| CMS Manual System | **Department of Health & Human Services (DHHS)** |
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| Pub 100-01 Medicare General Information, Eligibility, and Entitlement | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 58** | **Date: March 6, 2009** |
| | **Change Request 6306** |

**SUBJECT: Disclosure of Physician Ownership in Hospitals**

**I. SUMMARY OF CHANGES:** In the FY 2008 and FY 2009 IPPS regulations, we finalized changes that require hospitals to disclose to patients whether they are physician-owned, and if so, to disclose the names of the physician owners. In addition, physicians are required to disclose to their patients if the physician has an ownership interest in a hospital that the physician refers the patient to for services. If the physician fails to disclose this information, the physician may lose his or her hospital medical staff membership. We also finalized changes to our provider agreement regulations that would permit CMS to terminate agreements with hospitals that fail to make required disclosures on physician ownership.

**NEW / REVISED MATERIAL**
**EFFECTIVE DATE: *June 8, 2009**
**IMPLEMENTATION DATE: June 8, 2009**

*Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.*

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

| R/N/D | Chapter / Section / Subsection / Title |
|---|---|
| R | 5/10.1.1/Basic Commitment in Provider Agreement |

**III. FUNDING:**
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**IV. ATTACHMENTS:**

**Business Requirements**
**Manual Instruction**

**Unless otherwise specified, the effective date is the date of service.*

# Attachment - Business Requirements

| Pub. 100-01 | Transmittal: 58 | Date: March 6, 2009 | Change Request: 6306 |
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**SUBJECT: Disclosure of Physician Ownership in Hospitals**

**EFFECTIVE DATE**: June 8, 2009

**IMPLEMENTATION DATE:** June 8, 2009

## I. GENERAL INFORMATION

**A. Background:** Section 5006 of the Deficit Reduction Act of 2005 (DRA), enacted on February 8, 2006, required the Secretary to develop a "strategic and implementing plan" to address certain issues related to physician investment in specialty hospitals. On August 8, 2006, the Secretary issued a final report to the Congress on the strategic and implementing plan required by the DRA. We stated therein that we would adopt a disclosure requirement that would require hospitals to disclose to patients whether they are physician-owned, and if so, disclose the names of the physician owners. Accordingly, in the FY 2008 and FY 2009 IPPS rules, we finalized changes to our regulations governing provider agreements to require hospitals to disclose physician ownership information to patients when a referring physician (or his or her immediate family member) has an ownership interest in the hospital. These changes to our regulations will allow individuals to make an informed decision regarding their treatment and to decide if the existence of a financial relationship suggests a conflict of interest that may not be in the best interest of the patient.

**B. Policy:** Physician-owned hospital (as defined in 42 CFR §489.3) means any participating hospital (as defined in 42 CFR §489.24) in which a physician, or an immediate family member of a physician, has an ownership or investment interest in the hospital. The ownership or investment interest may be through equity, debt, or other means, and includes an interest in the entity that holds an ownership or investment interest in the hospital. Pursuant to 42 CFR §489.20(u), hospitals must: (1) furnish written notice to each patient at the beginning of the patient's hospital stay or outpatient visit that the hospital is a physician-owned hospital, in order to assist the patient in making an informed decision regarding his or her care. The notice must disclose the fact that the hospital meets the Federal definition of a physician-owned hospital and that the list of physician owners or immediate family members of physicians is available upon request and must be provided to the patient at the time of the request; and, (2) require each physician who is a member of the hospital's medical staff to agree, as a condition of continued medical staff membership or admitting privileges, to disclose, in writing, to all patients the physician refers to the hospital any ownership or investment interest in the hospital held by the physician or held by an immediate family member of the physician. Disclosure must be made at the time of the referral. Hospitals that do not have any physician owners who refer patients to the hospital are exempt from the disclosure requirements (see 42 CFR §489.20(v)). In addition, CMS may deny a provider agreement to a hospital that does not have procedures in place to notify patients of physician ownership in the hospital (see 42 CFR §489.12). Lastly, CMS may terminate a provider agreement with a physician-owned hospital if the hospital fails to comply with requirements (1) and (2) above (see 42 CFR §489.53).

