

Chapter 7

Regulatory and Legal Concerns for Rural Health Facilities

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Regulatory and Legal Concerns for Rural Health Facilities

INTRODUCTION

Rural facilities wishing to improve their efficiency and financial condition, and enhance their ability to deliver more appropriate and accessible services, cannot always pursue the strategies they prefer. This chapter discusses some of the Federal and State laws and regulations that may impede them.

FEDERAL ISSUES

Medicare Conditions of Participation

In order to participate in the Medicare program, hospitals and other health care facilities must meet certain “conditions of participation,” intended to ensure that facilities serving Medicare patients meet minimum standards of quality, regardless of where they are located.¹ Medicare conditions for hospitals define what provisions must exist with regard to governance, quality assurance, utilization review, medical and nurse staffing, clinical and support services, and the physical environment (e.g., facility specifications). The standards also describe what services a hospital participating in Medicare may deliver. The participating hospital must comply with applicable Federal health and safety laws, and its facility and personnel must be licensed or meet other standards set by the State. In most States a hospital’s accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is acceptable for meeting conditions of participation. However, many small rural hospitals are not JCAHO-accredited;² these facilities must be approved to participate in Medicare by State government agencies (51 FR 22042).

Some requirements set by the conditions of participation (or resulting from their interpretation) are viewed by many rural facilities as particularly

burdensome, vague, irrelevant to their settings, or limiting to the effectiveness of certain services.

Staffing Requirements—Medicare requires that hospitals provide 24-hour nursing service furnished or supervised by a registered nurse (RN) in each department or unit of the facility, including the emergency room. Hospitals must also use licensed laboratory and radiology technicians, and they must have a full-time director of food and dietary services. Small rural hospitals may have difficulty recruiting or affording such skilled staff, or they may not have enough patients to justify the presence of so many staff.³ Moreover, complex requirements for assuring quality of care (51 FR 22042) require several administrative committees that small medical staffs may find excessively burdensome.

Facility Requirements—Medicare requires hospitals to meet standards for architectural configuration and physical environment, many of which were developed by the National Fire Protection Association (51 FR 22042). Meeting these building standards (e.g., having emergency power and water supplies and building corridors of a minimum width) can add significantly to rural hospital renovation costs.

Administrative Requirements—Requirements for quality assurance, utilization review, and medical record services (51 FR 22042)—intensified by payer-induced incentives to monitor quality and utilization—have resulted in increased need for documentation, leading to longer work hours for administrative staff in many health care facilities (578). Paperwork is generally not reimbursable by payers, so facilities must absorb the related increase in staff costs. Many small rural facilities may lack the administrative depth and financial stability to adequately meet these requirements.

¹Facilities receiving Medicaid payments must meet similar conditions of participation.

²In 1987, 38 percent of all rural hospitals (compared with 11 percent of urban hospitals) were not accredited by JCAHO. The proportion rises to nearly 60 percent of rural hospitals with 25 to 49 beds and 80 percent of those facilities with fewer than 25 beds. Of urban hospitals, 30 percent with 25 to 49 beds and 84 percent with fewer than 25 beds were not JCAHO-accredited (625).

³These staffing requirements may be misunderstood by some hospitals, and not all small rural hospitals may be aware of certain flexibilities under the conditions for participation that may be granted under these situations. For example, under certain circumstances, temporary waivers of the 24-hour nursing staff requirement may be granted to rural hospitals with 50 or fewer beds found to be out of compliance with conditions of participation (42 CFR 1988 ed. 488.54).

Home Health Services—Hospital-based home health programs in some rural areas have difficulty complying with Medicare regulations because they lack a **full-time RN director** (219). Some rural local health departments with home health agencies have also had difficulty justifying and affording a full-time RN who is responsible solely for the home health service (519). Other rural home health agencies have expressed concern about their ability to obtain the required qualified instructors to conduct classroom teaching for home health aides (279).

Swing Beds—Some rural hospitals believe that Federal regulations on swing beds are too stringent or unclear. To qualify for swing-bed reimbursement, patients must meet the same standards of medical need as patients who qualify for reimbursement in skilled nursing facilities. Hospital patients discharged from acute care who need transitional care less intense than skilled nursing care are thus ineligible for Medicare swing-bed reimbursement (194). This creates a gap in health care coverage, particularly in areas with no easily available home health services. Hospitals also complain that Medicare intermediaries⁴ inconsistently interpret billing instruction manuals when classifying swing-bed patients as receiving skilled or intermediate care, creating confusion and limiting swing-bed use (732).

Rural Health Clinic Certification

Faced by increased financial pressures, rural health facilities are seeking ways to enhance reimbursement under Medicare and Medicaid. Recent congressional actions to improve reimbursement for certified rural health clinics (RHCs) (see ch. 3) have renewed provider interest in becoming or remaining certified as RHCs. However, providers often lack knowledge about the program or are concerned about RHC regulations. Major concerns include:

- *Delays in certification*—Many providers seeking RHC certification report that the application process is burdensome and lengthy, often lasting 6 or more months (87,713).
- *Discontinuance of billings*—Providers must stop billing Medicare and Medicaid while awaiting RHC certification, creating possible

cash flow problems for smaller providers heavily dependent on such sources of payment. (Once certification is received, RHCs are entitled to retroactive reimbursement under the new form of payment.)

