

# HEALTH REFORM **IMPACT**

## What you need to know NOW

NEWS FOR THE CLIENTS AND FRIENDS OF BASS, BERRY & SIMS PLC

### “Auld Lang Syne” for Physician Ownership of Hospitals<sup>1</sup>

December 17, 2010

As we discussed in earlier issues of *Health Reform IMPACT*,<sup>2</sup> the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act (collectively, the “Health Reform Legislation”), amended the “whole hospital” and rural provider exceptions to the Stark Law to restrict the ability of physicians (and their immediate family members) to hold an ownership interest in a hospital. While certain hospitals that put physician ownership in place on or before March 23, 2010 (the date of enactment of the Health Reform Legislation) are “grandfathered” and are therefore exempt from the outright ownership prohibition, they are nonetheless subject to significant operational restrictions and reporting requirements.

The Centers for Medicare & Medicaid Services (“CMS”) published the final regulations implementing these ownership restrictions<sup>3</sup> as part of the final calendar year (CY) 2011 updates to the Hospital Outpatient Prospective Payment System (“HOPPS”) and the ambulatory surgery center (“ASC”) payment system, which appeared in the Federal Register on November 24, 2010 (the “Final Rule”).<sup>4</sup> The Final Rule adopts the provisions of the earlier proposed version of the rule largely without modification. Unfortunately, the Final Rule does not address in sufficient detail some of the continuing ambiguities and operational complexities that will confront “grandfathered” hospitals as they seek to comply with the Final Rule on a going-forward basis.

#### *So Is The Confusing Interplay Of Dates Settled Now?*

As you may recall from our earlier issues of *Health Reform IMPACT*, the Health Reform Legislation introduced three separate compliance dates relating to the whole hospital exception — March 23, 2010, December 31, 2010, and September 23, 2011 — but failed to explain the interplay among them. For example, it was unclear whether a hospital under development as of March 23, 2010 (the enactment date of the Health Reform Legislation) would be required to have physician ownership as

<sup>1</sup> The phrase “Auld Lang Syne,” popularized in a tune sung at New Year’s, is said to stem from an ancient Scottish song and translates approximately as “times gone by.”

<sup>2</sup> See “Closing the Whole Hospital Window: Impact on Hospitals and Physicians,” dated April 6, 2010, [available here](#), and “Are We Clear Now? CMS Issues Proposed Rule Implementing Health Reform’s “Whole Hospital” Restrictions,” dated August 3, 2010, [available here](#).

<sup>3</sup> To be codified at 42 C.F.R. §§ 411.362, .356(c)(1).

<sup>4</sup> 75 Fed. Reg. 71800 et seq. (November 24, 2010).

of March 23, 2010 (the date beyond which aggregate physician ownership could not increase) or whether it could finalize its physician ownership sometime prior to December 31, 2010 (the date by which a physician-owned hospital must have in place both physician ownership and a Medicare provider agreement). Furthermore, it was unclear what Congress intended by establishing an overarching compliance deadline of September 23, 2011.

In the Final Rule, CMS reconciles these dates in the same manner as it had suggested it would do in the proposed version of the regulations. First, a physician-owned hospital must have had physician ownership in place as of March 23, 2010 in order to qualify for the whole hospital exception (or rural provider exception). As CMS states: “[I]f a hospital has no physician ownership or investment as of March 23, 2010, and later adds physician owners or investors, the hospital will not satisfy the whole hospital or rural provider exceptions.”<sup>5</sup> In the preamble commentary, CMS expressly refutes the argument that the March 23, 2010 deadline should apply only to hospitals that already had provider agreements in effect on March 23, 2010 and that those hospitals that were still under development on March 23, 2010 should be permitted until December 31, 2010 to put physician ownership in place.

CMS does clarify in the commentary to the Final Rule that a hospital may *decrease* its physician ownership after March 23, 2010, so long as it retains some physician ownership on December 31, 2010. “The hospital may not, for example,” states CMS, “reduce physician ownership to zero on December 31, 2010, and later increase physician ownership to the level that existed on March 23, 2010.”<sup>6</sup> Additionally, CMS clarifies that a physician-owned hospital may add or increase the number of physician owners or investors, or replace physician owners or investors, as long as the aggregate percentage of physician ownership or investment does not increase.

Second, as in the proposed rule, CMS states in the Final Rule that, in order to qualify for the whole hospital exception (or rural provider exception), a physician-owned hospital must have a Medicare provider agreement that is effective on or before December 31, 2010. CMS clarifies in the commentary to the Final Rule that a physician-owned hospital would satisfy the whole hospital or rural provider exception if its provider agreement is issued after December 31, 2010, so long as the provider agreement letter contains an effective date of on or before December 31, 2010.

