



## AMERICAN SURGICAL HOSPITAL ASSOCIATION

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March 30, 2006

Mr. Donald Romano  
Director, Division for Technical Payment Policy  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

Dear Mr. Romano:

The American Surgical Hospital Association (ASHA), representing the nation's physician owned specialized hospitals, is pleased to submit the following comments on the issues in the "strategic and implementing plan" under development by the Centers for Medicare and Medicaid Services (CMS), as required by section 5006 of the Deficit Reduction Act of 2005 (DRA). ASHA will also include comments on the recommendations of CMS Administrator Mark McClellan in his testimony to the House Energy and Commerce Committee on May 12, 2005.

### Deficit Reduction Act

Section 5006 requires the Secretary of Health and Human Services to develop a strategic and implementing plan to address a series of topics regarding physician investment in specialty hospitals. This plan is to be submitted to Congress within six months of enactment of the DRA. An interim report is due within three months of enactment. ASHA strongly urges CMS to meet these deadlines and allow specialty hospitals to again focus on providing high quality medical and surgical services to their patients.

The topics to be examined are (1) proportionality of investment return; (2) bona fide investment; (3) annual disclosure of investment information; (4) the provision by specialty hospitals of care to Medicaid patients and charity care; and (5) appropriate enforcement.

ASHA believes that the federal anti-kickback law and the Stark laws adequately address the first three issues and the question of enforcement. Under these statutes, a physician's return on investment in a specialty hospital must be tied to the percentage of ownership by the physician.

It cannot be tied to number of procedures, referrals or admissions. Any returns that are not directly tied to the percent of ownership may be construed as inducements to refer and are therefore suspect under the anti-kickback law. They may also run afoul of the Stark laws.

This same statutory framework governs the question of whether or not a physician's investment is truly an investment. The laws prohibit arrangements that are designed to look like investments, but do not, in reality, carry any risk for the physician owner.

These statutes provide for civil and/or criminal penalties and violations may trigger the False Claims Act. Qui tam actions provide another enforcement alternative. Competitors of physician owned specialty hospitals also have internal motives to report apparent violations of either the Stark laws or the anti-kickback statute. Such reports can trigger investigations by federal authorities who already have powerful enforcement tools if violations are found. It would appear that the federal government, and the general public, possesses ample authority to enforce these laws. The breadth of this authority precludes the need for additional legislation or regulation to define allowable investments, returns on investment or to expand federal enforcement powers.

We are not aware of any requirement for physician investors to disclose their investments. ASHA encourages all physician investors and member hospitals to inform patients about the ownership arrangements. There is no evidence that patients need additional information or even have widespread concern about ownership. However, should CMS see a need for disclosure of investment information, ASHA believes that this should apply to all investments in Medicare certified entities, whether or not the investor is a physician. If it is important for the public or the government to have information about the investments in specialty hospitals, we see no reason why it would not be equally important for all other investment arrangements in other Medicare providers. For example, for profit hospital corporations may have a variety of investors, both in their own companies as well as in their individual hospitals, and this information is just as useful to the public when making decisions on where to seek care. Likewise, many not for profit hospitals own physician practices or employ physicians. Disclosure of these arrangements to patients should be mandated also, if specialty hospitals are going to be affected by any new disclosure requirements.

The Centers for Medicare and Medicaid Services (CMS) also has the authority to review financial arrangements in physician owned hospitals when a new hospital applies for a Medicare number. Nothing prevents CMS, or its agents, from denying an applicant a Medicare number if a financial arrangement raises questions about fidelity to the intent of the statutes. Applicants may also request advisory opinions if they wish confirmation of the legality of the financial arrangements between physicians and a hospital.

The ownership of specialized hospitals by physicians is already subject to extensive federal oversight and regulation. Further action is not warranted absent a finding of widespread abuse of these federal laws. ASHA contends that such abuse does not exist.

The debate over specialty hospitals has focused attention on the extent to which these facilities accept Medicaid patients or provide charity care. The DRA calls on CMS to examine these issues as part of the strategic and implementing plan.

Several points are worthy of mention. First, the Medicare statute does not require any provider to provide charity care or to accept Medicaid patients, outside of the EMTALA standards. Internal Revenue Service regulations of not for profit organizations contain an expectation that hospitals receiving this federal tax favored status will provide medical care to individuals who cannot pay. There is no such expectation of for profit enterprises, which pay taxes to local, state, and federal entities.

In its study of specialty hospitals in 2005, CMS found that when the amount of taxes paid and charity care provided by for profit specialty hospitals were combined, the total exceeded the amount of charity care provided by not for profit general hospitals, as a percentage of income, by over 6%.

The federal government's own statistics appear to show that specialty hospitals make a relative contribution to the community equal to, or better than, their general hospital colleagues. Therefore, ASHA believes that no further action need be taken on the issue of charity care.

