



American Hospital
Association

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September 14, 2007

OMB Human Resources and Housing Branch
Attention: Carolyn Lovett
New Executive Office Building
725 17th Street, N.W., Room 10235
Washington, DC 20503

RE: CMS-10225 (OMB#: 0938-New), Medicare Program; Disclosures to Patients by Certain Hospitals and Critical Access Hospitals; Proposed Paperwork Requirement (Vol. 72, No. 158), August 16, 2007

Dear Ms. Lovett:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment to the Office of Management and Budget (OMB) on the Centers for Medicare & Medicaid Services' (CMS) proposed paperwork requirement regarding disclosures to patients by certain hospitals and critical access hospitals of physician ownership and their emergency services capacity. As indicated in our June 4 comments on the fiscal year 2008 inpatient prospective payment system (PPS) proposed rule and our June 22 comments to CMS on this proposed paperwork requirement, **the AHA supports implementation of a physician-ownership disclosure requirement. However the emergency services disclosure requirement should be scaled back significantly in the outpatient setting and in its application to small, rural and critical access hospitals.**

DISCLOSURE ON 24/7 PHYSICIAN AVAILABILITY AND EMERGENCY CAPACITY

As part of its *Deficit Reduction Act of 2005*-required report to Congress, CMS raised the issue of patient safety in physician-owned specialty hospitals. Recent events and media coverage also have drawn attention to potential patient-safety problems in these facilities. The proposed inpatient PPS rule addressed these issues in several ways. One aspect of the proposal called for a written disclosure to patients of how emergencies are handled when the hospital does not have a physician available on the premises 24 hours a day, seven days a week.



As indicated in our earlier comments to CMS, **the AHA believes that the proposed disclosure requirement would be applied much too broadly and, as such, would create an unnecessary burden on small, rural and critical access hospitals and, more generally, on the delivery of outpatient services.** While the requirement may sound reasonable, we believe it misses the mark on the real issue to be addressed: safety concerns in physician-owned specialty hospitals.

It makes sense to apply special requirements like these to physician-owned specialty hospitals, but not all hospitals. The reason: The safety concerns raised by physician-owned specialty hospitals occur because these facilities operate outside the traditional network of care delivery in this country. These facilities are free-standing, generally not part of a larger system of care, most often lack transfer agreements with other hospitals or providers of care in a community, and tend to specialize in one type of care delivery, challenging their ability to treat the unexpected event or emergency.

This is not the case with full-service community hospitals. Full-service community hospitals are part of a community network of care, involving referrals from local physician practices, reliance on local trauma-support networks, participation in local emergency medical transport systems and transfer agreements among facilities. Even small and rural hospitals located in more remote areas are part of a planned network of care and patient triage. Small and rural hospitals often stabilize and transport patients to other facilities, but that transport is communicated, the receiving hospital is alerted, and the patient's clinical information collected at one hospital goes with the patient to the next hospital. In addition, small and rural hospitals are often connected to a system of care through telemedicine, which allows for access in more remote areas to specialists and other clinical expertise available at larger, more urban hospitals. Furthermore, the capabilities of these hospitals are well known in their communities and are looked to as a local entry point into the health care system. **Applying additional requirements for this group of hospitals is unnecessary and costly.**

Participation in the broader network of care delivery, of which full-service community hospitals are a part, is the best way to ensure that care is provided to patients at the right time, in the right setting. This requirement can be used to assure that patients scheduled for admission to a physician-owned specialty hospital understand that, in the absence of being a part of the broader care network, the ability of these facilities to handle complications on-site may be limited.

The burden associated with this requirement should be further reduced by not applying the requirement to all outpatient visits. **The AHA recommends that this requirement be limited to inpatient admissions and only those outpatient visits that include surgery, other invasive procedures, the use of general anesthesia or other high-risk treatment. Emergency department (ED) services should be specifically excluded.**

Patients being admitted to a hospital expect that the hospital can handle emergencies that arise, and patients undergoing outpatient surgery or other procedures that are invasive, involve anesthesia or are higher risk expect that related complications can be handled. A patient coming for a mammogram or going to an arthritis clinic has a different set of expectations. Therefore, we do not believe it makes sense to paper every outpatient with the disclosure notice.

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Furthermore, providing the notice to ED patients seems fruitless because the decision to receive care at the hospital already has been made. If CMS is using this disclosure requirement to broadly expand community understanding of a hospital's limitations, we believe that goal can be accomplished through signs in hospital EDs and outpatient clinics and an annual notice in the local newspaper.

Finally, we feel compelled to point out that several major expansions in the paperwork requirements placed on hospitals have recently been approved or are pending, with little apparent attempt to minimize the burden. While CMS revised its estimates of the burden of *this* requirement, it did not make any attempt to minimize the burden on hospitals. The AHA urges OMB to exert the restraint on new paperwork burdens that was mandated when Congress passed the *Paperwork Reduction Act*.

If you have any questions, please feel free to contact me or Ellen Pryga, director for policy, at (202) 626-2267 or epryga@aha.org.

Sincerely,

Rick Pollack
Executive Vice President