

**Citizen's Health Care Association's Comments Regarding Physician Investment in
Specialty Hospitals and Related Issues**

Citizen's Health Care Association (CHCA) is responding to the request by the Centers for Medicare and Medicaid (CMS) for public comments on its proposed strategic and implementing plan for studying certain specialty hospital issues required by section 5006 of the Deficit Reduction Act of 2005 (DRA).

Before addressing specific issues, CHCA wants to extend an invitation to CMS to visit one or more of its member facilities. We welcome the opportunity to show you first hand what we do and the difference we make. We believe you will better understand how our specialty hospitals function and what they achieve if you see it in person.

CHCA is grateful for the chance to participate in this process. We will primarily focus on the issues we know that CMS is specifically interested in as follows: whether the physician investment in a specialty hospital is proportional; whether the investment is a bona fide investment; whether the Secretary should require annual disclosure of investment information; the issue of appropriate enforcement; and the provision by specialty hospitals of care to (a) Medicaid patients; (b) patients receiving medical assistance under a State demonstration project approved under title XI of the Act; and (c) patients receiving charity care.

Proportionality of Physician Investment

Most of CHCA's physician owners only own 1-2% of a facility. Further, all of CHCA's physician owners own 6.5% or less of a facility. Our model works and we are eager to share our information with CMS. Across the board we do a better job of delivering high quality care. We are prepared to work with CMS as you study these issues and will accommodate you for site visits to one or more of our many facilities. We are certain that if the study is conducted properly and thoroughly, CMS will see how much specialty hospitals achieve.

However, in order to obtain accurate findings regarding specialty hospitals and the proportionality of physician investment, CMS cannot look at specialty hospitals in a bubble. Specialty hospitals do not exist or function within a bubble. Such an isolated analysis would result in inherently flawed findings. Rather, CMS must also look at general acute care hospitals/facilities, the details of their ownership and investment structure, and how their physicians and owners are compensated. Proportionality of physician investment is perhaps one of the most complex issues CMS is focusing on for this study. It includes multiple sub-issues related to both specialty hospitals and acute care hospitals, all of which must be studied in order to render accurate findings. Some of those sub-issues include physician referral, compensation, ownership and investment structures, and employment and insurance contracts that include referral and compensation clauses.

The physician referral issue itself is far from straightforward, but CMS must explore it in full before any legitimate and meaningful conclusions can be made. Preserving access to high quality and affordable medical care in this county is too important a priority for CMS to cut any corners with this study. CHCA urges CMS to maximize the opportunities presented by this study to look at all aspects of this issue including but not limited to the following: (1) how physicians in acute care facilities are compensated for referrals; (2) how insurance plans impact referrals by acute care physicians; (3) how employment contracts impact referrals by acute care physicians; and (4) how ownership of a facility similar to a specialty hospital by an acute care facility impacts referrals.

There are a variety of ways in which physicians are compensated for referring patients to their acute care facility. Many insurance contracts are structured in a way that directs where referrals can be made. Often employment contracts directly spell out who a physician must refer patients to within a system plan or face penalties including loss of employment. In many areas of the country, there are very few unattached primary care physicians because large acute care facilities essentially own and control the physicians. When taking these scenarios into account, any conflict of interest, perceived or real, that may exist when a physician refers a patient to a specialty hospital in which he or she has an ownership interest is no different than a conflict of interest, perceived or real, that may exist when a physician in an acute care facility refers a patient to that facility or a related facility.

Further, as mentioned above, CMS must look into the ownership and investment interests of general acute care hospitals/facilities as related to specialty hospitals and physician practices. All across the United States, hospitals own ambulatory surgical centers, physician practices and facilities similar to specialty hospitals. Often the same ownership and investment issues that are being raised with regard to specialty hospitals apply. The same perceived conflicts of interest exist. CMS cannot ignore this if the results of this study are to be valid.

