Department of Health and Human Services Issues
Final Report to Congress on Specialty Hospitals

By: Scott Becker and Sarah Abraham

The United States Department of Health and Human Services recently released its Final Report ("Report") to Congress related to specialty hospitals. The Report contained (1) a review of the studies to date done by various different parties on the specialty hospital issue, (2) a review of the survey results and related information, (3) a review of interim reports and comments, and (4) the recommendations of the Department of Health and Human Services.

This short review of the Report notes several interesting aspects of the Report.

The Report, while overall positive in its conclusions towards specialty hospitals, over the long run may be viewed as doing little to benefit the specialty hospital industry. There are a number of findings in the report that can be read by an advocate of specialty hospitals as positive. On the other hand, there are a number of items of interest in the Report that can be viewed negatively by the proponents who are advocates of additional restrictions against physician ownership of specialty hospitals.

I. Core Recommendations.

The Report's core recommendations are as follows:

1. No new legislation or expansion of the Stark Act "at this time".
2. An expiration of the moratorium on issuing provider numbers to specialty hospitals.
3. Improve the payment system to improve payments for more severe and higher acuity cases and possibly lower payments for less severe cases.
4. Align Physician and Hospital Incentives – Gain Sharing and Group Purchasing.
5. Assure that hospitals meet EMTALA requirements
6. Create reporting requirements to CMS on physician ownership - names, nature and extent of ownership, compensation reporting, and penalties for not reporting.
7. Disclosure of ownership to patients.
8. Continued and enhanced enforcement of the Stark Act and the Anti-Kickback Statute.

II. Core Findings.

Certain of the key findings of the Report are as follows:

(A) Location of Physician Hospitals. The survey showed approximately 130 physician owned hospitals. It also showed that specialty hospitals remain concentrated in seven states; California, Kansas, Louisiana, Ohio, Oklahoma, South Dakota and Texas. Here, the DHHS also stated that specialty hospitals tend to be located in states

without CON requirements, in urban markets and primarily in more affluent high population growth markets, such as, Austin, Texas, Dallas/Ft. Worth, Houston and San Antonio.

(B) Non Responsiveness. The DHHS noted that to date the information they received on physician investment did not reveal any disproportionate or non bona fide arrangements that require CMS to seek a drastic shift in its approach. However, it also noted that the extent of non responsiveness gives CMS significant concern about potential tainted relationships. Thus, they will seek more ongoing and regular financial disclosure by these hospitals. It also suggested that it will impose significant penalties for hospitals that do not follow the financial reporting requirements.

CMS received surveys back from 64 specialty hospitals. Of these, it counts 35 of them as general surgical hospitals, 17 as orthopedic hospitals and 12 as cardiac hospitals.

> "In summary, the data we received on physician investment has not revealed, on its face, any disproportionate or non-bona fide arrangements that require CMS to institute a drastic shift in our enforcement approach. However, the extent that hospitals did not respond to our survey questions on investment interests and compensation arrangements (or did not respond completely), gives us sufficient concerns about potential tainted relationships or basis for their non-response that CMS will begin an initiative seeking financial disclosure with those hospitals and will implement a regular disclosure process."

(C) Characteristics of Respondent Hospitals. The following chart discloses certain of the overall characteristics that CMS found with respect to specialty and competitive acute care hospitals.

Table 1
Characteristics of Respondent Specialty and Competitor Hospitals

Characteristic	Competitor	Cardiac	Orthopedic	Surgical
Average Number of Staffed Beds	243 (74/76)	54 (12/12)	24 (17/17)	14 (34/35)
Average Daily Census	161 (74/76)	35 (12/12)	8 (17/17)	4 (33/35)
Average Length of Stay (in Days)	4.2 (65/76)	3.5 (12/12)	2.6 (17/17)	2.3 (31/35)
Average Operating Margin	10.9% (63/76)	-3.8% (10/12)	20.1% (14/17)	16.9% (23/25)
Average Number of Current Physician-Investors	0 (76/76)	31 (12/12)	25 (15/17)	39 (33/35)
Average Ownership Share Per Physician	0	2.1% (3/12)	2.6% (6/17)	2.2% (8/35)

