CAHPR CENTER FOR ADVANCING HEALTH POLICY THROUGH RESEARCH

School of Public Health
BROWN UNIVERSITY

June 4, 2024

The Honorable Jonathan Kanter
Assistant Attorney General
Antitrust Division
U.S. Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20503

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

The Honorable Lina Khan
Chair
Federal Trade Commission
600 Pennsylvania Ave, NW
Washington, DC 20580

RE: Comments on the Request for Information (RFI) on Consolidation in Health Care Markets

Dear Assistant Attorney General Kanter, Secretary Becerra, and Chair Khan:

On behalf of the Brown University Center for Advancing Health Policy through Research (CAHPR), we thank you for the opportunity to provide feedback on your cross-government efforts to seek information on the impacts of consolidation in health care. CAHPR is an evidence-based, nonpartisan research and policy center that aims to make fundamental contributions toward understanding and developing policies that will lower spending growth, improve patient outcomes, and drive structural change in health care delivery in the United States.

Our Center's team of investigators has been researching the impacts of provider vertical integration and the increase of private equity in health care markets on health care spending, access to care, and the variability of providers. The Center's goal in this research is to help inform policymakers on how hospital and corporate ownership changes the intensity of care, quality of care, provider staffing, and prices. We hope our research will inform policymakers on potential options to address these concerns.

Health care spending per capita in the U.S. has increased from $8,877 to $13,493 between 2012 and 2022.[1] The U.S. leads global health care spending, both in terms of per capita expenditure and as a percentage of GDP, nearly doubling that of similar nations as of 2021.[2] Much of this growth in expenditure can be attributed to health care consolidation,[3] which leads to higher prices for private insurance and Medicare by changing referral patterns.[4,5] In addition to increased prices, health care consolidation has been linked to decreases in care quality.[5,6]

As a result of decades of consolidation, U.S. health care markets are among the most concentrated of any major industry. A single health system dominates many markets. Hospital markets in 90 percent of US metropolitan areas

1 McGough M, Winger A, Rakshit S, Amin K. How has U.S. spending on healthcare changed over time? *Peterson-KFF Health System Tracker*. December 15, 2023. Accessed March 12, 2024.

2 Gunja MZ, Gumas ED, Williams II RD. U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes. *The Commonwealth Fund*. January 31, 2023. Accessed March 12, 2024.

are above concentration levels considered highly non-competitive by regulators.[3] A single insurer commands more than 50% of the market in two-thirds of US metro areas.[4]

While health care provider consolidation has traditionally been driven by hospital and physician group mergers and acquisitions, private equity (PE) has rapidly entered into health care markets over the past couple decades, accelerating the consolidation of key sectors of the health care markets, including a range of health care providers.[5,6] PE firms have spent hundreds of billions of dollars to acquire physician practices, hospitals, nursing facilities, and other health care providers.[7] The entry of PE into health care markets has become a growing cause of concern, as research has shown that PE acquisitions significantly drive up health care prices and spending, alter workforce composition[8] and morale,[9] and adversely affect patient access to care and safety.[10,11]

Below are CAHPR's responses to the specific RFI questions. The responses represent the views of faculty members affiliated with CAHPR at the Brown University School of Public Health. As a team of health economists, health services researchers, and lawyers, we hope our responses are helpful as you continue to investigate the impacts of consolidation.

Effects of Health Care Consolidation

Health care consolidation in the U.S. has experienced several waves. Beginning in the late 1990s, U.S. hospitals began rapidly consolidating and forming large, and often multi-state, health systems. Faced with a series of judicial losses and dwindling enforcement resources, antitrust authorities were unable to slow the rapid consolidation of U.S. hospital markets. As of 2016, the mean Herfindahl–Hirschman Index (HHI), a metric commonly used to measure market concentration, for hospital markets was greater than 5,500, which is considered "super concentrated, " and 90 percent of hospital markets in the U.S. were highly concentrated.[12] The trend has continued, with a large majority of hospitals and hospital services being provided by large health systems, rather than by

3 Fulton BD. Health Care Market Concentration Trends In The United States: Evidence And Policy Responses. *Health Affairs*. 2017;36(9):1530-1538. https://doi.org/10.1377/hlthaff.2017.0556

4 95% of U.S. health insurance markets are "highly concentrated. *American Medical Association*. Published January 10, 2024. Accessed April 18, 2024.

5 Schwartz K, Lopez E, Rae M, Neuman T. What We Know About Provider Consolidation. *KFF*. September 2, 2020. Accessed March 12, 2024.

