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May 6, 2024

Merrick B. Garland
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Department of Justice
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Washington, DC 20530

Lina M. Khan
Chair
Federal Trade Commission
Office of the Secretary
600 Pennsylvania Avenue NW
Suite CC-5610 (Annex C)
Washington, DC 20580

Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Request for Information on Consolidation in Health Care Markets, Docket No. ATR 102

Dear Attorney General Garland, Chairwoman Khan, and Secretary Becerra,

The American Osteopathic Association (AOA), on behalf of the more than 186,000 osteopathic physicians (DOs) and osteopathic medical students we represent, appreciates this opportunity to comment on the Department of Justice's (DOJ) Antitrust Division, the Federal Trade Commission (FTC), and the Department of Health and Human Services (HHS) Request for Information on Consolidation in Health Care Markets. We commend the agencies' efforts to understand the impact of healthcare consolidation on physicians and their patients and monitor trends that may indicate some institutions are engaging in anticompetitive business practices that negatively impact the delivery of affordable, high-quality, and safe healthcare. In the case of many organizations, the development of large, integrated health systems has improved the efficiency of providing care, improved the experiences of physicians who deliver care, and supported access to innovative technologies. However, there are also many organizations that prioritize maximizing revenue over optimizing care.

The AOA represents osteopathic physicians who practice across nearly every specialty and care setting. Across the country, physicians report experiencing challenges resulting from consolidation, regardless of specialty and whether the consolidation stems from private equity-backed acquisitions of private practices, mergers and acquisitions of hospitals and health systems, or consolidation across payers. Each of these forms of consolidation has implications for care quality, access and timeliness of care, workplace safety, and physician burnout. The AOA is concerned that many of these anti-competitive practices will become more commonplace as consolidation trends continue, catalyzed by payment policies that incentivize certain acquisitions and delivery of services in higher-cost sites of care. Meanwhile, inadequacy of payment for physician services has created a challenging environment for small and independent practices to keep their doors open, further driving consolidation.

The DOJ, FTC, and HHS requested information on the effects of transactions involving healthcare providers or facilities conducted by private equity funds, health systems, or private payers. The request specifically called for insights into the impacts of consolidation and acquisitions on patients, the experiences of healthcare workers employed by consolidated providers, and the broader trends in consolidation across our healthcare system. The below input

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reflects direct feedback from osteopathic physicians who shared their insight and experiences with consolidation, as well as literature on current trends. Overall, this letter outlines the following:

1. How consolidation is impacting the patient-physician relationship, including improvements to care delivery created by large, integrated entities as well as specific anti-competitive practices that are harming patient care;
2. The need for government action to address anti-competitive practices; and
3. The need for government action to address the financial incentives that are driving consolidation and distorting healthcare marketplaces.

As we outline below, while addressing the specific practices that some organizations engage in is a critical step to protect patients and physicians, larger systemic changes are also necessary to ensure that our country's overall payment systems support healthy competition in healthcare marketplaces.

Effects of Consolidation

Impact on Patients

While many physicians report that working for large integrated health systems improves care delivery with increased access to resources and a network of specialties for easy referral, we are concerned that certain anti-competitive trends are resulting in loss of access to timely and quality care for patients. These include payment policies that are driving acquisitions and limiting access to providers, some provider entities seeking to maximize revenue at the expense of care quality, and health plans developing limited networks. Below are examples recently shared by physicians.

In regard to the ways large enterprises can support care delivery, physicians note that large health systems and private equity groups can introduce them to resources that may be unavailable or inaccessible in smaller settings. Many physicians report positive outcomes following consolidation. Increased access to sophisticated electronic medical record systems and medical technology were two areas physicians noted as encouraging experiences when undergoing a consolidation. Multiple physicians reported satisfaction in their ability to communicate and coordinate care with other physicians in a system when joining a large health system. These reports align with a national survey of physicians who reported private equity acquisition led to integration of multidisciplinary care teams and investments in technology and infrastructure[1]. Other practices of large institutions that drive high-value, patient centered care include the establishment of accountable payment structures that incentivize high-value behaviors, and investments in case managers and other staff dedicated to population health management.[2] Overall, the resources that large systems often possess enable them to utilize technology, hire staff, or implement practices that benefit patients and physicians.

