PEPC
PARTNERSHIP TO EMPOWER PHYSICIAN-LED CARE

STATEMENT FOR THE RECORD

"Antitrust Applied: Hospital Consolidation Concerns and Solutions"

U.S. Senate Committee on the Judiciary, Subcommittee on Competition Policy, Antitrust, and Consumer Rights
May 19, 2021

The Partnership to Empower Physician-Led Care (PEPC) is a membership organization dedicated to supporting value-based care to reduce costs, improve quality, empower patients and physicians, and increase access to care for millions of Americans through a competitive health care provider market. We believe that it is impossible to achieve truly value-based care without a robust independent practice community. Our members include Aledade, American Academy of Family Physicians (AAFP), California Medical Association, Florida Medical Association, and Medical Group Management Association (MGMA). We also have individual and small medical group supporters across the country, many of whom are independent physicians or practices and wish to remain so.

We believe that physicians – especially independent physician practices – are the lynchpin of our nation's health care system. They have repeatedly demonstrated their superior ability to generate positive results in value-based care arrangements, both in improved health outcomes and reduced costs. In our vision of the future, this important piece of the health care system not only survives, but thrives as a result of policies that place independent physicians on a level playing field with other providers and opportunities to test new models with components that reflect their unique circumstances.

Increasing consolidation in the hospital and provider markets creates greater urgency to ensure that value-based care is a path to sustainability for practices and physicians who are independent and wish to remain so. Because many value-based care models are built on a foundation of federal policies that apply to providers regardless of their practice setting and mode of reimbursement, we are dedicated to advancing policies that create a level playing field. We believe that the primary care physician-patient relationship is most powerful when there is patient choice and provider competition within local markets. We support legislative and regulatory action that creates parity across practice settings; aligns incentives to enable a range of providers to move toward value-based care; and prohibits anti-competitive behavior such as information blocking.

We submit the following as evidence of the detrimental impact of hospital consolidation and value-based care as a path to sustainability if physician-led groups are appropriately leveraged:

1. **Hospital Consolidation Leads to Higher Costs Without Measurable Improvements in Quality.**

    - A March 2020 report by the Medicare Payment Advisory Commission (MedPAC) found that in most markets by 2017, a single hospital system accounted for over 50% of inpatient admissions. Incentives for physicians to join larger practices include higher commercial prices and increased efficiencies. In 2018, nearly 57% of physicians worked in small physician practices (10 or fewer physicians). Additionally, recent studies highlighted in the report found that provider consolidation with hospital/health systems led to an increase in commercial prices from 3% to 14%, however efficiencies aren't increasing with higher total spending as

was originally assumed given the potential for improved coordination via consolidated practices. This report also highlighted the following findings on quality as a result of hospital-physician integration:
    - Patients were more likely to choose a high-cost, low quality hospital when their provider was employed by the hospital.
    - Physicians whose practices were acquired by hospitals were more likely to bill for more services in the hospital setting and fewer in the office setting.
    - Hospital acquisitions of a physician practice had little effect on improved outcomes on a range of issues, such as mortality, acute circulatory conditions, and diabetes complications (Koch et al. 2019).
    - Vertical integration had a limited effect on quality metrics reported by CMS (Short and Ho 2019).
- A 2018 Health Affairs study on consolidation trends in California found that the percentage of physicians in practices owned by a hospital increased from 25% in 2010 to over 40% in 2016, and that increases in vertical integration led to a 12% increase in Marketplace premiums, 9% increase in specialist prices, and 5% increase in primary care prices between 2013 and 2016.
- A recent analysis by the American Medical Association found that the number of physicians working in independent practice dropped to 49.1% in 2020, down from 54% in 2018. A number of factors contributed to this accelerated shift toward larger practice size, including mergers and acquisitions and economic forces that will likely continue to have an impact beyond the pandemic. Additionally, the analysis found a concurrent increase of 5.3% in the number of physicians working for a hospital since 2018, with almost 40% of physicians working directly for a hospital or for a practice with at least partial hospital ownership in 2020.
- A 2020 Health Affairs study looked at the impact of vertical integration of physician practices with hospitals and health systems on referral patterns for common diagnostic imaging and laboratory services, and associated spending. The study found that vertical integration increased Medicare spending on such services by $40.2 million for imaging tests and $32.9 million for laboratory tests.
- A recent brief by the Committee for a Responsible Federal Budget outlined how increased consolidation in the health care market has led to less competition, an imbalance in negotiating power, and higher prices. For example, research has shown that provider consolidation has not led to improved quality or a reduction in costs, and many physician-hospital consolidation moves are motivated by enhanced bargaining power by reducing competition.
- According to another Health Affairs study, consolidation can also lead to higher prices being passed on to consumers, employers, or the government via higher premiums or cost-sharing; more concentrated hospital markets were associated with higher premium growth in California and New York. The number of providers working in practices of 11 or more increased from 20% in 1983 to 39% by 2014, giving providers more market power to negotiate higher reimbursement rates.
- Another study found that for 15 common high-cost procedures, private PPOs paid physicians 8-26% more in counties with the highest average consolidation for physician groups, compared to counties with the lowest average.
- A 2014 study found that vertical consolidation increased hospital prices paid by private insurers by 2-3% for each one-standard deviation increase in the market share of hospitals that owned physician practices (from 2001 to 2007).

