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FINAL RULE ON EXPANSION OF PHYSICIAN-OWNED HOSPITALS UNDER THE STARK PHYSICIANS SELF REFERRAL RULE

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On November 1, 2010, the Centers for Medicare and Medicaid Services ("CMS") released the final rule governing the procedures and requirements by which a physician-owned hospital may apply for an exception to the Stark Physician Self Referral Law's prohibition against expanding a physician-owned hospital's capacity. The rule, effective on January 1, 2012, will be published in the Federal Register on November 30, 2011.

The Stark Physician Self Referral Law, 42 USC §1395 (the "State Law") prohibits a physician from making a referral for a "designated health service" payable by Medicare to an entity with which the physician (or immediate family member) has a financial relationship, unless an exception applies. Additionally, an entity is prohibited from billing Medicare (or any other individual, entity or third-party payer) for designated health services provided pursuant to a prohibited referral. Physician ownership in a hospital implicates the Stark Law because inpatient and outpatient hospital services are designated health services. Therefore, referrals for such services from a physician-owner to the hospital are prohibited, unless an exception applies.

For a number of years, the "whole hospital" exception permitted a referring physician to have an ownership or investment interest in a hospital, provided that the referring physician is authorized to perform services at the hospital and the ownership or investment interests is in the hospital itself and not merely a subdivision of the hospital e.g. a department. Unfortunately, due to the proliferation of physician-owned hospitals that specialized in specific specialties of medical care and, therefore, did not provide the full range of care provided by general acute care hospitals and the perceived risks associated with such hospitals, Congress enacted additional requirements for the whole hospital exception as part of the Patient Protection and Affordable Care Act that placed restrictions on physician-owned hospitals in existence as of March 23, 2010 and, essentially prohibited the formation of new physician-owned hospitals. These additional requirements were implemented by CMS in a final rule effective January 1, 2011, 42 CFR §411.362.

One of the provisions of the amended "whole hospital" exception provided that a physician-owned hospital may not increase the number of operating rooms, procedure rooms and beds beyond that for which the hospital was licensed on March 23, 2010 (or, in the case of the hospital that did not have a provider agreement effective as of that date, but did have a provider agreement effective as of December 31, 2010, the date of effective of such agreement) (the "Baseline"). In order to allow physician-owned hospitals to expand the Baseline to meet the needs of the communities they serve, Congress required CMS to establish and implement a procedure to apply for an exception to this prohibition on expansion of facility capacity. Referrals are prohibited by a physician owner after a facility expansion and prior to CMS granting an exception.

The November final rule sets forth the procedures by which a hospital may apply for an exception to expand facility capacity. A hospital must qualify under one of two sets of criteria to qualify to apply for an exception: one for "applicable hospitals" and one for "high Medicaid facilities." Both sets of criteria require a hospital to not discriminate against beneficiaries of Federal healthcare programs and not permit physicians practicing at the hospital to do so.

In order to be considered an applicable hospital, a hospital must meet four criteria in addition to the non-discrimination requirement. First, the hospital must be located in a county that has seen a population increase that is at least 150% of the population increase seen by the rest of the state during the most recent five-year period for which estimates are available from the Bureau of Census. Second, the hospital must have an annual percent of total inpatient Medicaid admissions that is equal to or greater than the average percent of such admissions for all hospitals in the county during the most recent fiscal year. Third, the hospital must be in a state with an average bed capacity less than the national average

bed capacity for the most recent fiscal year. Fourth, the hospital must have an average bed occupancy rate that is greater than the average bed occupancy rate in the state. CMS requires the hospital to use its filed hospital cost report data to determine its total inpatient admissions and average bed occupancy rate. CMS will publish the other information on its website at http://www.cms.gov/physicianselfreferral/85_physician_owned_hospitals.asp.

A high Medicaid facility, on the other hand, only needs to meet two criteria in addition to nondiscrimination. First, there must be at least one other hospital in the county. Second, the hospital must have an annual percent of total inpatient Medicaid admissions greater than such percentage for any other hospital located in the county for the three most recent fiscal years. Again, the hospital must use its filed cost report data to establish the percentage of total Medicaid admissions and CMS will post the discharge data of for hospitals on its website.

Once a hospital has determined that it qualifies for an exception as an applicable hospital or as a high Medicaid facility, the hospital may submit a request for exception. A hospital may submit a request once every two (2) years. The request must include: (1) the hospital's identification information; (2) the county in which the hospital is located; (3) a contact person and contact information; (4) whether the hospital is an "applicable hospital" or "high Medicaid facility" and supporting documentation supporting such classification; (5) a statement that the hospital does not discriminate against beneficiaries of Federal healthcare programs and does not permit physicians practicing the hospital to do so; and (6) documentation supporting: (a) the hospital's calculation of its baseline number of operating rooms, procedure rooms and beds, (b) the number of operating rooms, procedure rooms and beds for which the hospital is licensed as of the date the hospital submits a request; and (c) the additional number of operating rooms, procedure rooms and beds by which the hospital requests to expand. The Chief Executive Officer, Chief Financial Officer or a comparable officer of the hospital must sign a certificate acknowledging, under federal penalties for perjury, that the request is true and correct to the best of their knowledge.

After a hospital submits a request, the hospital must disclose on its website that it is requesting an exception to expand the hospital. Individuals and entities in the hospital's community will have thirty (30) days after CMS publishes notice of the hospital's request in the Federal Register to provide written comments. If CMS does not receive any written comments by the end of the thirty-day period, the request will be considered complete. However, if CMS does receive comments from the community, the hospital has an additional 30 days after CMS notifies the hospital of their written comments to submit a rebuttal statement After the additional 30 days, the request will be considered completed.

A permitted increase cannot result in the number of operating rooms, procedure rooms and beds for which the hospital is licensed to be increased by more than 200% of the hospital's Baseline on its main campus. The hospital's main campus includes (a) the physical area immediately adjacent to the main buildings, (b) other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards, and (c) any areas determined on an case-by-case basis by CMS regional office. 42 C.F.R. §413.65(a)(2).

No later than sixty (60) days after receiving a complete request, CMS will publish its final decision in the Federal Register. CMS's final decision is not subject to administrative or judicial review under §1869, §1878 or otherwise. Unfortunately, this will make challenging a denial of a request for an exception difficult.

Additional Information

For more information on the OIG's Work Plan for 2012, please contact a member of Benesch's Health Care Department.

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