PARTNERSHIP TO EMPOWER PHYSICIAN-LED CARE

September 13, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Ave SW
Washington, DC

Re: **CMS-1772-P; Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating**

Dear Administrator Brooks-LaSure,

Thank you for the opportunity to comment on the proposed rule for the **Calendar Year (*CY) 2023 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs*.**

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, 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. Independent physicians 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.

However, consolidation in the health care sector has put the future of independent practice at risk. Increasing consolidation in the hospital and provider markets creates greater urgency to ensure the survival of independent practices. In recent years, there has been a historic pendulum swing between employed physicians and private practice. In 2021, for the first time, the American Medical Association found that less than 50 percent of physicians in the U.S. are in independent practice. Between July 2020 and January 2021, the rate at which hospitals employ physicians increased by three percent. Already in 2016, 90 percent of hospital markets were considered highly concentrated by Department of Justice and Federal Trade Commission guidelines. The situation has only worsened since then, as private equity firms and other players have redefined what consolidation looks like in health care.

With this background in mind, our comments focus on steps CMS can take to increase competition in the health care sector. We realize that this is a complicated problem with no silver bullet solution. However, CMS could make significant strides by expanding its current site neutral payment policies beyond clinic visits and improving the availability and type of consolidation-related data to increase transparency and inform future policy.

Site Neutral Payment Policies

We believe that beneficiaries and the physicians treating them should have their choice of lower-cost sites of service and not be encouraged to receive or provide care in higher paid settings solely for financial reasons. As we have previously commented, PEPC strongly supports CMS' prior action to establish a single reimbursement rate for clinic visits regardless of whether they are conducted in a physician's office or a facility designated as a hospital outpatient department. While CMS did not propose to expand its current site neutral payment policies beyond clinic visits, we urge CMS to do so.

In addition to the negative impact on beneficiaries through increased cost sharing and reduced choice, we note that payment disparities between sites of service make it difficult for independent practices to recruit and retain new physicians. It also negatively impacts the ability of independent practices to negotiate with payers, as physician practices purchased by hospitals can get higher payment rates from payers, both from facility fees and the greater leverage that hospitals have with private payers in negotiating payment rates for their employed physicians. The confluence of these factors make it difficult for independent practices to thrive, let alone invest the time and resources needed to successfully transition away from fee-for-service.

These circumstances are fueling the rapid consolidation of independent practices and physicians, which has increased in recent years. As many independent physician practices have been financially strained as a result of the ongoing COVID-19 pandemic, this trend is expected to continue.[1] Remaining independent physician practices are under dire financial strain, and even those who previously resisted acquisition are being faced with increased pressure to merge with large health care systems or private equity investors for stability and survival.[2] Consolidation is also increasing facility fees – one of the many negative ramifications – which is a significant factor in the price increases driven by hospital-physician consolidation.[3]

While more needs to be done to address market consolidation, expanding site neutral payment policies would be an important step. Following the same approach taken with respect to clinic visits, CMS should prioritize other services for site neutral payment which have demonstrated an unnecessary shift and/or spike in volume from physician office to the hospital outpatient department.

Request for Information on Use of CMS Data to Drive Competition in Health Care Marketplaces

Consolidation drives increases in costs and reduces patient choice, and despite the promises of mergers, does not increase efficiency or quality. Evidence suggests that consolidation drives increases in commercial spending, ranging from three percent to 14 percent.[4] Research has found that for certain

[1] https://news.bloomberglaw.com/health-law-and-business/pandemic-strain-on-physician-practices-drives-more-consolidation
[2] https://www.axios.com/coronavirus-doctors-practices-sell-close-d59aa9f0-1e01-4a90-82f7-d4ebab26e355.html
[3] https://www.nashp.org/state-policies-to-address-vertical-consolidation-in-health-care/
[4] https://www.rwjf.org/en/library/research/2012/06/the-impact-of-hospital-consolidation.html

services, such as imaging tests and laboratory tests, consolidation has increased Medicare spending by $40.2 million and $32.9 million, respectively.[5] Further, consolidation results in larger, exclusive networks, limiting consumer choice and charging higher prices to patients and health plans which are not offset by increased quality or efficiency.[6] To make matters worse, there is evidence to suggest that quality might be decreasing as a result of consolidation, with studies finding worse outcomes in Medicare beneficiaries in highly concentrated hospital markets than in less concentrated markets.[7]

Increasing consolidation in the provider market 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.

CMS requests information from the public on how data that CMS collects could be used to promote competition across the health care system or protect the public from the harmful effects of consolidation within health care. Below, we provide comments on several specific requests for feedback from CMS.

- ***What additional data that is already collected by form 855A (PECOS) would be helpful to release to the public and researchers, to help identify the impact of provider mergers, acquisitions, consolidations, and changes in ownership on the affordability and availability of medical care, and why?***

As has been noted by the Medicare Payment Advisory Commission (MedPAC), the information CMS collects through form 855A (PECOS) is of limited utility for program analysis or to research the prevalence of ownership types. Data from PECOS are generally used to support payment, fraud prevention, and law enforcement. Applicants self-report ownership details to PECOS and CMS has no centralized data source with which to verify that information. As a result, there have been longstanding issues associated with the accuracy and completeness of PECOS' ownership data.

