Specialty Hospitals - A Busy Summer, But No Answers in Washington

Those looking for final answers about physician ownership of specialty hospitals after the expiration of the moratorium in June will have to wait a bit longer. Congress, the Centers for Medicare and Medicaid Services (CMS), supporters and opponents have been busy in Washington making the future less than clear. Let’s look at recent developments in this “hot button” area.

Background

The Medicare Modernization Act of 2003 (MMA) included a provision that instructed CMS to prohibit the ownership of specialty hospitals by physicians who referred patients for a period of 18 months ending June 8, 2005. During the moratorium, Congress required the Medicare Payment Advisory Commission (MedPAC) and the Department of Health and Human Services (HHS) to study the issue of specialty hospitals and their ownership and operations. MedPAC issued its report in March and HHS issued its report in May. Congress ignored efforts to extend the moratorium beyond June 8, 2005, and it expired.

CMS Action

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- Reform payment rates for outpatient surgery centers (ASCs). In light of CMS findings that specialty hospitals tend to have few inpatient beds, the question of whether specialty hospitals are performing mostly outpatient procedures will be explored. CMS intends to focus on reducing the differences in hospital vs. ASC surgery payment rates, to minimize the possibility that outpatient procedures are being performed in specialty hospitals to receive increased rates for the same procedure in an ASC.

- Reform payment rates for inpatient hospital services. CMS vows to consider making changes to the inpatient prospective payment system. Severity of illness will be the focus, in light of the thinking of some that specialty hospitals treat patients with less-severe illness. CMS also plans to focus on specific DRGs in the cardiac, orthopedic and surgical areas that some believe create incentives for physicians to fund the formation of specialty hospitals.

- Review the procedures for the approval of specialty hospitals as Medicare providers and the process for commencing payment to new specialty hospitals. A hospital must meet the definition of a “hospital” under Medicare rules and primarily furnish care to inpatients. As a result,
CMS stated that if specialty hospitals are not primarily caring for inpatients, new provider agreements will be denied and previously approved provider agreements may be terminated. CMS also is going to determine if specialty hospitals should be subject to additional or different standards in light of the narrow scope of their services. Items on the CMS agenda include participation by specialty hospitals in community-wide emergency services and transfer arrangements between general acute care hospitals and specialty hospitals.

**Congressional Activity**

Just as the industry was absorbing the impact of the CMS announcement, Senators Charles E. Grassley and Max Baucus introduced the Hospital Fair Competition Act of 2005 (S. 1002). This bill amends the MMA to extend the moratorium indefinitely on specialty hospital ownership by physicians. The principal concern arising from S. 1002 is the "chilling" effect it may have on licensing and lenders in processing and financing new projects that are not now subject to the original moratorium. While industry reports indicate that grandfathered facilities and some other projects continue forward in spite of S. 1002, development may be slowed.

To add more fuel to the fire created by the CMS announcement and the introduction of S. 1002, three members of the House Ways and Means Committee asked CMS to investigate racial bias in the selection of patients treated at specialty hospitals. In a letter, the representatives claimed that specialty hospitals are contributing to the segmentation of the health care industry along racial lines.

**Research Findings**

The August 9, 2005 edition of *Health Affairs*, the respected journal of health care trends and studies, included a study suggesting that the market-driven approach in health care that has led to the development of physician-owned specialty hospitals and ASCs cannot continue without affecting care to low-income and elderly patients. The study’s authors argue that only a Certificate of Need system can provide the structure to keep the health care delivery system in balance. They appear to subscribe to the notion that wealthier, insured patients subsidize those without insurance or with lower levels of payor protection.

**Conclusion**

People on all sides of the specialty hospital issue thought there would be a final simple answer this summer to whether growth in specialty hospitals would continue. It now appears that the winter snows will be upon us when CMS issues its final say on the topic in January 2006. Meanwhile, debate will continue – especially in Washington – on the viability and necessity for physician-owned specialty hospitals. Those considering proceeding with projects should consult with knowledgeable counsel.
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Individuals earning an income that is greater than their state's median from filing for protection under chapter 7. The result of the means test will likely be to force a financially distressed physician to seek bankruptcy protection under Chapter 11 or 13.

Under the former Bankruptcy Code, a debtor who filed for protection under chapter 13 would not be required to liquidate non-exempt assets, provided that, over time, he or she pays creditors at least the same the creditors would have received if the debtor had filed under chapter 7, and, if any creditor objects, also pays all of his or her disposable income earned during the case to creditors.

The Act, however, alters the former dynamics of a chapter 13 case. First, the determination of a debtor’s “disposable income” is no longer a flexible, case-by-case determination. Rather, most expenses credited against gross income must be calculated by reference to strict IRS standards. As such, an affluent debtor forced into a chapter 13 case will likely be required to pay to creditors a much larger percentage of his or her post-filing income over a five year period, suffering a drastic reduction in his or her standard of living. As just one example, the Act only permits a debtor to claim as an expense up to $1,500 per year for elementary and secondary school tuition for dependants, and only if the debtor can prove that the tuition is reasonable and necessary and not already factored into the IRS standards.

Second, to confirm a plan over the objections of creditors, the debtor’s disposable income must be used to pay unsecured creditors, rather than to make any payment required by the plan. “Expenses” that can be credited against a debtor’s gross income do not include payments for arrearages on secured debt unless such payments are required to maintain possession of the debtor’s primary residence, motor vehicle or other property necessary for the support of the debtor and dependants. A debtor may be unable to retain collateral (for example, a second home) subject to a security agreement if there were pre-filing arrearages.

Individual debtors may choose not to file a case under chapter 11 of the Bankruptcy Code, because a chapter 11 case is often more expensive and less advantageous than cases under chapter 7 or 13. However, a debtor may not file a case under chapter 13 if the debtor’s individual debt, or the debtor’s and the debtor’s spouse’s combined debt, exceeds $307,675 of unsecured debt and $922,975 of secured debt. Since many physicians forced to seek bankruptcy protection due to an uninsured malpractice judgment will likely have debt in excess of the applicable limits, he or she may be forced to file a case under Chapter 11. One significant alteration by the Act to a case under chapter 11 is that a debtor’s income earned after filing and before the case is closed will be included within the bankruptcy estate.

Other changes apply to a proceeding under any chapter that affects an asset protection plan. One of the most-discussed changes is the modification to the homestead exemption, which protects a debtor’s principal residence. Under the former Bankruptcy Code, a debtor could claim a homestead exemption to the full extent permitted by

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Gay Parks Rainville Returns to Pepper

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As can be seen, the changes in the Bankruptcy Code as a result of the Act places significantly greater burdens on individual debtors seeking to obtain a bankruptcy discharge, putting a debtor’s assets and standard of living at greater risk for a longer period. A physician who is financially responsible, but is faced with a massive unsecured malpractice judgment, could suffer the loss of much of his or her personal assets, as well as the need to work for five years solely to pay off pre-filing debt, reserving only a small portion for actual expenses. To avoid this result, physicians should seek the advice of experienced counsel to ensure that their personal assets and lifestyle are adequately protected.

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The Act makes other modifications that may alter a physician’s asset protection planning. For example, the Act expressly exempts certain retirement funds, but not in excess of $1 million. Educational savings may also be protected, but are subject to certain limitations. The Act also permits the discharge of any debt owed to a single creditor made for the purchase of luxury goods and services totaling more than $500 and incurred within 90 days of filing, as well as cash advances in excess of $750 (per line of credit) made within 70 days of filing.

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