- *Administrative requirements*—The paperwork burden necessary to complete extensive cost reports and other requirements may be overwhelmingly complex for small unsophisticated RHCs with few administrative staff. Such centers may have to obtain costly outside accounting and financial assistance. RHCs can also encounter operational difficulties when States conduct annual recertification surveys without prior notice. Small centers where staff handle both administrative and clinical duties may be unable to fulfill all of their clinical obligations during unannounced recertification visits (713).
- *Requirements for midlevel practitioners*—A midlevel practitioner must be on site at an RHC at least 50 percent of the time the facility is open. (Congress reduced this requirement from 60 percent in 1989 (Public Law 101-239).) This requirement may be difficult for some clinics to meet. First, some RHCs have problems recruiting and retaining midlevel practitioners due to supply shortages, or due to restrictions in some States that affect the ability of midlevel providers to practice medicine (see ch. 12). Second, rural providers with several clinic sites that share midlevel practitioners **on a part-time** basis may be unable to qualify each site as an RHC, because the midlevel practitioners may not always be available at each site at least 50 percent of the time the center operates.
- *Limited guidance for provider-based clinics*—Health Care Financing Administration (HCFA) regulations for RHCs have focused on free-standing clinics (the vast majority of RHCs). Some observers report that the regulations lack sufficient guidance for provider-based sites (e.g., in hospitals or skilled nursing facilities) on acceptable methods of determining reasonable costs for reimbursement (523). Provider-based clinics are supposed to receive full cost-based reimbursement (see ch. 3).

⁴Medicare intermediaries are fiscal agents (typically Blue Cross plans or commercial insurance firms) under contract to the Health Care Financing Administration for administration of specific Medicare tasks (e.g., determining reasonable costs for items, making payments).

Performance Standards for Community Health Centers

All community health centers (CHCs) are expected to meet certain administrative and clinical standards of performance set by the Bureau of Health Care Delivery and Assistance (BHCDA) of the U.S. Public Health Service. Such measures include minimum productivity levels (e.g., numbers of patient encounters per physician, physician-to-patient ratios) and maximum ratios of administrative costs as a percent of total costs.

Small rural CHCs, particularly those in frontier areas, may find it difficult to meet these standards. In a survey of frontier centers in five States covering the years 1985-87, CHCs had higher proportions of administrative costs, higher medical costs per visit, and lower proportions of charges to costs than BHCDA considers acceptable. However, the centers on average met the standard for provider productivity (204,350). Recently, BHCDA has considered suggestions for changes in CHC performance measures that are more sensitive to the diverse populations served by centers (477).

Tax Laws Affecting Health Facilities

Essentially all of the Federal tax laws affecting the delivery of health care concern the activities of tax-exempt organizations and their affiliates. Exclusions, deductions, and credits are not generally available under Federal tax laws for the 10 percent of rural hospitals that are proprietary. This section discusses how such tax provisions affect the survival and expansion strategies of nonprofit rural hospitals.

Tax-Exempt Organization Status

Because the promotion of health is considered a charitable purpose, nonprofit hospitals and other health care providers generally have no difficulty obtaining tax-exempt organization status. However, a hospital providing services to other hospitals can endanger its exempt status. For example, in order for a hospital cooperative to retain its tax-exempt status while providing and receiving shared services:

- it may provide only the following ‘ ‘permissible’ ’ services: data processing, purchasing, warehousing, billing and collection, food, industrial engineering, laboratory, printing, com-

munications, record center, personnel, and clinical services;

- it may provide such services only to two or more exempt hospitals or to government owned and operated hospitals (“permissible recipients’ ’); and
- it must be organized and operated on a cooperative basis, it must have as members or shareholders only permissible recipients, and it must allocate or pay all net earnings to its patron hospitals on the basis of services performed for the patron hospitals (Internal Revenue Code Section 501 (e)).

The list of Permissible services is narrow and omits many services that rural hospitals in cooperatives and other arrangements might efficiently share (e.g., management, laundry, and housekeeping services). The penalty for providing nonpermissible services is stiff. If a shared service organization (e.g., a cooperative) provides any unlisted services, or if it provides services to any institution that is not a hospital, the organization will lose exemption for all of its services. Unlike other exempt institutions, shared service organizations are not simply subject to tax on such unrelated activities.

Efforts to recruit and retain well-qualified medical staff can also endanger exempt status. To attract physicians, a hospital may wish to offer loans, income guarantees, practice facilities, and other benefits. Offering incentives may endanger a hospital’s tax exemption by implying that the hospital is unduly furthering the interests of private individuals. Under Treasury regulations, a tax-exempt health provider must meet the following tests:

- it must be organized and operated exclusively for exempt purposes;
- no part of its net earnings may inure to the benefit of persons having a personal and private interest in the organization; and
- it must demonstrate that it is not organized or operated to benefit private interests (U.S. Treas. Reg. sec. 1.501).