Again, CHCA supports CMS' efforts in this study and will do all it can to help make certain the study is performed thoroughly and accurately. CHCA would not oppose annual disclosure of investment information. At the end of the day, CHCA supports disclosure and cooperation by specialty hospitals as well as by all physicians and acute care facilities. Our members are confident their good work and success can withstand any level of scrutiny.

Specialty Hospitals Provision of Care to Medicaid Patients, Patients Receiving other State Assistance and Patients Receiving Charity Care

Across the board, specialty hospitals out perform general acute care hospitals/facilities. Specialty hospitals deliver a better quality of care and better service

than general acute care facilities. Further, patient satisfaction is better at specialty hospitals than at general acute care facilities.

In general, specialty hospitals may not perform the same volume of overall Medicare and Medicaid work as do general acute care facilities. Further, depending on how CMS ultimately defines "charity care" specialty hospitals may not match the volumes of such work done by general acute care facilities.

However, as CMS works to define "charity care" and to determine the volume of Medicare, Medicaid and charity care performed by specialty hospitals, CHCA once again urges CMS to look at the whole picture. It would be unfair to simply take a snapshot of the volumes of such work and draw conclusions. Rather, CMS should look at the environment in which specialty hospitals function and what they do at all levels. Further, CMS should look into the environment in which general acute care facilities function and what they do at all levels. The reality is that general acute care facilities often have difficulty in distinguishing bad debt (services for which payment was expected but not obtained) from charity care (services for which payment was never expected). This often results in skewed and erroneous charity care figures for general acute care facilities.

For example, CMS cannot look at this "charity care" issue without taking into account the tax status of specialty hospitals versus general acute care facilities. Unlike general acute care facilities which enjoy a special tax exempt status, specialty hospitals pay city, state and federal taxes that in turn are invested into the communities within which they are located. Thus, in addition to providing these communities with an unmatched level of medical care, specialty hospitals provide valuable tax dollars that support communities in countless ways. Depending upon how "charity care" is defined, this issue alone may tip the scales in favor of specialty hospitals.

The tax issue has implications beyond the obvious. Specialty hospitals provide a significant benefit to the federal government (as well as to state and city governments) in terms of taxes paid each year. CMS cannot ignore this while making conclusions about "charity care" and decisions regarding certification of specialty hospitals and payment or nonpayment of particular Medicare and Medicaid services.

Appropriate Enforcement

CHCA fully supports disclosure and transparency as needed to appropriately enforce laws and to provide patients with fair information so they can make truly informed medical decisions. Patients should have the right to choose where they want to receive medical treatment. CMS should take steps to preserve all medical treatment options. In particular, CMS should not take away a medical treatment option – namely to seek service at a specialty hospital – when there is no justification to do so. CMS can properly address any existing problems such as apparent conflict of interest issues with adequate disclosure and transparency regulations.

Conclusion

CHCA thanks CMS for allowing it to take part in this process. CHCA is eager to do all it can to ensure the study is done thoroughly and accurately. CHCA will cooperate with CMS in any manner necessary and is eager to host CMS at any of its facilities. CHCA believes in the good work done by its specialty hospitals and is confident CMS will see the good work and its value to communities across the country.

CHCA wants to be a part of the process and part of any solution that CMS determines is needed. However, before any final action is taken, all of the above issues must be investigated as they relate to both specialty hospitals and general acute care hospitals/facilities. It would be wholly unfair to punish an entire industry – as well as to deprive citizens of the health care provide by specialty hospitals - based on an incomplete or expedited study. CMS should tread carefully before taking any action that would put specialty hospitals out of business. The impact will reach far beyond simply shuttering the doors of a specialty hospital and forcing the doctors and employees to seek other employment. CMS must give serious consideration to how the already overburdened and underperforming general acute care hospitals/facilities will care for the influx of additional patients. Further, CMS must consider how the federal government will address the resulting revenue shortfall.

In closing, CHCA again thanks CMS for all its hard work and looks forward to working with CMS as this study progresses.

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