



AMERICAN ACADEMY OF  
ORTHOPAEDIC SURGEONS

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ORTHOPAEDIC SURGEONS

January 24, 2018

John R. Graham  
Acting Assistant Secretary for Planning and Evaluation  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, D.C. 20201

Re: “Promoting Healthcare Choice and Competition Across the United States”

Dear Assistant Secretary Graham,

On behalf of over 34,000 orthopaedic surgeons and residents represented by the American Association of Orthopaedic Surgeons (AAOS), we appreciate the opportunity to provide input on the Department of Health and Human Services’ (HHS) “Promoting Healthcare Choice and Competition Across the United States” Request for Information. AAOS shares the Administration’s desire to see meaningful burden reduction while preserving valuable competition and patient choice and fulfilling statutory obligations.

AAOS urges the Department to consider the following recommendations, which address the needs of our members and the mutual goal of delivering high quality care at affordable prices to patients.

**What State or Federal laws, regulations, or policies (including Medicare, Medicaid, and other sources of payment) reduce or restrict competition and choice in healthcare markets?**

*Physician-Owned Hospitals*

Expanding patient choice is a necessary step to improving quality of care. Section 6001 of the Affordable Care Act (ACA) restricts choice by limiting the ability of physician-owned hospitals (POH) to expand and serve Medicare and Medicaid patients. Under the law, physician-owned hospitals are limited to “the number of operating rooms, procedure rooms, and beds for which the hospital [was] licensed” at the time of enactment. The inability of physician-owned hospitals to address the growing demand for high-quality healthcare services in their community is bad for our entire healthcare system and penalizes patients who should have the right to receive care at the hospital of their choice.

Physician-owned hospitals have been shown to provide care that is equal to or better than the care provided by their non-physician owned community counterparts. In fact, in FY2017, 7 out of the top 10 and 40 out of the top 100 hospitals were physician-owned. A comprehensive peer-reviewed study published by the British Medical Journal found that, overall, “physician-owned

hospitals have virtually identical proportions of Medicaid patients and racial minorities and perform very similar to other hospitals in terms of quality of care.” Moreover, per the Centers for Medicare and Medicaid Services (CMS) Hospital Star Ratings Update in December 2017, 51.1 percent of physician-owned hospitals received 4 or 5 stars, while only 40 percent of non-physician-owned hospitals received the same. Mitigating the current restrictions on physician-owned hospitals would therefore give patients access to facilities that show greater capacity for patient satisfaction and demonstrably better-quality care.

Through its restriction on the expansion of facility capacity, section 6001 limits both patient choice to demonstrably better quality care, as well as restricts competition that could drive down both patient costs and costs to the government. An analysis by Avalon Health Economics found current physician-owned hospitals alone are saving Medicare \$3.2 billion over ten years.

AAOS has been working with Reps. Sam Johnson (R-TX) and Sheila Jackson-Lee (D-TX) as well as with Sen. James Lankford (R-OK) and others to advance legislation that would reverse these arbitrary restrictions and ensure Medicare and Medicaid patients have access to high-quality healthcare. AAOS also submitted comments to CMS regarding regulatory solutions to the problem. Further, AAOS asks CMS to consider state models that would waive the physician-owned hospitals restriction and test an innovative model for care delivery for Medicare beneficiaries.

Specifically, AAOS is supportive of a “Physician-led Hospital Demo” focused on issues such as reducing infections, preventing post-operative complications, and improving pain management and associated opioid utilization. One important element of this demonstration request would be combatting the nationwide opioid crisis. AAOS strongly believes that universally restricting opioid access directly harms patients whose conditions may require them. However, changing the medical community culture must instead start with evidence-based research demonstrating that opioid use can be limited without sacrificing outcomes and patient satisfaction. This demonstration would initially focus on spinal, heart, and joint surgical procedures, and implement the CMS Innovation demonstration goals of improving quality of care for Medicare beneficiaries while reducing costs. Physician-owned hospitals are uniquely positioned to lead such a demo.

#### *Site Neutrality*

Traditionally, Medicare uses different payment systems depending on the location where a beneficiary receives services (e.g., inpatient, outpatient, Ambulatory Surgical Center, emergency department, physician office). Having payments that vary by facility site derives from the idea of payment based on total resources used in provision of healthcare services, something that has long been a part of Medicare and Medicaid payments, and remains the central part of payment systems like the Physician Fee Schedule. Even for prospective payment systems like the

Outpatient Prospective Payment System and the Ambulatory Surgical Center (ASC) payment system, varying payment by site is part of the overall calculations.

However, significant variation is all too common in the Medicare payment system and has resulted in inefficient care, increased consolidation of physician practices into hospital systems (because the office for an employed physician can be deemed as an outpatient setting when the physician is paid staff for a hospital system), and increased costs to Medicare patients who face higher co-pays for outpatient services compared to services provided in an office setting. Thus, payment variation has an important impact on patient choice.

Recently, CMS and Congress have explored eliminating this approach in favor of site-neutral payments. AAOS is generally supportive of efforts to reduce payment differentials by site for the same services and has consistently commented to CMS and Congress that we believe significant differences in payments by site creates economic inefficiencies that result in unnecessary expenditures by payers like Medicare and Medicaid. We have been supportive of making payments for services furnished in the physician office or the ASC equal to payments in the outpatient setting. However, we have consistently recommended seeking this equilibrium not by bluntly reducing the outpatient payments to equal ASC or office payments but by also increasing payments in those settings toward a more middle ground.

Expanding site-neutral payment policy – and in particular, equalizing rates for office visits and in-office procedures as well as ASC procedures – will continue the progress made towards addressing healthcare inefficiency and choice while increasing necessary competition in the healthcare system.