The Office of the General Counsel of the Internal Revenue Service (IRS) has indicated that physicians recruited as employees, or as individuals with a close professional relationship with a hospital, are subject to review under the inurement proscription (300).⁵ Hospitals also must demonstrate that their opera-

⁵General Counsel Memoranda are not binding but indicate how the IRS is likely to rule on an issue.

tions do not benefit private interests more than incidentally. In theory, this standard may not be difficult to meet. For example, the IRS has ruled that a rural area with a significant need to attract physicians could use community funds to construct a medical office complex, because any personal benefits physicians might derive would be incidental to the community benefit (298). However, the analysis that must be done to demonstrate this condition can be difficult. It requires that benefits provided by the physician to the hospital and the community be quantified and compared to the recruitment or retention benefits provided to the physician. This is not an easy task, since community benefits are often subjective and not easily quantifiable. Uncertainty about what hospitals may offer to attract and retain physicians is exacerbated by the recent IRS announcement that exempt hospital-physician relationships will be subject to heightened scrutiny.

Unrelated Business Income

Tax-exempt organizations are subject to Federal tax on income from any regular business that is not substantially related to the organization's charitable purpose (IRS Code Sections 511(a), 512(a)(1), 513(a)). These activities may be restricted not only by imposing tax, but also by concerns that status of the facility (or of bonds financing it) may be endangered. Recent proposals by Congress broaden the types of income classified as unrelated and limit the deductions permitted in computing taxable income (e.g., from hospital gift shops, royalties, and rent from organizations hospitals control).

In general, services provided by hospitals to physicians in private practice or to their patients generate taxable income. Such services include reference laboratory, administrative, and pharmacy services (294,295,296,299). However, the IRS has recognized to a limited extent that rural hospitals meet unique community needs that justify tax exemption of such activities. For example, a hospital's reference laboratory service may be exempt if the hospital is geographically isolated and the services are not reasonably available from commercial sources (299). This test is fact-specific, however, and does not provide general guidance for rural hospitals.

Although in considering these issues the IRS has indicated no "across-the-board" recognition of a rural hospital's role, courts have been sympathetic to rural hospitals. For example, in *Hi-Plains Hospital v. United States*, the court held that a rural hospital's pharmacy sales to private physicians' patients were not taxable income because the pharmacy's availability was an inducement to practice medicine in the hospital, and thus it contributed to the goal of making medical services available (257). Income from rent of office space to physicians has not been considered taxable because locating physicians on the hospital campus is, in the IRS's view, substantially related to the hospital's provision of medical care, whether the hospital is urban or rural (297).

Tax-Exempt Financing

As noted in chapter 5, access to tax-exempt financing is crucial for many nonprofit rural hospitals. Under the IRS Code, interest income from new bonds issued after August 1986 to finance tax-exempt health facilities is exempt from Federal tax if:

- all of the property obtained with the proceeds of the bonds is owned by the tax-exempt provider, and
- no more than 5 percent of the facilities financed by bond proceeds are used by a nonexempt person or in an unrelated trade or business (IRS Code Sections 103, 141, 145).⁶

Fraud and Abuse Regulations

The Antikickback Provisions

The Medicare and Medicaid antikickback provisions (42 U.S.C. § 1320a-7b) were first adopted by Congress in 1972. The provisions were intended to provide penalties for certain practices that have been long considered unethical by professional groups and that contribute significantly to the cost of the Medicare and Medicaid programs. The regulations prohibit offering, soliciting, paying, or receiving "any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind" in exchange for or to induce any of the following actions:

- referring an individual to a provider for the receipt of an item or service that is covered by Medicare or Medicaid; or

⁶Recent proposals by Congress have also called for linking a hospital's level of indigent care to continued eligibility for tax-exempt financing.

- **purchasing, leasing,** or ordering any item or service that is covered by Medicare or Medicaid.

If read literally, these regulations can be viewed as prohibiting a number of relatively common activities. The provision of free coffee by a hospital to members of its medical staff could be interpreted as an inducement to the physicians to admit their patients to the hospital. Although this particular common practice is unlikely to warrant prosecution, health care providers may find it difficult to clearly distinguish between permitted and prohibited conduct.

Many hospital strategies to recruit or retain physicians (e.g., offering physicians financial assistance in establishing a practice) can trigger antikickback provisions. Such arrangements might be viewed as the furnishing of compensation to a physician by an entity to which the physician refers patients.

The ownership of hospitals by physicians may also be viewed as a violation of antikickback laws if these physicians tend to refer patients to the hospitals they own. These "self-referrals" by physicians may be especially prevalent in rural areas where the physician-owned hospital is the only local hospital.

In other rural communities, some for-profit multi-hospital chains (e.g., Hospital Corp. of America and American Medical International) have explored the possibility of selling unprofitable facilities to members of the hospitals' medical staffs (584). Where a rural hospital is unprofitable, the members of its medical staff may be the only persons with sufficient capital to take over the facility and prevent its closure. Also, physician ownership may mean there is sufficient interest by local physicians in maintaining a practice at a nearby hospital, and that at least some of the income from the hospital's operations will remain invested in the community.

"Safe Harbor" Regulations

In an attempt to resolve some of the confusion surrounding the meaning and scope of the antikickback statute, Congress recently directed the Secretary of the Department of Health and Human

Services (DHHS) to develop regulations specifying "safe harbor" practices that would not be considered violations of the statute (Public Law 100-93). The proposed regulations were issued in January 1989 (54 FR 3088), but they have not resolved the uncertainty. For example, one of the proposed "safe harbors" would permit a physician to receive dividends from investments in large, publicly traded companies that operate entities to which the physician refers patients.⁷ The legality of this practice, however, was never seriously questioned. What had been (and remains) uncertain was the permissibility of physician investment in hospital-physician joint ventures, or physician ownership of community hospitals. Similarly, the proposed regulations would protect the purchase by a physician of the practice of another physician who is retiring or is leaving the area. However, the regulations say nothing about whether a hospital may purchase a physician's practice--a question that is likely to be far more important for the rural hospital trying to maintain its patient base. Final "safe harbor" regulations are expected to be published in 1990.

