AMA
AMERICAN MEDICAL ASSOCIATION

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April 30, 2015

The Honorable Edith Ramirez
Chairwoman
Federal Trade Commission
600 Pennsylvania Avenue, NW
Washington, DC 20580

Re: Health Care Workshop, Project No. P13-1207

Dear Chairwoman Ramirez:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am pleased to provide our comments on the February 2015 Federal Trade Commission (FTC) and Department of Justice (DOJ) *Examining Health Care Competition* workshop. We found both this and last years' workshops to be informative and timely given the numerous transformations occurring in medicine, which may have a significant impact on the health care marketplace. We appreciate the FTC-DOJ's continued attention to these issues and will continue to share our expertise to inform the agencies' work in examining health care competition. The following provides our specific comments with respect to the workshop.

Provider Network Design and Health Insurance Exchanges

The AMA recognizes that, in an effort to hold down costs, many health insurers offering coverage in the Health Insurance Marketplaces, Medicare Advantage, and employer-sponsored insurance are assembling tiered and narrow networks. While premiums may be lower in those plan designs, such limited provider networks may be inadequate to provide meaningful access to in-network care and, therefore, can result in higher out-of-pocket costs to patients when they are forced out-of-network.

While the AMA is not opposed to narrow or tiered networks to the extent they are adequate, we have serious concerns about the formation of networks based solely on economic criteria. Narrow networks often exclude providers who care for some of the most vulnerable or complex patients, thereby steering those patients to more costly plan options—or potentially cost prohibitive out-of-network care—in order to meet their medical needs. Tiered networks do not exclude providers who care for higher risk patients, but instead place them in lower tiers, giving the impression that they provide lower quality of care.

The AMA believes it is critical that state regulators put in place measureable, quantitative, and publically available standards to evaluate network adequacy and establish themselves as the primary enforcers of those requirements. Material changes to provider networks should be approved prior to the enrollment period and enrollees should be allowed to have continued access throughout the coverage year to the network they reasonably relied upon when purchasing the product. In the cases in which patients still find themselves in inadequate networks, they should have access to adequate and fair processes to ensure they are able to receive the care they need.

Additionally, it is important that health plans provide all consumers with accurate, complete, and detailed directories of participating physicians through multiple media outlets in order to help patients make informed decisions about their health insurance. Health insurers should be prohibited from falsely advertising that enrollees in their plans have access to providers that are not included in the health insurer's limited network. The FTC may wish to further examine the degree of transparency provided to both physicians and consumers when plans describe their networks and patient ability to access care.

Alternative Payment and Delivery Models

The AMA strongly supports new delivery and payment models and believes that innovation is necessary to transform our health care system. We also recognize that the federal government has made it a priority to move the health care system at large toward paying providers based on value, rather than quantity, setting a goal of tying 30 percent of traditional Medicare payments to alternative models by the end of 2016, and 50 percent of payments by the end of 2018. Indeed, in a 2012 AMA survey of physicians, 32 percent of participants reported that their practices already received some level of reimbursement via bundled payments and 29 percent reported having payments tied to pay-for-performance models.[1] In addition, the Medicare Access and CHIP Reauthorization Act of 2015 will further promote alternative payment models (APMs) by providing five percent bonus payments each year for five years to physicians who participate in models that are accountable for more than nominal financial risk.

While the workshop highlighted how shifting to APMs could help improve care, we continue to see barriers to participation, especially for small and specialty practices. Participation by these practices is essential because it ensures patient choice, preserves the physician-patient relationship, and provides greater competition in health care markets. It also protects against concerns highlighted by the panelists that health care consolidation may not appropriately align incentives among the merging parties, reduce costs, or improve care quality.

Despite the need for their participation, a recent study by the AMA in conjunction with the RAND Corporation found that small practices may face challenges participating in APMs due to the complex infrastructure needed to implement these models. The comprehensive review of 34 physician practices in diverse markets found that new models were leading to organizational changes—predominantly by affiliating or merging with other practices or becoming aligned or owned by hospitals. As noted in the report:

> Specifically, practice leaders reported that the most prominent payment model–related reasons for these mergers were to enhance practices' ability to make the capital investments required to succeed in certain alternative payment models (especially investments in computers and data infrastructure), to negotiate contracts with health plans (including which performance measures and targets would be included), and to gain a sense of "safety in numbers." Leaders and physicians in multiple practices described uncertainty about how they would fare in alternative payment programs (and how such programs might evolve over time). For some of these practices, joining with a larger

[1] AMA's 2012 Physician Practice Benchmark Survey.

