Specialty Hospital Moratorium Allowed to Expire

While such hospitals now can receive federal pay, CMS said ownership arrangements warrant scrutiny.

BY ALICIA AULT
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The Centers for Medicare and Medicaid Services has allowed the moratorium on physician-owned specialty hospitals to expire, which means that those facilities—whether old or new—again can receive federal reimbursement.

However, in its report to Congress that ended the moratorium, CMS said that ownership arrangements at the facilities—which offer specialized care in the cardiac, surgical, and orthopedic areas—warrant more federal scrutiny.

The moratorium began in 2003; from late that year until June 2005, specialty hospitals could open and receive a Medicare provider number, but physician-owners could not bill for services for Medicare beneficiaries they referred to the facilities. Hospitals also were prohibited from increasing the number of physician investors or the number of beds or changing the kind of services provided.

The moratorium was essentially extended in mid-2005, when no new hospitals were allowed to enroll in Medicare. In the meantime, Congress directed CMS to study the hospitals' financial arrangements and provision of charity care and report back by last Aug. 8.

The final report "provides a comprehensive path forward to address the concerns that have been raised," said CMS Administrator Mark McClellan at a press conference sponsored by CMS.

Now, specialty hospitals may receive Medicare payments provided they meet certain criteria outlined in the CMS report.

The report, combined with new proposals governing inpatient, outpatient, and ambulatory surgery center payments, "should put an end to the debate over specialty hospitals," said Randy Fenninger, Washington representative for the American Surgical Hospital Association, an organization of specialty hospitals.

But, the American Hospital Association and the Federation of American Hospitals said the report shows that specialty-oriented facilities are skirting the law. Both organizations said CMS found evidence that specialty hospitals are soliciting physician-investors who can refer a high volume of patients.

The CMS plan includes some potentially promising initiatives but falls short by not addressing the core issue of conflict of interest.

For instance, CMS reported that cardiac hospitals always offered the same payment terms to noninvestor and investor physicians, but that orthopedic and surgical hospitals offered noninvestors a lesser rate. According to a CMS statement, "Although not explicitly given by the hospitals as a criterion for selecting investors, it appears that the volume of referrals and revenue generated may have been a critical factor for some hospitals in determining which physicians were permitted to invest."

Mary Beth Savary Taylor, vice president for executive branch relations at the AHA, said, "More action is needed to really take a look at conflict of interest when physicians own and refer patients [to a facility]." She added that AHA believes that "physician referrals to limited-service hospitals should be banned."

"The CMS plan includes some potentially promising initiatives, such as increasing enforcement scrutiny, but it falls short by not addressing the core issue of conflict of interest," said the Federation of American Hospitals in a statement.

The CMS report is based on a survey of 130 specialty hospitals and 270 general acute care competitor hospitals.

While the response rate overall was good, there was a lack of full participation in many areas. Sen. Chuck Grassley (R-Iowa) and Sen. Max Baucus (D-Mont.) wrote to CMS just before the report was issued to complain about the paucity of responses. After the report's release, they said they would still seek more data. "I'm concerned that a survey of just 140 facilities was used to develop policy for the roughly 4,000 hospitals reimbursed by Medicare," said Sen. Baucus in a statement.

The senators are cosponsors of the Hospital Fair Competition Act of 2005 (S. 1002), which they said will "rein in the growth of physician-owned specialty hospitals."

In the survey, specialty hospitals were asked, for instance, to report on returns on physician investment. CMS found that among the hospitals that responded, the returns overall were proportionate to investment. But, said CMS, only 47% of the hospitals surveyed responded to this question.

The agency said it considers nonproportional returns to be violations of physician self-referral and antikickback laws, and that it would go after suspect arrangements.

Some hospitals are already being disciplined for violations under the moratorium. CMS said that four hospitals improperly sought Medicare reimbursement for patients who had been referred by physicians who had an ownership interest in the hospital, resulting in an overpayment of $12.1 million. The agency is seeking repayment of those funds.

In the report, CMS also said it would require all hospitals to disclose compensation arrangements and the fact that physicians are investors. Hospitals that did not fully respond to the survey will be the first to receive forms seeking such disclosures. If they don't respond in a timely manner, they will be fined up to $10,000 a day.