Antitrust Issues

Mergers and Acquisitions

Some rural hospitals may find it increasingly desirable to combine their assets and operations. However, recent increases in government oversight and enforcement of hospital consolidation activity by the U.S. Justice Department and by the Federal Trade Commission (FTC) raise important antitrust issues for these rural hospitals. Section 7 of the Clayton Act (15 U.S.C. 12-27) prohibits mergers or acquisitions that may substantially lessen competition or tend to create a monopoly. The Clayton Act's application requires a prediction of the likely effect of the merger or acquisition on consumer welfare. Guidelines for evaluating this effect were issued in 1984 by the Antitrust Division of the Department of Justice.

The principles and standards contained in these merger guidelines have recently been applied in two cases involving mergers of nonprofit hospitals--one in Roanoke, Virginia, the other in Rockford, Illinois.⁸ In each case, the Federal Government sought

⁷Rural facilities are exempted from legislation passed by Congress in 1989 that denies Medicare payment for clinical laboratory services if the referring physician has a financial interest in, or receives compensation from, the entity that provides the service (Public Law 101-239).

⁸Prior to 1988, the Federal agencies responsible for enforcing the antitrust laws had challenged only three mergers or acquisitions involving general medical and surgical hospitals.

to prevent the consolidation of two nonprofit hospitals in suburban communities with few acute-care facilities. Both cases were decided in early 1989. In the Rockford case, the court found that the merger violated the antitrust laws; in the Roanoke case, the court held that it did not. Both decisions have since been upheld by courts of appeal.⁹ The legal standards arising from these conflicting decisions are outlined below.

1. Product Market Definition—The first step in merger analysis is the definition of the relevant product markets. In the two recent hospital merger cases, the relevant product market alleged by the government was acute inpatient hospital care. Both hospital defendants, however, argued that the appropriate market included both inpatient and outpatient care provided by all health care providers. The court in the Rockford case adopted the government's narrower market; the court in the Roanoke case adopted the defendants' broader market.¹⁰ The product market definition was critical to the outcome of both cases. The court's adoption of the Roanoke hospitals' broad market definition meant that more providers (such as outpatient clinics, urgent centers, and even doctors' offices) would be viewed as competitors to the merging hospitals, and that the elimination of one of the hospitals would have less competitive impact. The opposite was true in Rockford; the court found that because there would be fewer hospitals if the merger took place, the loss of even one could have significant anticompetitive effects. The decision by other courts in the future regarding the appropriate product market definition may have a significant impact on the viability of consolidation as an option for rural hospitals.

2. Relevant Geographic Market—The definition of geographic markets of hospitals is the second element in a merger case. The courts in the Rockford and Roanoke cases used similar evidence to define the geographic market, but the results were remarkably different. In the Roanoke case, the court concluded that the relevant geographic market comprised 16 counties and 3 independent cities of

Virginia, and 3 counties of West Virginia. This conclusion was based on the court's finding that the hospitals involved drew a "substantial" number of patients from outside the immediate vicinity. In the Rockford case, the court defined the geographic market as the area representing about 90 percent of the admissions of the defendant hospitals. Factors involved in this decision included:

- the extent to which physicians admitted patients to nearby hospitals,
- usage of the hospitals by non-Rockford patients needing specialized care,
- the number of hospitals where individual physicians had admitting privileges,
- data on patient residence and destination for receiving services, and
- the physical geography of the area.

3. Market Structure—A third important component of merger analysis is an assessment of the competitive structure of the market and the way the merger will alter that structure. This is done by identifying the competitors in the market and estimating the market share of each before and after the merger. According to the merger guidelines, a postmerger projected market share over a threshold amount¹¹ implies concern that the merger may violate the antitrust statute. The merger guidelines were used by the courts in the Rockford case.

Most of the hospital markets in rural areas are considered to be highly concentrated. This is because most rural communities cannot support the minimum number of independent hospitals that must be in a market to keep the market share of combined hospitals below the threshold amount.¹² Consequently, mergers or acquisitions involving competing hospitals in nonmetropolitan areas will often create an apparent violation of the merger guidelines.

4. Other Factors Affecting Concentration—Other factors commonly considered by the courts in assessing the competitive effects and the legality of a hospital merger include:

⁹Subsequently, in the Roanoke case, the government decided to drop its opposition to the hospital merger.

¹⁰See *United States v. Health System*, 1989-1 Trade Cas. 68,451 (W.D. Va. 1989) ("Roanoke"); *United States v. Rockford Memorial Corp.*, 1989-1 Trade Case. 68,462 (N.D. Ill. 1989) ("Rockford").

¹¹The Herfindahl-Hirschman Index (HHI) sums the squares of each competitor's market share. A merger may violate the antitrust statute if the postmerger HHI exceeds 1,800, and if the merger increases the HHI by 50 points.

¹²For example, to keep the postmerger HHI below 1,800, a market would have to have at least six equally sized hospitals.

