AMA
AMERICAN
MEDICAL
ASSOCIATION

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

Re: *Strategic and Implementing Plan to Study Physician-Owned Specialty Hospitals*

Dear Mr. Romano:

The American Medical Association (AMA) appreciates the opportunity to provide the Centers for Medicare and Medicaid Services (CMS) with its comments regarding the development of a strategic and implementing plan to study physician-owned specialty hospitals. The AMA is hopeful that public comments on the methodology used to develop the plan will be an important step in finally ending the moratorium on new physician-owned specialty hospitals.

Specialty hospitals offer improved, cost-effective care. They have lower infection rates, fewer medical errors, shorter turnover times, and increased cost efficiencies. Moreover, specialty hospitals encourage competition between and among health facilities, which has led to the delivery of higher quality, more efficient, and innovative health care in the communities where they are located.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) imposed an 18-month moratorium on referrals of Medicare and Medicaid patients by physician investors in certain specialty hospitals not already in operation or under development as of November 18, 2003. The MMA required the Medicare Payment

Advisory Commission (MedPAC), in consultation with the Government Accountability Office (GAO), and the Secretary of the Department of Health and Human Services (HHS) to conduct studies of specialty hospitals and report their findings and recommendations to Congress. MedPAC and HHS completed their congressionally mandated reports. Because these studies are comprehensive and their findings confirm the myriad benefits of specialty hospitals, there should be no further official or de facto extension of the moratorium.

ADEQUATE STUDY OF SPECIALTY HOSPITALS HAS BEEN UNDERTAKEN AND REPORTED UPON

The AMA strongly believes that the thorough studies on specialty hospitals completed to date provide adequate information for evaluation and decision-making. Calls from opponents of specialty hospitals for collection of new data are nothing more than attempts to prolong the moratorium and play the odds, perhaps hoping that if enough additional data is collected and enough taxpayer dollars are expended, eventually data that supports their unsubstantiated claims will emerge. CMS should not indulge such obvious delay tactics.

The intent of Congress in enacting the initial moratorium was to determine, within a prescribed amount of time, whether additional legislative or administrative restrictions on specialty hospitals were necessary pending review of the issues by MedPAC and HHS. The studies were overwhelmingly positive for the continued development of physician-owned specialty hospitals. Given the time, effort, costs, and clear results of these studies, an entire new data collection effort aimed at answering the questions raised in Section 5006 of the Deficit Reduction Act (DRA) would unnecessarily waste resources and serve only to further delay a decision regarding specialty hospitals. The DRA is clear in calling for an interim report "not later than 3 months after the date of enactment of this Act." The AMA strongly urges CMS to utilize the comprehensive data already in its possession to issue its report in a timely manner.

MedPAC's report, which focused on the financial implications of specialty hospitals, concluded that while the majority of specialty hospitals have some physician owners, the individual physicians who have a financial interest in a specialty hospital are small investors, and that the majority of physicians who work in specialty hospitals do not have any ownership interest in the facility. The vast majority of physicians who admit patients to specialty hospitals, therefore, receive no financial incentive whatsoever to do so. In addition, MedPAC reported that Medicare inpatient margins averaged 9.4 percent at specialty hospitals, and 8.9 percent at general hospitals - a number that hardly substantiates opponents' claim that specialized facilities "cherry pick" the most profitable patients.

In addition, the MedPAC report found no conclusive data indicating financial harm to community hospitals resulting from the operation of specialty hospitals. The report states, "[t]he financial impact on community hospitals in the markets in which physician-owned specialty hospitals are located has been limited, thus far. Those community hospitals competing with specialty hospitals have demonstrated financial performance comparable

to other community hospitals." The report underscored this in noting that there has been "little impact on community-hospital profitability." Moreover, the report states, "specialty hospitals may be an important competitive force that promotes innovation."

Applying criteria similar to that used by MedPAC, CMS produced a report to Congress using a study sample of 11 specialty hospitals in six markets to review patient quality-of-care issues. Rather than finding harm, CMS Administrator, Dr. Mark McClellan testified to findings of high quality of care at specialty hospitals when he presented his agency's report. Specifically, he noted, "specialty hospitals generally provide a more uniform set of services and have fewer competing pressures than community hospitals and thus are able to provide more predictable scheduling and patient care." The CMS report also found fewer complications and lower mortality rates at cardiac hospitals, even when adjusted for severity, and noted that, "cardiac hospitals delivered high quality of care that was as good as or better than their competitor hospitals." As for surgical and orthopaedic hospitals, CMS found that patient satisfaction was extremely high.