> organization was seen as providing a general sense of security, no matter what payment programs might be introduced.[2]

To overcome these barriers and promote greater participation by small and specialty practices, we believe the regulatory framework for new care models must allow and encourage flexibility. The FTC and the DOJ recognized this problem previously and provided much needed relief by clarifying the application of antitrust laws in their Statement of Antitrust Enforcement Policy for Accountable Care Organizations (ACO) in the Medicare Shared Savings Program. The AMA strongly supports this effort and encourages the FTC and DOJ to consider additional clarifying guidance for other models, especially those developed by the Center for Medicare & Medicaid Innovation (CMMI).

Flexibility in application of some of the rules that govern the current payment system is also needed to make it more feasible for small, independent practices to participate in these models. For example, under the current system, primary care and specialist physicians who take the time to develop treatment plans for their patients with diabetes, Alzheimer's, heart disease, cancer, osteoarthritis, and other complex conditions cannot be compensated for the work involved in physician-to-physician consultations. In addition, both the primary care and specialist physicians will have to forgo revenue they could have earned from seeing patients face-to-face. Waiving the requirements that Medicare patients have a three-day inpatient hospital stay before they can be eligible for nursing home coverage and that they be homebound before they can receive covered home health care services would provide greater flexibility to physicians in managing rehabilitation and post-acute care services.

We also believe that clarification of other program integrity laws would help promote innovative arrangements that pose little risk of fraud and abuse, especially the overly broad prohibition against gainsharing arrangements. Allowing more flexibility in gainsharing arrangements could promote APMs that provide cost savings and improve efficiency. We urge the FTC to examine ways to modernize existing laws and requirements to reflect a more coordinated approach to delivering care.

Ultimately, physicians should be able to maintain their independent practices while at the same time have access to the infrastructure and resources necessary to participate in APMs. Practices are increasingly recognizing that the cost of health information technology (health IT) is a significant limitation when trying to adopt new care models. As noted in a recent Government Accountability Office (GAO) report, "several officials estimated various amounts between $50,000 and $80,000 that providers spend to establish data exchange interfaces" in addition to significant fees to maintain electronic health records (EHR) and connect with other technology.[3] We suspect these costs may be driving further consolidation of practices, which could limit competition in health care markets.

Recognizing these barriers, the Office of the Inspector General has created safe harbors that allow physicians to receive donations of health IT without forcing them into employment or other relationships with hospitals and larger practices. We, however, worry that these exceptions are still too rigid and generally do not support the expanding need for care coordination. We urge the FTC to consider and promote alternative ways for physicians to access health IT and the infrastructure needed to build

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[2] The RAND Corporation with Sponsorship by the American Medical Association. *Effects of Health Care Payment Models on Physician Practice in the United States.* March 2015. Available at http://www.rand.org/pubs/research_reports/RR869.html

[3] GAO (GAO-14-242), "Electronic Health Records HHS Strategy to Address Information Exchange Challenges Lacks Specific Prioritized Actions and Milestones" March 2014.

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The efficiencies of ASC and their added benefit of raising the performance of competing community hospitals have been acknowledged by the FTC and DOJ:

> Ambulatory surgery centers offered patients more convenient locations, shorter wait times, and lower coinsurance than hospital departments. Technological innovations, such as endoscopic surgery and advanced anesthetic agents, were a central factor in this success. Many traditional acute care hospitals have responded to these market innovations by improving the quality, variety, and value of their own surgical services, often developing on-or off-site ambulatory surgery centers of their own.[10]

Numerous studies have shown that CON laws have failed to achieve their intended goal of containing costs.[11] Instead, CON has taken on particular importance as a way to claim territory and to restrict the entry of new competitors.[12] It should go without saying that competition requires competitors. By restricting the entry of competitors, such as physician-owned facilities, CON laws have weakened the market's ability to contain health care costs, undercut consumer choice, and stifled innovation. Thus, the AMA urges FTC/DOJ to redouble their efforts in advocating for the repeal of CON laws.

2. Physician-Owned Hospitals

The Medicare Payment Advisory Commission (MedPAC) has observed that "some physicians want to expand the range of cases seen in ASCs to include patients who might require more monitoring and an overnight stay. Doing so requires conversion of the ASC to a hospital."[13] This was possible prior to the enactment of the ACA when there were approximately 265 POHs concentrated in states that do not have CON.[14] At that time, physicians enjoyed a "whole hospital exception" to the Stark law, meaning that if they had an ownership interest in an entire hospital, and were authorized to perform services there, they could refer patients to that hospital.

