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SFA BILL ANALYSIS

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Senate Bill 517 (as enrolled) **PUBLIC ACT 402 of 2002**
Sponsor: Senator Bev Hammerstrom
Senate Committee: Health Policy
House Committee: Health Policy

Date Completed: 1-8-03

RATIONALE

Both State and Federal laws restrict a physician's ability to refer a patient or patient's specimen to a facility in which the physician holds a financial interest. Under the State's Public Health Code, it was considered unprofessional conduct for a licensed health professional to engage in "directing or requiring individuals to purchase or secure a drug, device, treatment, procedure, or service from another person, place, facility, or business in which the licensee has a financial interest". This controversial prohibition received considerable attention in 1995, when the Michigan Court of Appeals upheld a 1989 Board of Medicine ruling concerning physician self-referrals. The case, *Indenbaum* v *Michigan Board of Medicine* (213 Mich App 263), examined whether referrals by a group of physicians to a facility in which the physicians were limited partners constituted "directing or requiring". Through a written notice posted in their offices, the physicians informed their patients that they might be referred to the facility in which the physicians held a financial interest, unless a patient specifically requested other arrangements. The Court upheld the Board's judgment that the physicians had violated the Public Health Code, finding that "'directing' means guiding, managing, regulating, or controlling by advice, instructions, orders, or commands and *does not exclude 'referring*.'" [Emphasis added.]

During the late 1980s and 1990s, while Michigan policy-makers and practitioners struggled with the issue of physician self-referrals, the Federal government also was addressing the issue. The Omnibus Budget Reconciliation Act (OBRA) of 1989 added Section 1877 to the Social Security Act to prohibit, with some exceptions, a physician from referring Medicare patients to an entity for clinical laboratory services, if the physician or a member of the physician's immediate family has a financial relationship with that entity. The relevant section of the 1989 OBRA is known as "Stark I", after its sponsor, U.S. Congressman Pete Stark. "Stark II", part of the 1993 OBRA, amended Section 1877 by expanding the self-referral prohibition to include a number of categories of "designated health services" for which a physician may not refer patients to a facility in which the physician has a financial interest. Stark II also added several new exceptions, and extended aspects of the prohibition to include Medicaid patients.

Some people believed that the Public Health Code unnecessarily restricted physicians' ability to self-refer. According to the Department of Consumer and Industry Services, which is responsible for enforcing the Code, "Virtually everyone affected...agreed that the finding in Indenbaum that the phrase 'directing and requiring' included 'referring' was problematic." Also, the Department was "extremely concerned that the interplay between Indenbaum and Stark would result in the department applying different requirements depending on how the patient's bills were paid". It was suggested that Section 1877 of the Social Security Act provides a more appropriate guide to physician self-referrals in Michigan and should be incorporated into State law.

CONTENT

The bill amended the Public Health Code to eliminate a provision that prevented a licensed physician from referring patients to a facility or business in which the

physician had a financial interest; instead, the bill restricts referrals by a physician for a designated health service in violation of the Social Security Act. Further, the bill specifies that a licensed health professional other than a physician may not require a patient to use a facility or business in which the licensee has a financial interest. The bill added to the description of unprofessional conduct a provision concerning physicians who refuse to accept Medicaid patients or refuse to accept Medicaid or Medicare payments for services for which the physician refers the individual and has a financial interest. The bill also requires the Department of Consumer and Industry Services (DCIS) to prepare three annual reports on the bill's effect on uninsured and Medicaid patients' access to care.

Under the Code, the DCIS may investigate activities related to the practice of a licensed health professional. The Department must report its findings to the appropriate disciplinary subcommittee. The disciplinary subcommittee may take various actions against the licensee if it finds certain grounds for action, such as unprofessional conduct.

Previously, unprofessional conduct included "directing or requiring an individual to purchase or secure a drug, device, treatment, procedure, or service from another person, place, facility, or business in which the licensee has a financial interest". The bill deleted this provision. Under the bill, unprofessional conduct includes "a referral by a physician for a designated health service that violates section 1877 of part D of title XVIII of the social security act, 42 U.S.C. 1395nn, or a regulation promulgated under that section". The bill states that Section 1877 and the regulations promulgated under it, as they existed on the bill's effective date, are incorporated by reference for purposes of this provision. A disciplinary subcommittee must apply Section 1877 and the regulations promulgated under it regardless of the source of payment for the designated health service referred and rendered.

If Section 1877 or a regulation promulgated under it is amended after the bill's effective date, the DCIS must officially take notice of the revision and, within 30 days after taking notice, must decide whether the revision pertains to referral by physicians for designated health services and continues to protect the public from inappropriate referrals by physicians. If the DCIS decides that the revision does both, it may promulgate rules to incorporate the revision by reference. If the Department does not promulgate such rules, it may not make any changes to the revision.

As used in these provisions, "designated health service" means that term as defined in Section 1877 and the regulations promulgated under it. (Section 1877 defines "designated health services" as any of the following: clinical laboratory services; physical therapy services; occupational therapy services; radiology services, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services; radiation therapy services and supplies; durable medical 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.) The bill defines "physician" with reference to the definitions in Sections 17001 and 17501 of the Public Health Code. (Those sections define "physician" as an individual licensed to engage in the practice of medicine and an individual licensed to engage in the practice of osteopathic medicine and surgery, respectively.)