> "In its MMA Study, MedPAC found that, with respect to physician-owned specialty hospitals, the aggregate physician investment averaged 35 percent in cardiac hospitals, 67 percent in orthopedic hospitals, and 73 percent in surgical hospitals. For the median specialty hospital, the largest share owned by a single physician was 4 percent. In approximately one-third of specialty hospitals, the largest share owned by a single physician was 2 percent or less, and in approximately one-fifth of specialty hospitals, the largest share was at least 15 percent. The HHS MMA Study concluded that the size of the ownership share appears to be a significant contributing factor in referral of patients."

(D) Limits on Physician Financial Risk.

CMS has long viewed situations where physicians are not required to have real capital at risk as problematic. Thus, in its survey, it asked whether there are provisions in these transactions which limit physician risk compared to other investors. In short, it found that of the 45 hospitals that responded to the question regarding physician limitations on risk, 41 reported that they have no special limitation as to physician liability. The question also requested data on the type of investment by physicians.

Table 2
Type of Payments Made by Physicians

	Average Initial Investment	Average Capital Calls	Average Loan Guarantee Fees
Cardiac	$85,043 (10/12)	$0 (0/12)	$5,514 (1/12)
Orthopedic	$111,522 (4/17)	$0 (0/17)	$0 (0/17)
Surgical	$85,327 (22/35)	$16,741 (1/35)	$0 (0/35)

> "Although respondents provided us with a listing, we are unable to ascertain the extent to which investments or capital calls were paid for with cash versus borrowed funds, and we note a significant number of payments for which the respondents (especially the orthopedic hospitals) did not provide details. The HHS MMA Study captured the price paid for ownership shares and noted that it varied widely. The average purchase price of an ownership share of 0.9 percent for a cardiac hospital ranged between $28,000 and $72,000, and, for an orthopedic/surgical hospital, where the average ownership share was 2.2 percent, the range was between $30,000 and $120,000."

(E.) Loans to Physicians.

CMS has long had a concern with either limited investments in hospitals or loaning money to physicians to make investments. The responses to these questions and some of the thoughts of the DHHS, as to the lack of loans and as to the use of an entity that needs less capital to allow physicians to own interests at lower costs, are as follows:

> "We analyzed the responses to assess the degree to which physicians at competitor acute care hospitals and specialty hospitals were receiving loans and loan guarantees. We received 84 responses from hospitals on this topic. Of this amount, 41 were from competitor acute care hospitals and 43 were from specialty hospitals. We found that only 18 responding hospitals reported loans or loan guarantees to physicians. Only three physician-owned specialty hospitals had such loans or loan guarantees, while 15 competitor acute care hospitals did.
>
> We have reviewed the three specialty hospitals referenced above. One of the hospitals made a

loan to 2 investors for terms ranging from 12 months to 60 months. Both were at a rate of interest of prime plus 1 percent. We are unable to conclude that these two loans were at less than market rates. The other two specialty hospitals identified loans from commercial lenders in response to the survey. However, the hospitals did not provide information as to the terms or recipients of any guarantees for these loans.

In addition to the above, MedCath, the owner and operator of multiple cardiac hospitals, including 10 of the 12 cardiac survey respondents, stated that it does not provide loans directly to physicians. However, MedCath does guarantee loans for individual physician investors where a third party lender to a hospital has required MedCath to do so. In this case, according to MedCath, the individual physician investors are charged a fair market value guarantee fee by MedCath based upon their pro rata portion of the guaranteed hospital debt."

Capital Assets

"We believe that an issue closely related to whether physicians choose to invest in specialty hospitals involves the capital assets required to operate the facility. Capital assets have been defined as assets that have an expected life of more than one year, cannot be turned into cash quickly, and include things such as land, buildings, and other fixed equipment. The size of a hospital, the working capital needed for operations, and the capital needs determine the amount of investment required in a specialty hospital. Importantly, ownership mix can affect the ability of a hospital to borrow funds. Without institutional investors, physicians may have to personally guarantee loans, interest rates may be higher, and access to capital can be more limited.

