PEPC
PARTNERSHIP TO EMPOWER PHYSICIAN-LED CARE

STATEMENT FOR THE RECORD

"Lowering Unaffordable Costs: Legislative Solutions to Increase Transparency and Competition in Health Care."

U.S. Committee on Energy and Commerce Subcommittee on Health

April 26, 2023

The Partnership to Empower Physician-Led Care (PEPC) is a membership organization dedicated to supporting value-based care for independent physicians and practices to reduce costs, improve quality, empower patients and physicians, and increase access to care through a competitive health care provider market. 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.

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 payment and delivery innovations in models that are adapted for their unique circumstances.

Increasing consolidation in the provider market creates greater urgency to ensure that value-based models are a path to sustainability for practices and physicians who are currently independent and wish to remain so, as well as for providers who are not currently independent but wish to make a change in their practice setting. We support legislative action that creates parity across practice settings; aligns incentives to enable a range of providers to move toward value-based care; and prohibits and/or dis-incentivizes anti-competitive behavior.

We commend the Committee for its consideration of this important issue, and putting forth legislation and proposals to increase transparency and competition in health care. Our comments below provide evidence of the detrimental impact of increasing provider consolidation, support and feedback on legislative proposals, and additional areas where we urge Congressional action.

1. **Provider Consolidation Continues to Accelerate, Leading to Higher Costs Without Measurable Improvements in Quality.**

    - A March 2023 study by the Harvard Kennedy School found that when physicians integrated with a hospital, they changed their care practices and increased their throughput, resulting in increased complications and worse patient outcomes. Moreover, integration increased rates of reimbursement by about 48 percent.
    - A March 2023 study by researchers from the National Bureau of Economic Research and Harvard Medical School found significantly higher costs for care, with only marginally better care, provided to patients in health systems compared to those at independent practices or hospitals. Physician services delivered within health systems cost between 12 percent and 26 percent more, and system-based hospital services cost 31 percent more, compared with care delivered by independent hospitals.
    - A January 2023 study found that, in 2018, health system physicians and hospitals delivered a marginally better performance on clinical quality and patient experience measures but

spending and prices were substantially higher. This was especially true for small practices, and researchers concluded that the small quality differentials combined with large price differentials suggest that health systems have not realized their potential for better care at equal or lower cost.

- A January 2023 report by the Commonwealth Fund found that two hospital systems accounted for more than half of traditional Medicare inpatient hospital spending in 85 percent of hospital referral regions (HRRs) and accounted for more than three-quarters of spending in 35 percent of the HRRs. In 10 states plus D.C., two hospital systems account for the majority of Medicare inpatient hospital spending in the entire state.
- An April 2022 analysis by Avalere Health and the Physicians Advocacy Institute (PAI) found a nearly 24 percent increase in the percentage of employed physicians during the COVID-19 pandemic (January 2020 to January 2022). By January 2022, the study found that 74 percent of physicians were employed by a hospital or corporate-entity.
- Trends in corporate ownership, such as insurers and private equity firms, are now outpacing hospitals and health system-ownership of physician practices, according to the Avalere Health and PAI analysis. Corporate ownership of physician practices increased over 50 percent from January 2019 to January 2022, while hospital ownership increased by eight percent. By January 2021, over 26 percent of physician practices were owned by hospitals and 22 percent of physician practices were owned by corporate entities, such as insurers and private equity firms.
- A Kaufman Hall review of merger and acquisition (M&A) activity between hospitals and health systems in the second quarter of 2022 found that M&A revenue hit a record high in, with 13 transactions generating $19.2 billion. Highlighting the degree of consolidation in the industry, the average size of the smaller party was nearly $1.5 billion, which was more than double the record-setting average size of $619 million at the end of 2021.
- A September 2020 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.
- 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 percent of inpatient admissions. Incentives for physicians to join larger practices include higher commercial prices and increased efficiencies. In 2018, nearly 57 percent 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 three percent to 14 percent, however efficiencies are not 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).

2. Comments on Legislation and Proposals Under Consideration.

- Competition and Consolidation: As highlighted above, consolidation in the health care sector continues to increase at an alarming rate, leading to higher costs without measurable improvements in quality. With that in mind, we applaud the Committee for putting forth legislation that would require the Secretary of Health and Human Services to explicitly examine the impact on provider and payer consolidation during the rulemaking process pertaining to payment systems, rate schedules, or other reimbursement, as well as CMS Innovation Center model evaluations.

