Will the Federal Government Shut Down Surgery Centers and Physician-Owned Hospitals?

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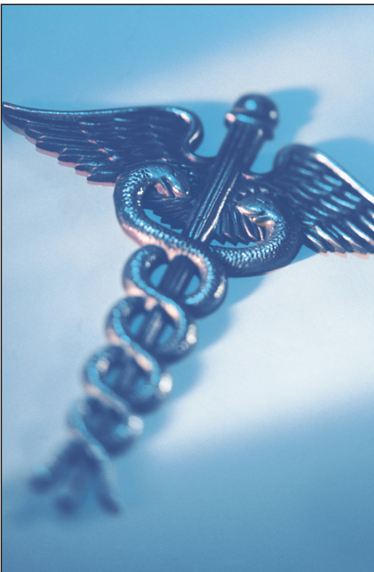
As the Democrats take control of the House, the Senate and the Presidency many question the impact of such a change on physician-owned hospitals and ambulatory surgery centers ("ASCs"). The most significant question being: Will the federal government shut down and/or restrict physician-owned hospitals and ASCs?

The short answer to this question is (1) no the federal government will not shut down ASCs, and (2) maybe the federal government will halt the development of new physician-owned hospitals and/or restrict the activities of and adopt new rules relating to existing physician-owned hospitals.



I. A Story of Numbers and Politics. Currently, there are approximately 5,800 ASCs in the United States. Of these, approximately 900 are not Medicare-certified. Forty percent (40%) of all ASCs are located in five (5) states: California, Florida, Texas, Georgia and Pennsylvania. In addition, there are approximately 200 physician-owned hospitals in the United States.

II. The Mood in Washington D.C. and States towards Physician Ownership. The mood in Washington and states towards physician ownerships is slightly more favorable than the Bush administration's view of Iran, Iraq, and North Korea. Essentially, physician ownership is viewed very negatively in Washington D.C. and in many states.

A. Imaging. In the imaging sector, there is a common perception that supply drives demand (i.e., the more imaging facilities that are available, the more procedures that will be performed). Recently, the Wall Street Journal published an article reporting that many payors are implementing new prescreening requirements to "ensure that physicians use high-tech scans only when it is clear that patients will benefit."1 Insurers such as Aetna, Inc, WellPoint Inc, and Cigna Corp. have hired radiology benefits managers to monitor scans. A Government Accountability Office report found that Medicare spending on scans varied based on geographic area, suggesting that all procedures may not be necessary or appropriate. Further, the federal government is implementing a series of rules relating to (i) the designation as an independent diagnostic testing facility; (ii) the inability to lease space to other Medicare providers; (iii) the elimination of per click relationships; (iv) the elimination of block leasing relationships; and (v) several other requirements designed to make physician-owned imaging, as well as imaging as a whole, less costly to the federal government.

The initial reasoning behind the Stark Act (initially only applicable to physician-owned labs), was based on an older study which found that the number of procedures performed at a facility increased when (i) a physician owned an interest in the facility, (ii) the physician was able to refer patients to such facility, and (iii) the physician did not have to personally perform the procedure at the facility. In 1998, the Department of Health and Human Services, in proposing the Phase I Rule of Stark II explained:

> Both the anti-kickback statute and section 1877 address Congress' concern that health care decision-making can be unduly influenced by a profit motive. When physicians have a financial incentive to refer, this incentive can affect utilization, patient choice, and competition. Physicians can overutlilize by ordering items and services for patients that, absent a profit movie, they would not have ordered.[2]

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1 Anna Wilde Mathews, *Insurers Hire Radiology Police to Vet Scanning*, WSJ online, Nov. 6, 2008.
2 63 Fed. Reg. 1659, 1662 (Jan. 9, 1998).

The Stark Act continues to develop around this concept, and thus, the Stark Act has traditionally restricted situations where a physician could refer a patient to a facility, such as a lab or imaging facility, but did not have to personally perform the services on the patient.

B. Physician-Owned Hospitals. The federal government has conducted approximately 10 different studies as to the effects of physician-owned hospitals. The vast majority of these studies have indicated that physician-ownership of a hospital is fairly benign. Notwithstanding this fact, the physician-owned hospital industry has a number of very strong opponents in Washington, D. C. These include Senator Max Baucus, Senator Charles Grassley and US Representative Pete Stark. For political and other reasons these individuals look very unfavorably upon physician-owned hospitals. In December 2007, the Washington Post quoted Senator Charles Grassley as follows:

> My motivation for seeking reforms over a long period of time is the effect that specialty hospitals have on community hospitals when specialty hospitals pass the buck on emergency care and cherry-pick based on profits rather than patient needs.[3]

Interestingly, many of these physician-owned hospitals are amongst the leaders in the country in certain quality studies. As expected, there are an extremely small number of aberrational types of physician-owned hospitals that provide a sub-standard level of care. However, notwithstanding the fact that (i) general acute care hospitals may also provide such substandard level of care, and (ii) infections picked up in a general hospital are one of the leading causes of death in this country, each time a bad action occurs at a physician-owned hospital, a congressional study and investigation commences.

