

Physician-Owned Specialty Hospital Moratorium Expired . . . Replaced with New Regulations and Continued Scrutiny

By

Cherilyn G. Murer, JD, CRA

Introduction

The issue of physician ownership of specialty hospitals has been hotly contested over the past few years and has sparked various forms of legislation, reports, and surveys. Physician-owned specialty hospitals represent a growing trend in health care. As defined by Congress, specialty hospitals are exclusively or primarily engaged in the care or treatment of one of the following categories of patients:

- Patients with a cardiac condition;
- Patients with an orthopedic condition;
- Patients receiving a surgical procedure.

Physicians who refer patients to specialty hospitals are often investors in the hospitals, although physician investors typically refer some patients to a community hospital, and most specialty hospitals will accept referrals from non-investor physicians. By focusing on certain types of cases, specialty hospitals have the potential to increase the quality of care and provide care in a more efficient manner. However, many critics of specialty hospitals have claimed that specialty hospitals seek the more profitable cases and patients with private insurance, leaving sicker and poorer patients to be treated at community hospitals.

Over the past several years, a moratorium prevented payments to specialty hospitals for services furnished to Medicare beneficiaries as a result of a referral from a physician with an investment interest in the hospital.

On August 8, 2006, the specialty hospital moratorium expired. While there is no longer a suspension of Medicare enrollment for new specialty hospitals, there are definitive guidelines that must be followed related to physician-owned specialty hospitals.

Background

The rapid growth of these facilities together with concerns about patient demand from self-referrals led Congress to impose an 18-month moratorium on these facilities in the 2003 Medicare Modernization Act (MMA). During this time period, new physician-owned specialty hospitals (excluding those physician-owned specialty hospitals that were found to be “under development” as of November 18, 2003) were unable to take advantage of the “whole hospital exception” of the physician self-referral statute. In other words, physician-owned specialty hospitals were prohibited from billing Medicare for services furnished to patients referred to the specialty hospital by a physician-owner.

Concerns about specialty hospitals sparked an investigation by the Medicare Payment Advisory Committee (MedPAC). MedPAC made a number of findings regarding an extensive review of specialty hospitals, including: (1) physician-owned surgical hospital costs were significantly higher than general hospitals, despite having shorter stays, (2) physician-owned hospitals see significantly fewer Medicaid or charitable patients, (3) physician-owned heart hospitals increase the number of heart procedures in a community when opened, and (4) physician-owned heart hospitals divert patients from community hospitals, decreasing revenue.

Another report on specialty hospitals was a survey conducted by the Government Accountability Office (GAO). In contrast to the Med PAC report, the GAO survey found that there was little effect on community hospitals when a specialty hospital enters the market.

Following the MMA moratorium, CMS went even further, suspending the enrollment of new specialty hospitals, while reviewing the Agency's enrollment procedures. Congress legislated in this area again in the Deficit Reduction Act of 2005 (DRA), requiring CMS to continue the enrollment suspension until CMS developed and provided Congress a "strategic and implementing plan" regarding physician investment in specialty hospitals.

Elements of Strategic and Implementing Plan

On August 8, 2006, CMS released a Final Report to Congress outlining a strategic and implementing plan to address key issues relating to physician investment in specialty hospitals.

CMS Administrator, Mark McClellan has announced that, "Specialty hospitals often achieve high levels of service, but especially under current payment methods, there have been questions about whether they focus on profitable patients rather than quality care." CMS's final report is a comprehensive review of the evidence on specialty hospitals and a path forward to address concerns that have been raised. McClellan states, "The steps we are taking in our final report will not only promote high-quality, appropriate care in specialty hospitals, but will also encourage appropriate hospital care for all patients, and better information about the financial arrangements involved in hospital care as well."

CMS's Strategic Plan details the action CMS took to enforce the 18-month moratorium on payments to certain specialty hospitals for services furnished to Medicare beneficiaries as a result of a referral from a physician with an investment interest in the hospital. After reviewing inpatient claims data, CMS identified 10 hospitals that may have been subject to the moratorium and sent letters to each hospital, requiring information concerning the ownership of the hospital and the nature of the services performed. Based on the information CMS received, CMS determined that four of these hospitals were subject to the MMA moratorium. Letters informing these hospitals of CMS's initial determination of an overpayment of approximately \$12.1 million in aggregate were sent in July 2006. These actions are in addition to overpayment notices issued to two hospitals that were mentioned in the Interim Report.