For a physician who makes referrals pursuant to Section 1877, unprofessional conduct also includes refusing to accept a reasonable proportion of Medicaid-eligible patients and refusing to accept payment from Medicaid or Medicare as payment in full for a treatment, procedure, or service for which the physician refers the individual and in which the physician has a financial interest. (This provision does not apply to a physician who owns all or part of a facility in which he or she performs a referred surgical procedure that is not reimbursed at a minimum of the appropriate Medicaid or Medicare outpatient fee schedule.

For a licensed health professional other than a physician, unprofessional conduct still includes requiring a patient to purchase or secure a drug, device, treatment, procedure, or service from an entity in which the licensee has a

financial interest.

The bill mandates that, beginning one year after its effective date, the DCIS prepare the first of three annual reports on the effect of the bill on access to care for the uninsured and Medicaid patients, including the number of referrals by licensees of uninsured and Medicaid patients to purchase or secure an item or service from an entity in which the licensee has a financial interest.

MCL 333.16221

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

The bill puts to rest a long-standing argument over a provision that was controversial when first enacted and became increasingly ambiguous as it was interpreted in different situations. The decision of the Court of Appeals in the *Indenbaum* case evidently changed the way "direct" had been interpreted. Up to that point, a referral to a facility in which the physician had a financial interest was considered permissible as long as there was no element of compulsion. The Court's decision prohibited many referrals that people previously believed were allowed under the State Code and that fit into one of the "safe harbors" outlined in Federal law. Dissonance between State and Federal law can make it difficult for physicians to provide basic services such as prescribing drugs. The bill relieves them of the burden of trying to comply with two sets of sometimes conflicting regulations.

The bill also simplifies regulation for the DCIS by requiring disciplinary subcommittees to enforce the law regardless of the source of payment. This goes one step beyond the protections offered by the Federal Stark law, which prohibits self-referrals only for Medicaid and Medicare patients. The bill also requires the DCIS to take notice of any amendments to the Federal law, and allows the Department to incorporate them if appropriate.

While health care providers should not have an unlimited ability to refer patients to facilities in which they have a financial stake, it is sometimes in a patient's best interest to do so. The State's ban on self-referrals was a blanket prohibition that did not take into account the particulars of each person's medical condition. The Federal regulations under Section 1877, on the other hand, allow for a more tailored approach to medical care but also designate certain categories of medical items and services that are prone to overutilization, as services for which a financially interested physician may not self-refer. The bill creates a framework that affords physicians considerable flexibility but still protects consumers from inappropriate referrals and higher health care costs that result from overutilization. It promotes competition between hospitals and physicians, maximizes health care options, and provides protection for patients.

Opposing Argument

While the bill attempts to clear up discrepancies between Federal law and the *Indenbaum* ruling, it is not an improvement. The new law creates just as many uncertainties as the old law did. First, when the bill was enacted, the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) had not yet issued "Phase II" of the final rule covering Stark II. This is problematic because, according to the bill, the DCIS *may* incorporate revisions into the Public Health Code but is not required to do so. If the Department chooses not to, or delays in incorporating the amendments, physicians will have to comply with the new version of the law for Federal enforcement officials and the unrevised version for State licensing officials. It was this type of bifurcated system that the bill sought to eliminate.

Second, the bill prohibits self-referrals by a physician who does not accept a "reasonable proportion" of Medicaid and Medicare patients, but offers no explanation of what is a "reasonable proportion". Presumably, this is left to the judgment of the DCIS. Additionally, the DCIS may not take the source of payment into account when enforcing regulations, even though the Stark law applies only to referrals of Medicare and Medicaid patients. Again, the bill does not reconcile the two channels of regulation.

Also, the bill lessens the protection against abuse with the health care system. The

previous law applied to all health services, not just those identified by the Federal government as being prone to overutilization. A physician still may self-refer for services that are not "designated health services", such as cardiac catheterization. Furthermore, the definitions of the various "designated health services" are complex and an extensive knowledge of U.S. Department of Health and Human Services regulations is required to understand them fully. Thus, the issue becomes one of semantics for physicians and their lawyers, instead of consumer protection.

Opposing Argument

The Public Health Code contains certain protections for consumers designed to ensure that a licensed health professional is always acting in the patient's best interest. The language in the bill regarding referrals by nonphysician licensed health professionals is significantly watered down from the previous law. Where the Code used to prohibit any licensed health professional from "directing or requiring" a patient to use a facility in which the professional had a financial interest, the bill prohibits only a requirement. This means that physician assistants, physical therapists, chiropractors, and other nonphysician licensees have a wide berth in directing patients to obtain items and services from certain facilities. The bill still leaves patients open to the kind of abuse that it was meant to curtail.

Response: This provision is consistent with the Stark law. Nonphysician "directives" are generally permissible under Section 1877, unless it becomes apparent that a physician is controlling the direction that another health professional gives a patient in order to circumvent the restriction on physician self-referrals.

Opposing Argument

The bill may be detrimental to not-for-profit hospitals since "designated health services" have a wide spectrum of profitability. Physicians might refer patients for the most profitable services to facilities in which they have a financial interest, and refer patients for unprofitable services to other hospitals. Not-for-profit hospitals often have patients who are uninsured and cannot pay for the treatment they receive. If these hospitals receive large numbers of poor patients needing unprofitable services, the hospitals might not be able to cover the cost of providing the services and might either eliminate certain necessary services or close, reducing access to health care for everyone.

Legislative Analyst: Julie Koval

FISCAL IMPACT

The bill will have no fiscal impact on State or local government.

Fiscal Analyst: Maria Tyszkiewicz

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