6 Appelbaum E, Batt R. Private Equity Buyouts in Healthcare: Who Wins, Who Loses? Center for Economic and Policy Research Working Paper No. 118. Published 2020. Accessed March 13, 2024. https://www.cepr.net/report/private-equity-buyouts-in-healthcare-who-wins-who-loses/

7 Scheffler, R., Alexander, L., & Godwin, J. Private Equity Investments Soaring in Healthcare: Consolidation Accelerated, Competition Undermined, And Patients At Risk. American Antitrust Institute. Published 2021, Accessed May 20, 2021

8 Bruch JD, Foot C, Singh Y, Song Z, Polsky D, Zhu JM. Workforce composition in private equity–acquired versus non–private equity–acquired physician practices. *Health Affairs*. 2023;42(1):121-129. https://doi.org/10.1377/hlthaff.2022.00308

9 Zhu JM, Zeveney A, Read S, Crowley R. Physician Perspectives on Private Equity Investment in Health Care. *JAMA Intern Med*. Published online March 11, 2024. https://do.org/10.1001/jamainternmed.2024.0062

10 Kannan S, Bruch JD, Song Z. Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition. *JAMA*. 2023;330(24):2365–2375. https://doi.org/10.1001/jama.2023.23147

11 Gupta A, Howell ST, Yannelis C, Gupta A. Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Home.National Bureau of Economic Research Working Paper No. 28474. February 2021. https://www.nber.org/papers/w28474

12 Fulton BD. 2017. Health Care Market Concentration Trends In The United States:Evidence And Policy Responses. *Health Affairs* 36 (9): 1530–38. https://doi.org/10.1377/hlthaff.2017.0556

independent hospitals.[13] From 2000 to 2020, the share of hospital beds owned by multi-hospital systems increased from 58 percent to 81 percent.[14]

Hospital mergers have been linked to higher prices, reductions in quality, and access to care. Higher prices from hospital mergers come directly from wages. We estimate that higher health care prices due to hospital mergers over the 2012 to 2022 period have reduced U.S. worker wages by nearly $1 trillion.[15] Hospital consolidation is ongoing, increasingly taking the form of cross-market mergers that span geographic areas, which has also been shown to increase hospital prices.[16,17,18] Later waves of consolidation have involved the rapid acquisition of physician practices by hospitals and health systems as well as by other corporate entities such as insurers or private equity firms. As a result of this "vertical consolidation" trend, the share of physicians who have left independent practice for employment or corporate ownership has increased over time, with over 55% percent of U.S. physicians now hospital-employed, and another 22.5% employed by other corporate owners.[19]

Hospital-physician vertical integration increases prices for physician care and creates an "arbitrage" opportunity to change referral patterns and steer patients to hospitals vs. independent providers for "downstream" care.[20,21,22,23,24] In Medicare and commercial insurance, outpatient office visits, surgeries, imaging tests, and diagnostic labs are reimbursed at higher rates in hospital vs. non-hospital settings–called the "site of service differential." Vertical hospital-physician consolidation increases health spending through the exploitation of the site-of-service payment differential.[19,25,26] However, most physician practice acquisitions are too small in dollar value to be reported under

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13 Johnson G, Frakt A. 2020. Hospital Markets in the United States, 2007–2017. *Healthcare* 8 (3): 100445. https://doi.org/10.1016/j.hjdsi.2020.100445

14 Andreyeva E, Gupta A, Ishitani C, Sylwestrzak M, Ukert B. 2022. The Corporatization of Hospital Care. SSRN Scholarly Paper. Rochester, NY. https://doi.org/10.2139/ssrn.4134007

15 Arnold D, Whaley CM. 2020. Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages. Santa Monica, CA: *RAND Corporation*. https://www.rand.org/pubs/working_papers/WRA621-2.html

16 Arnold DR, King JS, Fulton BD, et al. New evidence on the impacts of cross-market hospital mergers on commercial prices and measures of quality. *Health Services Research*. Published online April 23, 2024. https://doi.org/10.1111/1475-6773.14291

17 Fulton BD, Arnold DR, King JS, Montague AD, Greaney TL, Scheffler RM. The Rise Of Cross-Market Hospital Systems And Their Market Power In The US. *Health Affairs*. 2022;41(11):1652-1660. https://doi.org/10.1377/hlthaff.2022.00337

18 Dafny L, Ho K, Lee RS. The price effects of cross-market mergers: theory and evidence from the hospital industry. *The RAND Journal of Economics*. 2019;50(2):286-325. :https://doi.org/10.1111/1756-2171.12270

19 Physicians Advocacy Institute , Avalere Health. *Updated Report: Hospital and Corporate Acquisition of Physician Practices and Physician Employment 2019-2023*.; April 2024. https://www.physiciansadvocacyinstitute.org/PAI-Research/PAI-Avalere-Study-on-Physician-Employment-Practice-Ownership-Trends-2019-2023

