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**STATEMENT  
of the  
Federation of American Hospitals  
to the  
U.S. House of Representatives  
Committee on Energy and Commerce  
Subcommittee on Health**

**Re: “What’s the Prognosis?: Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors”**

**October 19, 2023**

The Federation of American Hospitals (FAH) submits the following Statement for the Record in advance of the House Energy and Commerce (E&C) Health Subcommittee’s hearing on *What’s the Prognosis?: Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors*.

The FAH commends the Subcommittee’s leadership in exploring improvements in patient access and minimizing red tape for physicians. We believe some of the legislative proposals being considered by the Subcommittee are significant steps in achieving those goals. For example, the FAH supports the *Improving Seniors’ Access to Timely Care of Act of 2023*, which will greatly improve access to care for Medicare Advantage enrollees. However, the FAH is deeply concerned about the legislative proposal that would open the door for broad expansion of self-referral to physician owned hospitals – as this proposal would harm hospitals and significantly reduce patient access to care.

The FAH is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC, and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children’s, and cancer services.

We welcome the opportunity to work with the E&C Health Subcommittee to find solutions for improving patient access to care while minimizing red tape and appreciate the

opportunity to provide input on these key issues. We look forward to continued dialogue with the Subcommittee in collaborating to achieve these goals.

### **Rolling Back the Current Limits on Self-Referral to Physician-Owned Hospitals (POHs)**

#### ***Sunsetting Limits on POH (Physician Owned Hospitals) Expansion and Eliminating Key Patient Safety and Program Integrity Protections for Patients in Rural and Urban Areas.***

The FAH strongly opposes the draft legislative proposal to open the door to POH expansion. To help achieve the important goal of ensuring that rural communities have access to the care they need, including 24/7 emergency services, as well as lowering health care costs, it is important that Congress continue to reject efforts by those who seek to weaken the ban on self-referral to POHs. Such arrangements are mired in conflicts of interest. Years of independent data show such arrangements result in not only over-utilization of Medicare services at significant cost to patients and the Medicare program, but less care for vulnerable Americans.

There is a substantial history of Congressional policy development and underlying research on the impact of self-referral to POHs. The empirical record is clear that these conflicts of interest arrangements of hospital ownership and self-referral by owner physicians promote unfair competition and result in cherry-picking of the healthiest and well-insured patients, excessive utilization of care, and patient safety concerns. The standing policy reflects more than a decade of work by Congress, involving numerous hearings, as well as analyses by the Department of Health and Human Services (HHS) Office of Inspector General (OIG), the Government Accountability Office (GAO), and the Medicare Payment Advisory Commission (MedPAC).

In 2010, Congress acted to protect the Medicare and Medicaid programs and the taxpayers that fund them by imposing a prospective ban on self-referral to new POHs, limiting the expansion of existing POHs, and requiring POHs to comply with a range of requirements focused on patient safety and program integrity. The bill before the Committee today would eviscerate those protections and expose patients in rural, as well as urban areas, to the well-documented harms that led Congress to act. The FAH strongly believes that the foundation for the current law must not be weakened. It is noteworthy that Congressional Budget Office (CBO) scoring of proposals to modify existing law consistently demonstrates that self-referral to POHs increases utilization, which increases Medicare costs and health care costs generally. CBO concluded that the current ban reduced the Federal deficit by \$500 million. Today's bill would undoubtedly add to the deficit.

Importantly, the current law helps ensure that full-service community hospitals—including those in rural areas—can continue to meet their mission to provide comprehensive, quality care to all the patients in their communities. Data from the health care consulting firm Dobson | DaVanzo, released earlier this year,<sup>1</sup> shows that POHs, when compared to other hospitals, treat less medically complex patients as well as fewer Medicare and Medicaid patients, and provide fewer emergency services. Specifically, the study shows that:

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<sup>1</sup> Dobson | DaVanzo Study: [https://www.fah.org/wp-content/uploads/2023/03/2023-FactSheet\\_20230323\\_wAppendixandCharts\\_POH-vs.-NonPOH-Only.pdf](https://www.fah.org/wp-content/uploads/2023/03/2023-FactSheet_20230323_wAppendixandCharts_POH-vs.-NonPOH-Only.pdf).