Also, CMS clarified that all hospitals, including specialty hospitals—even if they don't have an emergency department—will be required to comply with the transfer provisions of the Emergency Medical Treatment and Labor Act. That means they must accept transfers and provide emergency services for patients, regardless of their ability to pay.

Mr. Fenninger said specialty hospitals were in agreement with this provision.

As expected, CMS found that specialty hospitals provide less charity care than acute care hospitals do—an average 4% for cardiac hospitals, 1% for orthopedic hospitals, and 0.2% for surgical hospitals in fiscal 2004 and 2005, compared with 8% for general facilities.

Again, Mr. Fenninger said this was not surprising, claiming that most specialty hospitals were in geographic areas that did not serve many charity care cases.

CMS agreed that there might be extenuating circumstances, and pointed out that "the profile of services offered by specialty hospitals may contribute to the differences in patient mix." The agency said that Congress should consider whether further reforms are needed to ensure greater delivery of charity care by the facilities.

Dr. McClellan said the report should not be seen as a signal that the federal government would stop monitoring physician-owned facilities.

"When it comes to enforcing the requirements of the law when it comes to specialty hospitals, we mean it and we're going to do it," he said. ■

Federal Regs Avoid Deep Cuts in Payment for Stents, ICDs

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Hospitals and medical device makers have escaped deep cuts that had been proposed by Medicare for procedures such as implanting drug-eluting stents, defibrillators, and pacemakers.

The fiscal 2007 Inpatient Prospective Payment System final rule "is the most important reform for hospital payment in decades," said Centers for Medicare and Medicaid Services (CMS) Administrator Mark McClellan at a press conference sponsored by CMS.

The rule marks a return to a cost-based system, but no longer contains the drastic cuts first proposed for many procedures—33% for drug-eluting stents, 24% for implantable cardioverter defibrillators (ICDs), 15% for pacemakers, and 28% for ablations.

As such, it marks a victory of sorts for physicians' and hospital organizations and medical device makers. Such groups had voiced concern that the rule, as first proposed, would likely reduce access to many cardiac and orthopedic procedures because the reductions in reimbursement were so severe.

The American Hospital Association and the Federation of American Hospitals worried that the impact would be too much too soon, and—along with the medical-device industry group AdvaMed—called for at least a 1-year delay in implementation of the rule.

During the press briefing, Dr. McClellan said that CMS did not feel a delay was necessary. The agency took everyone's concerns into account, and instead decided to phase in the changes first proposed in April, he said.

Overall, Medicare will increase payment rates by 3.5% on average, for an increase of $3.4 billion. Cardiac specialty hospitals will receive a slightly lower boost—1.2% on average—in an effort to make payments more accurate, according to CMS.

And, answering critics, CMS will use cost reports from fiscal 2004—instead of fiscal 2003—for its 2007 payment calculations. Surgeons and device makers had noted that some devices, such as drug-eluting stents, had just barely hit the market in 2003.

The agency also is embarking on an overhaul of the diagnosis-related groups by creating 20 new DRGs and modifying 32 existing DRGs in 2007 to more accurately adjust for patients' severity of illness. By 2008, CMS hopes to have a new severity evaluation method; it is seeking input from outside contractors starting in September, said Dr. McClellan. After a report, the agency will take public comment before making changes for 2008.

Finally, hospitals that report on the 20 Hospital Quality Alliance–approved quality measures to the agency for posting on its Hospital Compare Web site will receive a full market basket increase in their payment rates.

Hospital and physician groups reacted positively. "We're gratified actually by the changes that have been made in the final rule," said Dwight W. Reynolds, president of the Heart Rhythm Society, in an interview. For example, ICDs are scheduled for only a 2% cut in 2007, compared with 24%. Further, the society is more comfortable with how payments are being calculated: "No one likes to see reductions, but these are much more manageable for the hospitals than the ones proposed in the draft."

AdvaMed also pronounced itself gratified, especially with the phase-in, according to a statement by president and CEO Stephen J. Ubl.

The rule addressed most of the AHA's concerns, but the organization was not entirely satisfied, said Rick Pollack, executive vice president, in a statement. "While we continue to believe a 1-year delay is needed given the rule's complexity, we are committed to working with CMS to ensure any needed changes are addressed in future years." ■