20 Baker LC, Bundorf MK, Kessler DP. Vertical Integration: Hospital Ownership Of Physician Practices Is Associated With Higher Prices And Spending. *Health Affairs*. 2014;33(5):756-763. https://doi.org/10.1377/hlthaff.2013.1279

21 Liu JL, Levinson ZM, Zhou A, Zhao X, Nguyen P, Qureshi N. *Environmental Scan on Consolidation Trends and Impacts in Health Care Markets*. RAND; 2022. https://www.rand.org/pubs/research_reports/RRA1820-1.html

22 Scheffler RM, Arnold DR, Whaley CM. Consolidation Trends In California's Health Care System: Impacts On ACA Premiums And Outpatient Visit Prices. *Health Affairs*. 2018;37(9):1409-1416. https://doi.org/10.1377/hlthaff.2018.0472

23 Richards MR, Seward J, Whaley CM. Treatment consolidation after vertical integration | Evidence from outpatient procedure markets. *RAND*. Published online July 2020. https://www.rand.org/pubs/working_papers/WRA621-1.html

24 Whaley CM, Zhao X, Richards M, Damberg CL. Higher Medicare Spending On Imaging And Lab Services After Primary Care Physician Group Vertical Integration. *Health Affairs*. 2021;40(5):702-709. https://doi.org/10.1377/hlthaff.2020.01006

25 Neprash HT, Chernew ME, Hicks AL, Gibson T, McWilliams JM. Association of Financial Integration Between Physicians and Hospitals With Commercial Health Care Prices. *JAMA Intern Med*. 2015;175(12):1932–1939. https://doi.org/10.1001/jamainternmed.2015.4610

26 Capps C, Dranove D, Ody C. The effect of hospital acquisitions of physician practices on prices and spending. *J Health Econ*. 2018;59:139-152. https://doi.org/10.1016/j.jhealeco.2018.04.001

the Hart-Scott-Rodino Act threshold, so most vertical acquisitions go unreviewed by antitrust enforcers.[27] While designed to promote care coordination, existing evidence suggests that vertical in health care consolidation has little overall impact on care quality, and may harm quality of care for older, sicker, and non-white patients. Despite increased revenue to health systems, we do not find increases in physician compensation.[28] Likewise, hospital mergers have been shown to lead to reductions in health care worker wages.[29] In addition to consolidation among health care institutions, corporate investors such as private equity have aggressively entered health care markets.

The Emergence of Private Equity in Health Care

PE investment in health care has increased significantly over the past two decades, accelerating in recent years, although slowing this past year largely due to high interest rates. Private equity capital investment in the health care industry-wide grew 2000% in the roughly 20 years from 2000 to 2018, from $5 billion to $100 billion.[6] Over the past decade, PE has invested $750 billion in acquiring US health care providers.[30]

More recently, PE's investment targets have shifted from hospitals and nursing facilities to physician practices, ambulatory surgery centers, hospices, telehealth, and behavioral health care providers, including opioid treatment programs.[31,32] Private equity investors have identified a particular revenue strategy for each of these specialty categories. But there is one thing that all these revenue playbooks have in common – consolidation through serial acquisitions via the "roll-up model."

There are 3 main risks that policymakers are concerned about related to private equity investment in health care:

1. **Consolidation and cost increases** from market power, up-coding, and aggressive risk-adjustment. Private equity revenue increases from exploitation of payment loopholes and financial engineering translate to higher health care costs for everyone else.
2. **Harms to patient care**, driven by staffing reductions, cost-cutting, closure of less profitable services and facilities.
3. **Harms to the clinical workforce**, including physician moral injury and burnout, exit, staffing shortages, and loss of professional autonomy.

Private Equity Impacts on Health Care Consolidation and Costs

Private equity acquisition of physician practices has led to higher prices, Medicare spending, and changes to referral patterns. Over the 2016 to 2020 period, PE dermatology, gastroenterology, and ophthalmology acquisitions led to an 11% price increase. Acquisitions also lead to increases in both the care intensity among established patients and the recruitment of new patients to the practice. [33] PE acquisitions of retina practices increase Medicare

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27 Capps C, Dranove D, Ody C. Physician Practice Consolidation Driven By Small Acquisitions, So Antitrust Agencies Have Few Tools To Intervene. *Health Affairs*. 2017;36(9):1556-1563. https://doi.org/10.1377/hlthaff.2017.0054

28 Whaley CM, Arnold DR, Gross N, Jena AB. Physician Compensation In Physician-Owned And Hospital-Owned Practices. *Health Affairs*. 2021;40(12):1865-1874. https://doi.org/10.1377/hlthaff.2021.01007

29 Prager E, Schmitt M. Employer Consolidation and Wages: Evidence from Hospitals. *American Economic Review*. 2021;111(2):397-427. https://doi.org/10.1257/aer.20190690

30 Scheffler RM, Alexander LM, Godwin JR. *Soaring Private Equity Investment in the Healthcare Sector : Consolidation Accelerated, Competition Undermined, and Patients at Risk*. American Antitrust Institute and Petris Center on Health Care Markets and Consumer Welfare at UC Berkeley; 2021.