## II. BUSINESS REQUIREMENTS TABLE

| Number | Requirement | Responsibility (place an "X" in each applicable column) |
|---|---|---|

| | | A/B MAC | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | FISS | MCS | VMS | CWF | |
| 6306.1 | Contractors shall inform hospitals about the disclosure requirements on physician ownership when a referring physician (or his or her immediate family member) has an ownership interest in the hospital. These requirements are discussed above in Section I. | X | | X | X | | | | | | |

## III. PROVIDER EDUCATION TABLE

| **Number** | **Requirement** | **Responsibility (place an "X" in each applicable column)** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | FISS | MCS | VMS | CWF | |
| 6306.2 | A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.<br>Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly. | X | | X | X | | | | | | |

## IV. SUPPORTING INFORMATION

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---|---|
| | **Physician-owned hospital** (as defined in 42 CFR §489.3) means any participating hospital (as defined in 42 CFR § 489.24) in which a physician, or an immediate family member of a physician, has an ownership or investment interest in the hospital. The ownership or investment interest may be through equity, debt, or other means, and includes an interest in the entity that holds an ownership or investment interest in the hospital. |

## V. CONTACTS

**Pre-Implementation Contact(s):** David Walczak (410) 786-4475
**Post-Implementation Contact(s):** David Walczak (410) 786-4475

## VI. FUNDING

**Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Intermediaries (RHHIs)*:**

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

**Section B: *For Medicare Administrative Contractors (MACs)*:**

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

# Medicare General Information, Eligibility, and Entitlement

## Chapter 5 - Definitions

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### 10.1.1 - Basic Commitment in Provider Agreement

***(Rev. 58, Issued: 03-06-09, Effective: 06-08-09, Implementation: 06-08-09)***

Section 1866 of the Act and 42 CFR 489 require the provider to agree to the following:

1. To limit its charges to beneficiaries and to other individuals on their behalf to:

- The deductible and coinsurance amounts (see §10.1.2 for details;
- The blood deductible (see §10.1.4 for details); and
- Services requested by the beneficiary. (See §10.1.5)

2. To return any amounts incorrectly collected from a beneficiary or any other person on the beneficiary's behalf;

3. To notify the intermediary promptly if it hires an individual who at any time during the preceding year was employed in a managerial, accounting, auditing, or similar capacity by an intermediary or carrier;

4. In the case of a hospital or a Critical Access Hospital (CAH), either to furnish directly or to make arrangements (as defined in §10.3 of this chapter) for all Medicare-covered services to inpatients of a hospital or a CAH except the following:

- Physicians' services that meet the criteria of 42 CFR 405.550(b) for payment on a reasonable charge basis;
- Physician assistant services, as defined in section 1861(s)(2)(K)(I) of the Act, that are furnished after December 31, 1990;
- Certified nurse-midwife services, as defined in section 1861(ff) of the Act, that are furnished after December 31, 1990;
- Qualified psychologist services, as defined in section 1861(ii) of the Act, that are furnished after December 31, 1990; and
- Services of an anesthetist, as defined in 42 CFR 410.69.

5. In the case of a hospital or CAH that furnishes inpatient hospital services or inpatient CAH services for which payment may be made under Medicare, to maintain an agreement with a PRO for that organization to review the admissions, quality, appropriateness, and diagnostic information related to those inpatient services. The requirement of this paragraph applies only if, for the area in which the hospital or CAH is located, there is a PRO that has a contract with CMS under Part B of title XI of the Act;

6. To maintain a system that, during the admission process, identifies any primary payers other than Medicare so that incorrect billing and Medicare overpayments can be prevented;

7. To bill other primary payers before billing;

8. If the provider receives payment for the same services from Medicare and another payer that is primary to Medicare, to reimburse Medicare any overpaid amount within 60 days;

9. If the provider receives, from a payer that is primary to Medicare, a payment that is reduced because the provider failed to file a proper claim; to reimburse Medicare any overpaid amount up to the amount that would have been paid had the provider filed a proper claim timely.

