ForrestGeneral
HOSPITAL

May 31, 2011

Mr. Donald S. Clark
Federal Trade Commission
Office of the Secretary
Room H-113 (Annex W)
600 Pennsylvania Avenue, N.W.
Washington, DC 20580

Re: Proposed Statement of Antitrust Enforcement Policy Regarding ACOs Participating in the Medicare Shared Savings Program, Matter V100017

Forrest County General Hospital (FGH) is pleased to provide these comments to the Federal Trade Commission and the Antitrust Division of the U.S. Department of Justice (collectively, the Antitrust Agencies) regarding the Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations (ACOs) Participating in the Medicare Shared Savings Program (Proposed Statement).[1]

ABOUT FGH

FGH is a 512-bed community hospital operated by a county-appointed Board of Trustees.[2] Located in Hattiesburg, Mississippi, FGH is the flagship facility of the Forrest General Health System. FGH opened in 1952 as a 90-bed hospital with a staff comprised of 70 employees and 31 doctors. Since 1952, FGH has grown from the original 90-bed single facility into a multi-facility 607-bed Level II regional trauma center hospital system (the Forrest General Health System), which employs more than 3,350 people and has a medical staff of more than 260 physicians.

FGH provides inbound tertiary services to patients referred from seven critical access hospitals in FGH's 19-county primary and secondary service areas. FGH has been a Rural Referral Center (RRC) in accordance with Medicare regulations since before 1991. This means, among other things, that FGH receives higher disproportionate share payments (based on an urban classification) because it has operating costs that are more similar to urban hospitals than to rural hospitals (due to bed size, large number of complex cases, high numbers of discharges, and large number of referrals from other hospitals or from physicians outside FGH's service areas). Since the time that FGH received RRC status, the U.S. Office of Management and Budget

[1] 76 Fed. Reg. 21894 (Apr. 19, 2011).

[2] FGH was established by Forrest County, Mississippi as a "community hospital" as defined by and pursuant to Section 41-13-10 *et seq.* of the Mississippi Code of 1972, as amended and supplemented from time to time.

P.O. Box 16389 • Hattiesburg, MS 39404-6389
6051 Highway 49 • Hattiesburg, MS 39401-7243
(601) 288-7000 • www.forrestgeneral.com

subsequently reclassified the Hattiesburg area as an urban metropolitan statistical area, but FGH still qualifies as an RRC under Medicare grandfathering rules. Although technically located in an urban area, FGH operates in more of a urban/rural area given the distribution of population and the fact that many of the counties served by FGH continue to be rural areas.

BACKGROUND

The characteristics of health care in rural communities are different than in urban areas. Patients tend to be older and poorer in rural communities and suffer from more chronic illnesses (e.g., diabetes), conditions (e.g., obesity), and health-related behaviors (e.g., smoking).[3] Community hospitals generally serve as the hub for a region's health care services.[4] The provision of health care to rural populations is often complicated by various factors including remote geographic locations of providers, highly fragmented or unaligned providers, limited workforces, physician shortages in primary care and specialties, and constrained financial resources.[5] Contributing to the limited resources is the fact that providers serving rural areas are highly dependent upon public programs (e.g., approximately 60% of rural hospital gross revenues come from Medicare and Medicaid), and they service large uninsured populations, which results in significant charity write-offs and bad debts.[6]

In recognition of the unique circumstances of hospitals that service rural areas and their dependence on Medicare funds, certain types of hospitals have been subject to special payment policies intended to provide increased Medicare payments and alleviate doubts that they could survive under the Medicare Prospective Payment System alone. Hospitals eligible for additional payments include, among others, critical access hospitals (CAHs), sole community hospitals (SCHs), and rural referral centers (RRCs). Designation as a CAH, SCH, or RRC is subject to specific eligibility requirements in Medicare regulations.[7]

Notwithstanding the challenges faced by hospitals serving rural areas—and perhaps because of them—participation in collaborative arrangements and strategic alliances (including through ACOs) is perceived as holding significant potential for improving quality of care, while at the same time reducing cost of care for rural populations.[8] Yet, despite the possibilities, it is far from

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[3] *See* Am. Hosp. Ass'n, The Opportunities and Challenges for Rural Hospitals in an Era of Health Reform, TrendWatch 2 (Apr. 2011); Quality Through Collaboration: The Future of Rural Health Care 38-39 (IOM, 2005) [hereinafter *Future of Rural Health*].

[4] *See Opportunities and Challenges for Rural Hospitals*, *supra* note 3, at 1; *Future of Rural Health*, *supra* note 3, at 64.

[5] *See Opportunities and Challenges for Rural Hospitals*, *supra* note 3, at 1; *Future of Rural Health*, *supra* note 3, at 39-40.

[6] *See Opportunities and Challenges for Rural Hospitals*, *supra* note 3, at 4; *Future of Rural Health*, *supra* note 3, at 127.

[7] *See* Social Security Act § 1820; 42 C.F.R. §§ 412.92, 412.96.

[8] *See generally Opportunities and Challenges for Rural Hospitals*, *supra* note 3; *Future of Rural Health*, *supra* note 3.

certain whether hospitals serving rural areas will seek to form or participate in ACOs under the current proposed rules. There are many barriers. These comments address what FGH perceives to be significant barriers in the Antirust Agencies' Proposed Statement to involvement by RRCs in ACOs seeking to participate in the Medicare Shared Savings Program (MSSP).