- POHs cherry-pick patients by avoiding Medicaid beneficiaries and uninsured patients;
- POHs treat fewer medically complex cases;
- POHs enjoy patient care margins 15 times those of community hospitals;
- POHs provide fewer emergency services—an essential community benefit; and
- POHs, despite their claims of higher quality, are penalized the maximum amount by CMS for unnecessary readmissions at five times the rate of community hospitals.

This data reinforces many of the findings of earlier studies by the HHS OIG, GAO, and MedPAC, among others, documenting the conflicts of interest inherent with POHs that led to the Congressional ban in 2010.

CMS itself recently finalized the reimposition of “program integrity restrictions” on POH expansion criteria to guard against “a significant risk of program or patient abuse,” and to “protect the Medicare program and its beneficiaries, as well as Medicaid beneficiaries, uninsured patients, and other underserved populations, from potential harms such as (but not limited to) overutilization, patient steering, cherry-picking, and lemon-dropping.”<sup>2</sup>

Thus, maintaining current law—including limitations on the expansion of existing POHs—is key to ensuring that full-service community hospitals can continue to meet their mission to provide access to quality care to all patients in their communities – rural and urban. Weakening or unwinding the current ban opens the door to expanding the very behaviors that Congress successfully has deterred for more than a decade.<sup>3</sup>

***Protecting Access to Care in Rural Communities.*** The FAH is particularly concerned about proposals to eliminate POH protections for patients in rural areas, who are typically older, sicker and more reliant on Medicare and Medicaid. Under draft legislation “*To amend title XVIII of the Social Security Act to revise certain physician self-referral exemptions relating to physician-owned hospitals,*” rural hospitals that are already under significant financial stress, may be placed in further jeopardy by newly physician-owned “covered rural hospitals” that cherry-pick and lemon-drop patients. This is particularly alarming for rural hospitals which must rely on Medicare and Medicaid payments that fall far below the cost of care.

Every day across our nation, millions of Americans in small communities depend on rural hospitals for vital and lifesaving care. Rural hospitals are pillars of the communities in which they operate and are often the largest economic drivers in rural towns. As employers, rural hospitals provide vital jobs in communities, and their tax dollars support local public schools, firehouses, police stations, and other critical infrastructure. Rural hospitals support one in 12 rural jobs in the U.S. and generate \$220 billion in economic activity in rural communities.<sup>4</sup>

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<sup>2</sup> 88 Fed. Reg. at 59,304 (Aug. 28, 2023): <https://www.federalregister.gov/d/2023-16252/p-5555>. See also FAH Blog on POH. April 24, 2023: <https://www.fah.org/physician-owned-hospitals-are-bad-for-patients-and-communities/>.

<sup>3</sup> FAH Blog on POH: March 28, 2023. <https://www.fah.org/blog/new-analysis-reaffirms-need-to-maintain-current-law-banning-self-referral-to-physician-owned-hospitals/?swcfpc=1>.

<sup>4</sup> American Hospital Association (AHA), Rural Hospital Closures Threaten Access (Aug. 2022): <https://www.aha.org/system/files/media/file/2022/09/rural-hospital-closures-threaten-access-report.pdf>.

Rural hospitals have overcome constant economic challenges to deliver care to an estimated 60 million people,<sup>5</sup> while facing financial and operational challenges including growing inflation, a unique patient mix, low patient volume, a growing workforce crisis, and funding shortfalls, all of which were, and remain, exacerbated by COVID-19. These factors have contributed to the shuttering of 136 rural hospitals since 2010, including a record 19 closures in 2020 alone.<sup>6</sup>

The draft bill would create broad loopholes enabling new physician ownership of hospitals that threaten the viability of existing rural hospitals. For example, the draft bill would enable an existing non-POH to be converted to a POH based only on the proximity of the hospital's main campus to other hospitals at the time of its initial enrollment in Medicare, even if that hospital competes very directly with other nearby hospitals. This reality is the product of two significant loopholes in the legislation. First, the definition of a "covered rural hospital" looks only to the hospital's proximity to other hospitals at the time of Medicare enrollment. As a result, a hospital could qualify as a covered rural hospital and convert to a POH despite no longer meeting the statutory distance requirement simply because the improved roads or competitor hospital may have opened in the intervening years after the hospital's initial Medicare enrollment.