10. In the State of Oregon, because of a court decision, and in the absence of a reversal on appeal or a statutory clarification overturning the decision, hospitals may bill liability insurers first. However, if the liability insurer does not pay "promptly," the hospital must withdraw its claim or lien and bill Medicare for covered services;

11. In the case of home health agencies, to offer to furnish catheters, catheter supplies, ostomy bags, and supplies related to ostomy care to any individual who requires them as part of their furnishing of home health services;

12. In the case of hospital emergency department services that provide for medical screening to determine if an emergency medical condition exists, CMS guidelines provided in CFR 42 489.24(d) for transfer of patients to other facilities should be followed;

13. In the case of hospital emergency department services report to CMS or the State Survey Agency any time it has reason to believe it may have received an individual who has been transferred in an unstable emergency medical condition from another hospital in violation of the requirements of CFR 42 489.24(d);

14. In the case of inpatient hospital services for admissions on and after January 1, 1987, to participate in the Tricare program;

15. In the case of inpatient hospital services for admissions on and after July 1, 1987, to admit veterans whose admission is authorized by the VA and to meet related VA admission and payment requirements;

16. In the case of a hospital, to give each beneficiary a notice about his or her discharge rights at or about the time of the individual's admission;

17. In the case of a hospital with an emergency department:

- To post conspicuously in any emergency department or in a place or places likely to be noticed by all individuals entering the emergency department, as well as those individuals waiting for examination and treatment in areas other than traditional emergency departments (that is, entrance, admitting area, waiting room, treatment area), a sign (in a form specified by the Secretary) specifying rights of individuals under Section 1867 of the Act with respect to examination and treatment for emergency medical conditions and women in labor; and

- To post conspicuously information indicating whether or not the hospital or critical access hospital participates in the Medicaid program under a State plan approved under title XIX;

18. In the case of a hospital with an emergency department (including both the transferring and receiving hospitals), to maintain:

- Medical and other records related to individuals transferred to or from the hospital for a period of 5 years from the date of the transfer;

- A list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition; and

- A central log on each individual who comes to the emergency department seeking assistance and whether he or she refused treatment, was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred, or discharged.

19. Effective December 1, 1991, in the case of a hospital to comply with the advance directive provisions of 4206 of OBRA 1990. Hospitals must, in accordance with written policies and procedures, for all adult individuals:

- Inform them, in writing, of State laws regarding advance directives;

- Inform them, in writing, of its policies regarding the implementation of advance directives (including a clear and concise explanation of a conscientious objection, to the extent that State law permits for a hospital or any agent of a hospital that, as a matter of conscience, cannot implement an advance directive);

- Document in the individual's medical record whether the individual has executed an advance directive;

- Not condition the provision of care or otherwise discriminate against an individual based on whether that individual has executed an advance directive (since the law does not require the individual to do so); and

- Educate staff and the community on issues concerning advance directives.

*20. Effective October 1, 2007, CMS revised the regulations governing provider agreements that require hospitals to disclose physician ownership information to patients when a referring physician (or his or her immediate family member) has an ownership interest in the hospital. Pursuant to 42 CFR 489.20(u), hospitals must: (1) furnish written notice to each patient at the beginning of the patient's hospital stay or outpatient visit that the hospital is a physician-owned hospital, in order to assist the patient in making an informed decision regarding his or her care. The notice must disclose the fact that the hospital meets the Federal definition of a physician-owned hospital and that the list of physician owners or immediate family members of physicians is available upon request and must be provided to the patient at the time of the request; and (2) require each physician who is a member of the hospital's medical staff to agree, as a condition of continued medical staff membership or admitting privileges, to disclose in writing to all patients the physician refers to the hospital any ownership or investment interest in the hospital held by the physician or held by an immediate family member of the physician. Disclosure must be made at the time of the referral.*

*Effective October 1, 2008, hospitals that do not have any physician owners who refer patients to the hospital are exempt from the disclosure requirements (See 42 CFR 489.20(v)). In addition, CMS may deny a provider agreement to a hospital that does not have procedures in place to notify patients of physician ownership in the hospital (See 42 CFR 489.12).*