Across many types of owners, health care providers and suppliers have changed the ways in which they structure themselves so as to limit their legal liability. Providers that have common ownership are now structured in ways that do not make this ownership obvious. Thus, it is extremely difficult to capture within a data set and lay out an ownership hierarchy among a web of interrelated entities, and CMS' ownership data typically do not indicate a parent organization atop a hierarchy of legal entities.

As a result, we suggest that CMS consider how it can aggregate data sets and/or perform analytics across data sets to draw corollaries on key data elements, such as changes in cost and quality post-merger, acquisition, or consolidation.

[5] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2020.01006?journalCode=hlthaff
[6] https://www.nashp.org/state-policies-to-address-vertical-consolidation-in-health-care/
[7] https://familiesusa.org/resources/health-care-industry-consolidation-a-driving-force-of-the-u-s-health-care-affordability-and-quality-crisis/

- ***Do commenters suggest that CMS release data on any mergers, acquisitions, consolidations, and changes in ownership that have taken place for any additional types of providers beyond nursing facilities and hospitals? If so, for which types of providers?***

According to the American Medical Association, in 2020 almost 40 percent of patient care physicians worked either directly for a hospital (9.3 percent) or for a practice with at least partial hospital or health system ownership (30.5 percent), up from 29 percent in 2012, and four percent of patient care physicians worked in practices owned by private equity firms.[8]

In primary care, the shift from fee-for-service to value-based reimbursement models has been one of the most impactful sources of innovation, driving significant and growing investment. In 2021 alone, investors, including large private equity and corporate health companies, poured $16 billion into primary care companies, a far cry from the $15 million invested in 2010.[9] Currently, over half of primary care physicians are affiliated with a health system, an increase from 38 percent of physicians in 2016. This trend is only expected to continue, and by 2030 it is estimated that new primary care models from nontraditional players, including advanced primary care providers, retailers, and payers, could capture as much as a third of the primary care market.[10] CMS releasing data on mergers, acquisitions, consolidations, and changes in ownership in primary care practices will be crucial to understanding and responding to the competitive and dynamic nature of this market.

- ***What additional information collected by CMS would be useful for the public or researchers who are studying the impacts of mergers, acquisitions, consolidations, or changes in ownership?***

With the increasing focus on health equity in health care, we cannot ignore the impacts of mergers on health care quality and access in underserved and underrepresented communities. Studies have shown as competition decreases in health care markets, rates of mortality[11] and major health setbacks increases,[12] which may be particularly detrimental for rural and underserved communities.

Merger activity has also been shown to impact health care access. In some cases, consolidation may help a provider group stay open, as many independent practices are facing financial difficulties. However, if all the providers get acquired by one group, patients may find themselves with little choice, if any at all. In some cases, a patient may even find themselves out of network at the now dominant health care system in a region. Without competition, hospitals may also be incentivized to only keep the most profitable service lines and not maintain their full range of offerings, further limiting access for patients in that region. The impact of merger activity on access can be particularly acute in rural areas, where patients may now have to travel further to see the types of doctors that they need. Considering these factors when analyzing health care sector merger activity can help to ensure that all Americans have access to quality, affordable health care.

As the Administration places further importance on closing health disparities and inequitable outcomes, PEPC urges CMS to release information on how merger activity contributes to quality and whether

[8] https://www.ama-assn.org/press-center/press-releases/ama-analysis-shows-most-physicians-work-outside-private-practice
[9] https://www.advisory.com/daily-briefing/2022/02/24/primary-care
[10] https://www.bain.com/insights/primary-care-2030/
[11] https://www.nber.org/papers/w7266
[12] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6153168/

consolidation exacerbates health care disparities. We urge CMS to consider releasing data sets on the impact of merger activity on key outcomes including access to care, quality of care, and cost of care.

- ***Section 6401 (a) of the Affordable Care Act established a requirement for all enrolled providers/suppliers to revalidate their Medicare enrollment information in PECOS under new enrollment screening criteria. In 2016, the Centers for Medicare & Medicaid Services (CMS) completed its initial round of revalidations and resumed regular revalidation cycles in accordance with 42 CFR 424.515. Would data for transactions occurring before the 2016 CMS revalidation effort be useful for the public or researchers, even if such data may be less complete?***

More recent data, including post-pandemic data, would be most helpful. Since 2016, the provider landscape has changed dramatically. In fact, 2020 was the first year in which less than half of physicians worked in practices owned by physicians (i.e., private practice), reflecting a steady decline since 2012 when over 60 percent of physicians were in private practice and an almost five percentage point drop since 2018 when 54 percent of physicians were in private practice.[13] While trends are consistent, data suggest that changes in provider ownership and employment status are increasing as a result of the pandemic, underscoring the importance of access to timely, reliable data.

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Thank you for the opportunity to submit feedback, and for considering our comments. Please do not hesitate to let me know if you have questions or if we can be a resource.

Best,

Kristen McGovern
Executive Director

[13] https://www.ama-assn.org/system/files/2021-05/2020-prp-physician-practice-arrangements.pdf