Finally, as in the proposed rule, the compliance deadline for all other provisions of the amended exception that do not contain an explicit deadline, including many of the requirements intended to ensure bona fide investments by physicians, will be September 23, 2011. CMS states that “compliance with all requirements must occur no later than September 23, 2011, and failure to satisfy earlier deadlines [i.e., the deadline of March 23, 2010 by which physician ownership must be in place and the deadline of December 31, 2010 by which the provider agreement must be effective] will preclude use of the revised exception after the earlier deadline has passed.”<sup>7</sup> A disconcerting implication of this statement is that hospitals that put physician ownership in place after March 23, 2010, during the period of ambiguity regarding the compliance dates and prior to the clarifications issued by CMS, may be technically deemed to have violated the Stark Law for periods of time between March 23, 2010 and the time when they can unwind their physician ownership. However, the countervailing argument is that, since the clarifications were not made by CMS until the issuance of a rulemaking that has an effective date of January 1, 2011, there should be no enforcement of any technical violations before January 1, 2011.

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<sup>5</sup> *Id.* at 72241.

<sup>6</sup> *Id.* at 72242.

<sup>7</sup> 75 Fed. Reg. at 72241.

### *"Grandfathered" Hospitals Still Face Ownership Hazards*

Even for those "grandfathered" hospitals that can clearly establish continuous physician ownership since March 23, 2010, there are hazards in complying with the new ownership restrictions on a going-forward basis. As we discussed in our earlier issue of *Health Reform IMPACT*, in implementing the requirement that the percentage of the total value of the ownership or investment interests held by physicians not exceed the percentage as of March 23, 2010 (i.e., the "bona fide investment level"), hospitals with physician ownership must use extreme caution in any transactions involving the sale or transfer of units of ownership. For example, this prohibition could be violated, perhaps inadvertently, by redeeming ownership units held by non-physicians. In other words, if the number of units held by physicians remains unchanged, but the overall number of units held by investors decreases, the percentage of ownership held by physicians will automatically increase.<sup>8</sup>

The Final Rule does nothing to eliminate this hazard. In the Final Rule, CMS clarifies that the "bona fide investment level may fluctuate as long as it never exceeds the level that existed on March 23, 2010."<sup>9</sup> CMS agrees with commenters that adding or reducing physician owners is permissible as long as the bona fide investment level does not exceed March 23, 2010 levels. However, the risk of inadvertently increasing the bona fide investment level through a redemption of non-physician owners remains, and hospitals with physician ownership must be aware of this risk.

Moreover, hospitals may face operational complexities in calculating and keeping track of the "bona fide investment level" of physicians. One commenter suggested that CMS allow the bona fide investment level to be based on the percentage of the *number* of shares held by physicians rather than the percentage of the *value* of the shares held by physicians. The commenter was concerned that basing the limit on a hospital's value would require the hospital to ascertain its value on a regular basis to make certain that the aggregate value of the physicians' ownership never exceeds the March 23, 2010 limit. However, CMS expressly rejects the commenter's suggestion in the Final Rule, citing the language of the statute, which refers to the "value" of the shares rather than the number of the shares held by physicians. Incidentally, we note our disagreement regarding the commenter's interpretation of the statutory language as requiring regular valuations of the hospital. At least for entities with a simple capital structure, e.g., one class of stock or membership interests, the percentage of the total value of the ownership interests in the hospital held by physicians should not fluctuate when the value of the hospital fluctuates.

In one bit of flexibility for physician-owned hospitals, CMS clarifies in the Final Rule that the "ownership or investment interests of nonreferring physicians need not be considered when calculating the baseline physician ownership level."<sup>10</sup> However, CMS cautions against any arrangements in which physician owners of a hospital in one state engage in any cross-referral or cross-investment scheme with physician owners of a hospital in another state.

### *Limitation on Expansion of Facility Capacity*

The Health Reform Legislation, as interpreted by CMS in the proposed rule, limits the number of operating rooms, procedure rooms, and beds that a physician-owned hospital may have to no greater than the number of such rooms that it had licensed on March 23, 2010 (or for hospitals that

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<sup>8</sup> Another issue that has received little attention is whether a distribution of shares from a trust or retirement plan held for the benefit of a physician will create an increase in the level of physician ownership.

<sup>9</sup> *Id.* at 72249.

<sup>10</sup> *Id.* at 72250.

did not have a provider agreement in effect on March 23, 2010, the number of such beds and rooms on the date its provider agreement became effective). In the Final Rule, CMS makes no major changes to this interpretation, but clarifies that the statutory phrase “for which the hospital is licensed” applies only to beds, recognizing that “States usually do not license the number of hospital operating and procedure rooms.” With respect to operating and procedure rooms, it is the number of such rooms that “existed” and “were operational” on March 23, 2010 (or when the provider agreement became effective, as applicable) that constitutes the facility’s baseline capacity.<sup>11</sup> As CMS explains: “A hospital that had a provider agreement in effect on March 23, 2010 and was in the process of expanding the number [of] operating rooms or procedure rooms, but did not have the rooms in existence by March 23, 2010, would not be able to include in its baseline facility capacity the rooms that were not operational.”