Second, the distance criterion for a "covered rural hospital" does not include distance limits for the hospital's additional practice locations. Thus, a new POH could establish or acquire a main campus that satisfies the distance criterion, but also acquire or build a second inpatient campus or extensive off-campus outpatient operations that are in close proximity to another hospital. In fact, those additional locations could be operated in a far-flung community that itself may not even qualify as rural and that is well served by existing hospitals. Last year, the FAH with the American Hospital Association (AHA) strongly opposed a request by a POH to expand into a competitive hospital market 55 miles from its main campus, noting that, if anything, the POH had failed to meet community needs near its main campus (despite having been previously received permission to expand on-campus capacity with 551 new operating rooms, procedure rooms, and beds under the "applicable hospital exception") and had failed to show the need or benefits of the proposed expansion in a community that is already well served by existing hospitals.<sup>7</sup>

Along similar lines, it is also concerning that the covered rural hospital exception would not include any requirements to serve the rural community. Rather, a covered rural hospital that does not qualify as a "rural provider" under section 1877(d)(3) because it largely serves a non-rural area could proceed under the so-called "whole hospital" exception under section 1877(d)(3). Such a hospital would not need to establish that "substantially all" of the designated health services it furnishes are furnished to individuals residing in a rural area, and in fact, as

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<sup>5</sup> FAH Blog on Rural Hospitals Week 2022: November 10, 2022: <https://www.fah.org/fah-celebrates-rural-hospital-week-2022/>.

<sup>6</sup> AHA Blog on Rural Hospital Closures: Sep. 8, 2022: <https://www.aha.org/news/headline/2022-09-08-aha-report-rural-hospital-closures-threaten-patient-access-care>.

<sup>7</sup> FAH and AHA Comments Opposing Expansion Request (CMS-1774-PN) (March 11, 2022): <https://www.fah.org/wp-content/uploads/2022/03/AHA-FAH-Comment.POH-Expansion-Exception-Request.03112022-1.pdf>.

described above, the hospital could even open a second inpatient campus or extensive outpatient services in a non-rural area.

***Protecting Patient Safety and Program Integrity in Rural Areas.*** The FAH also strongly opposes any initiative to limit key patient safety protections and program integrity requirements that have governed POHs for more than a decade. These protections and requirements are found in section 1877(i)(1)(C) through (E) of the Social Security Act. Under the draft bill, a covered rural hospital would no longer be subject to any of the requirements of subsection (i)(1). By way of example this includes key requirements involving patient safety, transparency, and conflicts of interest, as follows:

- *Physician Availability:* POHs are currently required to disclose and obtain patient consent with a signed acknowledgment if the POH does not have a physician available during all hours that the hospital provides services to the patient.
- *Emergencies and Complications:* POHs must have the capacity to provide assessment and initial treatment and to refer and transfer patients to hospitals with capacity.
- *Conflict of Interest Disclosure Policies:* POHs are required to implement procedures requiring referring physician owners or investors to disclose ownership and investment interests to the patient being referred with enough time for the patient to make a meaningful decision regarding care.
- *Conflicts of Interests and Program Integrity:* POHs are prohibited from conditioning ownership or investment on influencing referrals or otherwise generating business for the hospital.
- *Public Notice and Conflicts of Interest:* Each POH must disclose that it is partially owned or invested in by physicians on its public website and in public advertising.

Furthermore, from the standpoint of program integrity, since 2010, POHs have been required to ensure that referring physicians' ownership and investment interests are in fact *bona fide* ownership or investment interests. For example, the hospital cannot offer investment or ownership to physicians on more favorable terms than the terms offered to a non-physician and returns must be distributed to each owner or investor in the hospital in an amount that is directly proportional to the ownership or investment interest.<sup>8</sup>

These patient safety protections, transparency and disclosure requirements, conflict of interest protections, and program integrity provisions were the product of years of research into the harmful impacts of overutilization, patient steering, cherry-picking, and lemon-dropping by POHs and Congress' considered decision to protect patients and the Medicare trust fund by establishing targeted and pragmatic compliance requirements for POHs. Exempting covered rural hospitals from these requirements invites significant risk for patients in the rural (and non-rural) communities served by POHs that qualify as covered rural hospitals. These POHs might be existing POHs that have complied with these requirements for the past 13 years, as well as existing non-POHs hospitals that convert to physician ownership or investment under the covered rural hospital exception and new POHs established under this exception. Rural communities should not face the risk of being admitted to a POH that, for example, cannot

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<sup>8</sup> Social Security Act Sec. 1877(i)(1)(D)(ii) and (v).

provide assessment and initial treatment should complications or emergencies arise. Nor should a patient be referred to a POH without knowledge of their referring physician’s ownership and investment interest. These baseline protections should apply with full force to all POHs, whether in a rural or non-rural area.