It is well known that the distribution of Medicaid admissions varies widely among all hospitals and that this variation would not disappear if all physician owned specialty hospitals closed tomorrow. The factors affecting the number of Medicaid admissions are many, and include case mix (does the facility provide OB or pediatric care?); location (is the facility located in an area with a meaningful Medicaid population that might use the hospital?); the extent to which states have adopted a Medicaid managed care model which may exclude many hospitals from participation in the program; and whether or not the facility has an emergency department that is used frequently by Medicaid beneficiaries as a source of primary care.

Physician owned specialty hospitals also have operating policies that prohibit discrimination on the basis of ability to pay. It is easy for CMS to determine that hospitals applying for new Medicare numbers have such operating policies. It is also relatively straightforward to identify the non-discrimination standards used by already functioning hospitals.

CMS should not impose a requirement on Medicaid admissions to specialty hospitals that is not met equally by all general hospitals. Since the above mentioned factors affect all hospitals, it is virtually impossible to set any meaningful requirements on hospitals regarding Medicaid admissions.

ASHA recommends that CMS report to Congress that the federal government has more than ample authority to regulate the investment arrangements in physician owned specialty hospitals and to punish violators. Additional regulation or legislation is not necessary. Likewise, no case can be made for singling out physician owned specialty hospitals for their level of service to Medicaid participants or the level of charity care provided.

#### RECOMMENDATIONS FROM MAY 2005 CMS REPORT

When CMS issued the report on specialty hospitals mandated by the Medicare Modernization Act of 2003 in May 2005, several recommendations were made as a result of those findings and the experience of CMS in administering the 18 month moratorium on self referrals.

These included adoption of the recommendations of the Medicare Payment Advisory Commission (MedPAC) to refine the inpatient prospective payment system DRGs to better reflect the actual cost of treating the individual patient; improvements in the payment structure for ambulatory surgical centers (ASCs); review of CMS processes for determining which facilities qualified as hospitals under Medicare; and review of the application of EMTALA to specialty hospitals and their role in the provision of emergency services in the community.

ASHA had previously endorsed the DRG recommendations of MedPAC as well as the initial actions by CMS to implement them in 2006. ASHA encourages CMS to complete the revision of DRGs in time for implementation in the 2007 inpatient hospital payment rules.

We share the concern of CMS that some ambulatory surgical centers may attempt to “game” the system by adding a few inpatient beds in order to be classified as a hospital and be eligible for the much more generous outpatient prospective payment system rates. We agree that an overhaul of the ASC payment system is long overdue and encourage speedy action by the agency. ASHA cautions, however, that this action must ensure that ASC rates are high enough to eliminate the incentive for ASCs to convert to hospitals, even if they do not intend to provide much in the way of inpatient care. If the ASC rates are still low, after recalibration in the new system, the incentives will not change.

ASHA believes that CMS does not need to change the way it reviews applications from hospitals for new Medicare numbers or find a new definition of “hospital”. CMS has the authority to deny an application on a case by case basis and existing standards are sufficient. An application from a hospital with only a few inpatient beds would strongly suggest that the facility did not intend to provide inpatient care, depending on the size of the market and other local factors. A rigorous case by case review would eliminate those applicants and quickly send the message that such facilities would not be welcome in the rolls of Medicare inpatient facilities.

Regarding EMTALA, it is the position of ASHA that current law and regulations already apply to physician owned specialty hospitals. If the facility has a designated emergency department, either by its own choice or under state mandate, the hospital is subject to all EMTALA requirements. Authority to deal with violations of those standards already exists.

Further, EMTALA imposes obligations on licensed hospitals that do not have emergency departments, although they are not as stringent as those that apply to hospitals with emergency facilities. Even these minimum requirements obligate the hospital to act in the best interests of the patient and to quickly arrange appropriate medical care either at the hospital or at another, better equipped facility.

Specialty hospitals comply with the existing EMTALA standards. We do not believe that changes to EMTALA are needed to address the circumstances of specialty hospitals.

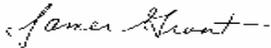
The determination of the level and distribution of emergency services is best left to state and local authorities that are familiar with the needs of their own citizens. The federal government should not impose uniform requirements, such as requiring all Medicare hospitals to have an emergency room, that may be counter to the needs of local communities.

Physician investors in specialty hospitals almost always maintain privileges at general hospitals in the community. Therefore, they are bound by the requirements of those hospitals on issues such as emergency call. These physicians have not abandoned these general hospitals (a fact substantiated by the CMS 2005 report), but remain part of the community's medical care delivery system.

While physician owned specialty hospitals offer patients significant advantages in convenience and outcome, there is nothing about their structure or operation that necessitates further action by CMS, beyond the payment changes already discussed.

ASHA appreciates the opportunity to submit these comments and would be pleased to discuss them with CMS staff at their convenience.

Sincerely,

A handwritten signature in cursive script that reads "James Grant".

James Grant  
President