



April 29, 2014

By Electronic Submission (<https://ftcpublic.commentworks.com/ftc/healthcareworkshop>)

Federal Trade Commission
Office of the Secretary
Room H-113 (Annex X)
600 Pennsylvania Avenue NW
Washington, DC 20580

Re: Health Care Workshop, Project No. P131207

To Whom It May Concern:

Adventist Health System (AHS) welcomes the opportunity to submit comments to the Federal Trade Commission (FTC) in response to the March 2014 Public Workshop: "Examining Health Care Competition."

AHS is the nation's largest not-for-profit Protestant health care provider. Our organization includes 44 hospital campuses that are spread across 10 states and comprises more than 7,700 licensed beds. AHS provides inpatient, outpatient and emergency room care for four million patient visits each year.

As a leading health care system, AHS is dedicated to achieving the Triple Aim of the health reform legislation known as the Affordable Care Act (ACA). AHS strives to improve the health of the communities we serve by providing accessible, affordable and high quality health care. In the following comments, we provide a brief synopsis of our viewpoint on each of the issue areas covered by the FTC's recent public workshop.

Professional Regulation of Health Care Providers

Many regions of the country, especially rural communities, already face noticeable shortages of nurses and physicians. This shortage is forecasted to become more prominent in the coming years. Some reports indicate that, by 2025, the United States could face a shortage of 130,600 doctors¹ and 260,000 nurses.²

Solving these shortages will require expanding medical education capacity. AHS believes that additional state and federal funding should be allocated for Graduate Medical Education (GME). Also, GME funding processes should be evaluated and updated in order to ensure that funding is allocated proportionally according to regional need.

¹ Association of American Medical Colleges (2010). Physician shortages to worsen without increases in residency training. Retrieved from website: https://www.aamc.org/download/153160/data/physician_shortages_to_worsen_without_increases_in_residency_tr.pdf

² American Association of Colleges of Nursing (2014). Nursing shortage fact sheet. Retrieved from website: <http://www.aacn.nche.edu/media-relations/NrsgShortageFS.pdf>

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Regulatory changes to expand the scope of practice of medical professionals, especially Advanced Registered Nurse Practitioners (ARNPs) and Physician's Assistants (PAs), have been proposed as a possible solution to caregiver shortages. AHS thinks that these changes can help rural areas and other communities that suffer from limited access to primary care providers. However, reimbursement models and scope of practice regulations must be designed to encourage these professionals to provide primary care services and help improve access to affordable care in rural or otherwise underserved communities.

AHS is concerned that imprudently expanding the scope of practice of ARNPs and PAs could lead to a further proliferation of medical specialists in more densely populated communities, as already seen amongst specialist and subspecialist physicians. This is problematic for two reasons:

- 1) This does not solve the access to care issues experienced by rural communities as well as other underserved, disadvantaged and vulnerable populations.
- 2) Higher concentrations of specialists drive up medical service utilization rates and lead to higher average per capita health care expenditures.

The regions of the U.S. with the highest per capita concentrations of specialist physicians also have the highest average per capita Medicare expenditures. However, these regions do not achieve comparative improvements in health care accessibility or quality.³

It has been found that regional differences in health care expenditures are not caused by health care prices, differences in average illness levels or socioeconomic status. In fact, greater regional average per capita health care expenditures are "due to the overall quantity of medical services provided and the relative predominance of internists and medical subspecialists in high-cost regions."⁴ Conversely, the regions with the most primary care physicians per capita have the lowest average per capita Medicare expenditures.⁵

The current fee-for-service reimbursement model provides fiscal incentives for specialized medical professionals to practice in wealthier and more densely populated areas where they can provide higher volumes of procedures. There is a high likelihood that non-physician practitioners will also concentrate in urban areas if permitted by regulatory changes. For this reason, proposals that would expand the scope of practice of ARNPs and PAs must be designed to encourage these medical professionals to provide primary care services in underserved communities. An irresponsible expansion of the scope of practice of ARNPs and PAs could counteract efforts to improve health care accessibility and reduce per capita health care expenditures.

Other proposed regulatory changes include greater state-to-state licensure portability. AHS is concerned that this could lead to further regional concentrations of medical professionals and exacerbate over-utilization issues. Additionally, AHS wonders which governing body would be responsible for regulating providers licensed in one state yet practicing in another. State-to-state licensure portability may hinder regulators' ability to fulfill their responsibility. AHS also worries that state-to-state licensure portability could allow a medical professional with an unsatisfactory quality record to cross state lines in order to evade their negative reputation and continue practicing despite patient safety risks.

