

31 March 2006

Mr. Donald Romano, Director
Division of Technical Payment Policy
Center for Medicare Management
Centers for Medicare and Medicaid Services (CMS)
7500 Security Blvd., Mailstop: C4-25-01
Baltimore, MD 21244-1850

Via E-Mail: Donald.Romano@cms.hhs.gov

Dear Mr. Romano:

During your March 8 Open Door Forum, you requested input as CMS develops its plan to address limited-service, physician-owned health care facilities as required by Section 5006 of the Deficit Reduction Act of 2005 (DRA). On behalf of the Ohio Hospital Association (OHA) and its over 170 hospital and 40 health system members, we appreciate the opportunity to offer comments.

The debate over limited-service, physician-owned facilities has been ongoing for years. In recent years, CMS, MedPAC, the GAO, and numerous academic researchers have investigated the intricacies involved. ***OHA strongly supports Congress' clear directive in the DRA for CMS to develop a plan for action, rather than merely continue to "study" the limited-service, physician-owned hospital business model which clearly ignores the intent of the Stark law.*** We would like to focus our comments on some major areas of congressional interest: investment by physicians, enforcement of regulations, grandfathering of existing versus developing facilities, and revision of the Medicare payment system.

Investment by Physicians

During the March 8 forum, you specifically requested input for fleshing out concepts like "proportionality of investment return," "disclosure of ownership," and "bona fide investments." OHA suggests the criteria developed by the Office of Inspector General (OIG) are an appropriate starting point for deciding whether physicians' financial interests qualify for the investment interest safe harbor under federal anti-kickback laws. The OIG's criteria include 1) measuring whether an investor's return is proportionate to the investment; 2) placing limitations on investors who are in a position to influence patient referrals; and 3) clearly defining bona fide investments to discourage sweetheart deals. Special attention should be given to closed investment models and joint ventures with non-healthcare entities. CMS should also explore the affect of physician investment in and referral to limited-service hospitals on the entire community health system, including referral patterns of non-investors and access to specialty services and consultations by primary care physicians and their patients.

CMS should not rely solely on applications by facilities who sought grandfathering under the recent moratorium nor on its own 2005 study for guidance on the issue of physician investment. OHA believes additional, specific data regarding physician ownership interests is necessary for CMS to develop an appropriate plan of action. Such data should be highly detailed, and should focus on physician investors' various investments and returns, the physician's referrals, all compensation paid by the facility in question to the physician for management or other functions, and all other contracts and ventures embarked upon by the facility. Under Stark II rules, facilities are required to maintain records of this information, and could easily provide it to CMS in a month or less. The American Hospital Association (AHA) recently sent you a list of questions for limited-service, physician-owned hospitals that provides an excellent template for obtaining such data from physician investors. Not only should CMS use this data in developing its plan for action, it should post the information online for public scrutiny.

Donald Romano, Director

31 March 2006

Page 2 of 2

Enforcement

OHA believes your strategic plan should detail how Medicare requirements for limited-service, physician-owned facilities are enforced, and how to strengthen some critical weaknesses within the current enforcement process. Specifically, corrective actions to these weaknesses should include, at a minimum, stronger enforcement of hospital-level standards, consistent enforcement of relevant physician anti-kickback and self-referral rules, and compliance with the present suspension of new limited-service facilities from enrolling in the Medicare program. Recent CMS investigations to determine whether certain orthopedic and surgical facilities qualify under the definition of “hospital” should prove useful in determining a plan of enforcement, as will recent court decisions involving physician referrals to facilities in which they have an investment interest. We also believe these findings will prove applicable to other limited-service, physician-owned facilities, such as some neurosurgical and cardiac hospitals.

Grandfathering

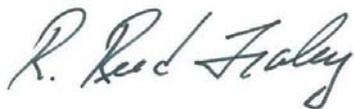
The Board of Trustees of the OHA has taken a position of opposing the expansion of limited-service, physician-owned facilities. While we acknowledge that facilities that were operational before the recent moratoria will have to be treated under unique measures, we strongly believe additional limited-service, physician-owned facilities in our state will be detrimental to Ohio’s health care system. Facilities that have been “merely under development” since November 18, 2003 (see [§ 507](#) of the Medicare Modernization Act (MMA) of 2003) have not been in compliance with the intention of the MMA and, as such, should not be permitted to participate in the Medicare program going forward.

Revision of the Medicare Payment System and Minimal Standards

OHA believes the CMS plan should include a recommendation that Congress revise the Medicare payment system to reduce financial incentives that have led to the development of these limited-service, “niche” facilities. Such a recommendation, however, should address the system as a whole, rather than focusing only on certain classes of diagnoses. Similarly, the CMS plan for action should set minimal standards for a facility to qualify as a “hospital” under Medicare. *The criteria should include language that the facility be a general acute-care provider of health care that treats a population with a wide range of conditions, rather than just a few classes of diagnosis related groups (DRGs).* The facility should also, at a minimum, offer their full range of services, including emergency services, twenty-four hours per day, seven days per week.

Once again, we appreciate your solicitation of our comments on this important issue, and we hope our suggestions prove useful as CMS develops its strategic plan of action. If you have any questions or require additional information, please contact me.

Sincerely,



R. Reed Fraley
Senior Vice President

RRF/mg/jsa