# Specialty Hospital Moratorium: Gone, But Not Forgotten

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Practice Area: Health Law

The moratorium on Medicare and Medicaid payments to physician-owned specialty hospitals officially expired on June 8, 2005, notwithstanding recommendations by the Medicare Payment Advisory Commission (MedPAC) to extend that moratorium, and recent legislation introduced by Senator Charles E. Grassley and Max Baucus to make the moratorium permanent. Despite the "official" expiration, administrative actions by the Centers for Medicare & Medicaid Services (CMS) have the effect of extending the moratorium until January 2006, while CMS reviews and implements certain recommendations relating to Medicare payment policies for physician-owned specialty hospitals.

**Background**
The specialty hospital moratorium was enacted by Congress in Fall 2003 as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). This moratorium had the effect of preventing physicians from referring Medicare patients to certain specialty hospitals in which the physicians were investors.

Under the Stark physician self-referral prohibitions, physicians cannot refer Medicare patients for certain designated health services to entities with which the physician has a financial relationship, unless an exception applies. The Stark law contains two important exceptions relating to physician ownership. First, the "whole hospital" exception allows physicians to make referrals to hospitals in which the physician has an ownership interest, so long as the ownership interest is in the whole hospital, rather than a subdivision of the hospital. Second, the "rural provider" exception allows referrals to rural providers in which the physician has an ownership interest, if the provider furnishes "substantially all" of the designated health services to individuals in that area.

MMA became effective December 8, 2003. MMA imposed a moratorium on specialty hospitals until June 8, 2005. During the MMA moratorium, the "whole hospital" and "rural provider" exception were no longer available for physician referrals to a "specialty" hospital in which the physician had an ownership or investment interest, and the hospital was not allowed to bill Medicare or any other entity for services provided as a result of the prohibited referral. The MMA moratorium applied to cardiac, orthopedic, and surgical hospitals, but the MMA grandfathered specialty hospitals that were in operation before, or under development as of, November 18, 2003.

**Reasons For Moratorium**
The moratorium allowed the government time to evaluate the impact of specialty hospitals on local full service community hospitals. MMA directed both MedPAC and the Secretary of Health and Human Services (HHS) to report to Congress on issues relating to specialty hospitals, including:

- Cost differences between physician-owned specialty hospitals and community hospitals.
- The financial impact of specialty hospitals on community hospitals.
- Quality of care comparisons.
- Differences in uncompensated care between the hospitals.

**MedPAC's Report**
In March 2005, MedPAC reported to Congress on its study of the impact of specialty hospitals on community hospitals. MedPAC voiced concerns about patient selection, utilization and efficiency, tied in part to the profitability across and within certain diagnosis-related groups. MedPAC recommended changes to the Medicare inpatient prospective payment system for acute care hospitals, principally involving revisions to DRG rates to more accurately reflect the cost of patient care. Most significantly, MedPAC recommended that Congress extend the specialty hospital moratorium until January 1, 2007, to allow Congress and the administration time to consider implementation of these recommendations.

**Congressional Action**
On May 11, 2005, Senators Grassley and Baucus introduced the Hospital Fair Competition Act of 2005 (S.1002), which would permanently extend the ban on new specialty hospitals and essentially freeze the operations of previously-grandfathered facilities. S.1002 would also implement a number of the specific hospital payment changes proposed by MedPAC in March. These include tying DRG payments to cost rather than charges, revising the calculation of DRG weights, and adjusting DRG payments to reflect severity of illnesses. In effect, S.1002 would make the "whole hospital" exception unavailable to new specialty hospitals.

Following its introduction, the bill was referred to the Senate's Committee on Finance, of which Senator Grassley is chair. If this bill is enacted in its present form, the effective date would be retroactive to June 8, 2005, the date on which the moratorium otherwise would expire. This bill remains in committee as of this date.

S.1002 faces an uncertain future, as the Administration and several key Republican senators have already expressed their lack of support. The Republican Policy Committee has issued its own report recommending against further extension of the moratorium, while at the same time recommending reform in the Medicare payment system for hospitals.

**HHS/CMS Proposals**
One reason for the lukewarm reception in Congress for S.1002 may be lawmakers' preference for other fixes proposed by the Bush administration. On May 12, CMS presented its report on specialty hospitals to Congress. Administrator Mark McClellan testified before the House Energy and Commerce Subcommittee on Health that CMS did not support extending the moratorium. Instead, CMS has proposed the following specific recommendations:

- Reforming payment rates for inpatient hospital services through refinements to the DRG system. This includes setting payment levels that are more closely tied to the severity of illness.
- Reforming payment rates for ambulatory surgery centers, by reducing payment differences between hospital outpatient environments and ambulatory surgery centers.
- Reviewing new applicants for Medicare participation approval to determine if they meet the definition of a hospital, particularly as to specialty-care hospitals that concentrate primarily on outpatient care, and hospital conditions of participation. CMS will also examine applicant hospitals to make sure that they satisfy other criteria, including emergency care procedures required under EMTALA.

CMS will also direct state survey and certification agencies to hold off on processing further participation applications from specialty hospitals until January 2006, in order to give CMS time to implement those recommendations. CMS' proposals are based in part on its analysis of the recommendations reported to Congress by MedPAC two months earlier.

**What's Next**

Congress, the Bush administration, community hospitals and physician groups remain at an impasse on how to deal with the specialty hospital issue. As a result, while the moratorium has officially expired, the door remains closed on new specialty hospitals for the time being. It is likely that Congress will eschew the permanent moratorium approach of S.1002 in favor of the Medicare payment reforms proposed by MedPAC and CMS. This would allow physicians once again to refer designated health services to physician-owned specialty hospitals in 2006, subject to reforms that reduce – but not eliminate – the financial incentives associated with that ownership.

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