^{3, 4, 5} Fisher ES, Wennberg DE, Stukel TA, et al. The implications of regional variations in Medicare spending. Part 1: The content, quality, and accessibility of care. *Ann Intern Med* 2003; 138(4): 273-87.

Innovations in Health Care Delivery

The ACA has initiated sweeping reforms to the way health care is delivered in the United States. These reforms seek to create innovative health care delivery and payment models that encourage health care providers to improve population health, advance quality and reduce costs. However, government regulations must change in order to boost innovation and facilitate the emergence of new health care delivery models.

The current regulatory approach was designed for a fee-for-service model of health care reimbursement. Regulations, such as the Stark Law and the False Claims Act, prevent health care providers from working together to coordinate health care services across the delivery spectrum. This prolongs the fractured nature of the U.S. health care system, encourages a volume-based rather than value-based delivery system and undercuts the goals of health reform.

More extensive and better articulated regulatory safe harbors are needed to facilitate the innovation and coordination required to improve the U.S. health care delivery system. For example, hospitals and physicians must be able to develop collaborative programs that incentivize the provision of high value health care services and reduce overall per capita health care expenditures. This alignment is currently barred by Stark Law.

In addition, uncertainty about the FTC's positions on vertical integration amongst health care providers may stifle innovation. Many of the programs promoted by the ACA, such as Accountable Care Organizations (ACOs) and Medicare Shared Savings Programs (MSSPs), encourage provider integration. However, the threat of future FTC interventions may discourage leading health care organizations from testing innovative models.

In the recent *St. Alphonsus Medical Center* case, the court found that:

[i]n a world that was not governed by the Clayton Act, the best result might be to approve the [acquisition of the multispecialty physician practice] and monitor its outcome to see if the predicted price increases actually occurred. In other words, the [acquisition of the physician practice] could serve as a controlled experiment. But the Clayton Act is in full force, and it must be enforced. The [Clayton] Act does not give the Court discretion to set it aside to conduct a health care experiment.⁶

AHS thinks that this a strong example of the need for broader and more clear regulatory safe harbors in order to foster the innovation necessary to achieve the goals of health reform.

Advancements in Health Care Technology

AHS is concerned that the lack of open Electronic Health Records (EHR) platform technology has become a chronic impediment to the smooth flow of health information. Additionally, the financial impediments of getting one vendor's EHR platform to speak to another's platform disrupts the exchange of health information and puts an undue financial burden on providers, especially small physician group practices. There is a need for a universal intermediary system or communication protocol that can facilitate a smooth and inexpensive exchange of medical information.

⁶ *St. Alphonsus v. St. Luke's*, No. 1:13-CV-00116-BLW (D. Idaho Jan. 24, 2014)
<http://www.ftc.gov/system/files/documents/cases/140124stlukesfindings.pdf>

Additionally, AHS has concerns about regulations regarding technological and professional standards for telemedicine. AHS is of the opinion that these regulations should be established by a panel of medical experts and specialists in order to account for the nuances of the vast variety of health care fields and services. AHS thinks that blanket telemedicine regulations are ineffective and dangerous. Patient safety risks and other particulars should be addressed via standardized credentialing for each telemedicine specialty.

Measuring and Assessing Quality of Health Care

AHS is very concerned that a failure to account for patient socioeconomic and sociodemographic complexity unjustly penalizes the health care providers that serve the most disadvantaged patients and can undermine consumers' ability to make informed health care decisions.

AHS believes that failing to adjust performance measures for patient socioeconomic status and other sociodemographic factors causes incorrect conclusions about health care quality. Research indicates that sociodemographically complex patients are at a higher risk of negative health care outcomes such as rehospitalizations.⁷ This is attributed to a number of confounding factors including limited transportation options, precarious housing situations and restricted access to primary care due to inadequate liquid assets.⁸ Failing to adjust for these risk factors renders quality performance measures inaccurate.

Large urban hospitals, many of which are safety net hospitals, are among the providers most negatively affected by the lack of risk adjustment for these confounding socioeconomic and sociodemographic factors. As a result of these inaccurate measures, quality incentive programs redirect scarce resources from large urban hospitals to suburban hospitals and other providers that serve less sociodemographically complex patient populations.⁹ This erodes the fiscal solvency of the providers that care for the most disadvantaged communities. AHS is very concerned that, without corrective action, this will further escalate health care disparities in this country.

