

STARK REALITY: PHYSICIAN-OWNED SPECIALTY HOSPITALS MAY NOT BE “WHOLE” FOR LONG

by

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A Hostile Environment

The federal physician self-referral law, commonly known as the “Stark Act,”¹ generally prohibits physicians and other healthcare professionals from referring their Medicare and Medicaid patients to facilities in which they or an immediate family member have an ownership or other investment interest. The philosophy behind the Stark Act is that, if physicians are permitted to make such “self-referrals,” they will make more referrals than are actually medically necessary, resulting in over-utilization of the system and an unwarranted drain on taxpayer dollars. From the very beginning, however, Congress recognized that there are many instances when self-referrals are not only not suspect, but are actually desirable from the point of view of program efficiency. Therefore, the Stark Act has always contained a number of exceptions to its general prohibition, including exceptions or “safe harbors” for such matters as space and equipment leases and physician recruitment, as long as certain requirements are met. One exception that has proved far more controversial than the drafters of the Act could ever have imagined is the “whole hospital exception.”

In 1989, when Congressman Pete Stark first introduced the law that would bear his name, it contained a very limited version of what today is known as the “whole hospital exception.” In Congressman Stark’s original proposal, the prohibition on physician referrals to entities in which they had an ownership interest would not have applied to investment interests in hospitals that were established prior to 1989. The idea was that most physician-owned hospitals were established years ago in small communities in rural states. The “whole hospital exception” was developed to continue patient access to these rural institutions.

What emerged in the final legislation, however, was considerably different. The whole hospital exception as it reads today, permits physicians to refer patients to a hospital in which they have an ownership interest if,

“(A) the referring physician is authorized to perform services at the hospital at the hospital, and

¹ Social Security Act § 1877, 42 U.S.C. §13195nn.

(B) the ownership or investment interest in the hospital itself (and not merely in a subdivision of the hospital).”²

Significantly, the exception contains no restriction on the date that hospital was established. Nor is there any limitation on the *type* of hospital that may come within the exception. Physician entrepreneurs were quick to see the opportunity that lay within the exception’s broad terms. The specialty hospital field, which had once been limited to a few types of institutions, such as children’s and rehabilitation hospitals, soon found itself crowded with physician-owned hospitals that focused on a single type of diagnosis or condition, such as cardiology, neurology, and orthopedics.³ These physician-owned single-specialty hospitals are quite different from their predecessors. They tend to be small, usually ranging in size from 15 to 70 beds, and quite lavish in both their furnishings and in their acquisition of state-of-the-art equipment.⁴

Advocates of physician-owned specialty hospitals focus on the exceptional quality of care that such hospitals can provide while pricing themselves competitively with larger, general hospitals. Because operational costs and processes can be streamlined, the specialty hospital can manage its resources more efficiently than the general hospital and, thus, maintain a competitive advantage over the larger hospital that is forced to absorb the high fixed costs required to deliver services across the entire spectrum of health care.

Others, however, see a darker side to physician-owned specialty hospitals. According to their critics, physician-owned specialty hospitals “cherry pick” the patients with the highest paying procedures and the best ability to pay. By doing so, they jeopardize the viability of the community’s general hospital by robbing them of their highest reimbursement patients, leave them to struggle with low-reimbursement or non-paying patients in an environment that is already challenging.

Unfortunately for the physician-owned hospitals, the ranks of the critics have included the most influential members of Congress, including the author of the Stark Act himself. One need only glance at Congressman Stark’s web site to appreciate his hostility to physician-owned specialty hospitals:

“The development of specialty hospitals is of great concern to our health care system and to communities across our nation because they deprive full-scale hospitals of their most profitable business, leaving those existing hospitals much worse off financially. The investors in these joint ventures and specialty hospitals skim the profits off full-scale hospitals, leaving them to struggle financially. Then the hospitals must look to Medicare and to their local communities to help them financially.”

² Social Security Act § 1877(d)(3), 42 U.S.C. § 1395nn(d)(3)

³ See Cherilyn G. Murer, *As the Focus Narrows*, Rehab Management (Feb. 2002).

⁴ *Id.*

In short, concludes Congressman Stark, physician-owned specialty hospitals are “exactly the type of behavior that the Stark laws were written to prevent.”

Stark’s Solution

Congressman Stark, together with Congressman Jerry Kleczka of Wisconsin, introduced in 2001 a bill designed to close the perceived “loophole” in the Stark Act. “The Hospital Investment Act” would have limited the whole hospital exception to ownership or investment interests that are purchased “on terms generally available to the public” at the time of the investment. In other words, the investment opportunity could no longer be offered only to physicians practicing in the particular specialty that was the focus of the hospital. Instead, a public offering would be required. As Congressman Stark acknowledged, the scope and expense involved with public stock offerings would have effectively outlawed physician-owned hospitals. In order to protect existing hospitals, however, Congressman Stark’s bill would have been limited to ownership or investment interests purchased after July 12, 2001.

