OHIO HOSPITAL ASSOCIATION

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Via Electronic Mail: Donald.Romano@cms.hhs.gov

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Subject: *Strategic Plan Regarding Physician Investment in Specialty Hospitals; Section 5006 of the Deficit Reduction Act; Interim Report*

Dear Mr. Romano:

Thank you for the opportunity to comment on the Interim Report on the Strategic Plan Regarding Physician Investment in Specialty Hospitals ("Interim Report") which was recently submitted to Congress by Health and Human Services ("HHS") Secretary Leavitt. The following are comments of the Ohio Hospital Association ("OHA") on behalf of its over 170 member hospitals and 40 health systems.

The Interim Report Ignores the Fundamental Issue of Conflict of Interest.
Although the Interim Report was in response to a specific request of Congress, HHS ignored the fundamental issue of conflict of interest. HHS must not lose sight of the original intent of the Stark physician self-referral laws – to curtail inappropriate financial conflicts of interest that result in over utilization and threaten the delicate health care delivery system. After all, the issue underlying Congress' study of physician investment in specialty hospitals is the harmful effects of the resulting conflicts of interest and physician self-referral.

Across Ohio, and across the nation, hospitals have seen their already razor thin margins eaten into by development of investor-owned health care facilities that drain away more profitable services. When the investors are also physicians in a position to make decisions about where their patients receive care — and tempted to make patient referral decisions based on investment concerns rather than pure medical considerations — a clear conflict develops that should be avoided. Preventing a few physicians from putting themselves in a situation of conflict will help preserve the community assets that are the nation's full-service hospitals. Access to quality health care depends on maintaining community hospitals' ability to meet local health care needs.

HHS should take every opportunity to focus on the fundamental issue of conflict of interest.

Definitions and Standards of Charity Care are Local Decisions.
In the Interim Report, HHS attempted to define "charity care" and suggested it was considering recommending a specific minimum threshold of charity care for every hospital. While the Ohio Hospital Association applauds the attention to the impact of physician-owned specialty hospitals

on the access to hospital care by indigent and uninsured patients, HHS' suggested definition and standard do little to strengthen, and may impede the health care system.

Consistent with their continued mission of caring, Ohio hospitals and health systems believe policies regarding charges, billing, and discounts should treat all patients in a fair and equitable manner, regardless of their income or insurance status. Ohio hospitals have specific free care policies and generous discount policies, adopted by their governing boards, for patients who are uninsured and of limited financial means. These policies consider factors such as the financial eligibility of the patient, economic situations of the community and hospital and base the value on cost. As noted in the Interim Report, charity care definitions vary – just as the charity care policies of hospitals vary based on the local community's economic situations. Any definition of charity care should acknowledge this appropriate local variance.

In addition, a definition of charity care must recognize the realities of health care delivery. More often than not, a hospital does not know the insurance or financial situation of a patient at the time of service, particularly when that service is received through the emergency department. Patients themselves may not know if they have insurance coverage, if they are eligible for government health programs or if they need to access hospital free care policies. And patients are often reluctant to disclose any personal financial information, leaving the hospital in the difficult position of issuing a bill without adequate documentation that the patient may qualify for free or discounted care. Any definition must recognize that the determination of whether care is "charity care" cannot be made sometimes for many months after the patient's hospital treatment.

The Interim Report also mentions HHS plans to offset monies provided by state and local government entities and private foundations and other non-public sources from the definition of charity care. Despite the difficulty in ascertaining and calculating private foundation funds that may have an impact on charity care, OHA questions the legal authority of HHS to define how funds earmarked by local political jurisdictions and private foundations are used. We object to this concept and the unintended consequences of discouraging local governments from assisting with the health needs of the communities and private foundations from contributing to charitable organizations.

The Interim Report suggests HHS is considering imposing a minimum level of charity care for all hospitals. Again, any nation-wide standard cannot recognize the local variances and community economics that drive hospital charity care numbers. In addition, tax-exempt hospitals meet a broader community benefit standard that includes much more than charity care alone. Research, teaching, health outreach and public health programs are common contributions of Ohio hospitals – none of which are reflected in charity care numbers, but all of which are threatened when hospitals lose profitable patients to physician-owned specialty hospitals.

Implement Reforms of Payment Rates and DRG Weights in One Step.

The Interim Report describes Centers for Medicare and Medicaid Services ("CMS") recommendations to Congress for reforming the hospital inpatient payment system to remove some financial incentives driving the specialty hospital boon. OHA supports these reforms, but cautions CMS that any reexamination of DRG weights and payment rates must be performed in

tandem. Phasing in these reforms step-by-step will only result in dramatic and expensive overhauls of hospital billing and payment systems year after year. All changes should be implemented at the same time – when CMS is confident it has adequately studied the impact and understands the full affect of the reforms.

EMTALA Reforms Should be Refined to be Effective in their Application.
OHA applauds CMS' proposal that hospitals with specialized capabilities accept transfers, regardless of whether the hospital has an emergency department. This helps address a growing problem as physician specialists increasingly refuse to provide on-call coverage in community hospitals. However, from a practical standpoint, physician-owned specialty hospitals often do not have emergency departments or 24-hour physician coverage. A transferring hospital will experience difficulties finding someone at the hospital with specialized capabilities to accept the transfer. While this policy is a step in the right direction, CMS and the EMTALA technical advisory group should consider creative reforms that can be effective in their application.

Proportionality of Physician Ownership Interests Needs More Data and Study.
As HHS develops the strategic plan called for by Congress, more light must be shone on the proportionality of physician investment return and bona fide investment in specialty hospitals. HHS should continue to collect data, compelling participation if necessary, to describe accurately the financial incentives involved. Until these data are accurately collected and results tallied, HHS cannot move forward with recommendations.

Conclusion
The Ohio Hospital Association believes the conflicts of interest inherent in physician-owned specialty threaten our health care system. We appreciate the opportunity to offer comments to address the situation. Thank you for your consideration of our comments. If you have any questions or would like to discuss these issues further, please contact us at (614) 221-7614.

Very truly yours,

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