

# **The Long and Changing Road**

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On August 5, 1997, former President Clinton signed the Balanced Budget Act of 1997 (H.R. 2015) into Public Law 105-33. Initial estimates projected the 1997 Balanced Budget Act would cut \$116 billion from Medicare spending. More recent estimates, however, project a five-year impact of about \$227 billion, with a large portion of the cuts coming from payments to hospitals. Additionally, many other types of healthcare entities have been effected by the BBA and subsequent legislation, such as the Schip Benefits Improvement and Protection Act (BIPA) among others. This article looks at four such entities in particular: Comprehensive Outpatient Rehabilitation Facilities (CORFs), Ambulatory Surgery Centers (ASCs), Independent Diagnostic Testing Facilities (IDTFs), and Long Term Acute Care Hospitals (LTACHs) and gives a brief overview of significant changes to these entities since the enactment of the BBA four years ago.

## **CORFS**

As healthcare continues to focus on outpatient settings as primary venues for delivery care, there is renewed interest in the long recognized Medicare entity known as a comprehensive outpatient rehabilitation facility (CORF). A CORF is a recognized provider of services paid by Medicare on a fee schedule basis. CORFs were established by Congress in 1980 with final regulations issued in 1982. The regulations define a CORF as a “nonresidential facility that... is established and operated exclusively for the purpose of providing diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons by or under the supervision of a physician...” The CORF program has not significantly changed since its inception, other than a provision in 1987 to allow for site billing for PT, OT and speech.

A CORF is simply a Federal designation that allows services to be billed to Medicare, essentially making the CORF certification a means of reimbursement for services provided in these facilities. CORF certification does not define programs, rather it allows for multidisciplinary services to be reimbursed based on a fee schedule including nursing, social services, respiratory therapy and drugs/biologicals, in addition to the traditional services of PT, OT, speech, and psychology.

However, the most recent change with respect to CORFs is the result of considerable activity within Congress and the Health Care Financing Administration (HCFA) that has brought about several regulatory changes. According to a recent HCFA Program Memorandum instructing CORFs on the billing of drugs, biologicals, and supplies, drugs and biologicals will no longer be reimbursed on a cost basis. Effective April 1, 2001, payment of drugs and biologicals are made according to the lower of the billed charge or 95 percent of wholesale price, with a differentiation made between single-source drugs or biologicals and multi-source drugs and biologicals. Further, supplies should not be billed separately. They are included under practice expense in the Medicare physician fee schedule and should be billed accordingly. The CORF remains a substantive avenue for providing comprehensive rehabilitation services in an outpatient setting.

## **ASCs**

Another venue that has experienced change since the passage of the BBA is the ambulatory surgery center or ASC. An ASC is a distinct entity that provides various outpatient services to patients not requiring inpatient hospitalization. It can be operated under common ownership, under licensure or control of a hospital, or as an independent or freestanding entity. Properly licensed ASCs are reimbursed under the Medicare program for facility services that are provided in connection with a covered surgical procedure.

Before November of 1999, physicians had to be cautious of investing in ASCs due to restrictions placed upon them by the Anti-Kickback statute. In pertinent part, the statute prohibits the knowing and willful offer or payment or remuneration to induce referrals or in return for purchasing or recommending the purchase of any item or service payable by a federal healthcare program. However, the Office of Inspector General established a "safe harbor" provision for ASCs, which was published in the Federal Register on November 19, 1999. This provision essentially acts as a relaxing of Stark with respect to physician ownership of ASCs. The ASC safe harbor has four specific categories: 1) Surgeon-owned ASCs; 2) Single-specialty ASCs; 3) Multi-specialty ASCs; and 4) Hospital/Physician ASCs. The safe harbors protect a narrow band of transactions from prosecution under the anti-kickback statute if certain, albeit, very strict standards, are met.

Although the four categories of protected transactions provided physicians with investment opportunities in ASCs each category has the fundamental requirement that a physician investor comply with the "one-third practice income" test. Under the test, the physician must derive one-third of his or her medical practice income for the previous year from procedures that must be performed in an ASC setting. The underlying rationale for the test is to ensure that ASC

investment represents a logical extension of the physician's practice and not a means to profit from improper referrals.