In addition, under its contract to CMS, RTI International produced a comprehensive report published in the journal, *Health Affairs,* that dealt with four policy issues related to specialty hospitals. RTI looked at: whether specialty hospitals enjoy an "unfair" competitive advantage in their markets driven by the incentive of physician-ownership; whether physician–ownership results in favorable referral patterns to specialty hospitals; how specialty hospital care and patient satisfaction compare to local community hospitals; and whether specialty hospitals bear an equal burden in providing community benefits compared with community hospitals. The researchers found that specialty hospitals stimulate a competitive environment in many markets, which could have positive effects on quality of care. With regard to referral patterns, they found that while physician owners often refer patients to their own facilities, many do so for reasons not related to profits. Concerning hospital care and patient satisfaction, the study found that specialty hospitals generally provide high-quality care "to satisfied patients." Finally, the study concluded that while specialty facilities provide less uncompensated care, they contribute substantial tax revenues, contrary to the notion that these facilities are simply a drain on community resources. In fact, they reported that the "total proportion of net revenue that specialty hospitals devoted to uncompensated care and taxes combined exceeded the proportion of net revenues that community hospitals devoted to uncompensated care."

The MedPAC and CMS studies of specialty hospitals have made it plain that specialty hospitals represent a desirable, alternative form of care for many Medicare patients and are in many respects an asset to the communities they serve. In addressing the questions raised by the DRA, CMS should consider the substantial body of evidence already assembled, and should relay to the Congress, in the timeframe specified in the law, their consistent findings favoring continued growth of specialty hospitals.

THERE IS NO EVIDENCE THAT PHYSICIAN REFERRALS TO SPECIALTY HOSPITALS ARE FINANCIALLY MOTIVATED

The studies completed by MedPAC and HHS provide no support for claims that physician referrals to specialty hospitals are financially motivated or inappropriate. The comprehensive studies performed to date demonstrate that the majority of physicians who admit patients to specialty hospitals have no ownership interest and thus receive no financial incentives to refer patients to them. In fact, MedPAC found that of the specialty hospitals identified by the GAO with some degree of physician ownership, the average share owned by an individual physician was less than two percent. Of particular significance, the GAO found that while almost 70 percent of specialty hospitals have some physician owners, individual physicians who have financial interests in specialty hospitals are small investors - the average investment amounting to less than two percent.

The congressionally mandated studies also found that physicians refer patients to specialty hospitals for myriad reasons not related to financial gain. The RTI International study found that physicians refer to specialty hospitals for many reasons, including insurance contracts, patient preferences, scheduling of procedures, and the location of the hospital relative to physician offices.

Finally, there is no evidence that physician ownership and referrals to specialty hospitals leads to inappropriate utilization. MedPAC found no evidence that overall utilization rates in communities with specialty hospitals rose more rapidly than utilization in other communities. In addition, HHS found no evidence that physicians who have an ownership interest in a specialty hospital inappropriately refer patients to that hospital or have increased utilization. In fact, data shows no difference in referral patterns between physician owners and non-owners. Thus, there is no support for claims that physicians, motivated by financial gain, are improperly referring patients to specialty hospitals.

SPECIALTY HOSPITALS PROMOTE COMPETITION AND CONTRIBUTE TO THE COSTS OF CHARITY CARE

The cumulative evidence garnered from the studies performed by MedPAC and CMS prove that general hospitals are not suffering financially as a result of the growth of physician-owned specialty hospitals. In fact, MedPAC found that the financial impact on community hospitals in the markets where physician owned specialty hospitals are located has been limited. These hospitals have demonstrated financial performance comparable to other community hospitals. MedPAC also found that specialty hospitals have forced community hospitals to become more competitive, and that specialty hospitals are an attractive alternative for patients and their families.

Furthermore, specialty hospitals also benefit their communities through charity care and tax expenditures. As noted above, the CMS study concluded that the total proportion of net revenue that specialty hospitals devote to both uncompensated care and taxes

"significantly exceeds" the proportion of net revenues general hospitals devote to uncompensated care. Whereas nonprofit hospitals are exempt from federal and state income taxes, as well as local property taxes, they have access to tax-exempt financing, and most nonprofit hospitals receive Medicare and Medicaid Disproportionate Share Hospital (DSH) payments to help defray the costs of uncompensated care.

It also important to point out that any comparison of the provision of care to Medicaid patients in specialty hospitals versus community hospitals must factor in the types of services provided, rather than simply comparing a specialty hospital's proportion of Medicaid patients or revenues to that of a competitor community hospital. Medicaid covers a large proportion of many services offered by community hospitals, such as perinatal, pediatric, and neonatal care, which typically are not provided by most surgical and cardiac hospitals.

ADDITIONAL ENFORCEMENT EFFORTS TARGETING PHYSICIAN INVESTMENT IN SPECIALTY HOSPITALS ARE NOT APPROPRIATE

Physician investment in specialty hospitals is adequately addressed by existing self-referral laws and no modifications to the whole hospital exception are necessary. The physician self-referral law, the "Stark law," permits physician ownership of a hospital, and referral of patients to that hospital, if the physician is authorized to perform services at that hospital and the ownership interest is in the "hospital itself" and "not merely in a subdivision of the hospital." Although this whole hospital exception has been referred to as a "loophole," such allegations are unsupportable.

Specialty hospitals are entire hospitals, not subdivisions of a hospital. They are independent legally organized operating entities that provide a wide range of services for patients, from the beginning to the end of a course of treatment including specialty and sub-specialty physician services, and a full range of ancillary services. In fact, a significant number of specialty hospitals also provide primary care, intensive care, and emergency services.