31 Brown B, O'Donnell E, Casalino LP. Private Equity Investment in Behavioral Health Treatment Centers. *JAMA Psychiatry*. 2020;77(3):229-230. https://doi.org/10.1001/jamapsychiatry.2019.3880

32 Teno JM. Hospice Acquisitions by Profit-Driven Private Equity Firms. JAMA Health Forum. 2021;2(9):e213745. Published 2021 Sep 3. https://doi.org/10.1001/jamahealthforum.2021.3745

33 Singh Y, Song Z, Polsky D, Bruch JD, Zhu JM. Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization. *JAMA Health Forum*. 2022;3(9):e222886. https://doi.org/10.1001/jamahealthforum.2022.2886

use of and spending on expensive injectable drugs such as anti-vascular endothelial growth factor (VEGF) agents, resulting in additional Medicare expenditure by over $260,000 per practice in a given year.[34]PE acquisitions increase self-referrals for surgical care from generalists to co-owned specialists within the acquired practice, resulting in no improvements to health care spending or post-surgical outcomes. Increases in self-referrals may be violating federal fraud and abuse laws, consistent with emerging whistleblower lawsuits against PE-backed practices.[35,36]

Consolidation and Private Equity Impacts on the Health Care Workforce

Private equity acquisition of physician practices changes workforce composition: PE acquisitions change the workforce composition at acquired practices. Following acquisitions in the three specialties with the largest number of PE acquisitions between 2016-2020 (dermatology, gastroenterology, and ophthalmology), PE acquisitions increased the clinician replacement ratio, or the ratio of physician entry and exit, indicating higher physician churn at PE-acquired practices. Acquisitions also increase the hiring of advanced practice providers (nurse practitioners and physician assistants), lower cost-alternatives to the physician workforce (MDs and DOs).[37]

Effects of the Private Equity Business Model on Health Care Facilities

The business objective of PE firms undertaking investments is to generate outsized returns upon sale of investment in 3-8 years (i.e., the exit). Over half (51.6%) of PE-acquired physician practices underwent an exit within 3 years after initial PE investment. In nearly all cases, PE firms predominantly exited investments through secondary buyouts, where physician practices were resold from one PE firm to another PE firm with a larger investment fund. Between investment and exit, PE funds increased the number of physician practices affiliated with the PE firm by 595% in 3 years, highlighting the rapid pace of a consolidation under PE investments. [38]

Private equity acquisitions of hospitals and nursing homes leaves these facilities financially gutted. PE firms that acquire health care facilities such as hospitals or skilled nursing facilities typically profit from selling the real estate and physical plant (typically to a related real estate investment trust (REIT), leasing the real estate back to the health care entity.[39] These sale-leasebacks generate transaction fees for the private equity fund, transfer the entity's most valuable assets to the REIT, but they place the health care entity in a financially precarious position having to pay escalating lease payments and leveraging the entity's real estate to service the large amount of debt placed on the entity by the PE firm.[40] High-profile examples of PE-driven sale-leasebacks include HCR Manorcare, a large nursing home chain that filed for bankruptcy in 2018, and Steward Health care, the struggling hospital system in Massachusetts that declared bankruptcy in 2024, as well as Prospect Medical Holdings, which used the

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34 Singh Y, Aderman CM, Song Z, Polsky D, Zhu JM. Increases in Medicare Spending and Use after Private Equity Acquisition of Retina Practices. *Ophthalmology*. 2024;131(2):150-158. https://doi.org/10.1016/j.ophtha.2023.07.031

35 Singh Y. *Can Private Equity Buy Referrals? Evidence from Multispecialty Physician Practice Acquisitions* (Working Paper); 2022. Accessed August 16, 2023. https://www.yashaswinisingh.com/files/PE_Referrals_Singh_JMP.pdf

36 District of Rhode Island | Former Owner of RI Ophthalmology Chain to Pay $1.1M in Settlement of False Claims Inquiry by the United States | *United States Department of Justice*. Published April 13, 2023. Accessed April 18, 2024.

