FAILURE TO BE "PRIMARILY ENGAGED" IN PATIENT CARE PUTS HOSPITALS' MEDICARE PROVIDER AGREEMENTS AT RISK

OVERVIEW

In recent years, the Centers for Medicare & Medicaid Services ("CMS") has been committed to enforcing the requirement that hospitals must be "primarily engaged" in providing inpatient services to be qualified as a hospital under the Social Security Act and thus eligible to participate in Medicare. This enforcement trend has resulted in the termination of the Medicare provider agreements of hospitals with low inpatient volumes, many of which are small physician-owned hospitals, micro hospitals or specialty hospitals. A finding by CMS that a hospital fails to meet the definition of the term "hospital" can result in the hospital's loss of its Medicare provider agreement. In the case of physician-owned hospitals in particular, this determination is fatal because the hospital is no longer able to avail itself of the Stark Law whole hospital exception, which requires the hospital to have had a Medicare provider agreement on or before December 31, 2010.

SUMMARY OF THE ISSUE

The Social Security Act and corresponding regulations define a "hospital" as an institution that is "primarily engaged" in providing services to inpatients. CMS has declined to provide formal guidance regarding the interpretation of this definition. However, informal agency guidance, governmental reports and Departmental Appeals Board ("DAB") decisions interpreting the phrase "primarily engaged" provide hospitals with insight into the definition of "hospital." See below for a brief discussion of CMS guidance and current enforcement activities, as well as recommendations and best practices to mitigate the potential risk for hospitals.

HISTORY & BACKGROUND

In 2003, the Government Accountability Office conducted an investigation surrounding the growth of physician-owned specialty hospitals, discovering that such hospitals derived a smaller share of revenues from inpatient services as compared to other general acute care hospitals. In 2005, the Secretary of the Department of Health and Human Services ("HHS") commented and advised Congress that preliminary results suggested some specialty hospitals primarily provided outpatient services and may not qualify as hospitals.1 Additionally, the Secretary noted that a hospital that does not meet the statutory definition of "hospital" could be terminated from Medicare participation. The Secretary noted that these concerns would be revisited, and new procedures would be examined. Later that year, during testimony in front of a House Committee, a CMS Administrator reiterated the intent to increase scrutiny of small specialty hospitals. The CMS Administrator speculated that these small specialty hospitals enroll in Medicare as hospitals to take advantage of more favorable reimbursement rates.2

In 2006, HHS released a Final Report to Congress, indicating that industry stakeholders communicated their opposition to a fixed standard or quantitative definition of "primarily engaged" in the delivery of inpatient services due to the potential for unintended consequences to rural hospitals. In the Final Report, HHS explained that it was not in a position to define "primarily engaged" and would continue to interpret this provision on a case-by-case basis.3

DECISIONS & GUIDANCE

In 2008, CMS issued formal guidance to state survey agency directors regarding hospitals that specialize in the provision of *emergency services*. Although directed at emergency services hospitals, this is the only available guidance that numerically defines the phrase "primarily engaged" as it relates to the delivery of inpatient services. The guidance suggested that CMS interpret the statutory requirement that a hospital be "primarily engaged" in the provision of inpatient services to mean that the provider "devotes *51 percent or more of its beds to inpatient beds*." However, CMS noted that the 51 percent rule may not be dipositive in all cases, and CMS would consider other factors in addition to bed ratio if that information was provided. Finally, CMS stated that the burden of proof was on the hospital to demonstrate compliance, and in the absence of any clearly persuasive data, CMS would look to inpatient beds in relation to all other beds.4