- *Barriers to entry*—Barriers to entry make merger approval less likely. If there are few barriers to entry, it is less likely that incumbent hospitals could exercise control of the market. State certificate-of-need (CON) regulations and insufficient demand for services render entry by new hospitals unlikely in many rural markets.
- *Nature of competition in the market*—The courts in Rockford and Roanoke recognized that hospitals generally have been forced to become more competitive; the court concluded in the Rockford case that hospitals in the market could benefit by engaging in anticompetitive activities (e.g., price fixing) at the expense of consumer welfare.
- *Financial condition of the merging hospitals*—If one of the merging hospitals in a market is likely to fail in the near future and is unlikely to successfully reorganize under the Bankruptcy Act, and there are no less anticompetitive alternative purchasers, courts may find the merger more acceptable (the so-called “failing company defense”).
- *Likelihood that the merger will allow the hospitals to achieve efficiencies that could not be obtained individually*—The procompetitive benefits of certain otherwise unattainable efficiencies may outweigh the potential anticompetitive effects of a merger. The savings from such efficiencies will vary in each case; courts reviewing mergers have balanced claims for efficiencies against the anticipated anticompetitive effects.

Although the legal issues and factual settings in the recent Rockford and Roanoke cases were remarkably similar, the courts’ decisions are diametrically opposed on virtually every major issue. The legality of any hospital merger inevitably will depend on the competitive environment in which the merging hospitals exist, and at present there are few consistent legal guidelines to help hospitals assess the legality in their specific situations.

Recent action by the FTC may make more costly the mergers and acquisitions of many larger rural health care facilities. In late 1989, the FTC began requiring entities (including hospitals) interested in

acquiring another entity to pay a \$20,000 filing fee as part of FTC’s premerger notification requirements. For hospital mergers, the filing fee is required if:

1. the acquiring entity has at least \$100 million in total assets or net patient revenue, and the other entity has at least \$10 million in assets or net patient revenue; and
2. the total value of the assets actually bought in the acquisition will be at least \$15 million.

Medical Staff Credentialing

Antitrust cases brought against hospitals and their medical staffs by physicians who have been denied medical staff privileges are perhaps the single largest category of antitrust cases involving health care providers. In these cases, the issue is whether the hospital and its medical staff conspired to prevent the excluded physician from competing for patients needing hospital care. In areas with many physicians, the exclusion of a single physician is unlikely to result in an antitrust judgment.¹³ Cases in which the hospital board unilaterally decides for valid reasons that a physician should be denied privileges also generally do not incur antitrust liability.

More usual antitrust cases involve hospitals that have entered into exclusive contracts with a physician or physician group (most commonly for such services as anesthesiology, emergency medicine, pathology, and radiology). Where the hospital bends to pressure from the medical staff to insulate certain practitioners from competition by giving them an exclusive contract, and where the hospital has a dominant share of the market, it may invite an antitrust action. Rural hospitals are especially susceptible to this threat because of their large market share. In a Montana case, for example, anesthesiologists on the staff of a hospital that had 84 percent of the market share for general surgical services had threatened to leave the hospital unless they got an exclusive contract. The contract resulted in the exclusion of a nurse anesthetist, and the anesthesiologists subsequently increased their annual earnings by 40 to 50 percent. Given these circumstances, the court found that the exclusive contract unreasonably restrained trade in violation of the antitrust laws.¹⁴

¹³See *Ezpeleta v. Sisters of Mercy Health Corp.*, @1 F.Supp. 1262 (N.D. Ind. 1985), aff’d, 800 F.2d 119 (7th Cir. 1986).

¹⁴See *Oltz v. St. Peter’s Community Hospital*, 1988-2 Trade Cas. (C.C.H.) 68,345 (9th Cir. 1988).

The argument that a competing physician was excluded based on review of that physician's record by the hospital medical staff is not always a successful defense, even in a State with a statute encouraging such peer review. In an Oregon case involving this issue (see *Patrick v. Burget*, 108 S. Ct. 1658 (1988)), the Supreme Court held that the State of Oregon did not actively supervise peer review activities, nor did it have a mechanism for overturning inappropriate peer review decisions. Therefore, the Court concluded, such activities were not immune from antitrust challenge.

Joint Ventures

Hospitals that have a very large market share for hospital services in a particular area maybe in joint ventures (e.g., for provision of home medical equipment) that effectively limit competition by suppliers not included in the ventures. Likewise, a group of rural physicians who account for a majority of the physicians in a particular community may face antitrust risks associated with joint ventures. Agreements with joint venture partners to refer all patients for durable medical equipment or home health to the venture, for example, may have antitrust implications.

STATE ISSUES

Facility Licensure

State licensure standards are intended to ensure that patients using licensed facilities will be provided care of at least a minimum level of safety and quality. (In addition to receiving State licensure, facilities wishing to be certified by Medicare and Medicaid, as noted earlier, must meet standards set by JCAHO or State licensing agencies mandated under Medicare conditions of participation.) These standards, however, may sometimes inhibit rural hospitals from undertaking some activities to enhance their survival.

