PUBLICATION

Relocation of Physician-Owned Hospitals: CMS Advisory Insights

Authors: Joseph B. Keillor, Jerrell B. Miller, II
April 03, 2025

The Centers for Medicare and Medicaid Services (CMS) issued CMS Advisory Opinion No. CMS-AO-2025-1 on February 26, 2025, blessing the relocation of a physician-owned hospital. The hospital planned to relocate eight miles from its current location and add an emergency department (the Proposed Relocation). The hospital requested a determination from CMS regarding whether the Proposed Relocation would be consistent with the "whole hospital exception" to the Ethics in Patient Referrals Act (the Stark Law).

The Stark Law prohibits physicians from referring Medicare patients for certain designated health services to entities with which the physician (or an immediate family member of the physician) has a financial relationship unless an exception applies. The Stark Law also prohibits an entity from billing for services provided pursuant to a prohibited referral.

Under the "whole hospital exception" to the Stark Law, a physician may refer patients to a hospital in which he or she has an ownership or investment interest if: (i) the physician is authorized to perform services at the hospital; (ii) the ownership interest is in the entire hospital (not a distinct part or department of the hospital); and (iii) the hospital satisfies certain additional requirements.

Among such other additional requirements, the Stark Law requires the hospital to have had physician ownership and a Medicare provider agreement on December 31, 2010, and prohibits the hospital from increasing the number of operating rooms, procedure rooms, and beds beyond that for which it was licensed as of March 23, 2010 (or certain alternative timing within 2010).

CMS had previously explained in preamble commentary that the whole hospital exception is not intended to prevent a hospital that otherwise satisfies the exception from relocating some or all of its operating rooms, procedure rooms, or beds. Specifically, CMS stated that ". . . for a hospital to bill Medicare (or another individual, entity, or third-party payor) for a designated health service furnished as a result of a physician owner's referral *following the relocation* of . . . operating rooms, procedure rooms, or beds to a location other than the main campus of a hospital, the hospital (including all of its provider-based locations) *must remain the same hospital* that had both physician ownership or investment and a Medicare provider agreement on December 31, 2010."[1]

In separate preamble commentary, CMS had set forth various factors to consider when evaluating whether a relocating hospital is the "same hospital" as an original hospital for purposes of under the whole hospital exception, noting that no one factor is determinative. These factors include:

1. The status of, type of, and party to the state license for both the relocated hospital and the original hospital, including any lapses in state licensure or operation of either the relocated hospital or the original hospital.

2. Status of and party to the Medicare provider agreement, including any lapses in Medicare participation of either the relocated hospital or the original hospital.

3. Whether the relocated hospital has the same Medicare provider number as the original hospital.

4. The location and structure of the relocated hospital's buildings and those of the original hospital.

5. Whether the relocated hospital is under the same state's licensure regime as the original hospital.

6. Whether the relocated hospital serves the same community as the original hospital.

7. Whether the relocated hospital provides the same scope of services as the original hospital.

8. The relocated hospital's ownership and that of the original hospital.

9. The number of operating rooms, procedure rooms, and beds operated by the relocated hospital and the original hospital.

In Advisory Opinion No. CMS-AO-2025-1, CMS evaluated the Proposed Relocation using these factors and determined that the relocating hospital would be the "same hospital" as the original hospital for purposes of the whole hospital exception and would, therefore, continue to satisfy the whole hospital exception after the relocation. In this regard, CMS relied on the hospital's certifications that: (i) it will attempt to maintain the same license after relocation; (ii) it would seek to continue participating in Medicare under the same provider agreement and it would maintain its federal tax identification number; (iii) it would not alter the community or patient base served by the pre-location hospital because three-quarters of the hospital's patients do not reside in the metropolitan area where the hospital is located; (iv) it would not change its existing name, logo, or branding; (v) it would provide the same services (except for the addition of the emergency department); (vi) it would not exceed the number of operating rooms, procedure rooms, and beds for which the hospital was licensed on March 2010; and (vii) the Proposed Relocation would not affect its ownership.

Notably, CMS also stated that the relocated hospital's proposed addition of the emergency department did not, in its view, substantially alter the overall scope of services provided by the relocated hospital.

Practical Takeaways

Relocating hospitals may have some flexibility to expand their line of services. Though the whole hospital exception prohibits a relocated hospital from increasing the aggregate number of operating rooms, procedure rooms, and beds, in this Advisory Opinion, CMS blessed the requestor's addition of an emergency department, which, from a business perspective, is generally perceived to be a material change.

More broadly, CMS's application of a facts-and-circumstances test to evaluate whether a hospital is the "same hospital" for purposes of evaluating a potential relocation under the whole hospital exception provides helpful flexibility because each hospital will face different challenges when contemplating a potential relocation. For example, some states issue new licenses for relocated hospitals, which is a factor outside of the control of the relocating hospital. Particularly where there will be an unfavorable factor that is either outside of the control of the relocating hospital or otherwise fundamental to the relocation, extra care should be given to positioning the hospital to rate as favorably as possible on the other factors. For example, if it would be convenient, but not critical, to concurrently buy out certain owners, if at all possible, consider ensuring that any non-routine ownership shifts do not occur within one year of the relocation. Additionally, in similar spirit to CMS citing the continuity of the name, logo, and branding as helpful, a relocating hospital should consider affirming its existing medical staff bylaws (to be adapted by the reader as context requires, such as for erroneous address

references), and wait at least a year to accomplish an overhaul of such bylaws. Being judicious about these and other changes within the hospital's control will help maximize the chances that a physician-owned hospital will not lose its grandfathered status under the Stark Law.

For more information, please contact Joseph Keillor, Bernard Miller, or any member of Baker Donelson's Health Law Group.

[1] *See* 88 Fed. Reg. 59,302 (Aug. 28, 2023) (emphasis added).