Trinity Health

June 13, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS – CMS–1677–P
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Submitted electronically via http://www.regulations.gov

Re: CMS-1677-P, Request for Information on Physician-Owned Hospitals

Dear Administrator Verma:

Trinity Health is delighted to respond to CMS's "Request for Information Regarding Physican-Owned Hospitals."[1] We appreciate your request for industry input on the appropriate role of physician-owned hospitals in the delivery system, and how the current scope of and restrictions on physician-owned hospitals affects healthcare delivery, particularly for Medicare beneficiaries.

Our comments and recommendations to CMS reflect a strong interest in public policies that support better health, better care and lower costs to ensure affordable, high-quality, and people-centered care for all. For this reason, Trinity Health remains categorically opposed to changes that would resume the opportunity for physicians to own and self-refer to hospitals, unless such changes are accompanied by corresponding payment changes that account for the anticipated difference in case and payor mix between physician-owned and non-physician-owned hospitals.

Trinity Health is one of the largest multi-institutional Catholic health care delivery systems in the nation, serving diverse communities that include more than 30 million people across 22 states. Trinity Health includes 93 hospitals as well as 121 continuing care locations that include PACE, senior living facilities, and home care and hospice services. Our continuing care programs provide nearly 2.5 million visits annually. Committed to those who are poor and underserved, Trinity Health returns almost $1 billion to our communities annually in the form of charity care and other community benefit programs. We have 35 teaching hospitals with Graduate Medical Education (GME) programs providing training for 2,080 residents and fellows in 184 specialty and subspecialty programs. We employ approximately 131,000 colleagues, including more than 7,500 employed physicians and clinicians, and have more than 15,000 physicians and

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[1] 81 *Fed. Reg.* 19,796, 20,002 (Apr. 28, 2017)

advanced practice professionals committed to 22 Clinically Integrated Networks that are accountable for 1.3 million lives across the country.

Trinity Health is firmly committed to transforming our delivery system into a People-Centered Health System focused on delivering better health, better care, and lower costs in our communities, and we view bundled payments as an important part of that journey. Trinity Health has committed to having 75 percent of our revenue in value based arrangements by 2020 as a member of the Health Care Transformation Task Force.

Federal law generally prohibits a physician from referring Medicare and Medicaid patients to facilities in which the physician has a financial interest. Most states have similar laws that extend these prohibitions to all payors, beyond just federal sources of payment. The core of these restrictions, commonly referred to as the "Stark Law," are premised on a perceived and broadly accepted concern that the opportunity for a physician to refer patients for certain types of health services in which the physician has a financial interest creates an inherent financially-motivated conflict of interest, and that conflict results in increased utilization and cost.

In the 1990s, physicians and other entrepreneurs exploited a loophole in the original Stark Law that enabled physicians to develop and self-refer to specialty hospitals. According to the US Government Accountablity Office, by 2003, there were nearly 100 specialty hospitals with physician ownership.[2]

Throughout the 2000s, Congress and other policymakers engaged in a considered debate about the implications of physician ownership of hospitals. Congress and CMS took various actions to stem the development, culminating in legislation enacted in 2010 that effectively bars physicians with ownership interests in hospitals from self-referring for designated health services to those hospitals, unless the hospital meets certain exceptions.[3] Trinity Health endorsed the 2010 law, and remains supportive of these restrictions.

Trinity Health generally discourages CMS from diluting current restrictions on physician self-referrals for hospital services. It is generally accepted that financial self-interest leads to increased utilization for certain services. Numerous studies released during the decade when Congress was evaluating the emergence of specialty hospitals found that the introduction of financial incentives linked to ownership coincided with a significant change in the practice patterns of physician owners, whereas such changes were not evident among physician nonowners.[4] A 2006 report by the Medicare Payment Advisory Commission focusing on physician-owned specialty hospitals found that rates of coronary artery bypass graft surgery for Medicare beneficiaries grew faster in areas that gained a physician-owned cardiac

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[2] U.S. General Accounting Office, "Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served," April 18, 2003. Specifically, there were 17 cardiac, 36 orthopedic, 22 surgical, and 17 women's hospitals that met GAO's definition of a specialty hospital.

