

An Endangered Species: Physician-Owned Hospitals

Law360, New York (January 28, 2010) -- Both the concept and reality of physician-owned hospitals have been contentious. For that reason, whether health care reform is enacted — or not — the ongoing debate involving physician-owned hospitals is unlikely to subside.

There have been approximately a dozen attempts, in one form or another, to pass legislation banning or restricting physician-owned hospitals, including an 18-month moratorium on building new physician-owned hospitals that expired in 2006. Thus, even without health care reform physician ownership of hospitals will remain a target of lawmakers and regulators.

There are more than 200 physician-owned hospitals in the United States, including general acute care hospitals, multispecialty hospitals, as well as rehabilitation, long-term care, cardiac and orthopedic hospitals. A majority of these are the product of joint ventures with third parties. Many more physician-owned hospitals are currently under development.

Proponents argue physician-owned hospitals provide quality care at a lower cost without harming community-based hospitals in neighborhoods that need access to physician and hospital services.

Opponents argue that physician-owned hospitals cherry pick only the healthiest and wealthiest patients in order for physicians to pocket the profits often to the detriment of both patient safety and the financial viability of community-based hospitals. Emotions run strong on both sides of the arguments.

Current bills in the United States Congress, which are part of the health care reform effort, would effectively prohibit the development of any new physician-owned hospitals and significantly limit the expansion of existing such hospitals.

Such provisions, as currently drafted, have the potential to affect hundreds of planned and existing physician-owned hospitals with the potential to severely curtail or even eliminate this type of hospital ownership model altogether.[1]

However, specific provisions contained in the bills are not as black and white as some commentators have argued.

Under both the House and Senate versions, a physician could maintain an ownership interest in a hospital if: (1) the hospital was physician-owned on or before a certain date (Jan. 1, 2009, and Feb. 1, 2010, under the House and Senate bills, respectively); and (2) a provider agreement between Medicare and the physician-owned hospital under Section 1866 of the Social Security Act was in effect on or before a certain date. Thereafter, however, a physician owner may not own a greater percentage of the hospital than was owned on the date the law was enacted.

Only the Senate bill defines a “physician owner or investor,” describing such a person as “a physician (or an immediate family member of such physician) with a direct or an indirect ownership or investment interest in the hospital.” The bill does not further elaborate on the definition. There are, however, provisions in both bills that impose restrictions on ownership, such as:

- ownership cannot be conditioned on the ability to refer patients to the hospital;
- there can be no loans to physician owners;
- distributions of profits must be equal to ownership percentage; and
- there can be no right to purchase other business interests related to the hospital based on ownership.

The question arises how a physician demonstrates ownership in the hospital on or before the required date. Must the hospital and the physicians have already executed loan documents for the physicians to be considered owners or investors in the hospital?

If the ownership arrangement involves a joint venture between physicians and a third party, does the joint venture paperwork (and perhaps other operating documents) need to be executed before the required date for the physicians to be considered owners?

Or, is execution of a letter of intent stating that the physicians shall possess an ownership percentage in the yet-to-be built hospital sufficient to demonstrate physician ownership or investment as of the required date? Would it make a difference if the letter of intent was binding? What other evidence of existing or future ownership or investment interests would be acceptable to meet the required date?

It is difficult to advise physicians on exactly what constitutes physician ownership or investment since the required evidence is not entirely clear. Nonetheless, given the drastic nature of the proposed language in the bills — and the potential significant investments by physicians that could hang in the balance — it is important to consider such questions.

Furthermore, upon enactment of the law, expansion in the number of operating rooms, procedure rooms or beds of existing physician-owned hospitals is prohibited without meeting the requirements of certain exceptions. Both the House and Senate bills state that the number of rooms and beds of the physician-owned hospital may not increase after the date the new law is enacted.

The House bill enumerates numerous conditions to meet an exception, which can be applied for once every two years. To meet the exception, the following conditions must be fulfilled:

- the population in the county in which the hospital is located must increase by a certain percentage over a given time period;
- the percentage of inpatient admissions at the hospital must increase a certain amount in comparison to other hospitals in the same county;
- the state must have an average bed capacity that is less than the national average;
- the hospital may not discriminate against federal health care beneficiaries;

- the hospital must have an average occupancy rate greater than that of the average occupancy rate in the same state; and

- certain other requirements as may be promulgated from time to time by the Secretary of Health and Human Services ("Secretary").

The Senate bill simply grants the Secretary authority to promulgate the conditions required to meet an exception.

Interestingly, however, all but two of the House requirements are waived for physician-owned hospitals that can document certain increases in Medicaid patient admissions.

Specifically, if during the three most recent cost reporting periods, the increase in Medicaid admissions at the physician-owned hospital demonstrate a greater percent increase than the increase in Medicaid admissions at any other hospital in the same county, then only the two following requirements apply to obtain an exception: (1) the physician-owned hospital does not discriminate against beneficiaries; and (2) the physician-owned hospital complies with any other requirements promulgated from time to time by the Secretary.

Unfortunately, there is uncertainty about the expansion of operating rooms, procedure rooms or beds, even if a physician-owned hospital qualifies for and receives an exemption. For example, the Senate bill states that the number of rooms and beds of the physician-owned hospital may not increase beyond the number of rooms and beds for which such hospital is already licensed. The House bill offers no such language regarding licensure.

This raises a number of questions. If a physician-owned hospital has begun a certificate of need process to increase its number of rooms or beds, but those rooms or beds are not yet licensed to the physician-owned hospital, does either bill permit such hospital to include those rooms or beds in the number currently licensed to it?

Or must the physician-owned hospital already actually possess the licenses in order to include them in the then-current count, thereby excluding those rooms or beds still subject to the certificate of need process? (Ironically, the current bills essentially create a second, federal-level certificate of need process.)

Even if there is no certificate of need process in a given jurisdiction, if room or bed licenses are pending before another regulatory agency, or subject to state legislative action, can they be included in the then-current count? The Senate bill raises questions and the House bill offers no guidance. This makes it difficult for physician-owned hospitals to plan for expansion with any certainty.

The absence of clarity and guidance creates the potential for requirements that represent a moving target, which physician-owned hospitals may rarely, if ever, be able to satisfy in order to expand.

Therefore, if enacted, the Secretary will need to promulgate regulations to clarify, among other things, the questions illustrated above. The law requires the Secretary to promulgate such regulations within 18 months after enactment.

This means, even if some form of health care reform is enacted that includes language regarding physician-owned hospitals, physician owners and their ownership partners will have little guidance for many months on key questions about whether they may expand their operations and under what conditions.

This is likely to negatively affect the ability of existing physician-owned hospitals to attract new revenue streams for capital investment, create difficulty for projecting future operating revenue and curtail plans to expand many hospital operations that rely on increased room and bed capacity.

Taken together, these factors may in fact — for good or bad — cause significant disruption in the future plans of physician-owned hospitals in the United States.

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The opinions expressed are those of the author and do not necessarily reflect the views of Portfolio Media, publisher of Law360.

[1] For the Senate bill, see: Patient Protection and Affordable Care Act, H.R. 3590, §6001, 111th Cong. (2009). For the House bill, see: Affordable Health Care for America Act, H.R. 3962, §1156, 111th Cong. (2009).