The 1999 regulations tend to be skeptical of joint ventures between hospitals and physicians or physician groups. This is in part a product of the OIGs belief that such joint ventures are often susceptible to fraud and abuse. Nevertheless, safe and harbor protection was extended to hospital/physician ASCs under limited circumstances. For example, safe harbor protection is available for hospital/physician ASCs if the hospital is not in a position to make or influence referrals to the ASC or to the ASCs investors. Therefore, ASCs remain viable care delivery sites when they are structured appropriately and are driven by market need rather than hospital/physician joint ventures as necessary relationships.

## **IDTFs**

Unlike ASCs, rules describing physician ownership or investment in an independent diagnostic testing facility (IDTF) are not as clearly delineated. The classification of IDTF was established by federal regulation in October of 1997 to clarify ambiguities surrounding the operation of the independent physiological laboratory (IPL). The next year, pursuant to regulations published in the 1998 Fee Schedule and Payment Policies for Physicians' Medical Services, the IDTF replaced the IPL classification as a Medicare certified entity licensed to perform diagnostic tests.

Currently, an interesting issue with respect to IDTFs is whether or not an IDTF may be owned by a physician-owned hospital. Stark, the physician self-referral law, prohibits certain indirect financial relationships between physicians and healthcare entities furnishing designated health services (DHS) to which physicians refer. The ownership of IDTFs by physician-owned hospitals may arguably create a prohibited indirect financial relationship between the physician and IDTF. HCFA has yet to release the final rule on this matter. However, in January 1998, HCFA published proposed regulations interpreting and implementing "Stark II", and on January 4, 2001, HCFA published the first portion of the final rule with a 90-day comment period. The second portion of the final rule, including provisions for physician ownership and investment interests in health entities, is expected to be published shortly. Although physician-owned hospitals interested in owning an IDTF would be wise to wait until the publishing of the final Stark rule regarding physician ownership of entities, there is indication that it may be possible for physician-owned hospitals to take advantages of the opportunities afforded them by IDTF ownership.

## **LTACHs**

Today, an effective health system must have within its continuum appropriate venues of care to minimize revenue losses and the detrimental

effects of the prospective payment system. The long term acute care hospital (LTACH) serves as one of these venues. LTACHs serve patients who require long lengths of stay and highly skilled nurse care with access to technologically advanced therapies, but no longer require an acute level of care. Ideally, an LTACH operates within a total healthcare system to complete the full care continuum while providing a venue of care where the patient can be treated most cost effectively for an extended length of stay. Patients in LTACHs generally fall into one of two categories: rehabilitation patients or chronically ill patients. At present, LTACHs are excluded from the prospective payment system (PPS). However, in the near future, they will be reimbursed under PPS. Although the PPS for LTACHs will likely be based on a DRG system, the system will be modified from the one currently utilized by acute care hospitals, to account for the severity of illness and higher risk of mortality found in LTACH patients.

One overwhelming regulatory misunderstanding is that a not-for-profit health care system cannot own an LTACH if it is a hospital within a hospital. HCFA recognizes that a facility may qualify for exclusion as long as it meets the criteria, even if it is owned by the same entity as the hospital with which it shares a building or campus. A separately operated hospital is not ineligible for exclusion solely because it and the host facility are under common ownership. It was never the intention of Congress to deny availability of this key venue to health systems. Rather, Congress was sensitive to establish mandates that would inhibit a hospital within a hospital to be treated as a unit. Congress did not intend that all hospitals within hospitals must be outsourced to a for-profit third party.

Since the promulgation of the BBA in 1997, LTACHs have undergone changes, not the least of which were brought about by BIPA. BIPA was signed into law on December 21, 2000, and brought about a number of revisions to the Outpatient Prospective Payment System (OPPS), as well as containing numerous provisions affecting inpatient hospital payment policies.

With respect to LTACHs, BIPA provided for a 2 percent increase to the wage-adjusted 75<sup>th</sup> percentile cap on the target amount for LTACHs effective for cost reporting periods beginning during FY 2001. This new legislation requires a revision to the cap on the target amounts applicable to LTACHs that were subject to the 75<sup>th</sup> percentile cap. BIPA also provided a 25 percent increase in the target amounts of LTACHs for cost reporting periods beginning during fiscal year 2001. However, the 25 percent target amount increase is limited to and cannot exceed an LTACHs wage-adjusted national cap.

The past four years have proved to be a dynamic period in healthcare with few areas left unaffected. CORFs, ASCs, IDTFs and LTACHs are a small representation of the many healthcare entities changed since the passing of the

BBA. As patient care enters the 21<sup>st</sup> century, we must remain poised for ever greater challenges and vigorous change with our attention focused on providing patients with the highest level of care possible within the confines of available financial and human resources.

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