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October 1, 2020

The Honorable Seema Verma
Administrator, Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8011,
Baltimore, MD 21244-1850

Attention: CMS-1736-P

Re: Hospital Outpatient Prospective Payment System (OPPS) for Calendar Year 2021 (CMS-1736-P); Section XIX, Physician-Owned Hospitals

Dear Administrator Verma,

On behalf of the undersigned healthcare providers, facilities, systems, organizations, societies, and associations, we thank you for the opportunity to provide comment on the above referenced Hospital Outpatient Prospective Payment System (OPPS) rule for CY 2021. We write to you to express our support for the Center for Medicare & Medicaid Services' (CMS) proposal to: (1) remove certain restrictions imposed on physician-owned hospitals (POH) qualifying as "high Medicaid facilities"; and (2) clarify that state law governs under the physician self-referral Whole Hospital Exception (WHE) for the purposes of calculating a hospital's baseline number of beds.

Physician-Owned Hospitals

Section 6001 of the Patient Protection and Affordable Care Act[1] established a ban on the creation and expansion of POHs and limited then existing POHs to the number of beds, operating rooms, and procedure rooms for which they were licensed of as of March 23, 2010. This provision has stifled competition, limited job growth, inhibited innovation, and restricted patient access. These restrictions also interfere with physician autonomy, patient choice, and the doctor-patient relationship.

Physicians have an ownership stake in approximately 250 hospitals across the United States which operate in 34 states. These community hospitals have largely sprouted in areas with high population growth by local area physicians and in response to expanding local community needs that were unmet by existing healthcare providers. POHs have a strong track record of providing community benefits, quality care, increasing competition, and operating the most efficient, state-of-the-art facilities. This is largely due to having local physicians not only treating patients but also being heavily involved in making detailed decisions about hospital operations, staff, equipment, training, and procedures that can best serve their patients and their community.

In the most comprehensive study to-date on the issue, a peer-reviewed Harvard study released in August 2015 and published in the British Medical Journal (BMJ) compared 219 acute-care physician-owned hospitals

to 1,967 of their peers within the same hospital region and found that POHs do not cherry-pick patients, stating that POHs *"do not seem to systematically select more profitable or less disadvantaged patients or provide lower value care*." In fact, the study found that 120 of the 219 POHs studies were general hospitals and as a whole, all POHs were equally likely to serve minority and Medicaid patients.[1]

Additionally, recent studies show that POHs provide their communities with significant benefits, including higher quality care at a lower cost. POHs have been found to provide their communities with more charity care than other hospitals. A CMS study on physician-owned hospitals found that POHs spend nearly 6% of their total revenue on community benefits compared to less than 1% for other hospitals.[2] Furthermore, an analysis by Avalon Health Economics found that POHs have lower net payments than other hospitals and have saved Medicare $3.2 billion over 10 years based on a review of the 100 most common Diagnosis Related Groups (DRGs) and 30 most common Ambulatory Payment Classifications (APCs).[3] The study also found that POHs "have consistently outperformed their non-POH counterparts" and that if patients were assigned to non-POHs, an additional $6.8 billion in medical care costs associated with adverse events, complications, and readmissions would be incurred.[4]

Physician-owned hospitals are an integral part of the American health care system and one of the last vestiges of locally-driven, community hospitals remaining. POHs are in both rural and urban areas, including full-service general acute care and specialty hospitals. A majority of physician owners have less than a 2% interest in the hospital and join POHs so that they can practice in an environment where their medical expertise contributes to the overall goal of improving patient care. However, in contrast to the grassroots model of POHs, the national trend toward hospital consolidations, physician integration into hospitals, and hospital acquisition of physician practices seen over the past few years has resulted in higher costs and less options for patients. For example, the Medicare Payment Advisory Commission (MedPac) as well as the Department of Health and Human Services have found that POH's are an "*important competitive force*" and "*an appropriate response to physician frustration with community hospitals' lack of responsiveness and physicians' desire for control."*[5] Yet, home-grown, physician-driven alternative competition is restricted and the trend towards consolidation marches on.