- An article published in the New York Times highlighted how as competition decreases in health care markets, rates of mortality and major health setbacks increase, in addition to increased prices. Martin Gaynor, an economist and expert on competition, said that "evidence from three decades of hospital mergers does not support the claim that consolidation improves quality," especially when the government constrains prices like with Medicare and hospitals instead must compete on quality. The article also highlights another study that found when cardiology markets are more concentrated, Medicare beneficiaries who had been treated for hypertension were more likely to have a heart attack, visit the ED, be readmitted to the hospital, or die.
- A Kaiser Family Foundation brief examining health care consolidation looked at a number of studies, including one examining Medicare beneficiary patterns of health care utilization, which found that "patients are more likely to choose a high-cost, low-quality hospital when their physician is owned by that hospital." The brief also noted that quality of care does not improve and sometimes gets worse following both vertical and horizontal consolidation. For vertical consolidation, one study of 15 integrated delivery networks found no evidence of better clinical quality or safety scores compared to competitors outside the networks, and another study found that hospital-based provider groups had higher per beneficiary Medicare spending and higher readmission rates compared to smaller groups.

2. Without Further Action by Congress and/or the Administration, Hospital Consolidation Is Expected to Continue and Accelerate As a Result of the COVID-19 Pandemic.

- According to a Bloomberg Law article, the first two years of 2021 saw 71 health care transactions involving over a dozen physician specialties, including 16 primary care deals. As many independent physician practices have been financially strained as a result of the ongoing COVID-19 pandemic, this trend is expected to continue.
- A Kaufman Hall review of 2020 mergers and acquisitions found that COVID-19 served as a catalyst for health care consolidation. Although a lower number of hospital and health system transactions occurred as a result of the pandemic, the number announced still remained in a historical range over the last decade, with 79 transactions taking place in 2020 (compared to 92 in 2019).
- According to an Axios article, hospitals, insurance companies, and private equity firms will see opportunity for M&A deals with physician practices who experienced financial hardships during the pandemic.
- According to the Kaiser Family Foundation, some hospital and physician practices may find it difficult to operate independently depending on the severity and duration of revenue loss as a result of the pandemic. Financial assistance provided by the government via CARES Act and the Paycheck Protection Program, for example, may not be sufficient to prevent an increase in consolidation in the coming months. The majority of aid via these sources were not targeted at health care providers that may be most vulnerable to financial hardships from the pandemic, and additional aid may not prevent health care markets from becoming more concentrated given this was a trend occurring prior to the pandemic.
- A recent September 2020 report from Bain & Company found that nearly 70% of independent physician practices were amenable to a merger or acquisition, largely due to the strained finances and drop in procedure volumes experienced during the pandemic. This finding was consistent across specialties – including primary care physicians (69%) and office-based

practices (67%). In 2019, 30% of physicians who owned practices reported they would sell their practice in the next two years.