- *Operating room requirements*—States generally require all licensed hospitals to have fully equipped operating rooms. Even if a small rural hospital no longer performs surgeries due to declines in demand and availability of surgeons, it must continue to maintain surgical facilities and staff.
- *Hospital-based SNF requirements*—Some State licensure laws pertaining to hospital-based skilled nursing facilities ("distinct part SNFs")

may require SNFs to have their own nurses' station apart from the hospital's acute-care nurses' station. Medicare certification also generally requires hospital SNFs to remain distinct units with separate beds and staff. Complying with such standards may result in both SNF and acute-care nursing staff being underused, especially in small rural hospitals whose acute-care census is low.

- *Personnel training requirements*—Some States limit the use of multiskilled allied health care personnel. Many rural hospitals incur higher costs because they must, according to State licensure laws (and Medicare conditions of participation), employ several full-time individuals to perform tasks that a single professional could do if appropriately trained and licensed.
- *Higher license fees*—Certain States reportedly have instituted significant increases in fees for facility licenses, CON applications, and other business requirements for health care facilities. These fees are proportionately more difficult for small providers than for large providers to pay.

Little is known about the costs these regulations entail, and what impact they have on rural hospital efforts to preserve quality of care, maintain operations, and adapt to environmental changes.

Where States have made substantial changes in response to rural hospital concerns, hospitals may still be faced with incompatible Federal certification regulations. The State of Montana recently requested a waiver of Medicare conditions of participation and certain reimbursement policies from HCFA that would permit the State to create a new class of rural facilities (medical assistance facilities) as an alternative to a rural hospital (see ch. 8). Changes in State licensure laws are sufficient to permit such facilities to function, but changes in Medicare certification requirements are probably necessary to make them financially viable.

Certificate-of-Need Requirements

In 1972, the Federal Government required States to begin instituting CON programs to more effectively control health care capital expenditures and other medical costs. In general, CON was seen as a way of limiting unnecessary investment by hospitals and other health facilities in new beds, plant, and

equipment. States were required to establish health planning agencies to conduct CON reviews of health facility capital projects, and develop regional plans for rationally allocating and distributing limited resources and services (Public Law 93-641). In 1987, Federal requirements for State health planning and CON review were repealed.

With the end of Federal oversight, many States have modified or eliminated their CON laws. A 1989 survey found that 11 States have eliminated their CON programs. In addition, some States have (or are considering) CON laws that exempt certain facilities and services from review (34). A number of States without CON laws are limiting expansion in other ways (e.g., through moratoria) on certain new services. Only seven States have no limits at all on the numbers of skilled nursing, swing, rehabilitation, psychiatric, and alcohol/drug treatment beds in general acute-care hospitals (474).

State mechanisms to limit expansion may conflict with survival strategies of rural hospitals. For example, a State with a moratorium on new SNF beds might not permit a rural hospital to convert unused acute-care beds to long-term beds if the statewide supply of SNF beds is already at the regulatory limit.¹⁵ Many health facilities view CON thresholds for capital expenditures (the minimum expenditure levels at which the CON review and approval process is invoked) as too low and the related application process too burdensome and lengthy, threatening their access to capital.

Also, some States make swing-bed conversions contingent on a hospital's acute-bed capacity or the availability of nursing home beds in the area. Kentucky, for instance, places limits on hospital Medicaid participation by restricting the number of swing-beds in a hospital to 25 beds or 10 percent of the hospital's acute-bed capacity (whichever is greatest), but not to exceed 40 percent of acute-bed capacity (474).

On the other hand, CON in some States may serve to maintain the continued existence of some rural facilities and services by giving them special consideration. Many rural facilities concerned about com-

petition support CON efforts and other restrictions that prevent other facilities from expanding.

A few States have amended (or are currently considering amending) their CON laws to enable rural hospitals to more easily diversify into new services or to convert to alternatively licensed health care facilities. For example, some States have raised the CON review thresholds for certain capital expenditures. Others have exempted certain projects or facilities from CON review altogether. Other States now allow qualified rural hospitals to convert up to a certain number of acute-care beds to swing-bed status without CON review (see ch. 6) (440,450).

Property Tax Laws

Requirements for exemption from State and local property tax laws generally are more restrictive than conditions for exemption from Federal income tax. Only 17 States and the District of Columbia have enacted laws that expressly recognize the delivery of hospital care by a nonprofit entity as sufficient for property tax exemption. State and local laws typically require a property to be owned by a charitable organization and to be used exclusively for charitable purposes. Under States having "all-or-nothing" requirements, use of any part of a property for nonexempt purposes or on behalf of nonexempt persons renders the entire property subject to tax. Many States, however, permit proration of a property between exempt and nonexempt portions for tax purposes.

In addition, many State and local legislative, administrative, and judicial initiatives have responded to needs for increased revenues, and complaints by small businesses of unfair competition from the nonprofit sector, by proposing to revoke tax exemptions. Recent challenges to property tax exemption have been mounted in California, Missouri, Pennsylvania, Tennessee, Texas, Utah, and Vermont (202,271). Charitable organizations have been challenged to justify their exemption by showing public benefits provided, such as the amount and availability of uncompensated care.¹⁶ Following a recent Utah decision, local taxing authorities in several States have attempted to

¹⁵Moratoria on additional SNF beds in many States is often attributed, in part, to efforts by nursing homes to prevent competition from acute-care hospitals providing long-term care services (474).