Congressman Stark’s proposal, however, did not make it out of committee in the 107th Congress. Critics of the bill pointed out that its terms were so broad that it would outlaw not only the specialty hospitals that were the object of the Congressman’s wrath, but physician-owned general hospitals as well. Nevertheless, Congressmen Stark and Kleczka reintroduced their bill in 2003,⁵ where it remains in committee as of this writing. As we shall see, events have overtaken Congressman’s Stark’s bill, making it very unlikely that it will ever become law.

CMS Steps In, Then Out

In its semi-annual regulatory agenda, which was published in the May 27, 2003, issue of the Federal Register, CMS announced its intention to publish in July, 2003, a proposed rule that would have attempted to accomplish by administrative regulation what Congressman Stark had been unable to do through the legislative process. The agenda stated that the proposed rule would revise the regulation implementing the Stark Act⁶ by providing that certain physician ownership and investment interests in specialty hospitals would not qualify for the whole hospital exception. However, no sooner was CMS’s intention announced, then CMS Administrator Tom Scully announced that the agency was dropping its plans to publish the rule. Apparently CMS had come to the conclusion that it lacked the administrative authority to define the term “hospital” for Stark Act purposes. In any event, action in the United States Senate soon rendered CMS’s aborted effort moot.

⁵ H.R. 1539.

⁶ 42 C.F.R. § 411.356.

Senator Breaux's Amendment

As the Prescription Drug and Medicare Improvement Act of 2003⁷ was nearing passage in the Senate, Senator John Breaux of Louisiana introduced as an amendment that may have far-reaching effects on the future of physician-owned hospitals. This amendment adds a provision to the Stark Act which removes from the whole hospital exception "specialty hospitals." Unlike Congressman Stark's broad proposal, however, Senator Breaux's amendment narrowly defines "specialty hospital" as:

"[A] hospital that is primarily or exclusively engaged in the care and treatment of one of the following:

- `(i) patients with a cardiac condition;
- `(ii) patients with an orthopedic condition;
- `(iii) patients receiving a surgical procedure; or
- `(iv) any other specialized category of patients or cases that the Secretary designates as inconsistent with the purpose of permitting physician ownership and investment interests in a hospital under this section."

The use of the "one of the following" language in the amendment is highly significant. Unlike the Stark proposal, Senator Breaux's amendment is limited to three types of single-diagnosis specialty hospitals: heart hospitals, spine hospitals, and orthopedic hospitals. At least until CMS says otherwise, other forms of physician-owned hospitals will remain within the whole hospital exception, including long term acute care hospitals (LTACHs), children's hospitals, and rehabilitation hospitals.

Moreover, Senator Breaux's amendment provides greater protection to existing physician-owned hospitals than did Congressman Stark's proposal. The amendment excludes from the definition of "specialty hospital" any hospital,

"(i) determined by the Secretary--

- `(I) to be in operation before June 12, 2003; or
- `(II) under development as of such date;

`(ii) for which the number of beds and the number of physician investors at any time on or after such date is no greater than the number of such beds or investors as of such date; and

`(iii) that meets such other requirements as the Secretary may specify."

Thus, all existing physician-owned hospitals will remain within the whole hospital exception as long as they do not increase their number of beds or the number of physician investors.

⁷ S.1.

Regardless what form the final version of Prescription Drug and Medicare Improvement Act takes,⁸ Senator Breaux's amendment or a variation represents the likely future of the whole hospital exception. Congressmen Stark and Kleczka have issued statements indicating their support for Senator Breaux's amendment, and even if the House and Senate fail to resolve their differences over the Medicare prescription drug benefit, it is highly probable that Senator Breaux's proposal will find significant support if it is introduced as separate legislation.

Although this will mean that the physician-owned hospital of the future will take a decidedly different shape than today's model, Senator Breaux's amendment is not necessarily the death knell for physician investment in hospitals. The Breaux amendment will prohibit only certain single-diagnosis hospitals. Physician ownership of LTACHs, rehabilitation hospitals, and children's hospitals, for example, will still be permitted. Moreover, hospitals featuring a true partnership between complementary specialties, such as orthopedics and rehabilitation or cardiology and pulmonology will also be able to take advantage of the whole hospital exception. Thus, for the physician investor with foresight and creativity, there is still a future in hospital ownership.

About the Author:

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⁸ As of this writing, the Act was in Conference Committee to resolve differences between the House and Senate versions.