We carefully reviewed the documentation submitted by specialty hospitals that were seeking a determination that the specialty hospital was "under development" and, thus, not subject to the moratorium. When describing the funding that was received for the project and the arrangement to create the hospital, many requestors stated that physicians contributed money only for an ownership interest in the entity that was to be licensed as a hospital. The physician-investors

would not have any ownership interest in the land or the building where the hospital was to be located or the capital equipment that would be used in the hospital. We saw this pattern most often with orthopedic and surgical hospitals (but not with cardiac hospitals) that were set up by a syndicator that purchased the land, contracted to build the hospital and other structures (which the syndicator will then own alone or with a limited number of partners, including, perhaps, some physicians), and that also purchased the capital equipment. We note that, in arrangements structured in this manner, typically, the land, building, and capital equipment are rented to the operating entity, which incurs costs for them over time. We recognize that this structure of a hospital and its operation could bear significantly on the physician's risk of loss or liability. The amount of physician investment needed in the operating entity could be significantly lower under these types of scenarios, and could bear on the amount of a physician's rate of return on his or her investment."

Table 3
Capital Asset Ownership by Hospital[1]

	LAND	BUILDING	EQUIPMENT
Cardiac	83.3% (10/12)	100.0% (11/11)	72.7% (8/11)
Orthopedic	25.0% (4/16)	18.8% (3/16)	50.0% (8/16)
Surgical	15.6% (5/32)	21.4% (6/28)	65.4% (17/26)
Competitor Acute	85.3% (58/68)	75.4% (46/61)	83.0% (49/59)

Business structures that relieve investors of up-front capital costs, such as land, building and equipment costs, raise particular concerns regarding whether investors are assuming *bona fide* business risk and whether they may be benefiting inappropriately in connection with their

[1] The numbers in parentheses represent the number of survey respondents answering in the affirmative over the total number of respondents in that category minus those that did not answer the question or provided incomplete information. For example, we received 8 affirmative responses from cardiac hospitals on whether the hospital is the sole owner of the capital equipment out of 11 cardiac hospital survey respondents that provided complete responses to the question (although 12 cardiac hospitals responded to our survey).

referrals. Moreover, a relevant factor in assessing *bona fide* business risk is whether an investment interest is comparable to a typical investment in a *bona fide* new business enterprise. These and other factors relating to the venture would be relevant to any inquiry under the Federal fraud and abuse laws.

(F.) Offerings to Physicians; Revenues From Owners.

The DHHS also inquired as to whether the offering of interests was made exclusively to physicians and whether the physician owners generated a great deal of the hospital's revenues.

Table 4
Offering of Investment Interests[2]

	Investment Interest Offered to Non-Physicians For Similar Terms
Cardiac Hospital	100.0% (12/12)
Orthopedic Hospital	70.6% (12/17)
Surgical Hospital	80.0% (28/35)

"There are several limitations to our findings. For instance, we did not request data concerning whether there was any type of cap on the number of non-physician investors or the shares they could purchase. Additionally, we must emphasize that the survey was voluntary, the data was self-reported, and, given the time constraints for completing the report, we were unable to validate the data. Nevertheless, we note that each of the subscription agreements that CMS reviewed as part of the Advisory opinion process left to the discretion of the specialty hospital's founding members whether to accept a physician who was interested in purchasing an ownership share. Most of the subscription agreements made inquiry as to the amount of revenue the physician generated in the previous two years, the names of the hospitals to whom he or she referred patients, and the

[2] The numbers in parentheses represent the number of survey respondents that answering in the affirmative over the total number of respondents in that category. For example, we received 12 affirmative responses from orthopedic hospitals on whether non-physicians were given an opportunity to invest for terms similar to physicians out of 17 orthopedic hospital survey respondents. Because our analysis focused on investment in specialty hospitals, we did not include competitor hospitals in Table 4.

volume of patients referred. Although not explicitly given as a criterion for selecting investors, it appears that the volume of referrals and/or revenue generated may have been a significant factor for some hospitals in determining which physicians were permitted to invest."