Despite all of the foregoing restrictions, CMS does add some flexibility in the Final Rule. First, CMS confirms that a physician-owned hospital may replace operating rooms, procedure rooms and beds with new ones as long as the total numbers do not increase beyond the baseline number that the hospital had on March 23, 2010. Second, CMS clarifies that the restriction is on the *aggregate* number of operating rooms, procedure rooms and beds and, thus, there is no restriction regarding the manner in which a physician-owned hospital allocates its baseline facility capacity among its beds, operating rooms, or procedure rooms. By way of example, CMS states that “if a hospital is authorized to operate 20 beds, 2 operating rooms, and 2 procedure rooms, the hospital may reduce or increase the number of beds, operating rooms or procedure rooms as long as the resulting aggregate number of beds, operating rooms and procedure rooms does not exceed 24.”<sup>12</sup> Third, CMS seems to suggest that the relocation of beds (and perhaps other rooms) would not constitute an increase in the number of licensed beds.<sup>13</sup> And fourth, CMS finalized its proposal to adopt a narrow definition of procedure room by limiting the types of rooms that qualify as procedure rooms to rooms in which catheterizations, angiographies, angiograms and endoscopies are performed.

The Health Reform Legislation permits the Secretary of the Department of Health and Human Services to grant exceptions to the foregoing capacity restrictions. CMS plans to issue a separate rulemaking to implement the exception process.

### *Conflicts of Interest*

The Final Rule also contains provisions that: (1) require each referring physician owner or investor to agree, as a “condition of continued medical staff membership or admitting privileges, to provide written disclosure of his or her ownership/investment interest in the hospital (and, if applicable, the ownership or investment interest of any treating physician) to all patients the physician refers to the hospital” by “a time that permits the patient to make a meaningful decision regarding the receipt of care;” (2) stipulate that a hospital may not condition any physician ownership/investment either directly or indirectly on the physician making or influencing referrals to the hospital or otherwise generating business for the hospital; and (3) specify that the hospital must disclose on any public Web site for the hospital and in any public advertising that it is owned or invested in by physicians.

In the preamble commentary to the Final Rule, CMS clarifies that for emergency room patients who are treated by the hospital’s physician owners, no physician-ownership disclosure is necessary under this rule. The reasoning of CMS is that, by the time a patient is presented at the emergency

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<sup>11</sup> 75 Fed. Reg. at 72246.

<sup>12</sup> 75 Fed. Reg. at 72245.

<sup>13</sup> *Id.* at 72245.

department, the patient or the patient's representative has already made a decision about where to receive care.<sup>14</sup>

The Final Rule also includes an annual reporting requirement for physician-owned hospitals, which involves disclosing and detailing to CMS the identity of each physician-owner. However, CMS has deferred until a later date implementing procedures for this annual reporting requirement.

### *Bona Fide Investment*

CMS incorporates the remaining bona fide investment requirements of the Health Reform Legislation, which must be met by September 23, 2011, into the Final Rule. For example, among other things, the hospital may not offer a physician more favorable terms than non-physician investors/owners or directly or indirectly provide loans or financing for any investment in the hospital by a physician.

In addition, the Health Reform Legislation prohibits a hospital from conditioning physician ownership either directly or indirectly on the physician's ability to make or influence referrals to the hospital. In the preamble discussion to the Final Rule, CMS suggests that it may interpret this provision broadly and, in so doing, perhaps unintentionally casts a taint on standard provisions that hospitals have previously used in order to *comply* with the whole hospital exception. For example, one commenter representing a hospital system asked whether hospitals may continue to condition a physician's ownership interest on his or her continued practice of medicine and require the physician to divest his or her interest in the hospital if the physician retires or ceases to practice medicine in the community served by the hospital.

CMS responds in the Final Rule commentary that, depending on the facts, these types of provisions "could implicate" the prohibition against conditioning a physician's ownership on making or influencing referrals to the hospital. However, CMS fails to harmonize this statement with the fact that, in order to comply with other parts of the "whole hospital" exception, hospitals must ensure that physicians are authorized to perform services at the hospital, which has been interpreted to mean that they must have a bona fide medical staff appointment. Physicians who retire or cease to practice medicine in the hospital's community typically would not be eligible for a bona fide medical staff appointment at the hospital and would not actively be expected to perform services at the hospital.

### *Patient Safety*

As it had proposed to do in the proposed version of the regulations, CMS extends patient safety requirements imposed by the Health Reform Legislation to both inpatients and outpatients and incorporates these requirements into the Final Rule. CMS clarifies that the hospital's failure to obtain a signed acknowledgment from the patient that the hospital does not have a physician available on the premises to provide services during all hours, inadvertent or not, would constitute non-compliance.<sup>15</sup>

If you have any questions about this issue of *Health Reform IMPACT*, please contact any of the attorneys in our Healthcare Practice Group listed below.

Also, please [click here](#) to visit our special Web page for Health Reform IMPACT.

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<sup>14</sup> *Id.* at 72248.

<sup>15</sup> *Id.* at 72252.

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