¹⁶See *Utah County v. Intermountain Healthcare Inc.*, 709 P.2d 265 (Utah 1985), and *Medical Center Hospital of Vermont v. City of Burlington*, No. 87-501; Oct. 13, 1989.

revoke property tax exemptions held by some nonprofit hospitals within their jurisdictions. In some States, hospitals have agreed to donate cash and services in lieu of paying property taxes (397). Proposals have also been made that would require payments to local governments to cover costs for municipal services (467).

To date, such actions have been primarily in urban areas. This may be because the community benefits provided by a rural hospital are more readily apparent to local taxing authorities. But loss of exemption from property tax is nonetheless an ominous spectre for rural hospitals, particularly those with a shaky financial foundation.

Public Hospital Issues

Rural government-owned hospitals, whether entities of a county, district, township, or other municipal authority, are confronted by State statutory, judicial, and constitutional impediments to their ability to diversify and engage in joint ventures.

Statutory Restraints on Diversification

Rural public hospitals, like public hospitals generally, are creatures of their enabling statutes. Public hospital enabling acts are, almost without exception, strictly construed by State courts and attorneys general. The single most important restriction on the ability of public hospitals to diversify and to provide a full range of health care and nonhealth related services is based on State court interpretations of "Dillon's Rule," which reads as follows:

Local governments have only those powers specifically granted by constitution or statute or necessarily arising by implications from the expressed powers (177).

The impact of this restrictive rule on public hospitals is considerable. As a result of this rule, a public hospital may engage in a specified activity only if its enabling act expressly empowers it to do so. But, because most public hospital enabling acts were drafted decades ago (often before the 1940s), the services empowered by their statutes are very limited. Thus, for example, many public hospitals are unable to own or operate a durable medical equipment company or provide nonacute care services.

State courts typically resolve any doubts about whether such powers exist against the hospital. For example, a 1982 opinion of the Alabama attorney



Photo credit: Peter Beeson

Due to State enabling statutes, most publicly owned hospitals face strict limits on their ability to diversify services and compete for patients.

general (see Ala. AGO 82-00510) provides that a public hospital has no clear authority to pay a physician interest-free loans or income guarantees. A 1985 Georgia court decision concluded that a county hospital did not have the power to operate a durable medical equipment business (406).

Statutory Restraints on Competition

Rural public hospitals are also confronted by the following statutory barriers to competition arising out of their restrictive enabling acts.

Extraterritoriality--Almost without exception, public hospital enabling acts prohibit municipal corporations or political subdivisions from exercising any authority, or owning or operating any property or business, outside of the geographical territory in which they are empowered to operate. For example, a hospital district wishing to establish a physician satellite clinic outside the boundaries of the district would probably lose a court challenge to this action. This effectively precludes the hospital from capturing primary and secondary care patients outside of the limited service area.

Board Composition--Most public hospital enabling acts expressly limit the number and types of individuals who may serve on the board of the public hospital. They often prohibit medical staff members, persons who do not reside within the boundaries of the municipality or political subdivision, and public

hospital employees from serving on the board.¹⁷ Such restrictions may make it difficult for some rural public hospitals to find trustees knowledgeable about hospital and health care issues.

Public Disclosure Laws—Most States have public disclosure laws that require public bodies, including government-owned hospitals, to hold open meetings and provide the public access to numerous records of the public body. Although these laws serve this purpose well, they also may place public hospitals at a severe competitive disadvantage. In a rural area with more than one hospital, a public hospital is disadvantaged by having sensitive business plans reported on the evening news or heralded on the front page of the local newspaper. In 1986, the California Legislature addressed this problem by amending the State's Hospital District Law to enable a district hospital board to order a closed session to discuss or deliberate on hospital "trade secrets" where necessary to initiate a new hospital service or program that would, if prematurely disclosed, create a 'substantial probability of depriving the hospital of a substantial economic benefit.'"¹⁸

Certificate-of-Need Laws--Public hospitals typically are not empowered by their enabling acts to engage in the corporate restructurings that might be used to circumvent CON review of a major project in many States. The ability of private hospital competitors to do so thus may give them an important competitive advantage over public hospitals.

Investment Restrictions--Many State enabling acts place severe limitations on the types of investments in which public hospitals may place their funds. For example, the Illinois Investment of Public Funds Act prohibits public entities from owning stock for investment purposes.¹⁹ In Alabama, public hospitals may only invest in "direct obligations of the United States."²⁰ Restrictions of this kind protect the public purse but also prevent public hospitals from placing hospital funds in higher interest-yielding investments.

Public Bidding Laws—Almost every State has a competitive bidding process that is applicable to public hospitals. The considerable delay and expense generated by these statutes may impede or prevent rural public hospital administrators from reacting to changing market conditions in their purchase of property and services.

Judicial Restraints

Decisions by public hospitals concerning the credentials of medical staff are reviewed by State courts, both to review the hospital's compliance with the bylaws procedures and to affirm the underlying merits of the decision. In contrast, so long as a private hospital follows the procedural guidelines set forth in its medical staff bylaws, courts in most States will not step in to second-guess the substantive decision of those hospitals.

Constitutional Restraints

Almost every State constitution prohibits municipal corporations, including public hospitals, from owning stock or serving as a partner with a private entity. This prohibition arises out of States' concerns about the commingling of public with private funds, and the potential "gift" of tax dollars that would enrich private individuals. Such absolute prohibition from equity ownership precludes almost all types of joint ventures between public hospitals and physicians or private hospitals. Thus, a method used successfully by private hospitals to encourage closer relations between hospitals and physicians and to access additional sources of capital is usually unavailable to public hospitals.