COMMENTS

FGH believes that an appropriate antitrust policy for ACOs must account for the unique circumstances and challenges of rural health care delivery, while at the same time allowing for a rigorous assessment of the ACO's likely impact on competition. To that end, FGH appreciates the Antitrust Agencies shared efforts to provide greater clarity and guidance concerning the antitrust analysis of ACOs that involve providers serving rural areas. The rural exception to the "market" share screen in the Proposed Statement seems to be an acknowledgment of the unique characteristics of rural providers and settings, and, as a result, it is an important component of the guidance that may be intended to facilitate participation by rural providers in ACOs.[9] However, as discussed below, the limitation of the rural exception to CAHs and SCHs (defined as Rural Hospitals in the Proposed Statement) is confusing and arguably leads to increased barriers to participation in ACOs by other types of rural providers.

At a minimum, the rationale for limiting the definition of Rural Hospitals to CAHs and SCHs is not clear and should be explained. In order to provide the intended antitrust clarity and guidance that is needed for providers to form procompetitive ACOs, it would be useful to understand the basis not only for the limitation to, but also for the exclusion of other types of hospitals from, the definition of "Rural Hospitals" as set forth in the Proposed Statement.

FGH also believes that exclusion of RRCs from possible safety zone treatment creates disincentives for RRCs to form or join ACOs. RRCs are uniquely situated to form and participate in ACOs under the MSSP, and could provide significant opportunities for the Medicare program to achieve its three-part aim of better care for individuals, better health for populations and lower growth in expenditures in rural communities. Many RRCs tend to have characteristics and capabilities of urban or more integrated delivery systems. They often have access to more resources, infrastructure, and know-how that can be leveraged for purposes of creating ACO platforms. They also tend to have larger numbers of discharges, covering a wider range of services furnished to geographically dispersed populations (as a result of the referral of patients from CAHs), and larger medical staffs than other types of rural providers. All of these characteristics make RRCs the ideal type of hospital to become involved with an ACO.

However, for the same reason that RRCs are particularly poised to form or participate in ACOs, FGH is concerned that including them in an ACO is likely almost always to require mandatory antitrust review under the Proposed Statement. RRCs effectively provide the structural and financial foundation for broad-based collaboration with other rural hospitals, physician group practices, clinics and other types of providers. Thus, because of their very nature as a larger

[9] The Proposed Statement does not purport to assess true antitrust markets, but instead seeks to analyze primary service areas (PSAs) and PSA shares as proxies for markets and market power.

referral intake facility, including RRCs in an ACO could yield high PSA shares for services furnished in common with the other participants.[10]

FGH is mindful of the need to protect competition and to have an appropriate framework for assessing risks to competition that may be presented by ACOs seeking to participate in the MSSP and in commercial markets. However, a framework that appears to require mandatory antitrust review of any ACO involving a particular type of provider may be disproportionately biased against those providers, while, at the same time, resulting in a competitive advantage to competing ACOs that include smaller providers. The framework also creates too rigid a standard to provide useful guidance or clarity to entities that wish to set up procompetitive ACOs short of having to pass through, what many fear will be an expensive and complicated, antitrust review process. Rather than promoting or facilitating participation by the type of hospital most ideally-situated to form or participate in ACOs, the Proposed Statement effectively precludes it.

Mandatory antitrust review could be the death knell for many ACOs involving RRCs. The framework established by the Proposed Statement requires the ACO to present a case against the presumption ("the valuable indication") that the high shares reflect the potential for competitive harm. In many instances, due to the unique characteristics and conditions of health care furnished in rural areas, there may well be substantial procompetitive benefits and justifications or alternative data showing that the PSA shares for ACOs that include RRCs do not accurately reflect the ACO's "market" power. However, FGH believes that few entities will be interested in assuming the large expense, burden and risk of rebutting a presumption of the potential for competitive harm, particularly in light of the fact that antitrust clearance from mandatory review is a gating item for eligibility to participate in MSSP.

For these reasons, FGH urges the Antitrust Agencies to reconsider the framework under which an ACO with an RRC participant would be analyzed. One option would be to expand the definition of Rural Hospitals for purposes of applying the rural exception under the Proposed Rule to include RRCs. Such a proposed expansion of the exception would be quite narrow in effect as there are only 125 hospitals (out of 5,000) that qualify for RRC status (compared to the 1,325 CAHs and 395 SCHs). Alternatively, the Antitrust Agencies could provide a more flexible framework for analyzing ACOs that reduces (to the extent possible) the burdens of antitrust review of ACOs involving RRCs.

As their name implies, RRCs provide important services for patients referred by small rural community hospitals, and an antitrust framework that creates barriers to inclusion of RRCs in ACOs would clearly frustrate the objectives of the MSSP. We appreciate the opportunity to submit comments on the Proposed Statement. We hope they are helpful in highlighting some of the effects the Proposed Statement could have on ACOs that seek to include RRCs.

Respectfully submitted,

[10] High PSA shares could result in ACOs that include RRCs and surrounding CAHs / SCHs or from those that include RRCs and physician practices, or some combination of the both.