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[1] Blumenthal, Daniel M., Orave, John E., Jena, Anuparm B., Dudzinski, David M., Le, Sidney T., Kjha, Ashish; "Access, quality, and costs of care at physician owned hospitals in the United States: observational study." BMJ 2015; 351. < http://www.bmj.com/content/351/bmj.h4466 >

[2] CMS: Study of Physician-Owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003

[3] Greenwald, Leslie; Cromwell, Jerry; Adamche, Walter; Bernard, Shulamit; Drozd, Edward; Root, Elisabeth, and Devers, Kelly, "Specialty Versus Community Hospitals: Referrals, Quality, and Community Benefits", *Health Affairs* 25, no. 1 (2006): 106-118 doi:10.1377/hlthaff.25.1.106. < http://content.healthaffairs.org/content/25/1/106.full.pdf >

[4] *Id.*

[5] Medicare Payment Advisory Committee, *Report to the Congress: Physician-Owned Specialty Hospitals*; 2005. <https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/RTC-StudyofPhysOwnedSpecHosp.pdf>; *See also* Plummer, Elizabeth and Wempe, William: "*The Affordable Care Act's Effects On The Formation, Expansion, And Operation Of Physician-Owned Hospitals",* Health Affairs, August 2016 35:81452-1460 finding that "*it is unambiguous that curtailing the formation of physician-owned hospitals decreases competition*"; < http://content.healthaffairs.org/content/35/8/1452.full >

Comments on the Proposed Rule

(1) High Medicaid facilities

POHs qualifying as high Medicaid facilities are safety-net hospitals which serve as a lifeline for their communities. We support CMS' proposal to remove certain regulatory restrictions not intended by Congress so that these hospitals can continue to increase access to care for the most vulnerable in their communities.

By definition, to qualify as a high Medicaid facility, the hospital must be approved by CMS and meet the following criteria:

(1) Not be the sole hospital in the county;
(2) Have the highest Medicaid admission of any hospital in the county for the three most recent years; and
(3) Certify that they do not discriminate against federal health care beneficiaries.[6]

Sections 6001 and 10601 of the Patient Protection and Affordable Care Act ("PPACA") and section 1106 of the Health Care and Education Reconciliation Act of 2010 ("HCERA") prohibit the establishment of new physician owned hospitals and restrict the ability of those existing as of March 23, 2010 to expand. However, the law does allow community physician owned hospitals limited expansion if they are in an underserved area, approved by CMS, and qualify as a "high Medicaid facility"[7] or an "applicable hospital."[8] Only 6 hospitals nationwide have been granted one of the two exceptions to-date.[9]

Recognizing the importance of increasing access to care for Medicaid beneficiaries, in drafting the PPACA Congress chose not to impose three additional restrictions on "high Medicaid facilities" that it did apply to hospitals qualifying as an "applicable hospital". Specifically, Congress: (1) placed a 200% cap on the total number of additional beds, operating rooms, and procedure rooms that can be approved in an exception for an applicable hospital;[10] (2) required expansion to occur on the applicable hospital's main campus;[11] and (3) limited the ability of applicable hospitals to apply for an exception once every two years.[12]

Despite Congress intentionally exempting high Medicaid facilities from these additional restrictions, through rulemaking, CMS has imposed these additional restrictions on high Medicaid facilities[13] causing unnecessary regulatory burden. CMS' proposal would allow these safety-net hospital to increase access to care in their