AHS is also worried that a lack of risk adjustment for socioeconomic and sociodemographic factors may prevent consumers from making informed health care decisions. Without such risk adjustment, publicly reported performance measures do not portray health care providers' true underlying quality of care. Studies have indicated that consumers and payers will tend to avoid providers that serve greater populations of disadvantaged patients due to lower publicly reported performance scores.¹⁰ This can have dangerous consequences. Patients suffering from complex acute conditions may misguidedly choose to avoid the large tertiary hospitals most capable of handling highly complex cases in favor of hospitals accustomed to serving less complex patient populations.

Health care providers across the United States are striving to improve the health of the populations they serve, advance the quality of care they deliver and reduce the per capita costs of health care services. In our own efforts to achieve this Triple Aim, AHS has found that the interactions that take place within the walls of health care facilities are only one piece of the puzzle. The reality of health care is that economic, demographic and societal factors are just as critically important to patient health and wellness as clinical factors.

^{7,8} Link BG, Phelan J. Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior* 1995; 35: 80-94.

⁹ Joynt KE, Orav EJ, Jha AK. Thirty-day readmission rates for Medicare beneficiaries by race and site of care. *JAMA* 2011; 305(7): 675-681.

¹⁰ Haider AH, Pronovost PJ. Health information technology and the collection of race, ethnicity, and language data to reduce disparities in quality of care. *Joint Commission/Journal on Quality and Patient Safety* 2011; 2011/10/22: 435-436.

AHS believes that accountability is a crucial aspect of the improvement process because: ‘what gets measured – gets done.’ Quality measures are vital to ensuring that health care organizations are accountable for the health and wellness of their patients. Unclear and unjust quality measures have a dangerous potential to harm and hinder provider improvement efforts. In addition, these measures create a negative incentive to treat high-risk patient populations and have the potential to worsen health care disparities.

Price Transparency of Health Care Services

Health care pricing transparency has become the recent focus of much discussion. For the most part, this conversation has centered on the Medicare billing datasets recently released by the Centers for Medicare & Medicaid Services (CMS) and the wide variance in hospital charges. This data was released with the intention of increasing transparency in the U.S. health system. However, it instead illustrates the complexity of health care pricing and the challenges consumers face when seeking clarity about health care costs.

Health care price transparency is a very complex subject because the definition of meaningful information depends on the stakeholder. Patients, purchasers, and providers each have very different perspectives. For patients, the most important price information is their out-of-pocket costs such as co-pays and deductibles. Health care purchasers, including insurance plans, employers, and Medicare, see health care prices as the total expenditure for covered services. Hospitals and other health care providers view pricing information as a balancing act between regulations, financial considerations and diverse stakeholder values.

The CMS data includes hospital “charges,” the prices billed to Medicare. CMS requires that hospitals have a uniform list of prices, called the “charge master.” However, charges neither represent the actual amounts that hospitals are paid nor the actual financial obligations of the patient.

Private health insurance groups typically negotiate discounted payment rates with hospitals. Conversely, Medicare hospital payment rates are non-negotiable. They are set by laws and administrative rules. Medicare pays hospitals a lump sum payment for each patient. The payment amount is determined using a complicated formula based on the Diagnostic Related Group (DRG) for the patient’s medical condition.

The amount that a patient actually pays depends on two primary factors: the nature of patients’ health insurance coverage and the complexity of their condition. Patients’ health care coverage, whether it is private insurance or a public payer such as Medicare, determines the co-pays and deductibles they may be responsible for paying out-of-pocket. The financial obligation for uninsured patients is usually based on their household incomes. (AHS provides charity discounts for patients with annual household incomes up to 400% of the federal poverty level, about \$95,000 for a family of four.)

AHS thinks that the real health care price transparency issue is not charges; instead, it is a question of how best to translate price and quality data into meaningful information. Patients, purchasers and referring clinicians should be able to use this information to compare options and make value-based health care decisions. Price transparency information must clearly explain to patients their out-of-pocket costs as well as quality information such as the risk of harm and expected recovery time. AHS also believes that meaningful information includes more than just transactional costs. It is important to understand the intrinsic value behind health care options. Some options may cost more upfront but offer long-term savings due to shorter recovery times and a reduced risk of complications.

Sincerely,

Richard E. Morrison
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Adventist Health System