37 Bruch JD, Foot C, Singh Y, Song Z, Polsky D, Zhu JM. Workforce composition in private equity–acquired versus non–private equity–acquired physician practices. *Health Affairs*. 2023;42(1):121-129. https://doi.org/10.1377/hlthaff.2022.00308

38 Singh Y, Reddy M, Zhu JM. Life Cycle of Private Equity Investments in Physician Practices: An Overview of Private Equity Exits, *Health Affairs Scholar*, 2024;, qxae047, https://doi.org/10.1093/haschl/qxae047

39 Bruch JD, Katz T, Ramesh T, Appelbaum E, Batt R, Tsai TC. Trends in Real Estate Investment Trust Ownership of US Health Care Properties. *JAMA Health Forum*. 2022;3(5):e221012. Published 2022 May 13. https://doi.org/10.1001/jamahealthforum.2022.1012

40 Batt R, Applebaum E, Katz T. The Role of Public REITs in Financialization and Industry Restructuring (Institute for New Economic Thinking Working Paper No 189). Published online July 9, 2022. https://doi.org/10.36687/inetwp189

sale-leaseback strategy on acquired hospitals in Rhode Island, Connecticut, Pennsylvania, and across the country. In each of these instances, the PE firm and the related REIT earned substantial profits and exited the investment, leaving the health facility financially gutted by the transaction and threatening patient access in the communities they serve.

Private equity acquisition of hospitals and nursing facilities are associated with substantial declines in quality. To earn outsized returns in their brief investment window, PE firms simultaneously seek to cut operating costs of target health care entities, usually in the form of staffing reductions or substitution of higher-paid physicians with lower-paid ancillary providers. One study found that hospital-acquired adverse events increased 25% on average, following PE acquisition, relative to non-PE control hospitals, including a 38% increase in central-line blood infections in PE-acquired hospitals, despite 16% fewer central lines being placed.[41] Patients in PE-acquired nursing homes suffered an 11% increase in mortality and declines in other measures of well-being, such as decreased mobility and increased pressure ulcers and pain, compared with non-PE controls.[42]

Private Equity Targets Specific Physician Markets with Exploitable Revenue Opportunities

Private equity acquisition of physician practices is concentrated in certain geographic areas and clinical specialties: We examined geographic variation in PE penetration of US physician practices across 6 specialties: dermatology, gastroenterology, ophthalmology, obstetrics/gynecology, orthopedics, and urology. PE acquisitions were concentrated in the Northeast, Texas, Florida, and Arizona. As of 2019 the physician specialties with the highest PE penetration were dermatology (7.5%), gastroenterology (7.4%), urology (6.5%), ophthalmology (5.1%), obstetrics/gynecology (4.7%), and orthopedics (1.9%).[43] Since 2019, PE acquisitions have increased in value-based specialties including primary care, cardiology, and behavioral health.[44] Because some PE acquisitions consolidate physician practices into larger organizations, geographic concentration of PE penetration may be associated with reduced physician competition, which could lead to increased prices.

Private equity pursues different revenue strategies for different specialties and market segments. Over the last decade PE entered the physician market aggressively, targeting particular specialties, which can be grouped into 3 main categories: (1) Hospital-based physicians, including emergency, anesthesiology, and radiology; (2) Office-based specialties, such as those described in the prior paragraph; and (3) Primary care. PE investors target certain market segments because they have found a revenue opportunity to exploit – the revenue playbook. [37]

There are some features of the PE revenue playbook that are common across specialties. Consolidation is a common strategy across specialty types, using the roll-up model to build market share and pricing power. Another common tactic is for the PE-backed management services organization (MSO) to control the captive physicians. The MSO takes controls over the practices -- hiring, firing, scheduling, contracting, billing, coding, which can threaten professional autonomy and cause burnout and damage morale, while using non-competes and gag clauses to prevent physicians from leaving or speaking out if they have concerns about these practices or quality of care.

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41 Kannan S, Bruch JD, Song Z. Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition. *JAMA*. 2023 Dec 26;330(24):2365-2375. https://doi.org/10.1001/jama.2023.23147

42 Gupta A, Howell ST, Yannelis C, Gupta A. 2023. Owner Incentives and Performance in Healthcare: Private Equity Investment in Nursing Homes. *National Bureau of Economic Research*. https://doi.org/10.3386/w28474

43 Singh Y, Zhu JM, Polsky D, Song Z. Geographic Variation in Private Equity Penetration Across Select Office-Based Physician Specialties in the US. *JAMA Health Forum.* 2022;3(4):e220825. https://doi.org/10.1001/jamahealthforum.2022.0825

44 Brown EF, Adler L, Duffy E, Ginsberg PB, Hall M, Valdez S. Private Equity Investment as a Divining Rod for Market Failure: Policy Responses to Harmful Physician Practice Acquisitions. *USC-Brookings Schaeffer Initiative for Health Policy*; 2021. https://www.brookings.edu/wp-content/uploads/2021/10/Private-Equity-Investment-As-A-Divining-Rod-For-Market-Failure-14.pdf

In addition, each specialty area may be susceptible to the following revenue strategies targeted by PE.

