



AMERICAN SURGICAL  
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Mark C. McClellan, MD  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attn: CMS-1500-P  
P.O. Box 8011  
Baltimore, MD 21244-1850

Re: Specialty Hospitals  
MedPAC Recommendations

Dear Dr. McClellan:

The American Surgical Hospital Association is the national trade association for physician owned acute care hospitals that specialize in the delivery of elective surgical services and other types of specialized care. We are responding to the discussion of the definition of a hospital in the proposed rule on the inpatient prospective payment system published on May 4, 2005. We will also comment on CMS' actions with regard to the recommendations of the Medicare Payment Advisory Commission (MedPAC) relating to specialty hospitals.

SPECIALTY HOSPITALS

Medicare law, regulations, and provider manuals define a hospital as “an institution which is primarily engaged in providing, by or under the supervision of physicians, to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment and care of injured, disabled, or sick persons...” The discussion in the proposed rule suggests that

specialty hospitals “may be primarily engaged in furnishing services to outpatients, and thus might not meet the definition of a hospital”.

Failure to meet the requirements for the definition of a hospital could lead to revocation of the facility’s Medicare provider number, which could have serious consequences for the institution, including loss of Medicare inpatient revenue, as well as contracts for inpatient services with private health plans. In some states, loss of Medicare certification would also result in revocation of the hospital’s state license.

It is difficult to determine exactly what CMS is looking for in this discussion. While it raises the threat against specialty hospitals, it provides no particulars for public comment. For example, the key issue is the way that CMS determines the meaning of “primarily engaged in providing inpatient services.” Yet the agency does not propose a standard that the public can react to or comment on. Certainly this issue is too important to be left to informal processes like manual instructions. We believe this vagueness undermines any legal effect that this discussion may have. We recommend that there be a separate proposed rule, with specific issues raised, on the definition of what Medicare considers a hospital. We also note that CMS did not evaluate the impact of a change in policy, even though it would have a significant impact on affected hospitals.

While the discussion in the proposed rule is titled “Definition of a Hospital in Connection with Specialty Hospitals”, Medicare law defining “hospital” does not differentiate the kind of hospital except to exclude psychiatric facilities from the definition. While the MMA 2003 defined specialty hospital for purposes of the now expired 18 month moratorium, it did not alter the definition of “hospital” in terms of participation in Medicare. We do not believe that there is a definition of “specialty hospital” which can be applied to participation in Medicare, which is the thrust of the text in the proposed rule. There is no legal basis for Medicare to set one set of participation standards for “traditional” hospitals and another for “specialty” hospitals. Therefore, the review of participation criteria should apply to all hospitals. Specialty hospitals are almost always licensed by the state as acute care hospitals. We believe that this fact also argues for a review of the definition as it applies to every hospital.

We believe that the law requires the application of one test for determining the participation of any hospital, other than psychiatric facilities, and that is the measurement of inpatient services. However, the law and regulations offer no guidance on the application of this 40-year-old definition to the hospitals of the 21<sup>st</sup> century. We do not believe that very many hospitals, whether specialty or general hospitals of any kind, and whether or not they have physician investors, would pass a strict reading of the statute. This leads to the inevitable conclusion that today's hospitals no longer qualify to participate in Medicare because the nature of the services they provide has changed so dramatically.

In 1965 virtually all hospital services, particularly surgical, were provided on an inpatient basis. In 2005, the reverse is true. In absolute numbers, hospitals provide far more outpatient services that they do inpatient. Medicare data and information from the American Hospital Association suggest that the ratio of outpatient to inpatient services is approximately four to one. On average 80% of all surgery performed in this country is now done on an outpatient basis. Since the entire thrust of healthcare is to move patients to the least expensive setting, and for hospitals to limit their services to those things they can do best, we question the point of this entire discussion.

A literal reading of the statute and regulations would deny almost every hospital the opportunity to participate in Medicare since virtually no facility provides primarily inpatient services if the measure is the number of patient encounters. We do not believe it is the intent of CMS to exclude all hospitals from Medicare. Some other test must then be devised to satisfy the statute and the current circumstances of medical care delivery. However, the rulemaking is silent on what the test might be.

Data from CMS and AHA do show that on average hospitals earn far more from their inpatient surgery than from their outpatient care. It is estimated that the average hospital earns at least 60% of its total revenue from inpatient surgery. For specialty hospitals, that number is lower, approaching 50% in most cases. That situation does not occur evenly across all hospitals, however. Many small community and rural hospitals do not have the same dollar volume of inpatient service as their larger, more urbanized cousins. This circumstance argues against using a dollar figure or ratio to determine whether or not a hospital meets the

Medicare definition. The unintended consequences of such a move would certainly draw the attention of the hospital industry, Medicare beneficiaries and Congress.