**What State or Federal laws, regulations, or policies (including Medicare, Medicaid, and other sources of payment) may promote or encourage anticompetitive behavior in healthcare markets?**

#### *Antitrust*

Antitrust laws are designed to prevent restraints on trade that harm consumers and less powerful competitors. Any action the Department takes to counter anticompetitive behavior must ensure that the playing field is level for all participants. However, the issue of equal enforcement of antitrust laws and their applicability to physicians' negotiations with health insurance plans remains a matter of great concern for AAOS. Presently, the McCarran-Ferguson Act effectively exempts insurance companies from the very antitrust laws which physicians are required to follow. While at one time the exemption protected small insurance companies, today this has led to consolidation and concentration within the health insurance industry. This creates a system in which insurance companies, health plans, and hospitals have an unfair advantage in setting prices. Physicians are frequently placed in positions of diminished bargaining strength, and

health plans can impose unilateral, non-negotiable contracts. Instead, physicians should be allowed to share information and negotiate collectively with health plans.

Equitable negotiations between physicians and health insurance plans could be accomplished through a combination of two approaches. First, the currently introduced H.R. 372 (“Competitive Health Insurance Reform Act of 2017”) would amend the McCarren-Ferguson Act to ensure that federal antitrust laws apply to the business of health insurance. As was expressed in the March 21, 2017 Statement of Administration Policy, the bill “supports the goal of giving American families and businesses more control over their own healthcare choices by promoting greater health insurance competition.”

Second, further antitrust reform that levels the playing field and proactively protects healthcare professionals would ensure patient access to affordable healthcare is not compromised as a result of insurer monopsony. Absent the solution proposed in H.R. 372, AAOS believes healthcare professionals must be allowed to negotiate meaningful contracts that deliver high-quality health services and protect patient safety. Further, this approach would allow healthcare providers to engage in care coordination endeavors, including participation in Accountable Care Organizations and bundled payment models, without fear of antitrust prosecution. Toward this end, AAOS has supported past solutions like those contained in the Quality Health Care Coalition Act. Importantly, the collective negotiation rights contained in the Act would not extend to Medicare and Medicaid, and it would not grant healthcare providers the right to strike. Permitting physicians to have the same negotiating power as other market participants would stifle the current anticompetitive environment, stimulate higher-quality patient care, and do a better job freezing current health insurance market concentration.

State-based certificates of need (CON) represent an additional anticompetitive element of the current healthcare marketplace. The Department of Justice and Federal Trade Commission even issued a joint statement in January 2016 acknowledging that “it is now apparent that CON laws can prevent the efficient functioning of health care markets in several ways that may undermine” the goals of increasing access and reducing costs. AAOS has consistently encouraged states to repeal these outdated laws.

**What suggestions do you have for policies or other solutions (including those pertaining to Medicare, Medicaid, and other sources of payment) to promote or encourage the development of a more competitive healthcare market that provides high quality care at affordable prices for the American people?**

Apart from our detailed suggestions and initiatives discussed above, we would like to note that the current trend of consolidation in healthcare markets across the nation has created high barriers for accessing necessary care for the American people. With national healthcare expenditures increasing from 12.5 percent of GDP in 1990 to nearly 18 percent today, reducing healthcare expenditure is a top national priority. The shift from volume to value-based care

across Medicare, Medicaid, other public payers and the commercial health insurance markets has speeded consolidation of physician practices, hospitals, post-acute care providers, and others. Vertical and horizontal integration may be driven by strategic goals such as increasing market share, improving cost position for economy of scale, moving into another service category and acquiring talent. Huge healthcare systems (e.g. Mayo Clinic, Geisinger Health Systems), insurance companies (e.g. Aetna/Humana, Anthem/Cigna, and Centene/HealthNet) and even service providers such as DaVita Health Network have undertaken strategic acquisitions steadily in the last two decades. However, such consolidation has not reduced prices for consumers and may not have always improved quality or outcomes.

Physicians are concerned that they are increasingly losing leverage for negotiating a fair value for their services. The government has a role to play via effective policymaking. One solution to foster competition in provider markets involves encouraging independent medical practices. All models of medical practice should be enabled and incentivized. Medicare has taken several steps to ease participation and reporting burdens for small, solo, and rural medical practices in its Quality Payment Program (QPP) as well as via participation requirements in its innovative payment models. Such initiatives should continue in the public health insurance sphere and commercial players will follow the new direction. In tandem with these initiatives, states should address restrictions on anti-competitive practices such as anti-tiering restrictions, all-or-none contracting restrictions, and most favored nation clauses. All stakeholders including the government (both as regulator and payer), other payers, employers and consumers have a role to play in improving competition and efficiencies in the American healthcare markets.

Lastly, AAOS is encouraged by CMS's decision to convene an inter-agency task force to address the regulatory burdens created by federal anti-kickback laws. Current Stark prohibitions pose considerable barriers to care coordination in innovative payment models such as Merit-based Incentive Payment System (MIPS) and Alternative Payment Models.

Thank you for your time and consideration of the American Association of Orthopaedic Surgeons' suggestions to increase choice and competition in the current healthcare system. If you have any questions on our comments, please do not hesitate to contact William Shaffer, MD, AAOS Medical Director by email at [shaffer@aaos.org](mailto:shaffer@aaos.org).

Sincerely,

A handwritten signature in black ink, appearing to read "Wilford K. Gibson". The signature is written in a cursive, somewhat stylized font.

Wilford K. Gibson, MD

Chair, Council on Advocacy, American Association of Orthopaedic Surgeons

cc: Thomas E. Arend, Jr., Esq., CAE, AAOS Chief Executive Officer  
William O. Shaffer, MD, AAOS Medical Director  
Graham Newson, AAOS Director of the Office of Government Relations