There are five key elements of CMS's implementing strategic plan relating to the future of physician owned specialty hospitals:

1. *Mandatory Hospital Investment Disclosure*

CMS will require hospitals to disclose information concerning physician investment and compensation arrangements. CMS will begin by requiring such disclosure for hospitals that have not yet fully responded to the CMS survey on hospital investment. Hospitals that do not respond timely with the required information can face stiff penalties, including a fine of up to \$10,000 for each day that the response is late. Specialty hospitals will also be required to disclose to patients, in advance of providing care, that their staff physicians have an investment interest in the hospital. In addition, CMS is changing the hospital enrollment form for the Medicare program to clearly identify specialty hospitals.

2. *Continued Enforcement of Stark and Anti-Kickback Rules for Improper Investment*

The Strategic Plan announces CMS's position that non-proportional returns on investments, and non-bona fide investments, may violate the physician self-referral statute and are suspect under the anti-kickback statute. Although the survey results to date did not reveal, on their face, any disproportionate or non-bona fide arrangements, CMS and the Office of the Inspector General (OIG) will take appropriate action against any such arrangements that are identified. The required disclosure of these financial arrangements provides CMS and the OIG with the information needed to identify potentially concerning investment relationships for further investigation.

3. *Major Hospital and Ambulatory Surgery Payment Reforms to Better Align Medicare Payments with Costs of Care*

The Strategic Plan, as outlined in CMS's Final Report, emphasizes the need to continue the payment reforms that CMS identified in the Interim Report. In other words, CMS will continue to work to make the hospital inpatient prospective and ambulatory surgical center payment systems more accurate, which CMS and Medicare Payment Advisory Commission (MedPAC) believe will address some of the incentives physicians have to form, or invest in, specialty hospitals.

4. *New Opportunities to Support Hospitals and Physicians Working Together to Improve Care*

Traditional full-service hospitals have expressed concern that specialty hospitals can promote better coordination between the facility and the staff physicians because of the opportunity for physician ownership. In order to level the playing field by enabling hospitals to provide better financial support for high-quality, low-cost care, CMS will implement demonstration programs to support better hospital-physician collaboration. This includes a "gainsharing" demonstration as required by the DRA, as well as use of other CMS authorities including authorities in the Medicare Healthcare Quality Demonstration program (under Section 646 of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) to support physician-hospital collaboration to improve care.

5. Required Emergency Service for Patients When Appropriate, Regardless of Ability to Pay

CMS has clarified EMTALA requirements to state that, even if a hospital does not have an emergency department (and many specialty hospitals do not), they must nonetheless accept transfers of cases when they have the capacity to provide appropriate care.

Industry Reaction

Lawmakers and hospital industry leaders have expressed mixed reactions to CMS's proposal which requires specialty hospitals to provide the government with information about physician investment and compensation.

Thomas Nickels, senior vice president of the American Hospital Association, which opposes specialty hospitals, said, "Patients have a right to know whether a conflict of interest may affect their care," but added, "[G]iven the growing evidence that financial interest may be overtaking patient interest, the AHA continues to believe physician self-referral to limited-service hospitals they own should be banned."

Senate Finance Committee Chair Chuck Grassley (R-Iowa) said that the plan "is important" but added that "these steps alone won't unravel the web of conflicts that have been created by these limited-service hospitals, which cherry-pick patients based on dollars rather than diagnosis and put the well-being of both individual patients and the health care delivery system at risk."

Conclusion

Despite these negative reactions, specialty-hospital developers have been moving forward with development plans since May of 2006. Just days after CMS Administrator Mark McClellan testified at the interim Senate hearing on specialty hospitals in May, signs of growth began. However, as expressed by Senator Max Baucus of Montana, the industry will be "watching closely to see whether the proposals in this report achieve their intended effect."

NEW CMS REGULATIONS FOR PHYSICIAN-OWNED SPECIALTY HOSPITALS

Physician-owned specialty hospitals MUST now:

- **Provide CMS with information concerning physician investment and compensations arrangements**
- **Disclose to patients whether the hospital has physician investors**
- **Continue to comply with all federal physician ownership and anti-kickback statutes and regulations**
- **Provide emergency care to patients regardless of ability to pay**
- **Designate "specialty hospital" status on Medicare and Medicaid enrollment forms**

Thus, while specialty hospital developers can proceed with projects, new regulations and continued scrutiny remain.

About the Author:

Cherilyn G. Murer, J.D., C.R.A. is CEO and founder of the Murer Group, a legal based healthcare management consulting firm in Joliet, IL, specializing in strategic analysis and business development. Ms. Murer may be reached at (815) 727-3355 or viewed on her web site: <http://www.murer.com>