Hospital-based physicians. The revenue playbook motivating PE investment in hospital-based physicians, such as emergency physicians and anesthesiology, was an out-of-network surprise billing strategy. About a decade ago, PEy investors like KKR and Blackstone targeted hospital-based specialties. Patients do not choose these physicians, so their patient volume does not depend on being in-network with health insurance plans. They can stay out of network, charge higher rates, and balance-bill patients for what health plans do not cover. Although the No Surprises Act of 2020 banned balance-billing for surprise out-of-network services, PE-backed providers dominate the dispute resolution process, flooding arbitrators with claims and pushing out-of-network payments higher in the majority of disputes. [45,46]

Office-based specialties. The revenue playbook for office-based specialties like dermatology, ophthalmology, and gastroenterology that engage in a lot of outpatient procedures that are typically reimbursed on a fee-for-service basis by Medicare and commercial payers. In particular, these practices can self-refer a number of lucrative "ancillary services" (e.g., physician-administered drugs, pathology labs, imaging, or physical therapy) for which they can bill intensively. The strategy is to capture and consolidate the market, increase the volume of patients and self-referrals for ancillary procedures, increase intensity of procedures, reduce staffing levels or substitute lower-paid ancillary providers (nurse practitioners or physician assistants) for higher-paid physicians.[47] This can lead to higher prices, unnecessary services, and potentially understaffed or inadequately supervised care.

Primary Care. For primary care, investors have figured out a way to exploit the ability to game coding practices to increase risk-adjusted payments from Medicare Advantage (MA) and other value-based payment models. This strategy targets primary care practices predominantly serving patients enrolled in MA plans and sell or combine the private equity-owned primary care practice and a MA plan into a vertically consolidated payer-provider entity.[48] The revenue strategy is to extensively code—or even exaggerate—Medicare beneficiaries' diagnoses, which increases federal payments to the plans and translates to more revenue for the investors. Capitated MA and value-based payment models may also create financial incentives to stint on care through prior authorization and utilization controls, increasing the risk that patients will be denied needed care. There is also an incentive to reduce costs by substituting less expensive providers for physicians, further threatening patient care, access, and quality.

Identifying the revenue playbooks that are drawing investor acquisition points to different policy responses to address the risks of forms of horizontal and vertical consolidation in health care, driven by PE, incumbent health systems, and insurer-backed conglomerates.

Potential Policy Options to Address Consolidation in Health Care

1. **Enhance antitrust scrutiny of smaller transactions that fall below the Hart-Scott-Rodino reporting threshold as well as vertical and cross-market consolidation.**

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45 Hoadley J, Lucia K. Report Shows Dispute Resolution Process in No Surprises Act Favors Providers. *The Commonwealth Fund*. Published March 1, 2024. https://www.commonwealthfund.org/blog/2024/report-shows-dispute-resolution-process-no-surprises-act-favors-providers

46 Fenne M. Private equity firms overwhelm federal dispute process. *Private Equity Stakeholder Project PESP*. Published February 28, 2024. Accessed May 1, 2024. https://pestakeholder.org/news/private-equity-firms-overwhelm-federal-dispute-process/

47 Fuse Brown EC, Hall MA. Private Equity and the Corporatization of Health Care. *Stanford Law Review*. Published March 31, 2024. Accessed May 1, 2024. https://www.stanfordlawreview.org/print/article/private-equity-and-the-corporatization-of-health-care/

48 Shah S, Rooke-Ley H, Fuse EC. Corporate Investors in Primary Care — Profits, Progress, and Pitfalls. *The New England Journal of Medicine*. 2023;388(2):99-101. https://doi.org/10.1056/nejmp2212841

Currently, many health care acquisitions fall below the Hart-Scott-Rodino Act reporting thresholds ($119.5 million as of 2024)[49] and thus go unreviewed**.** This proposed policy aims to improve antitrust monitoring by reviewing below-the-radar physician practice acquisitions by PE firms, health systems, payers (like UnitedHealth's Optum, or CVS-Aetna, and retailers (such as Walmart or Amazon). Many states, including Connecticut, Illinois, Massachusetts, New York, Oregon, and Washington, have passed laws to increase scrutiny of health care transactions that fall below reporting thresholds and improve antitrust monitoring.[50] Reforming the HSR reporting threshold to capture more of these transactions would provide more visibility to enforcement authorities and the public. This could be done by lowering the HSR reporting threshold for health care transactions or combining the value of serial transactions to trigger reporting. However, this policy should be accompanied by enhanced funding for antitrust agencies to ensure the appropriate allocation of resources for oversight of acquisitions most likely to reduce competition.[51]

Despite mounting evidence of their anticompetitive impacts, challenging non-horizontal mergers is more difficult than horizontal mergers because of the dearth of precedent and prior experience. The FTC should use its authority under the Merger Retrospective Program to study the effects of vertical and cross-market mergers and develop economic models and legal strategies to challenge these mergers moving forward.