Possible Solutions

Amendments of State public hospital enabling acts and other statutes may aid public hospital efforts to expand their scope and array of activities to enhance their survival. Also, some public hospitals have created "parent-subsidiary" or "brother-sister" multicorporate structures to avoid statutory and constitutional constraints. These partial solutions, however, are not without their own problems. First, it may be unclear whether the newly created affiliate can be capitalized by the governmental body without violating the State constitutional

¹⁷See, e.g., *Michigan op. Atty. Gen. No. 6067, P. 646* (1982).

¹⁸See *California Health and Safety Code, Section 32106*.

¹⁹See *Illinois, Rev. Stat. ch. 85 § 2401 et seq.* (1983).

²⁰See *Alabama Code § 22-21-77(15)* (1989).

prohibition on “public gifts.” Second, the greater the control by the governmental body over the affiliate, the greater the likelihood that (for regulatory purposes) such transactions will be considered improper. The adoption of these structures is clearly not without legal risk.

A third issue involving public hospitals has been a national movement toward allowing public hospitals, through State enabling act amendments, to “convert” to private, nonprofit status by selling or leasing all of the public hospitals’ assets and operations to newly created nonprofit corporations. Once legal authority to “convert” exists, the mechanics of conversion must be investigated. One of the major concerns in any public hospital conversion is the degree to which the nonprofit entity that operates the hospital will be accountable to the public after the conversion. Public concerns may include potential reduction of services, reduction or elimination of uncompensated care, and unreasonable “inside deals” between the public body and the new nonprofit hospital board. These concerns must be addressed expressly in either the lease or sales agreement between the public body and the new hospital corporation, or in the new hospital corporation’s articles and bylaws.

SUMMARY OF FINDINGS

Federal and State laws and regulations governing delivery of services have created a number of concerns for rural providers.

Some State licensure rules and Medicare participation requirements are seen as inhibiting operations and strategies for effective change. Many rural hospitals, especially smaller ones in more remote settings, argue that standards for minimum staffing and service requirements are impractical to follow, because staff are unavailable, too costly, or cannot be justified due to insufficient patient demand. Some recent State efforts (e.g., in Montana) to alter licensure rules for struggling hospitals in isolated rural areas may face Medicare certification requirements that cannot accommodate anything less than a full-service, acute-care facility.

Eligibility requirements for Federal tax exemption are seen as endangering some survival strategies of rural hospitals. A rural nonprofit hospital’s exemption from Federal income tax is threatened if it offers incentives to attract physicians that may be seen as unduly tiering the physician’s private

interests; or if it receives substantial income from any business not related in a major way to the hospital’s charitable activities (e.g., sharing management services). In a time when many hospitals are considering participating in shared service cooperatives and diversifying into new services, the similar limits that apply to these ventures may inhibit hospitals from carrying out such strategies. Nearly one-half of rural hospitals are private nonprofit institutions, and loss of tax exemption for many would further weaken their financial condition.

Some referral practices that rural hospitals might undertake to maintain their patient base and retain physicians may be subject to Federal antikickback regulations. Because many providers consider the scope of antikickback rules to be vague, certain practices deemed to be ‘safe harbors’ under the law have been proposed by DHHS. Uncertainty remains, however, over the legality of many practices such as physician investment in hospital-physician joint ventures, physician ownership of hospitals, and hospital purchase of physician practices.

Hospital mergers and physician relations are now facing greater scrutiny under Federal anti-trust laws. The legality of any merger depends on the specific competitive environment of the merging hospitals. Legal decisions regarding Federal efforts to regulate hospital mergers, however, have brought opposing results even in factually similar cases, perpetuating the uncertainty in many hospital markets.

Federal performance and certification standards for some rural clinics are seen as inappropriate or overly burdensome. Some small federally funded CHCs, especially in remote areas, believe Federal performance standards governing administrative and clinical operations of all CHCs are irrelevant or too inflexible for their environments. Rural centers wishing to become certified rural health clinics believe the process of certification is unduly long, complex, and sometimes impractical.

State CON rules and other laws that place limits on the number of new long-term care beds are sometimes seen as preventing rural hospitals from converting away from acute care. Such restrictions in all but a few States are believed by some rural hospitals to restrict conversions of excess acute care beds to nonacute or other specialty care beds. Some

States, however, have changed their CON laws to allow hospitals to more easily convert beds or diversify into new services.

State and local property tax exemptions for hospitals and other providers are facing greater scrutiny. At least seven States recently have challenged property tax exemptions of hospitals and other providers. Loss of tax exemption might further endanger the financial viability of some small rural facilities.

Rural public hospitals face strict limits on their ability to diversify and compete. Strict State enabling acts and constitutional provisions are seen as inhibiting survival efforts of rural public hospitals when they:

- prohibit a public hospital's operation of related businesses;
- limit operations to a specific service area;
- limit trustees to residence in a specific area (possibly restricting the hospital's ability to find qualified governance);
- require public disclosure of sensitive business and marketing strategies; and
- place other restrictions on investments, medical staff credentialing, and joint ventures.

Solutions being considered by States to these restraints on public hospital activity are not without risk. For example, States that allow public hospitals to restructure to private, nonprofit corporation status may lessen the hospital's public accountability.