  We are supportive of the following discussion draft, and urge the Committee to work with stakeholders to identify appropriate evaluation criteria for CMS Innovation Center models. We believe appropriate criteria could include accountable care organization (ACO) ownership structure and specific policies related to the model themselves that might favor larger entities:

  - **H.R. ___**, To require the Secretary of Health and Human Services to consider, within the annual rulemaking process, the effect of regulatory changes to certain Medicare payment systems on provider and payer consolidation, and for other purposes

- Site-Neutral Payment Policy: As outlined in a recent Brookings Institution brief, a broader set of site neutral payments would further reduce Medicare spending, beneficiary costs, and incentives for hospitals to purchase physician practices. MedPAC estimates that aligning payments across sites of care for the list of services identified would have saved Medicare $6.6 billion and beneficiaries an additional $1.7 billion if in place in 2019, even before accounting for the potential dynamic effects on vertical consolidation.

  We applaud the Committee for putting forth legislation that would build upon existing site-neutrality rules and create more fairness in the payment system by passing legislation to ensure CMS pays the same rates across practice settings. We are supportive of the following legislative discussion drafts:

  - **H.R. ___**, To amend title XVIII of the Social Security Act to require payment for all hospital-owned physician offices located off-campus be paid in accordance with the applicable payment system for the items and services furnished
  - **H.R. ___,** To amend XVIII of the Social Security Act to provide for site neutral payments under the Medicare program for certain services furnished in ambulatory settings

  However, we are concerned that a four-year lookback period to determine the services for which site neutral payments apply may incentivize even more services to be rendered in the inpatient setting and drive further consolidation between hospitals and physician practices. We

encourage Committee staff to ensure site neutral legislation does not have the unintended consequence of driving more consolidation.

Further, we believe site neutral payment policies should be accompanied by an increase to reimbursement for Part B services given that reimbursement for these services is currently inadequate. We also urge the Committee to consider the tools available to ensure that that cuts to facilities are not disproportionately passed along to clinicians

- Inpatient Only List: The inpatient only (IPO) list currently includes over 1,500 Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) codes, which are services automatically approved for Medicare Part A coverage and must be performed in a hospital. We are supportive of CMS working with stakeholders to implement measured, clinically-based reforms to the IPO list. Eliminating services from the list that can be safely performed in outpatient settings will level the playing field between various sites of service, resulting in more cost-effective care.

  We are supportive of the following legislative discussion draft, but urge the Committee to ensure that any reforms to the IPO list are made transparently with appropriate stakeholder input and opportunity for comment:

  - **H.R.___**, To phase out certain services designated as inpatient-only services under the Medicare program.

3. Additional Congressional Action That is Needed to Promote Competition.

- Physician Payment Reform: To give independent practices and physicians a chance to remain independent if they choose to, reimbursement structures for federal programs such as Medicare must keep pace. Because many value-based care models continue to be built on the FFS chassis, Medicare fee-for-service (FFS) payment rates and policies are integral to the success of CMS' value-based care models. A recent survey found average physician pay fell by 2.4 percent from 2021 to 2022, at a time when physicians are facing significant challenges, including economic strains, a growing shortage, and high rates of work-related burnout.

  Congress must invest in the Medicare physician fee schedule to ensure that providers are appropriately reimbursed for their services and to ensure that reimbursement accounts for rising overhead costs and inflation.

- Transparency and Antitrust Enforcement: As outlined by the Brookings Institution, antitrust authorities are currently constrained in a number of ways, including limited available data and resources, as well as a high threshold of pre-merger notification. In 2023, pre-merger notification to federal antitrust authorities was required for transactions over $111.4 million, meaning that many acquisitions, particularly of physician practice, go unnoticed until the merger has been finalized. Greater transparency and strengthened antitrust statutes could help reduce the amount of anticompetitive consolidation in health care.

Congress should ensure that oversight agencies such as the Federal Trade Commission have the resources needed to be effective in researching and pursuing new and develop issues related to health care consolidation and competition.

- Leverage Physician-led Payment Models to Drive Quality and Cost Outcomes: There is an urgent need for Congress to ensure that value-based care models are fully leveraged as an option to keep provider markets competitive. Getting providers off the fee-for-service chassis enables them to provide higher-quality, more coordinated care for their patients, and provides financial predictability and stability. Through models such as Comprehensive Primary Care+ and the Medicare Shared Savings Program, physician-led groups have demonstrated their ability to drive results in the form of increase outcomes and reduced costs by moving away from utilization-based approaches to the payment and delivery of health care.

  Congress should urge CMS to prioritize physician-led models, and should extend the MACRA bonus for providers participating in advanced alternative payment models (AAPMs). Congress should also consider approaches to MACRA reform that focus on the doctor-patient relationship, and leverage the unique capability of physician-led groups to transform health care for the benefit of patients.

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We hope you will consider this evidence and recommendations as Congress looks to take action to address 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 (kristen@physiciansforvalue.org).

Sincerely,

Kristen McGovern
Executive Director