The protection of referrals to an entire hospital, and not just a "subdivision of a hospital," originally included in Stark I, was intended to prevent circumvention of the ban on referrals of laboratory services. When Stark II was enacted, Congress expanded the ban on physician referrals from clinical laboratory services to an entire list of ancillary services referred to as "designated health services." These designated health services are ancillary services, not physician services. Thus, Congress clearly intended the Stark laws to prevent referrals for ancillary services, not professional services performed by a physician.

In addition to addressing alleged problems related to the referral of ancillary services, the Stark laws also prohibit referrals to locations where the referring physician is not directly involved in the care of the patient. Under the Stark laws, referrals to physician-owned facilities are permissible only when the referring physician personally performs the service,

or when the service is performed or supervised by another physician in the referring physician's group practice, in the same building where the referring physician regularly practices, or in a centralized building used by the referring physician for some or all of the designated health services performed by the group practice. Thus, the Stark laws provide adequate restrictions on physician investment in specialty hospitals prohibiting physicians from making referrals to facilities where they do not practice and at which only ancillary services are provided.

The Stark laws were intended to prohibit referrals only where studies demonstrated increased or inappropriate utilization of such services by physician-owners. There is no evidence of increased utilization of hospital services resulting from physician referrals. To the contrary, as noted above, MedPAC found no evidence that overall utilization rates in communities with specialty hospitals rose more rapidly than utilization in other communities. Similarly, HHS found no evidence that physicians who have an ownership interest in a specialty hospital inappropriately refer patients to that hospital or have increased utilization. Thus, there is no rationale, other than to stifle competition, for enacting additional enforcement measures aimed at specialty hospitals.

Permitting physicians to own specialty hospitals and refer patients to them is consistent with Congress' intent - to permit physician investments in facilities where the physician-investors provide care. Specialty hospitals are entire hospitals, they do not provide only ancillary services, and physicians who invest in them not only refer their patients to them, but also treat their patients there.

The AMA believes that if CMS is considering additional enforcement regulations, it should focus its efforts on prohibiting general hospitals from engaging in inappropriate self-referral practices. Such practices include economic/exclusive credentialing/conflict of interest policies and medical staff development plans that revoke or refuse to grant medical staff membership or clinical privileges to physicians or other licensed independent practitioners that have an indirect or direct financial investment in a competing entity, thereby requiring referrals and channeling patients to their facilities. Such actions restrict a physician's ability to provide health care based on his or her professional judgment and the patient's best interest. This harms not only individual patients, but federal health care programs, and the health care marketplace, as a whole. As such, the AMA strongly urges that any enforcement action focus on these troublesome practices.

CMS SHOULD RECOMMEND ADOPTION OF THE PAYMENT CHANGES SUGGESTED BY MEDPAC AND HHS

The AMA believes that the growth in specialty hospitals is an appropriate market-based response to a mature health care delivery system and a logical response to incentives in the payment structure for services. The only real problem faced by general hospitals is inefficient payment rates for hospital services. Because inefficiencies exist in the hospital

industry, the entry of new competitors, such as specialty hospitals, is a typical market response that will create incentives for general hospitals to increase efficiencies to stay competitive. Specialty hospitals are creating such incentives, as some general hospitals have conceded. In addition, because some general hospitals use earnings from profitable services to enable them to provide unprofitable services, these cross-subsidies should be eliminated by making the payments adequate for all hospital services, as recommended in the congressionally mandated reports submitted by MedPAC and CMS.

MedPAC, the Federal Trade Commission, and the Department of Justice agree that cross-subsidies inherent in hospital payments should be eliminated. In fact, MedPAC urged Congress not to take action that would effectively shut specialty hospitals out of the Medicare and Medicaid markets without first making certain payment changes to improve accuracy in the hospital inpatient prospective payment system (PPS) diagnosis related group (DRG) payments. The AMA supports these recommendations to ensure full and fair competition in the market for hospital services. And we believe that these concrete recommendations further demonstrate the futility of prolonging the specialty hospital moratorium either officially, or constructively, by engaging in new data collection efforts rather than moving forward on the steps that everyone agrees are needed for both community and specialty hospitals to prevent hospitals from needing to subsidize relatively underpaid services with revenues from more profitable services.

CONCLUSION

In conclusion, there is substantial and conclusive evidence that physicians are not inappropriately referring patients to specialty hospitals and that general hospitals are not suffering as a result of the growth of physician owned specialty hospitals. The studies completed to date conclusively establish that specialty hospitals increase competition in the hospital industry and provide patients with higher satisfaction and more choice—forcing existing hospitals to innovate to stay competitive. Thus, the AMA urges CMS to adhere to the original timeframe, expeditiously complete the report required by the DRA, and, based upon the copious data currently available, recommend that no restrictions be imposed on the ability of physicians to refer patients to specialty hospitals in which they have an ownership interest. If you have any questions regarding these comments, please contact Sandy Marks by phone, 202-789-7400, or by email, sandy.marks@ama-assn.org.

Sincerely,

Michael D. Maves, MD, MBA