As the Subcommittee considers legislation to fine-tune Medicare payment to best serve seniors and strengthen the program, we urge you to consider the negative consequences of any legislation that lifts or creates exemptions on the existing POH bans.

### **Improving Seniors’ Timely Access to Care Act of 2023**

The FAH is increasingly concerned by the alarming practices of Medicare Advantage (MA) and other insurance plans that harm patients by eroding access to and affordability of medically necessary care, and require hospitals and caregivers to divert precious resources and time to respond to these tactics. And for small rural hospitals, in some states these hospitals are realizing greater financial losses on services provided to MA patients than those with original Medicare.<sup>9</sup>

Some of these concerns were included in an HHS OIG Report<sup>10</sup> showing that MA organizations (MAOs) systemically apply problematic operating policies, procedures and protocols that limit care for MA enrollees. The OIG Report also identifies a pattern by which MAOs apply utilization controls to improperly withhold coverage or care from MA enrollees. Specifically:

- *Improper prior authorization denials.* The OIG found that 13 percent of prior authorization requests denied by MAOs would have been approved for beneficiaries under original Medicare.
- *Improper denials for lack of documentation.* The OIG found that in many cases beneficiary medical records were sufficient to support the medical necessity of the services provided.
- *Improper payment request denials.* The OIG found that 18% of payment requests denied by MAOs actually met Medicare coverage rules and MAO billing rules.

These OIG findings reflect a broader pattern of MAO practices that inappropriately deny, limit, modify or delay the delivery of or access to services and care for MA beneficiaries. CMS also recently acknowledged many of these concerns in a December 2022 proposed rule regarding improving prior authorization processes and an April 2023 final regulation with MA policy

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<sup>9</sup> <https://ruralhospitals.chqpr.org/Problems.html#profits-and-losses-based-on-type-of-private-insurance-in-california>.

<sup>10</sup> Christi A. Grimm, U.S. Department of Health and Human Services Office of the Inspector General (“OIG”), OEI09-18-00260, “Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care” (April 2022), <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf>.

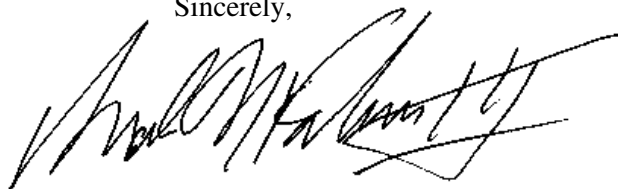
changes<sup>11</sup> that would constrain some of the bad behaviors MA plans employ related to prior authorization and non-coverage of items and services that would be covered for beneficiaries under the traditional Medicare fee-for-service program.

As the Health Subcommittee explores ways to ensure timely access to care for Medicare Advantage enrollees, we urge you to investigate these practices and, at a minimum, exercise oversight authority to help protect patients against harmful MA plan behaviors through, for example, prior authorization reforms and comprehensive provider networks.

We commend the Subcommittee's leadership and focus today on the *Improving Seniors' Timely Access to Care Act of 2023*, which addresses many of these shortcomings by reducing unnecessary delays and denials of patient care while giving health care providers and clinicians greater ability to treat patients in a timely manner. And we urge Congressional passage of this important legislation and look forward to working with you and your colleagues in Congress to protect patients' access to affordable health care services.

If you have any questions or would like to discuss these comments further, please do not hesitate to contact me or a member of my staff at (202) 624-1534.

Sincerely,

A handwritten signature in black ink, appearing to be "Andrew R. Lewin", written in a cursive style.

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<sup>11</sup> <https://www.cms.gov/newsroom/press-releases/cms-proposes-rule-expand-access-health-information-and-improve-prior-authorization-process>; <https://www.cms.gov/newsroom/fact-sheets/2024-medicare-advantage-andpart-d-final-rule-cms-4201-f>.