However, provisions within section 6001 of the ACA (42 USC 1395nn) "essentially create a federal certificate of need requirement" for POH.[15] First, section 6001 eliminates the Stark exception for physicians who do not have an ownership or investment interest and a provider agreement in effect as of December 31, 2010. Second, the POH cannot expand its treatment capacity unless certain restrictive exceptions can be met. Thus, Professor Greaney observes, "the ACA all but put an end to one source of new competition in hospital markets by banning new physician-owned hospitals that depend on Medicare reimbursement."[16]

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[10] Joint Statement of the Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission Before the Illinois Task Force on Health Planning Reform (September 15, 2008).

[11] *See* Michael A. Morissey, *State Health Care Reform: Protecting the Provider*, in American Health Care: Government, Market Processes, and the Public Interest 243-66 (Roger D. Feldman ed., Transaction Publishers 2000).

[12] *Id;* Tracy Yee et al., *Health Care Certificate-of-Need Laws: Policy or Politics,* Research Brief 4, National Institute for Health Care Reform (May 2011).

[13] Medicare Payment Advisory Commission, Report to the Congress; Physician-Owned Specialty Hospitals, (March 2005) at 8. Available at http://medpac.gov/documents/reports/Mar05_SpecHospitals .

[14] H.R. REP.NO. 111-443, at 4 (2010): Casalino at 56-67.

[15] *See* Joshua Perry*, An Obituary for Physician-Owned Specialty Hospitals*; 23 No. 2 Health Lawyer 24 (American Bar Association, December, 2010).

[16] Greaney, *supra* note 5, at 841.

i. Quality and Cost Record of Physician-Owned Hospitals

The lost source of competition is especially missed because the POH has developed an enviable track record for high quality and low cost care. A Centers for Medicare & Medicaid Services (CMS) study found that measures of quality at physician-owned cardiac hospitals are generally at least as good, and in some cases better, than at local community hospitals. According to CMS, specialty hospitals offer very high patient satisfaction and high quality of care.[17] More recently, the comparative efficiencies of POHs are shown in the results of CMS' Hospital Value-Based Purchasing Program. Nine of the top 10 performing U.S. hospitals listed in late 2012 by CMS were POH. Of the 238 POHs in the U.S., 48 were ranked in the top 100.[18]

There are additional studies showing that many of the POHs facilities achieve greater patient satisfaction, reduce costs, and improve infection rates.[19] Professor Swanson's research finds that "treatment at a POH can lead to substantial improvements in mortality risks for cardiac patients."[20] She concludes that "the results suggest that banning of further physician ownership as part of the ACA may have detrimental effects on patient health."[21]

ii. The Established Efficiencies of POH

Accounting for the high performance of POHs is a number of efficiencies that CMS identifies in its report. They include: specialization, improved nursing staff ratios and expertise, patient amenities, patient communication and education, emphasis on quality monitoring, and clinical staff perspectives on physician ownership.[22] For example, POH staff has the ability to focus on a limited number of procedures and diseases. Nurses do not have to be pulled to different types of inpatient wards to care for patients with a broad range of clinical problems. Efficiencies of this sort have led Casalino (2003) to characterize POH (and their relative, the ASC) as "focused factories." Clayton M. Christensen, a noted Harvard scholar on disruption in industry, has observed that the hospital industry is the only industry worldwide where the factory (a hospital) is not specialized. He projects that specialty hospitals could reduce costs for hospitalizations by 15 to 20 percent and is the disruptive solution for health care.[23]

Perhaps the most essential efficiency of the POH as characterized by CMS is the fact of physician ownership itself:

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[17] Study of Physician-owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, pp 36-55 (CMS Report). Available at http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/RTC-StudyofPhysOwnedSpecHosp.pdf .

[18] *See* American Medical News (April 29, 2013).

[19] *See e.g.* Casalino, *supra* note 8, at 56-67; Ashley Swanson PhD Assistant Professor, The Wharton School, University of Pennsylvania and Faculty Research Fellow, National Bureau of Economics, *Physician Investment in Hospitals: Specialization, Incentives, and the Quality of Cardiac Care,* December 18, 2013, Working paper, available at https://www.econ.berkeley.edu/sites/default/files/swanson_poh_curr%20(1).pdf

[20] Swanson, *supra* note 19, at 48.

[21] *Id.*

[22] *See* CMS report, *supra* note 17, at 48-50.