However, despite these process improvements and access to resources, many organizations engage in practices that can disrupt or harm patient care. One physician noted that after smaller, rural entities were bought out by larger systems, some patients in Idaho were forced to wait 6-8 weeks to see a primary care provider and longer for a specialist. This physician saw patients with terminal illnesses who were not diagnosed in a timely manner due to excessive wait times. Studies show that cancer screenings done at the recommended interval and at the discretion of the physician lead to improved outcomes for patients and reduce the risk of mortality due to cancer diagnosis[3,4]. We are concerned

[1] NORC and Physicians Advocacy Institute. "The Impact of Practice Acquisitions and Employment on Physician Experience and Care Delivery." 2023. Available here.
[2] Simpson, K., Nham, W., Thariath, J. et al. How health systems facilitate patient-centered care and care coordination: a case series analysis to identify best practices. BMC Health Serv Res 22, 1448 (2022).
[3] Preventing Chronic Diseases. "Peer reviewed: patterns and trends in cancer screening in the United States." 2018. Available here.
[4] Prev. Med. "Impact of provider-patient communication on cancer screening adherence: a systematic review." 2016. Available here.

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that patients are unable to access continuous care in the face of consolidation due to factors beyond their control, such as when an organization acquires their physician's practice or their insurance plan has a limited provider network.

Another physician reported receiving patients who lost access to their primary care physician after a practice closed following consolidation in their market; in addition to delayed screening and detection of cancer, the physician reported lapses in patients' diabetic care which led to poorly controlled glucose levels with subsequent health consequences. In the midst of practices being acquired by health systems due to the inability to compete and keep their doors open, several physicians reported patients being forced to terminate their long-standing relationships with their primary care physicians as a result. This is because the acquiring health system does not accept the patients' insurance, forcing patients to establish care with a new physician. While this is a typical outcome due to the nature of plan network contracting, consolidation is disrupting relationships and resulting in patients having fewer options for where to receive care.

Following acquisition by a private equity firm, one physician reported their hospital decreased pay for consultant physicians, particularly in gastroenterology, forcing the consultants to no longer provide full time coverage; the physician observed that patients have been transferred to other facilities more frequently following this decrease in coverage. When transferred to other facilities, patients and their families can face significant stress, challenges maintaining family responsibilities, and loss of connection while a patient is ill, resulting in longer term impacts beyond the acute illness[5].

Overall, patients have been found to face poorer outcomes following a private equity acquisition; a 2023 study found that private equity acquisition was linked with a 25 percent increase in hospital-acquired conditions, led by falls and central line-associated bloodstream infections[6]. Another study found that 42 percent of physicians reported a worse relationship with patients after ownership changed to a venture capital or private equity firm, largely due to decreased time and communication with patients[7]. A heavy focus by private-equity backed practices is to maximize profits by cutting what venture capitalists view as unnecessary costs or services with low margins, and in many cases, there is little regard for the overall impact on patients, particularly when decisions are driven by individuals without clinical backgrounds. Patients are not active participants in these business transactions, yet their health is greatly impacted by resulting mergers and acquisitions.

The above examples and literature reflect behaviors by larger providers that are not isolated, and federal agencies can take action to mitigate harm to patients. Steps federal agencies can take to protect patients include:

- Establishing and enforcing more stringent network adequacy standards for plans, where agencies have authority to do so, to account for provider availability and limit wait times, particularly for specialists;
- Ensure more stringent medical oversight of operations of private equity owned medical groups and hospitals;
- Strengthening anti-trust oversight and enforcement to closely monitor healthcare markets across the country and identify consolidation and potential monopoly by insurers, large health systems, or provider groups.

[5] Journal of Family Nursing. "Critically Ill Patients: Family Experiences of Interfacility Transfers from Rural to Urban Centers and Impact on Family Relationships." 2023. Available here.
[6] JAMA. "Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition." 2023. Available here.
[7] NORC and Physicians Advocacy Institute. "The Impact of Practice Acquisitions and Employment on Physician Experience and Care Delivery." 2023. Available here.

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Impact on providers, health care workers, and support staff

Mergers and acquisitions in healthcare marketplaces, and the resulting consolidation, have had significant implications for physicians - the ways in which they deliver care, their career experiences, and even levels of burnout. Some of the changes are positive. There are many organizations committed to improving care, and employment within a health system is preferred by many physicians due to the advantages it offers. However, policy needs to enable high-quality care while limiting the anti-competitive practices that are driving workforce challenges and harming care quality. For example, most physicians employed by health systems have access to a variety of tools that streamline their work, such as EMRs that are integrated with point of care tools that allow the physician to access information while patients are present. Acquisitions can lead to physicians' access to technical support and staffing for administrative tasks, such as prior authorization. Physicians report that nearly 14 hours per week are needed to keep up with the demands of prior authorization[8], a significant dedication of resources for small practices. Facilities also often have additional staff and technical support for quality reporting and administrative functions, which can potentially reduce burnout and allow physicians to spend more time with patients[9]. However, many of the staffing and employment models, which have become common as the result of consolidation, are often anti-competitive and designed around maximizing revenue within the medical group or health system.

