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The OIG Report on Specialty Hospitals

On January 10, 2008, the Office of Inspector General for the federal Department of Health and Human Services issued its report titled "Physician-Owned Specialty Hospitals' Ability To Manage Medical Emergencies." This report was commissioned by the Senate Finance Committee, which is chaired by Senate Finance Chairman Max Baucus, D-Mont., and whose minority-ranking senator is Charles E. Grassley, R-Iowa. In hearings and in the press, both Senators have been vocal opponents of specialty hospitals. A moratorium on specialty hospitals was included in the 2003 Medicare drug bill (PL 108-173), which the senators helped to write. When the ban expired, Grassley and Baucus wrote provisions into the Deficit Reduction Act of 2005 (PL 109-171) that banned CMS from approving new specialty hospitals until 2006.

Not surprisingly, the OIG concluded that specialty hospitals were not particularly well equipped to handle emergencies and provided the Center for Medicare and Medicaid Services with four recommendations for on-going study. CMS agreed in principle with the OIG's recommendations and has already implemented some changes. CMS will now consider additional regulatory changes to create more specific requirements. However, the study itself and the data it uncovered does not paint as black a picture of specialty hospitals as Senator Grassley did when he announced the death of two patients in physician-owned specialty hospitals in 2005. In both cases, the specialty hospital called 9-1-1 to handle the emergency treatment required for the patients. In both cases, the patients died.

The OIG surveyed 109 physician-owned specialty hospitals located in a total of 20 states. The breakdown with the highest concentration of specialty hospitals contacted by the OIG is Texas (33 hospitals); Louisiana (15 hospitals); Oklahoma (9 hospitals); Kansas (9 hospitals) and South Dakota (8 hospitals). The survey consisted of reviewing staffing information provided by the hospital covering eight

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sample days selected by the OIG, reviewing hospital policies and procedures for emergency care, and conducting telephone interviews with the hospital administrators about the staffing information and the policies and procedures.

In brief, the OIG's findings were as follows:

1. 55% of the 109 specialty hospitals have emergency departments. 45% do not. Medicare does not require emergency departments. Most state hospital licensure laws do require that hospitals have an emergency department. Of the hospitals with no emergency department, 13 of them stated that they are located adjacent to or across from or are connected to a hospital with an emergency department. 58% of the hospitals which have an emergency department have a single bed in the department.
2. 93% of the specialty hospitals had a nurse on duty and a physician on call during the eight sample days. This is a Medicare requirement. Of the eight hospitals which did not meet the requirement, seven hospitals did not have a registered nurse on duty at least one of the eight sample days and one hospital did not have a physician on call at least one of the eight sample days.
3. 28% of the 109 hospitals had a physician on site 24 hours per day, seven days per week. Medicare does not require that hospitals have physicians on site at all times.
4. 34% of the 109 hospitals have used 9-1-1 to obtain medical assistance to stabilize or treat a patient. This practice violates the Medicare requirement found in their Conditions of Participation that a hospital must be able to provide appraisal and initial treatment of emergency conditions. 46% of the 109 hospitals use 9-1-1 to transfer patients. This is a practice which is permitted by Medicare.
5. All of the surveyed hospitals have written policies and procedures governing the management of medical emergencies. However, 24% of the 109 specialty hospitals do not have policies and procedures that mention the use of emergency response equipment such as defibrillators; 21% do not have a policy for handling medical emergencies in the absence of a physician on site; 15% of the hospitals do not have policies that mention the use of cardiopulmonary resuscitation or Advanced Cardiac Life Support protocols; 6% do not have policies that indicate who should respond to medical emergencies.

It must be noted that the OIG did not contact any non-physician owned specialty hospitals or any other hospitals at all to compare the emergency preparedness with the 109 physician-owned specialty hospitals which participated in the survey.

Based on its findings, the OIG made the following recommendations to CMS:

1. Develop a system to identify and regularly track physician-owned specialty hospitals.¹
2. Ensure that hospitals meet the Medicare Conditions of Participation requirement that all hospitals have a registered nurse on duty 24 hours per day, seven days per week and a physician on call if one is not on site.
3. Ensure that hospitals have the capability to provide for the appraisal and initial treatment of emergency patients on site without turning to 9-1-1 to provide those services.
4. Require hospitals to include the necessary information in their protocols and procedures for managing a medical emergency, use of emergency response equipment and life-saving protocols.

Additionally, the names of the eight hospitals which were not in compliance with the requirement regarding nurse staffing and physician on-call and the 37 hospitals that used 9-1-1 to obtain medical assistance were submitted to CMS for appropriate action.

CMS will institute the following processes immediately in response to the OIG report:

1. Add a place on the CMS provider enrollment forms to indicate whether a hospital provider is a physician-owned specialty hospital.
2. CMS will contact the other accrediting agencies, such as the Joint Commission and the American Osteopathic Association, to be certain they are aware of the shortcomings regarding Conditions of Participation requirements as well as the other recommendations made by the OIG.
3. CMS has already contacted the State Survey Agencies through a program memorandum that states hospitals are not in compliance with their Conditions of Participation if they rely on 9-1-1 as a substitute for

providing their own emergency services. 9-1-1 may still be used, but only for transfer of a stabilized patient to another hospital. That information has also been provided to the public on the CMS Web site and has been sent to the national accreditation organizations. In August 2007, CMS adopted a final rule requiring hospitals to inform all patients in writing at the beginning of their hospital stay or outpatient visit if a physician is not present in the hospital 24 hours per day, seven days per week. The hospital must also inform the patients how the hospital would meet the medical needs of any patient who develops an emergency medical condition when no physician is present.

4. CMS will consider regulatory changes to create more specific requirements for emergency, life-saving equipment and staff qualifications.

The debate rages on with regard to physician-owned specialty hospitals. On one hand, it seems the prior studies had supported continuing specialty hospitals as part of the medical choices available to patients. For example, the prior study conducted by the Government Accountability Office in 2006 concluded that community hospitals in markets with and without specialty hospitals did not differ substantially in their operations or clinical services provided. This finding ran counter to the argument propounded by community hospitals that if physician-owned specialty hospitals were allowed to take the highest paying patients (into heart hospitals or surgical hospitals) that they would be unable to continue to provide the services to all of their patients, including those who could not afford to pay. In 2005, the Medicare Payment Advisory Commission reported that there was no statistically significant difference in the cost of providing care to patients in physician-owned specialty hospitals compared to the costs in community hospitals. Also in 2005, HHS conducted a study which concluded that physician-owners of specialty hospitals did not exhibit clear and consistent preference for the hospitals in which they had an ownership interest, compared to physicians with no hospital ownership. That study also concluded that patients treated at physician-owned specialty hospitals received similarly high quality of care as in other hospitals but that patient satisfaction was very high compared to high in competitor community hospitals. In most studies, it is found that physician-owned specialty hospitals treat less sick patients. That seemed to be the worst of the study-based criticisms.

The OIG is clearly opening the discussion for additional bases of attack. Certainly specialty hospitals that have emergency departments need to review the data and their own operations to assure compliance with state and federal law. However, that same advice is well given to all hospitals. The Senate Finance Committee will continue its studies and at some point, additional legislation will likely be introduced. Based on all of the studies done so far, however, including this new one from the OIG, the data seems to support the operations of physician-owned specialty hospitals as part of the panoply of medical services available to the public.

¹Since the end of the moratorium and the end of the suspension on enrollment of physician-owned specialty hospitals in 2006, CMS has not had any way to track newly enrolled physician-owned specialty hospitals nor does it track hospitals which are no longer physician-owned specialty hospitals.

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