Table 5
Physician Ownership and Hospital Revenues[3]

	Average Aggregate Percentage of Physician Ownership in Hospital	**Average Revenue Generated by Physician-Owners**	**Average Revenue Generated by Non-Owner Physicians**
Cardiac	37.2% (12/12)	47.6% (12/12)	52.4% (12/12)
Orthopedic	67.5% (13/17)	86.2% (12/17)	13.8% (12/17)
Surgical	66.3% (26/35)	78.7% (25/35)	21.3% (25/35)

"We requested information in our survey regarding physician-investors' capital contributions and the returns on their investments. Specifically, we wanted to determine whether the return on investment was proportional to the capital contributed. In other words, we wanted to ascertain whether physicians make capital investments of a certain percentage and receive returns on invested capital as if they made a higher capital investment.

Thirty specialty hospital respondents reported proportionate returns compared to physician investment. We note, however, that 34 out of 64 specialty hospitals (53.1 percent) did not complete this portion of the survey (or did not complete it in time for us to analyze the responses) and, thus, we are unable to determine at this point whether the physician-investors in such hospitals received proportionate returns on their investment

[3] The numbers in parentheses represent the number of survey respondents that provided complete information for the question over the total number of respondents in that category. For example, we received 26 responses from surgical hospitals on the aggregate percentage of physician ownership out of 35 surgical hospital survey respondents. Competitor acute care hospitals are not included in this table as none of the 76 reported physician investors.

Our survey requested information concerning compensation arrangements between hospitals and physician-investors[4]. Hospitals were asked whether the physician-investor has or had any management contract or other compensation arrangement (including a loan) with the hospital or an entity related by common ownership or control. We received responses from 64 specialty hospitals. Thirty-four of these respondents reported a total of 135 compensation arrangements with physicians (not including payments to entities such as real estate companies, equipment leasing entities, and management companies, which were reported separately on Worksheet 5 of the survey). The services for which compensation was paid were largely for medical directors, on-call coverage, administrative (non-Board) services, and clinical services such as diagnostic test interpretations.

All 12 of the responding cardiac hospitals reported having at least one compensation arrangement, and, in the aggregate, they had a total of 66 arrangements: 11 for medical directors; seven for on-call coverage; 25 for hospital administrative duties; one for board of director duties; seven for readings or interpretations; three for provider-based physician services; and 12 for unspecified services.

Many hospitals reported proportionality of investment between the amount invested and the returns by physicians. Here, the OIG expressed concern that 34 out of 64 hospitals did not respond to the question. Other concerns raised by CMS related to the number of compensation relationships both in general hospitals and specialty hospitals."

(G.) Services to Medicaid and Charity Patients.

CMS reported significantly lower amounts of charity care and services to Medicaid patients by specialty hospitals than by acute hospitals.

[4] None of the 76 responding competitor hospitals reported having physician investors; however, of the 47 responding nonprofit competitor hospitals, several noted in their responses that nonprofit hospitals sometimes sell participating bonds to affiliated or referring physicians. Participating bonds are tax-exempt offerings that are sold at least partly to physicians to allow them to participate in the success or failure of a section 501(c)(3) (of the Internal Revenue Code) hospital. The interest rate paid on the bonds may be much higher (for example, between 10 and 12 percent) and the issues may be much smaller.

Table 6
Medicaid Patient Case Mix of Responding Hospitals[5]
(as a percentage of Total Inpatient Discharges or Total Outpatient Visits)

	Medicaid Inpatient Discharges	**Medicaid Outpatient Visits**
Competitor Acute	18.4%	12.3%
Cardiac	4.6%	6.7%
Orthopedic	2.5%	4.3%
Surgical	2.4%	7.7%
Specialty (All)	3.6%	6.1%

> "We also analyzed reported revenue data for the responding hospitals.[6] For competitor hospitals responding to our survey, we found that Medicaid revenues averaged 7.0 percent of total net patient revenues, whereas the specialty hospitals averaged only 2.3 percent. The distinction is even greater for cardiac hospitals: only 1.1 percent of revenues were generated from services provided to Medicaid patients. Orthopedic and surgical hospitals had Medicaid revenues of only 1.7 percent and 3.4 percent, respectively."