[6] 42 U.S.C. sec. 1395nn(i)(3)(F).
[7] *Id.*
[8] *Id.* at (i)(3)(E).
[9] https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Physician_Owned_Hospitals
[10] 42 U.S.C. sec. 1395nn(i)(3)(C)(ii).
[11] *Id.* at (i)(3)(D).
[12] *Id.* at (i)(3)(B).
[13] 76 Fed. Reg. 74122, 74524 (Nov. 30, 2011); 42 C.F.R. 411.362(c)(1) (2018) (applying the "Applicable Hospital" once every two-year application restriction to "High Medicaid Facilities"); 42 C.F.R. 411.362(c)(6)(i) (applying the "Applicable Hospital" 200% of hospital's baseline restriction to "High Medicaid Facilities)"; and 42 C.F.R. 411.362(c)(6)(ii) (applying the "Applicable Hospital" main campus restriction to "High Medicaid Facilities").

communities and align the regulations with Congressional intent: by: (1) lifting the 200% of baseline cap on high Medicaid facilities only, (2) removing the restriction that the expansion must occur only in facilities on the main campus of the hospital qualifying as a high Medicaid facility, and (3) allowing high Medicaid facilities to apply for an exception more than once every two years provided that they only apply once at a time.

CMS' proposal is tightly structured to align the regulations with Congressional intent and the letter of the law. By removing unnecessary barriers for expansion, the proposal should increase access to care for Medicaid beneficiaries while not eliminating Stark physician-self referral protections or allowing unlimited hospital expansion. Under the proposal, POHs qualifying as high-Medicaid facilities would still be required to meet the statutorily prescribed criteria, file and application, and be approved by CMS prior to any additional expansion. Furthermore, the moratorium on a POH being able to acquire a CMS provider agreement restricts the geographic area in which an existing hospital can operate.[14]

We support CMS' proposal and urge the agency to continue finding ways to reduce regulatory burdens and improve the overall efficiency of the health care system in line with President Trump's Executive Order on Regulatory Relief to Support Economic Recovery.[15]

(2) Clarification on State Law Governing Baseline Count

In the proposed rule, CMS clarifies that it defers to state law with respect to the determination of whether a bed is licensed as of a certain date for the purposes of calculating a hospital's "baseline" under Section 1877 of the Social Security Act. Furthermore, CMS proposes to revise the definition of "baseline number of operating rooms, procedure rooms, and beds" at 42 C.F.R. § 411.362(a) to include a statement that, for purposes of determining the number of beds in a hospital's baseline number of operating rooms, procedure rooms, and beds, a bed is included if the bed is considered licensed for purposes of State licensure, regardless of the specific number of beds identified on the physical license issued to the hospital by the State. CMS seeks comment on its proposal to include this language in regulation text at § 411.362(a) generally, and specifically whether the inclusion of this language is necessary or could be perceived as inadvertently limiting the definition of "baseline number of operating rooms, procedure rooms, and beds."

We thank CMS for clarifying that state law governs whether a bed is licensed as of a certain date for the purposes of calculating a hospital's "baseline number of operating rooms, procedure rooms, and beds" under Section 1877 of the Social Security Act. We support CMS' proposal to revise § 411.362(a) and are not concerned that such revision would inadvertently limit the definition of "baseline number of operating rooms, procedure rooms, and beds."

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[14] *See* 42 CFR 413.65(e)(3).
[15] Exec. Order No. 13,924, 85 Fed. Reg. 31353 (May 22, 2020).

Sincerely,

American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
Arizona Medical Association
Baylor Scott & White Texas Spine & Joint Hospital
Congress of Neurological Surgeons
Clinical Orthopaedic Society
DHR Health
Eastern Orthopaedic Association
Harsha Behavioral Center
Houston Physicians' Hospital
Indiana State Medical Association
Maryland Orthopaedic Association
Methodist McKinney Hospital
Mississippi State Medical Association
Ohio State Medical Association
Oklahoma State Medical Association
OSS Health
Pennsylvania Orthopaedic Society
Physician Hospitals of America
Renaissance Medical Foundation
Rothman Orthopaedic Institute
South Carolina Medical Association
Southern Orthopaedic Association
Surgical Specialty Center of Baton Rouge
Texas Orthopaedic Association
Texas Medical Association
Utah Medical Association
Western Orthopaedic Association