2. **Strengthen legislative & regulatory frameworks to close existing payment loopholes exploited by PE, particularly in Medicare.**

   Reforming Medicare's Part B payment formula for physician-administered drugs is necessary to reduce incentives for overuse of and unnecessary spending on expensive medications. Furthermore, reforms to risk-adjustment systems and increased auditing in Medicare Advantage and Accountable Care Organization (ACO) programs can deter corporate investors in primary care from exploiting existing reimbursement incentives.

   Regulations of medical loss ratios in Medicare Advantage should be tightened to avoid evasion by vertically consolidated insurance conglomerates, who can hide profits by shifting them to the patient care side of the ledger through related party transfers to subsidiary PBMs, pharmacies, and provider groups.[52]

3. **Strengthen laws to protect physicians' clinical and professional autonomy**

   State and federal policymakers can strengthen prohibitions on the corporate practice of medicine and physician non-compete clauses to protect the clinical and professional autonomy of physicians in PE-acquired practices. These protections would allow physicians to speak out or leave over ethical or professional concerns they encounter in practice, including those driven by revenue-maximization strategies of PE investors.

   The "corporate practice of medicine" prohibition bars nonprofessionals like PE investors from owning or controlling medical practices. Yet, PE investors have figured out how to contractually circumvent the corporate practice prohibition through the use of management services organizations and so-called "friendly-PC" arrangements to control the physician practice, even without formal ownership.

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49 New HSR thresholds and filing fees for 2024. *Federal Trade Commission*. Published February 1, 2024. Accessed March 13, 2024. https://www.ftc.gov/enforcement/competition-matters/2024/02/new-hsr-thresholds-filing-fees-2024

50 Fuse Brown EC, Gudiksen KL. Models for Enhanced Health Care Market Oversight — State Attorneys General, Health Departments, and Independent Oversight Entities. *The Milbank Memorial Fund*. January 2024. https://www.milbank.org/publications/models-for-enhanced-health-care-market-oversight-state-attorneys-general-health-departments-and-independent-oversight-entities/

51 Dayen D. Conflicts of Interest Surround the DOJ Antitrust Budget Cut. *The American Prospect*. Published March 7, 2024. Accessed March 18, 2024. https://prospect.org/power/2024-03-07-conflicts-of-interest-doj-antitrust-budget-cut/#

52 Frank RG, Milhaupt C. Related businesses and preservation of Medicare's Medical Loss Ratio rules. *Brookings*. Published June 29, 2023. Accessed May 1, 2024. https://www.brookings.edu/articles/related-businesses-and-preservation-of-medicares-medical-loss-ratio-rules/

Policymakers can strengthen the corporate practice of medicine to allow professional practices to maintain ultimate control over key business as well as clinical decisions.[53]The FTC could provide guidance clarifying the position on the competitive implications of stronger corporate practice of medicine prohibitions.

These reforms are bolstered by restrictions on non-compete terms for employed physicians that preclude group members from practicing in the areas where the firm operates for a prescribed length of time. The large geographic scope of PE roll-ups increases the restrictions on physician mobility. The FTC (and several states) have enacted laws to restrict non-compete clauses in physician employment contracts.[54] The FTC's non-compete clause rule was immediately challenged in court, raising the possibility that implementation may be blocked or delayed, and emphasizing the need for state and federal legislation to strengthen policies to restrict non-competes.

4. **Enhance ownership transparency: an essential piece of health care transparency**

Policymakers, researchers, and the public currently lack comprehensive data on who owns or controls physician practices, often acquired or controlled through complex corporate and contractual structures that obscure the identity of PE or corporate investors.[55] Providing a centralized national database to enhance transparency on practice ownership and control can allow patients, policymakers, researchers, and other stakeholders to understand the extent and effects of PE and other corporate investment in health care, including changes in prices, utilization, and quality of care while holding acquired practices accountable. While steps have been taken to improve ownership transparency in certain settings like nursing homes, significant gaps regarding lack of comprehensive data on ownership structures, and financial details of ownership, currently hinder effective oversight and accountability measures.[56]

5. Expand site-neutral payment policy to reduce incentives for vertical hospital-physician consolidation

To blunt incentives for and cost-increases from vertical consolidation, policymakers at the federal and state levels should: (1) expand site-neutral payment policy within and beyond Medicare to commercial insurance markets; and (2) ban unwarranted facility fees for physician office visits and for off-campus outpatient services.[57] Medicare has taken limited steps toward payment reform that would pay the same rate for the same service, regardless of where it is provided, referred to as "site-neutral payment." MedPAC and others have advocated for expansion of Medicare's site-neutral payment policy to all off-campus physician offices owned by hospitals and to eliminate the exception for grandfathered locations. Beyond Medicare, federal and state policymakers could consider expanding site-neutral payment policies to the commercial insurance market. As part of a broader site-neutral payment reform, policymakers could limit the ability of providers to charge unwarranted facility fees for physician office visits and certain outpatient services that hospital-owned providers can charge in addition to the physician's professional service fee. Policymakers could also take steps to improve transparency over the location where a service is provided through policies