The data also showed that specialty hospitals provide a lower amount of charity care as a percentage of net patient revenues than competitor acute hospitals.

Table 7
Charity Care

	Charity Care as a Percent of Net Patient Revenue
Cardiac	3.9% (9/10)
Orthopedic	1.0% (12/14)
Surgical	0.2% (16/23)
Competitor Acute	7.9% (60/63)

[5] The inpatient figures are based on information provided by 64 of 76 competitor hospital respondents and 61 of 64 specialty hospital respondents. The outpatient figures are based on information provided by 57 of 76 competitor hospital respondents and 59 of 64 specialty hospital respondents. The differential is due to survey responses that were excluded either because no data was provided or the data provided could not be validated.

[6] Our survey obtained revenue data for FY 2004 and FY 2005. In our analysis, we combined data for both years, eliminating from consideration hospitals that provided incomplete data for one or both years. This resulted in a total sample size of 63 responding competitor hospitals and 47 responding specialty hospitals.

(H.) Medicare Patients.

CMS also analyzed payor data to see the extent to which Medicare patients are served by specialty hospitals. Here, the survey found that competitor hospitals had Medicare revenues on average of approximately 38%. Interesting enough, cardiac hospitals had a greater amount of Medicare revenues than competitor acute care hospitals. However, surgical hospitals and orthopedic hospitals had a lower percentage of Medicare revenues.

> "First, we analyzed reported revenue data for the responding hospitals. Our survey found that competitor hospitals had Medicaid revenue of 7.0 percent, Medicare revenue of 31.2 percent, and other sources of revenue of 61.8 percent of total net patient revenue, for combined FY 2004 and FY 2005. In contrast, physician-owned specialty hospitals had Medicaid revenue of 2.3 percent, Medicare revenue of 22.5 percent, and other sources of revenue of 75.2 percent of total net patient revenue in the same time period.
>
> We broke down the data for specialty hospitals to further understand the payer mix of cardiac, orthopedic, and surgical hospitals. For responding cardiac hospitals, Medicaid revenue was 1.1 percent, Medicare revenue averaged approximately 52.6 percent, and other sources constituted 46.3 percent of total net patient revenue for combined FY 2004 and FY 2005. Responses of orthopedic hospitals reflected Medicaid revenue of 1.7 percent, Medicare revenue of 18.1 percent, and revenue from other sources of 80.2 percent of total net patient revenue for combined FY 2004 and FY 2005. For responding surgical hospitals, Medicaid revenue averaged 3.4 percent, Medicare revenue averaged 16.3 percent, and other sources constituted 80.3 percent of total net patient revenue for combined FY 2004 and FY 2005."

(I.) Inpatient versus Outpatient Revenues.

GAO also noted dissimilarities between specialty and general acute care hospitals in terms of the mix of inpatient and outpatient revenues. GAO found that specialty hospitals reported inpatient revenues of 46 percent of total revenues, compared to 57 percent of total revenues for general hospitals.[7]

---

[7] *Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance,* GAO Report, GAO-04-167 (October 2003) at 22.

> "We designed our survey to allow us to examine the relative characteristics of specialty hospitals and their competitors in terms of the volume of inpatient and outpatient services. Our survey indicates that (1) cardiac hospitals provide substantial higher numbers of services to inpatients than other hospitals reporting to us; and (2) orthopedic and surgical hospitals focus slightly more on the provision of outpatient services than do competitor acute care hospitals and much more on the provision of outpatient services than do cardiac hospitals."

The Report also noted that specialty hospitals and competitor acute hospitals each treat a much greater percentage of outpatients than inpatients. It also showed that acute hospitals generally had 57% of the revenues from inpatient services whereas specialty hospitals had approximately 46% of total revenues from inpatients. The distinction between outpatient and inpatient services and revenues was not significant.

The study did show that acute care hospitals are more likely to operate significant emergency departments than orthopedic, surgical or cardiac hospitals.