In addition to CMS's guidance on the meaning of "primarily engaged", the DAB has interpreted the legal definition of a hospital very narrowly. In at least two cases, the DAB looked to American Heritage Dictionary definitions of the term "primarily" and "engaged" to analyze the statutory definition of the phrase "primarily engaged." By way of example, a hospital had a 42-day window in which the hospital did not

furnish services to inpatients, as it was waiting for its initial Medicare certification survey and could not bill Medicare for the inpatient services (DAB No. 3362 (2014)). The hospital argued it met the statutory definition of a "hospital" because the hospital served 88 inpatients in a 4 month period prior to the 42-day lapse and maintained the staff to support inpatient operations. However, the DAB held that the 42-day lapse coupled with the fact that the hospital did not have an inpatient at the time of initial survey was determinative that the hospital was not "primarily engaged" in the delivery of inpatient services; therefore, the DAB denied the hospital's participation in Medicare.[5]

More recently, a hospital provided notice of termination of its provider agreement to CMS on June 15, 2015 in connection with the hospital's petition for bankruptcy (DAB No. CR4500 (2016)). The termination letter stated that the hospital was going to file in bankruptcy court and indicated that the hospital would transition from providing inpatient services to only providing outpatient services as of June 18, 2015. On June 18, 2015, all inpatients were transferred to other facilities and the hospital closed its inpatient unit. The following day, CMS issued a letter to the hospital indicating that CMS had accepted the notice of termination and determined that the effective date of termination would be June 18, 2015 due to the fact that the hospital ceased inpatient operations on that day. The DAB ultimately affirmed CMS's termination but changed the effective date to July 4, 2015 due to the fact that the DAB found that CMS was required to provide at least 15 days' notice of termination. Of note, however, is that CMS indicated a willingness to rescind the notice of termination if the hospital reopened its inpatient operations. While the facts in this case are unique in that the hospital, in fact, intended to terminate its inpatient operations, it is noteworthy because CMS, the administrative law judge and the DAB determined that the termination should be effective at the time that inpatient operations ceased.

PRACTICAL TAKEAWAYS

Although CMS has declined to engage in formal rulemaking to define the meaning of "primarily engaged," informal guidance suggests that there are certain indicators that might be used to assess risk. For example, a hospital could determine whether at least 51 percent of its beds are devoted to inpatient care or may review whether staffing numbers suggest consistent inpatient operations. The 51 percent rule is not dispositive in all cases, and there are a number of factors that could be considered in each individual case. The lack of clear guidance from CMS gives hospitals some flexibility to use any "clearly persuasive data" to prove that the hospital is "primarily engaged" in providing inpatient services if ever challenged.

It is important to note that if a hospital's Medicare provider agreement is terminated, then the hospital may not re-enroll in Medicare (as a hospital or otherwise) until the hospital can prove that there is reasonable assurance that the reason for the termination will not recur.[6] If the hospital is owned by physicians, however, the termination of the hospital's Medicare provider agreement would preclude the hospital from re-enrolling due to the fact that the hospital's Medicare provider agreement would not be dated on or prior to December 31, 2010. Therefore, it is recommended that specialty and physician-owned hospitals evaluate their circumstances as described above as often as necessary. Physician-owned hospitals should also maintain such information in the event the hospital is surveyed and questions arise regarding the hospital's inpatient operations.

If you have any questions regarding whether your hospital is "primarily engaged" in the provision of inpatient services or would like help analyzing particular facts and circumstances to determine whether your hospital is at risk for failing to meet the definition of a hospital, please contact:

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Please visit the Hall Render Blog at http://blogs.hallrender.com/ or click here to sign up to receive Hall Render alert topics related to health care law.

1 See Michael O. Leavitt, Secretary, HHS, Recommendations Regarding Physician-Owned Hospitals, 7-8, availablehere.

2 Mark B. McClellan, MD, PhD, Administrator, CMS, Testimony Before the House Committee on Energy and Commerce Hearing on Specialty

Hospitals: Assessing Their Role in the Delivery of Quality Health Care, 2-3, May 12, 2005, available here.

3 HHS, Final Report to Congress and Strategic and Implementing Plan Required under Section 5006 of the Deficit Reduction Act of 2005.

4 CMS, Survey & Certification Memorandum S&C-08-08, Jan. 11, 2008.

5 *Kearney Regional Medical Center, LLC* DAB No. 3362 (2014). 6 42 CFR § 489.57.