[23] *See The Innovators Prescription: A Disruptive Solution for Healthcare*, Christiansen et al. McGraw-Hill (2008)

> In our site visits, staff at specialty hospitals described the physician owners as being very involved in every aspect of patient care. The physicians monitored patient satisfaction data, established a culture that focused on patient satisfaction and were viewed by the staff as being very approachable and amenable to suggestions that would improve care processes.[24]

These CMS observations are consistent with the field of organizational economics that has long recognized that the performance of an organization may critically depend on who owns it. As explained in *Economics of Strategy*, ownership can affect critical incentives to invest in the future of the organization.[25]

In a nutshell, workers may be unwilling to make critical investments in a firm if they do not trust ownership to reward them for it. At a practical level in the context of hospitals, this might manifest itself in terms of the time invested by physicians to work with ownership to develop treatment protocols, implement and enhance the performance of EHRs, and develop and maintain relationships with patients. Physicians might trust physician owners to keep implicit promises regarding compensation and other aspects of job satisfaction, and a physician-owned hospital might therefore perform better than a hospital with more traditional ownership structures where relationships with medical staffs may be more tenuous.

In sum, physician ownership represents an important alternative that provides a different, potentially superior, opportunity to create efficiencies in the provision of health care.

iii. The POH Relative Ease of Market Entry and Competitive Response of Established Hospitals

New competition is vital to markets that are dominated by a single powerful hospital or system and POH have advantages over non-physician owner/investors. The latter may be reluctant to enter such markets because a first step in successful entry is physician recruitment, and it may be difficult to lure physicians away from systems where so many physicians are employed. Physician owners may have an advantage in building a medical staff de novo, and could therefore successfully enter where others dare not.

Lifting the ban on POHs could raise the performance of the entire hospital market. The market entry of POH induces community hospitals to attempt to "meet the competition" in inpatient services by extending patient hours, improving scheduling, and upgrading equipment.[26]

iv. Potential Promising Role for POH in New Delivery and Payment Models

Lifting the ban on POHs could also allow physicians who run other new care models to acquire hospitals, to better control hospital costs, and to supervise the overall health care product sold. The existing hospital systems have responded to the call for ACO's, bundled payments, and other forms of value purchasing by vertically integrating with physician practices, raising the concern of noncompetitive vertically integrated markets.[27] Why not allow an alternative to the existing hospital-dominated integration by permitting

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[24] *See* CMS report, *supra* note 17, at 50.
[25] Besanko, D. et al., 2013 *Economics of Strategy, 6th Edition. Chapter 4. New York: Wiley*
[26] *See* Med PAC Report, *supra* note 13, at 10.
[27] Synthesis Project, *supra* note 4, at 6.

physicians to acquire hospitals and to compete as vertically integrated systems delivering an overall health product?

v. The "Cherry Picking" Fallacy

Opponents of POHs point out that they tend to treat patients who are less severely ill and less costly to treat than patients treated for the same conditions in general hospitals. They misleadingly call this "cherry picking" conduct that they ascribe to the physician owners. CMS studied referral patterns associated with specialty hospitals and concluded that it "did not see clear, consistent patterns for referring to specialty hospitals among physician owners relative to their peers."[28] CMS concluded "we are unable to conclude that referrals were driven primarily based on incentives for financial gain."[29] CMS found that while patients treated in community hospitals are more severely ill than those treated in specialty hospitals, this was true both for patients admitted by physicians with ownership in specialty hospitals and by other physicians without such ownership. That is, CMS' analysis found no difference in referral patterns to community hospitals between physician owners and non-owners. CMS concluded that the lower severity levels seen in specialty hospitals "may be an indicator of quality in the sense that it shows that the hospital has focused on a particular type of patient. A hospital that accepts patients that it cannot properly treat may not exhibit good quality healthcare."[30]

Moreover, CMS' analysis with patients transferred out of cardiac hospitals also does not suggest any particular pattern. The proportion of patients transferred from cardiac hospitals to community hospitals is about the same, around one percent, as the proportion of patients transferred between community hospitals. Similarly Professor Swanson concludes from her current research "that for cardiac care, the hospital choice incentives of physicians in physician owned hospitals are *not* distorted."[31]

Clearly, the advantages of POH should not be lost to the unsubstantiated fears of "cherry picking." This is especially true presently when new entry into many hospital markets is critical to their competitiveness and when alternative delivery and payment models requiring physicians to control hospital costs are the order of the day. Therefore, we strongly recommend that the FTC/DOJ consider and weigh-in on the need to remove restrictions on POHs to improve competition.

Conclusion

We appreciate the opportunity to comment on the FTC-DOJ's *Examining Health Care Competition* workshop and look forward to continuing our work with the agencies on improving plan networks and promoting innovative delivery and payment models. If you have any questions about our comments, please contact Kristen O'Brien, Washington Counsel, at 202-789-7428 or kristen.o'brien@ama-assn.org.

Sincerely,

James L. Madara, MD

[28] CMS Report, *supra* note 17, at 26.
[29] *Id.*
[30] *Id.* at 61.
[31] Swanson, *supra* note 19, at 48 (emphasis added).