For the same reasons, the use of average daily census or number of beds will not suffice as a basis for determining whether or not a hospital meets the Medicare definition. There is simply too much variation among hospitals across the country. According to AHA data, in 2002 there were 321 hospitals in the 6-24 bed size category. Only 26 were investor owned. Most were rural hospitals. They had an average daily census of fewer than 6 patients.

In the same year, 931 hospitals were classified in the 25-49 bed range. Investors owned 107 of these facilities. The average daily census was just over 15 patients. More than 700 were in rural areas. It appears that use of number of inpatient beds or average daily census as the basis for determining if a hospital qualifies for Medicare may disadvantage small and rural hospitals.

According to the American Hospital Association, the smaller hospitals, 6-24 beds, reported 161,716 inpatient admissions in 2002, compared with 5,929,797 outpatient visits. In the next category, 25-49 beds, 1,062,147 inpatient admissions were counted in 2002. These facilities reported 29,726,357 outpatient visits.

This relationship does not dramatically change as the size of the hospital increases. This AHA data amply demonstrate that the hospital of the 21<sup>st</sup> Century is not “primarily engaged in the provision of inpatient services”.

There is a very good reason that Medicare has been flexible in its interpretation of the term “hospital” and that is the dynamic nature of the hospital sector. Today’s hospital would barely be recognized by an administrator or physician who practiced in the pre Medicare period. The discussion in the proposed rule fails to take these changes into account.

Medicare has relied on state licensing as the fundamental determinant of what facility can be considered a hospital. Using the flexibility available to the state to respond to the unique circumstances of its own situation and needs has allowed Medicare to keep up with the changing hospital sector. For the federal government to attempt to usurp this role and override the

effect of state law and regulation only means that CMS will have to struggle with the reality that virtually no hospital, by any standard, qualifies for Medicare under a strict reading of the statute.

The Association believes that CMS should abandon this attempt to discriminate against specialty hospitals. The agency already has authority to withdraw a Medicare number from a facility that no longer meets Medicare standards, including whether or not it sees hospital inpatients. There is no evidence presented that this authority is no longer sufficient. In the absence of such evidence, we fail to understand why a new stance on the issue is required.

We also do not understand why CMS would want to exclude specialized hospitals from the program. According to its own study of specialty hospitals, the morbidity and mortality levels are superior to those found in general hospitals. We presume that CMS would want to increase the quality of healthcare for its beneficiaries, especially when it is not costing the agency more money to achieve these improved results.

The CMS study also demonstrates high levels of patient satisfaction with specialty hospitals. Why would the agency want to take an action to deny beneficiaries a choice they find more satisfactory?

Reliance on state licensing as the basic standard has allowed the agency to adapt to the changing nature of hospitals over the life of the program. We believe that CMS should use the state's grant of a hospital license as the basic evidence of qualification for Medicare. Any national standard will only create unintended consequences for hospitals and their patients. At the very least, the agency should issue a separate rulemaking in which it poses some specifics for public comment. As previously noted, this is too important an issue to be left to informal processes, like provider manual revisions.

Although not discussed in the proposed rule, CMS has announced that it will revise payments to ambulatory surgery centers (ASCs) to assure that the current discrepancies do not create an incentive for ASCs to convert to hospitals only for reimbursement reasons. We welcome an effort to create a more logical ASC payment system, one that is related to the current hospital outpatient reimbursement structure.

## MEDPAC RECOMMENDATIONS

One outcome of the MedPAC study of specialty hospitals was identification of DRGs that were “more profitable” than others. In other words, some DRGs paid more than the cost of care provided, and some DRGs paid less. These discrepancies create the potential that hospitals might select their Medicare admissions with payment rates in mind, perhaps discriminating against certain patients. At the very least, the variation in value forced hospitals to use higher paying DRGs to subsidize the care provided in lower paying DRGs.

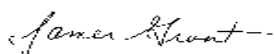
It should come as no surprise that a payment system that has been in place more than 20 years now has some anomalies in it. Whether or not one accepts the arguments about incentives that have been raised as a result of these distortions, it does make sense to try to make sure that the inpatient prospective payment system reimburses for the cost of care as accurately as possible. We believe that the MedPAC recommendations go a long way to achieving that goal and would greatly reduce the need for hospitals to use cross subsidies to sustain services that are today underreimbursed.

The American Surgical Hospital Association has supported the MedPAC recommendations, and we are pleased that CMS is actively working to implement them. We believe that their adoption will go a long way to establishing an even basis for fair competition among hospitals. Further action addressing issues in the specialty hospital debate will not, we believe, be necessary if CMS adopts these payment changes promptly.

While we support an appropriate phase in of the new rates, we urge CMS to act with dispatch to implement these important revisions.

The American Surgical Hospital Association appreciates the opportunity to comment on these important issues. We look forward to a continued and constructive dialogue with CMS on specialty hospitals.

Sincerely,



James Grant  
President