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53 Zhu JM, Rooke-Ley H, Fuse Brown EC. A Doctrine in Name Only — Strengthening Prohibitions against the Corporate Practice of Medicine. *The New England Journal of Medicine*. 2023;389(11):965-968. https://doi.org/10.1056/nejmp2306904

54 FTC, Non-Compete Clause Rule, https://www.ftc.gov/legal-library/browse/rules/noncompete-rule (to be codified at 16 C.F.R. pt. 910).

55 Singh Y, Fuse Brown EC. The Missing Piece In Health Care Transparency: Ownership Transparency. *Health Affairs Forefront*. Published online September 23, 2022. https://doi.org/10.1377/forefront.20230921.886842

56 Chen AC, Skinner RJ, Robert Tyler Braun, R. Tamara Konetzka, Stevenson DG, Grabowski DC. New CMS Nursing Home Ownership Data: Major Gaps And Discrepancies. *Health Affairs*. 2024;43(3):318-326. https://doi.org/10.1377/hlthaff.2023.01110

57 Fuse Brown EC. Health Care Consolidation: Background, Consequences, and Policy Levers. *Alliance for Fair Health Pricing*; 2023. https://allianceforfairhealthpricing.org/publications/health careconsolidationreport/

requiring every facility to have its own unique provider identifier number or requiring that physician offices owned by hospitals bill directly on office claims forms instead of hospital claims forms.

6. **Increase enforcement of existing fraud and abuse laws**

   PE firms' incentives to increase the profits of acquired practices may increase risks of overutilization, overbilling or upcoding, and self-referrals for ancillary services and also lead to stinting, reduced staffing levels, or inadequate supervision. In addition, Medicare Advantage organizations may acquire physician practices, home health entities, and other provider organizations to maximize diagnosis codes to increase risk adjusted payments. To penalize PE- and insurer-acquired practices from engaging in fraudulent billing, upcoding, self-referrals, and kickback schemes, the False Claims Act (FCA), Stark Law, Anti-Kickback Statute (AKS), and Medicare Overpayment Rule could be more strictly enforced by federal enforcers, regulators, and private whistleblowers. Moreover, enforcers should attempt to hold investor-backed management companies liable, because their active management control of portfolio practices suggests they knowingly participated in the improper conduct.

7. **Strengthen the No Surprises Act**

   The No Surprises Act (NSA) bans surprise out-of-network (OON) billing used as a revenue strategy by PE-backed physician staffing firms. Yet, there's room for enhancement to curtail the potential abuse of the Act's independent dispute resolution (IDR) mechanism aimed at inflating OON reimbursements.

   Recent data[58] showed that nearly 80% of the disputes were won by health care providers at rates above the median in-network rate with the majority of these disputes being initiated by providers or management companies that are PE-backed.[59] Hence, the current IDR process has been overloaded and weakened, where provider groups (including those who are PE-backed) are still leveraging loopholes to profit from the IDR methodology created by the NSA.

***Relevant Authority by Policy Option Number**: Federal Trade Commission (FTC)[1,3], Department of Justice (DOJ)[1,5], The Medicare Payment Advisory Commission [2,5], Centers for Medicare & Medicaid (CMS)[2,4,5,6], Department of Health and Human Services (HHS) [2,5,6] , State Legislatures and Attorney General[1,3,4,5]*

CAHPR appreciates your interest in seeking more information on the impacts of health care consolidation, specifically private equity. We hope the information we provided will be helpful as you continue the next steps in your process to address these issues. Should you have any questions about our comments, please contact us at christopher_whaley@brown.edu, yashaswini_singh@brown.edu, and/or Jared Perkins, Assistant Director of Health Policy Strategy, at jared_perkins@brown.edu.

Sincerely,

58 Independent Dispute Resolution Reports. *Centers for Medicare & Medicaid Services* (CMS); 2024. Accessed March 13, 2024. https://www.cms.gov/nosurprises/policies-and-resources/reports

59 Ranganathan S, Baron ZL. No Surprises Act Litigation: Where We Are and What Comes Next. *O'Neill Institute for National and Global Health Law*: Georgetown University Law Center; 2024. https://oneill.law.georgetown.edu/no-surprises-act-litigation-where-we-are-and-what-comes-next/

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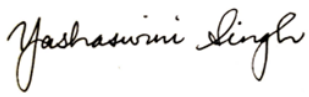

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