C. Surgery Centers. Many at CMS have long taken the view that, although they do not love ASCs or physician-owned hospitals, ASCs are located in so many congressional districts and a large outcry would result if they tried to outlaw physician ownership, that it will be impossible to now prohibit physician ownership of ASCs. That stated, their belief is that the ASCs ship on restriction has sailed but prohibitions may still be possible for physician-owned hospitals. Thus, there is perceived to be the ability to still restrict or prohibit physician ownership of hospitals.

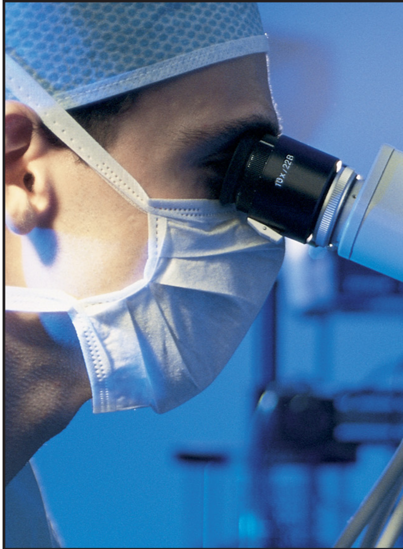
D. The New Jersey Codey Law. For nearly a decade, the New Jersey Codey Law, New Jersey's version of the Stark Act, had been read to permit physician-ownership of ASCs. However, in recent cases completely unrelated to the Codey Law, judges have opined that the Codey Law prohibits physician-ownership of ASCs in the traditional sense. In *Garcia v. Health Net of New Jersey, Inc.*, the court found that referrals to an ASC in which the referring physician had a significant financial interest violated the Codey Law. Due to such decisions, New Jersey may become one of the first states to prohibit and outlaw the new development of physician-owned ASCs. The compromise likely to result in New Jersey is typical of such political struggles and outcomes. In essence, those already developed physician-owned ASCs have political clout and thus will likely maintain their facilities without prohibition. In contrast, there is no one to protect the unborn ASCs. This type of situation is precisely why many new laws include a grandfathering clause. Such a clause allows the politicians to protect themselves, by allowing the existing ASCs or hospitals to survive, while simultaneously pleasing

3 Christopher Lee, *Limits Weight on Physician-Owned Hospitals*, The Washington Post, Dec. 9, 2007 at A03.

their allies in the American Hospital Association or the Federation of American Hospitals by outlawing new developments. In January 2008, the New Jersey Board of Medical Examiners elected to move forward on an emergency rule in response to these recent cases.

E. Pain Management. The government has made pain management part of its work plan for 2009. In essence, much like imaging, the government believes that pain management has grown to unnecessary proportions and that the ownership and profit that pain management procedures provide has led to unnecessary procedures.

F. PET and Radiation Therapy Ventures. CMS has extended the Stark Act to apply to radiation therapy ventures and positron emission tomography ("PET") services. Therefore, these arrangements may only operate if structured to meet an exception to the Stark Act.



G. Miscellaneous – Block Leasing, Per Click and Under Arrangements. The federal government has also made negative comments on "indirect" referrals in various advisory opinions. CMS has also taken action to prohibit most types of per click leases and under arrangements structures. It has also determined that the anti-markup rules apply to block leases. Further, in Advisory Opinion No. 08-10 issued on August 19, 2008, the Office of Inspector General also raised concerns regarding block lease arrangements under the Anti-Kickback Statute.

III. What Will Happen Next? ASCs are likely to survive largely intact. While ASCs may be challenged in some states, the outstanding work of the ASC Association and the fact that for each patient treated in an ASC, the Medicare program receives a 35% discount or savings for the procedure (as opposed to the procedure being performed in a hospital outpatient department), it is likely that ASCs will survive the upcoming political changes.

The physician-owned hospital situation is more challenging. The House and Senate over the last year have reached agreement on different types of provisions that would essentially eliminate the new development of physician-owned hospitals. The physician-owned hospital industry has been protected by both the White House and a number of Republican and conservative Democratic senators who support entrepreneurial healthcare growth and service (as opposed to protecting acute care hospitals from competition). That stated, the change in the make-up of the House, the Senate and the White House is not beneficial to physician-owned hospitals. In many ways, it is a story of political clout. Because physician-owned hospitals are in few districts, the Congressmen and Senators in the numerous districts without such facilities may take campaign contributions and abide by the wishes of certain enemies of physician-owned hospitals (i.e., the American Hospital Association and the Federation of American Hospitals), without fear of retribution. In essence, a Congressman or Senator who does not have a physician-owned hospital in his or her district need not worry about retribution in voting positively to restrict physician-ownership. Thus, the risk of applying physician-owned hospital prohibition rules to existing physician-owned hospitals significantly rises.

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