence that problems exist, we believe that enacting further self-referral restrictions, on top of the existing federal Stark law and anti-kickback statute, will only pile on additional penalties and further increase administrative costs for physicians.

We firmly believe the federal laws have effectively addressed abusive self-referral practices. All that HB 2522 really accomplishes is adding draconian state penalties and imposing a strict liability standard. In the end, physicians will have to hire attorneys to review any financial relationships to ensure compliance. More costs. More hassles. No perceived benefits—— for both patients and physicians.

These are our over-arching concerns with HB 2522, but we also have concerns with ambiguities in the drafting that may have unintended consequences.

For example, the bill lists "designated health services," such as diagnostic radiology, but does not define them. Does diagnostic radiology include vascular diagnostic studies, ultrasounds, myocardial perfusion studies, echocardiography, or even mammography? Will the self-referral prohibition apply when one of the designated health services is reimbursed as part of a composite rate for a non-covered service? An example would be a clinical laboratory service that is part and parcel with ambulatory surgery.

Yes, you can fix each of these concerns one by one, but the Stark experience shows that new issues will inevitably arise. And, given the pace of the changing health care delivery system, the unintended consequences of enacting this bill could be to cripple an already handicapped system.

Another alarming aspect of the bill is that it would directly tie state self-referral law to federal Medicare rules. This means that self-referral restrictions could be increased by changes at the

federal level. But changes in Medicare are largely driven by federal budgetary woes or problems in other states. Rather than delineating exceptions for appropriate physician financial relationships, HB 2522 incorporates the exceptions under the Stark law and the safe harbors to the anti-kickback statute. The problem with this is that the federal government can change those rules at its whim. For example, the Stark in-office ancillary services exception is critical to allow physicians to provide imaging in their offices. If the federal government excludes echocardiograms from this exception, does that same restriction now apply in Pennsylvania?

Yet another problem with the bill is that it gives hospitals an unfair competitive advantage. For just a moment, let's examine the playing field between hospitals and physicians since hospitals appear to be most threatened by the efficiency of physician-owned facilities. Under the federal Stark law, which HB 2522 largely mimics, physicians cannot refer patients to independent diagnostic imaging centers that they own. Yet a hospital that owns a diagnostic imaging center can direct its employed physicians to refer only to that center, exclude physicians from its medical staff who refer patients to a competing imaging center, or refuse to lease space in a hospital-owned physician office to those physicians who provide competing diagnostic imaging.

Adding insult to injury, physicians may provide in-office CAT scans but are required to provide patients with a list of other CAT scan providers in the area. Hospitals funnel patients to their CAT scan centers without any requirement to advise patients of alternatives. If hospitals truly were concerned about conflict of interests driving physician referrals, they would likewise oppose abusive practices that channel patients to their facilities.

Pennsylvania is not the most attractive state in which to practice medicine given our liability system and poor reimbursements. Placing further restrictions on physician self-referral will further impede our ability to compete for quality physicians. Physicians want to practice in facilities and with technology that offer high quality, cost-effective, and convenient care for their patients.

Rather than continuing to bog down a health care delivery system at the brink of collapse, I believe that the best approach to this dilemma is simple: transparency.

Require all health care providers—including both physicians and hospitals—to fully disclose their financial relationship with an entity to which a patient is being referred. If the patient has concerns, let them decide where to receive their care or diagnostic imaging. When I refer a patient for diagnostic imaging, or for that matter to another physician, the first question I get is, "Is that where you would go?"

Let's give patients the information they deserve to make an informed decision and stop trying to legislate where they must go for treatment.

In the end, improved outcomes and clinical integration mean better care for less. If we disrupt these principles, we will create a delivery system that can't embrace change or capitalize on technological advances and cost savings.

Thank you again for the opportunity to share with you our thoughts on HB 2522. To the best of my ability, I will be happy to answer any questions you may have.