[3] Section 6001 of the Patient Protection and Affordable Care Act, as amended by sec. 10601 of the same law, and by section 1106 of the Health Care and Education Reconciliation Act of 2010.

[4] *See, for example,* Mitchell, Jean, Ph.d., "Do Financial Incentives Linked to Ownership of Specialty Hospitals Affect Physicians' Practice Patterns?" Medical Care, July 2008.

hospital.[5] Notably, the Congressional Budget Office estimated that the 2010 provision banning new physician-owned hospitals would reduce the deficit by $500 million over 10 years.

For these and other reasons, Trinity Health urges CMS to leave the current restrictions in tact. Nonetheless, should CMS choose to loosen current restrictions on physician self-referrals, such changes must be accompanied by accommodating payment changes for inpatient and outpatient services. Medicare's inpatient and outpatient prospective payment systems, and the payment systems of many private payers, are premised on the idea that payments are based on the cost of caring for a patient whose disease and overall health are *average*. Selecting the healthiest patients therefore can be profitable. It is well-documented that limited-service, physician-owned hospitals typically "cherry pick" lucrative procedures and patients, leaving more expensive cases for community hospitals, who serve a charitable mission and fulfill community needs, and have less desire or ability to self-select patients to maximize profits. A 2003 report by the GAO found that specialty hospitals treated a lower percentage of patients who were severely ill than did the general hospitals.[6]

Moreover, selecting patients with more favorable insurance also can create imbalances. A 2005 report by MedPAC found that Medicaid beneficiaries comprised 13 percent of a community hospital's patients, but only 2 percent of orthopedic and surgical hospital patients, and 3 percent of cardiac hospital patients.[7] The key to its financial viability for a hospital is cross-subsidization, whereby revenues from insured patients subsidize the care of the uninsured and underinsured, and profits from well-compensated services support those operating at a loss. Cross-subsidization is challenged when one provider in a community can cream-skim highly reimbursed cases while avoiding care to Medicaid and uninsured patients, and tilt the balance of payor and case mix, leaving the community hospital with poorly compensated services and poorly-insured patients. The relevance of payor mix is even more acute in a time when Congress is examining changes to the insurance expansions made by Affordable Care Act, which could result in an increase in the number of uninsured Americans.

In May 2006, CMS submitted a report to Congress that recommended a number of steps the agency could take to adjust reimbursement to account for these discrepancies. More research and thought would need to be given, especially given the changes to reimbursement that have occurred in the intervening decade. As CMS has moved boldly to link traditional fee-for-service Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations or bundled payment arrangements, the need to adjust payments to recognize and account for these imbalances would be particularly acute. To the extent CMS wants to truly evaluate shared-risk models, it must either maintain balance and general equity in the regulatory expectations of hospitals, or risk-adjust payments and cost-savings targets to recognize that the patient mix (and payor mix) could be vastly different between participating hospitals.

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[5] Medicare Payment Advisory Commission, "Report to Congress: Physician-Owned Specialty Hospitals Revisited," August 2006.
[6] U.S. General Accounting Office, "Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served," April 18, 2003.
[7] Medicare Payment Advisory Commission, "Report to the Congress: Physician-Owned Specialty Hospitals," March 2005.

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For these and other reasons, Trinity Health supports the continuation of the ban on physician self-referral to limited-service hospitals, and we urge the Administration and Congress to leave this provision of the ACA unchanged, unless the agency is willing to develop and implement corresponding, accommodating changes to inpatient and outpatient payment systems.

WIf you have any questions about these comments, please contact me at wellstk@trinity-health.org or 734-343-0824.

Sincerely,

Tonya K. Wells
Vice President, Public Policy & Federal Advocacy
Trinity Health