Some physicians have reported that their referrals are monitored, and that their contracts require them to refer patients for care within their employer's health system. While requirements to refer within the health system or to designated providers may be important for successful participation in value-based arrangements, such as participation in an accountable care organization, we are concerned that large hospitals and health systems are abusing flexibilities granted under Stark law regulations for directed referrals to maximize revenue, rather than ensure optimal patient outcomes. Often, these practices stem from a desire to prevent what is referred to as "patient leakage", which occurs when a patient seeks care from another provider, resulting in what the system views as a lost revenue opportunity. In 2021, the Centers for Medicare & Medicaid Services (CMS) finalized provisions to expand Stark law exceptions to more broadly enable organizations to require compliance with the directed referral contract provisions[10]. This expansion permits healthcare systems to include directed referral requirements in a physician's contract and tie compensation to referral thresholds. While the regulation technically prohibits providers from requiring directed referrals in certain circumstances (i.e. when a patient expresses a preference, when a service is not covered by the insurer for that provider, or when the referral is not in the patient's medical interest), physicians have expressed concern for being punished financially when they don't comply with their contracts. We believe the regulation promulgated by CMS is having the unintended consequence of discouraging competition across providers to provide high-quality care by empowering large health systems to focus on preventing "patient leakage".

Physicians should have the flexibility to refer patients to specialists and other providers that will provide the highest quality of care and meet the needs of the individual patient, and physicians should not be punished by their employer, or face administrative hurdles, for referring outside their health system when it is in the patient's best interest. While we support physicians being able to refer within their hospital or health system's network, we oppose them being contractually obligated to do so outside a specific value-based arrangement, which recent changes to Stark law rules now more expansively allow. Regulations should be modified to ensure large health systems are not permitted to

[8] AMA. "2022 AMA Prior Authorization (PA) Physician Survey." Available here.
[9] JAMA Netw Open. "Association of Clinician Health System Affiliation with Outpatient Performance Ratings in the Medicare Merit-based Incentive Payment System." 2020. Available here.
[10] CMS Final Rule. "Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations." Available here.

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develop contracts that force physicians into the position of having to choose between providing the best care to their patient over financial incentives to refer within their health system.

Multiple physicians reported being subjected to more stringent performance metrics following consolidation, including employers tracking productivity using relative value units (RVUs). RVUs were created to provide relative values for medical care based on a combination of physician work, practice expense, and professional liability for reimbursement purposes[11]. While RVUs have been used to determine bonuses and compensation for physicians, one physician reported that their consolidated facility now requires minimum RVUs to stay employed full-time at the facility. In this instance, the RVUs are evaluated every six months, and if a physician falls below the threshold determined by the facility management, they are no longer employed full-time and lose their benefits associated with full-time status. We have also heard from physicians that organizations' productivity requirements don't account for time away from work. While we recognize that businesses must have some metric to measure and monitor productivity, we are concerned about organizations setting overly aggressive RVU targets. This is of particular concern with private equity-backed medical groups and health systems that take on substantial amounts of debt, often necessitating substantial service volume to meet revenue targets. In many instances, these thresholds can be challenging for physicians, especially when they choose to take time away from work or need sick leave, as they must then compensate for this time away from practice at a later point or lose out on payment and benefits.

After consolidation, some physicians reported they were required to work longer and more intensive hours without additional compensation for the required additional work. Many physicians reported having staffing shortages following consolidation, requiring longer days of work to keep the facility afloat and patients cared for appropriately. Conversely, another physician reported that when shifts are slow at their facility, the staff are sent home and forced to use their paid leave for the remainder of the shift, even if they do not choose to cut their shift short.

Physicians train for years to learn effective ways to diagnose and treat their patients; however, many reported that following mergers or acquisitions, they were given instructions to practice medicine based on cost and revenue. While physicians work to always provide the highest standard of care to their patients, many have voiced concern regarding being placed in a position where they fear being penalized for providing (or not prescribing) services based on the needs of their patient. Multiple physicians reported being inappropriately told by non-physicians which tests they should order for their patients. One physician noted that their facility sought to drive greater volume of higher revenue procedures, which also resulted in unnecessary utilization of diagnostic testing and procedures. Numerous studies and surveys indicate the prevalence of the experiences DOs reported. A 2022 study found that 81 percent of physicians interviewed were concerned about physician autonomy when private equity transactions occur in outpatient care, specifically surrounding their experiences with private equity companies making operational decisions despite lacking the required medical expertise[12]. Another study showed that 51 percent of physicians who experienced a change in ownership to a venture capital or private equity firm reported policies influence or limit their decision-making on drug therapies for patients[13].