- A series of quarterly reports from Moody's Investors Service highlighted how mergers and acquisitions (M&A) in the health care sector are expected to increase throughout the remainder of 2021. Hospitals and health systems will likely target geographic expansion and revenue diversification in M&A activity, while smaller hospitals and independent practices will continue to feel the financial strain from COVID-19. The reports suggest that independent physicians will be more open to considering affiliations with larger health systems that can offer them financial incentives.

3. There is an Urgent Need for Congress and the Administration to Ensure that Value-Based Care Models Are Fully Leveraged as an Option to Keep Provider Markets Competitive.

- ***Physician-Led Models Have Generated Superior Results Compared to Other Models. For Example:***
  - Comprehensive Primary Care+ is an example of a model where physicians and physician practices demonstrated their ability to reduce emergency room and acute care visits through advanced primary care medical homes. Independent practices outperformed system-owned practices by 15% in PY2017 and 18% in PY2019, even though both practice types improved their performance on overall utilization.
  - Physician-led ACOs are also creating a better experience for patients while lowering costs across the entire system. Medicare Shared Savings Program (MSSP) results from 2019 show that, across the health care system, ACOs led by physicians, often called "low revenue," typically create more than twice the Medicare savings per beneficiary than hospital-led ACOs, often known as "high revenue." According to CMS data, in 2019, physician-led MSSP ACOs had gross per-beneficiary savings of $458 compared to $169 per beneficiary for hospital-led MSSP ACOs. In the new Pathways to Success program, physician-led ACOs had per-beneficiary savings of $429 while hospital-led ACOs had per-beneficiary savings of $258.
  - The CMS Innovation Center's test of Track 1+ and ACO Investment Model (AIM) test showed that physician-led groups demonstrate better results than groups led by other types of providers. Across all three performance years of AIM, the first cohort of AIM ACOs reduced both spending and utilization relative to comparison beneficiaries. These AIM ACOs saved $39 per beneficiary per month by 2018 and generated $119.7 million in net Medicare savings. Additionally, in 2018, 63% of Track 1+ ACOs earned shared savings, compared to 32% of Track 1 ACOs and 56% of Track 3 ACOs.

- ***Congress and/or the Administration Could Take the Following Action:***
  - Expand Medicare site neutral payment policies to additional services/procedures proven to increase in cost after a practice's acquisition without an increase in quality.
  - Enforce information blocking regulations to ensure that patient information is not used as a strategic asset to retain patients.
  - Implement recent CMS regulations establishing a new Medicare/Medicaid Condition of Participation requiring event notifications to be shared with a patient's provider of record when they go to the ER, or are admitted or discharged from the hospital,

in a manner that requires hospitals to send notifications to a practice's roster of patients.

- Build new physician-led model options based on successful underlying chassis (e.g., CPC+, MSSP, etc.) to encourage providers to enter into value-based care models with predictable implementation and proven results.
- Ensure options for providers to join entry-level value-based care models with a glidepath to greater amounts of risk and/or more sophisticated requirements while also clearly communicating the bridge or "off ramp" to another model at the end of the model test.
- Revise regulations and/or pass legislation directing the Secretary to remove an ACO's own beneficiaries from an ACO's benchmark, thus putting rural and urban ACOs on even footing with respect to their ability to be rewarded for care improvements and cost reductions.

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Thank you for reviewing our statement on the detrimental impact of hospital consolidation on provider competition and value-based care as a path to sustainability for independent physician practices. We hope you will consider this evidence and recommendations as Congress looks to take legislative and regulatory action to address the increasing trend of consolidation in the provider market.

Please do not hesitate to reach out to me if the Partnership to Empower Physician-Led Care can be a resource to you. I can be reached at kristen@physiciansforvalue.org.

Sincerely,

Kristen McGovern
Executive Director