The AOA has heard from many physicians that their employment contracts contain non-compete clauses. The AOA appreciates FTC's recent efforts to limit the enforceability of these clauses by enterprises across the country. Non-

[11] JAMA. "Relative value units and the measurement of physician performance." Available here.
[12] International Journal of Environmental Research and Public Health. "Physicians' Perspectives Regarding Private Equity Transactions in Outpatient Health Care—A Scoping Review and Qualitative Analysis." 2022. Available here.
[13] NORC and Physicians Advocacy Institute. "The Impact of Practice Acquisitions and Employment on Physician Experience and Care Delivery." 2023. Available here.

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compete clauses and other corporate policies that limit physician autonomy result in gaps in patient care and disrupt the physician-patient relationship. If a physician is bound to a non-compete clause, they may be unable to continue a relationship with their patient should they choose to leave the organization, especially when these clauses prohibit the physician from practicing within the same region as their prior employer. While the FTC's recent action is an important step forward, we want to highlight that there is a critical gap in the impact of this rule as it does not apply to nonprofit entities including nonprofit hospitals. We look forward to working with federal agencies to identify opportunities to address this gap.

The anti-competitive practices impacting the practice of medicine that are outlined above can largely be addressed through federal policy action. Steps lawmakers can take to preserve physician autonomy and the patient-physician relationship include:

- Limiting the moral hazard that increases risk of site closures following leveraged private-equity buyouts and necessitates harmful staffing practices (e.g. understaffing, excessive productivity requirements that impact patient care and exacerbate burnout, and requiring employees to take time without pay);
- Reforming physician self-referral (Stark law) regulation to walk back some of the flexibilities granted in 2021 allowing health systems to increasingly self-refer and limit patients from accessing care at competing sites;
- Establishing more stringent staffing requirements for certain sites of care; and
- Limiting non-compete enforcement by nonprofit organizations.

Need for Government Action

As consolidation in healthcare has accelerated in recent years, the need for government action to mitigate this trend is urgent. While we have documented steps that the government can take to address this issue, we want to delineate areas where we feel federal agencies have sufficient authority to take immediate action, and areas where we believe agencies should work with Congress towards a long-term solution. These are outlined below.

Regulatory Action

Immediate steps that federal agencies can take to address anti-competitive practices in healthcare and mitigate harms associated with consolidation include the following.

- CMS can strengthen network adequacy requirements for health plans that it regulates and improve oversight of staffing at facilities participating in federal programs;
- CMS can revise the physician self-referral (Stark law) regulation of 2021, which allowed health systems to increasingly self-refer and limit patients from accessing care at competing sites;
- CMS can expand price transparency requirements to include practice settings that have substantial private-equity investment;
- FTC can investigate the concentration of healthcare markets and take the necessary actions to reestablish a healthy market; and
- FTC can investigate private-equity backed medical groups and hospitals for anti-competitive practices that seek to establish market control within a specific specialty or setting type within a region.

Legislative Action

Some of the solutions discussed in this letter can only be addressed through legislative reform. The AOA strongly urges the tri-agencies to work with Congress to advance reform in the following areas.

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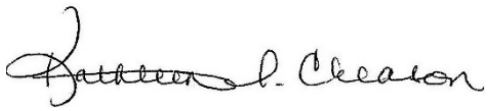
- Establishing a stable annual update to Medicare physician payment will ensure that payment keeps pace with the cost of practicing medicine, and will enable practices to keep their doors open and compete with other providers;
- Establishing site-neutral payment for certain ambulatory services to address inequities in payment across settings that incentivizes acquisition of physician practices and delivery of care in higher cost settings;
- Expanding value-based payment models that meet the needs of smaller providers and enable them to make investments in staff and infrastructure to perform successfully while maintaining independent ownership;
- Establishing clearer standards for what defines "community benefit" that nonprofit hospitals must provide to satisfy their requirements to maintain their tax-exempt status, and ensure that nonprofit hospitals are truly using funds to support their communities in meaningful ways and not engaging in business-like anticompetitive practices[14]; and
- Establishing greater oversight of private equity owned providers and implementing measures that limit leveraged buyouts that entail excessively high levels of risk that could threaten patient care.

Conclusion

Once again, the AOA is pleased to have the opportunity to provide insight on this request for information. We commend the DOJ, FTC, and HHS for making efforts to preserve competition in healthcare markets across the country. The AOA looks forward to continuing to work with the agencies on developing next steps and potential regulation. We are happy to provide greater details and further discuss any of the examples cited above. Should you have any questions regarding our comments or recommendations, please contact John-Michael Villarama, MA, AOA Vice President of Public Policy, at (202) 349-8748 or jvillarama@osteopathic.org at any time.

Sincerely,



Ira P. Monka, DO, FACOFP (Dist.)
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Kathleen Creason, MBA
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[14] Government Accountability Office. "Tax Administration: IRS Oversight of Hospitals' Tax-Exempt Status." April 26, 2023.Available here.