June 4, 2024

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U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Chair Lina Khan
Federal Trade Commission
600 Pennsylvania Avenue, NW
Washington DC 20580

Attorney General Merrick B. Garland
U.S. Department of Justice
950 Pennsylvania Avenue, NW
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Re: Request for Information on Consolidation in Health Care Markets (Docket No. ATR 102)

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

Arnold Ventures thanks you for the opportunity to respond to your joint Request for Information on consolidation in health care markets. We appreciate your work to strengthen competition and limit consolidation in health care markets to lower health care costs for patients, consumers, employers, taxpayers, and the Medicare and Medicaid programs, and improve quality of and access to care for patients and consumers.

Arnold Ventures is a philanthropy dedicated to investing in evidence-based policy solutions that maximize opportunity and minimize injustice. We work to develop evidence to drive reform across a range of issues including health care, education, and criminal justice. Our work within the health care sector is driven by a recognition that the system costs too much and fails to adequately care for the people it serves.

We are interested in improving competition across and among a range of health care providers, including hospitals, physicians, nursing homes, health plans, and pharmaceuticals. More specifically, our work has focused on how health care consolidation affects patients and consumers, employers, and/or the government across Medicare, Medicaid, and the commercial market — and how those effects vary depending on the tactics and mechanisms used to consolidate market power. These tactics include horizontal and vertical consolidation, roll-up acquisitions and acquisitions by private equity, and related-party transactions, among other emerging issues.

We are particularly concerned that consolidation raises health care costs in many markets. Evidence shows that consolidation raises health care prices in the commercial market and leads to higher health care costs in Medicare and Medicaid, which can translate into increased government spending and fewer dollars available for patient care, as certain providers or sectors exploit system loopholes to maximize revenue. Beyond costs, consolidation does not improve and may even worsen quality, likely reduces patient choice and access to care, and can make it harder for government purchasers to implement important reforms.

Our response to this Request for Information outlines specifics around the tactics used to consolidate health care markets and how each impacts health care costs, quality, and access across public and private payers. We also identify policy opportunities to limit further consolidation and improve competition in the health care system. The table below provides a summary overview of our response.
## Effects and Drivers of Consolidation

### In the Commercial Market
- Horizontal Consolidation Among Hospitals
- Vertical Consolidation Between Hospitals and Physicians
- Vertical Consolidation Between Health Plans and Providers
- Vertical Consolidation Between Pharmacy Benefit Managers and Insurers
- Vertical Consolidation Between PBMs and Pharmacies
- Private Equity
- Roll-Up Acquisitions
- Implications of Consolidation Beyond Prices

### Affecting Public Payers
- Vertical Consolidation Between Medicare Advantage Plans and Providers:
  - Risk Score Gaming
  - Medical Loss Ratio (MLR) Gaming
  - Star Rating Gaming
- Horizontal and Vertical Integration of PBMs and Medicare Part D Premiums
- Private equity in Nursing Homes and Other Medicare and Medicaid Providers
- Related Party Transactions

### Need for Government Action: Policy Recommendations

<table>
<thead>
<tr>
<th>Need for Government Action</th>
<th>Policy Recommendations</th>
</tr>
</thead>
</table>
| **Strengthen Ownership Transparency and Related Party Transaction Data and Ensure Accuracy of Data** | Enhance ownership transparency  
Increase transparency into PBM contracting |
| **Limit Further Health Care Provider Consolidation and Improve Provider Competition** | Enhance site-neutral payments  
Strengthen antitrust enforcement  
Limit anticompetitive conduct |
| **Limit the Effects of Vertical Integration Between Insurers and Providers in Medicare Advantage** | Make risk score data available to researchers  
Mitigate risk score gaming  
Protect against MLR gaming |
| **Encourage Cross-Administration Data Sharing and Coordination** | |

### Request for Information: Full Response

**Effects and Drivers of Consolidation in the Commercial Market**

Provider consolidation in health care markets has increased dramatically over the past few decades, with large health systems merging or acquiring other hospitals and physician practices. There is clear evidence that hospital and physician consolidation has led to higher prices for the privately insured while the quality of care has remained relatively constant or, in some cases, worsened. Dominant health systems use their market power to negotiate excessive prices with insurers, on average charging more than 2.5 times what Medicare pays for the same service, with some systems charging three to four times Medicare rates.
These high prices flow through the system as a tax on consumers and employers in the form of rising premiums and out-of-pocket costs, including high deductibles. The average family employee premium increased by 47% over the last ten years, and now is nearly $24,000 per year.iii Given these high costs, many patients (about 35% of Americans in 2020) report problems accessing medical care due to costs, a quarter of adults with insurance reported problems paying medical bills, and 100 million Americans face medical debt.iv, v

Rising prices also have a negative impact on labor market outcomes and the federal budget. Economists connect rising health care costs to stagnant wages, finding that hospital mergers lead to a reduction in wages for workers who receive employer-sponsored insurance.x Money that employers could have put toward higher wages has instead gone toward the cost of providing increasingly expensive health benefits. High health care prices also affect the federal budget – and as a result, taxpayers – through changes in Affordable Care Act marketplace subsidies and tax preferences tied to the provision of employer-sponsored insurance.xi

Addressing health care market competition is an important step in addressing provider prices to lower health care costs for the privately-insured, employers, and taxpayers. More broadly, health care consolidation may not improve – and could even harm – quality of care and likely limits patient choice and access. These outcomes manifest in varying ways depending on the provider entities consolidating and the tactics they use to garner market power.

While evidence around hospital consolidation is well-established, emerging evidence and trends also suggest that other tactics or types of consolidation – such as that being driven by private equity or between health plans and providers – may be leading to higher commercial market prices with limited effects on quality or access, though research is more nascent. Below, we outline the various types of consolidation occurring and their particular effects relevant to the commercial market, including between hospitals, physicians, and other entities – such as private equity firms, health plans, and pharmacy benefit managers.

**Horizontal Consolidation Among Hospitals.** Mergers and acquisitions between hospitals and health systems have traditionally been the predominant form of health care provider consolidation. 90% of hospital markets are considered highly concentrated per the Federal Trade Commission (FTC), and nearly every major metropolitan area is now dominated by one or more mega-health care systems.viii Many of these systems are tax-exempt nonprofit systems, and many cross state lines and geographic regions.ix Between 2000 and 2020, the share of hospital beds owned by multi-hospital systems increased from 58 percent to 81 percent.x Further, recent work indicates that the ten largest systems in 2017 earned comparable revenues to major international companies; for example, Cleveland Clinic’s $8.4 billion revenue was equivalent to that of the National Basketball Association, and UPMC’s $16 billion compared with the revenues of Whole Foods that year.xi

Numerous studies have documented an increase in commercial health care prices ranging from 6% to as high as 65% following hospital mergers, without corresponding improvements in health care quality.xi,xiii Not only do merged hospitals increase their prices — their nearby competitors raise their prices as well. In one study, neighboring hospitals increased prices by 8%.xiv,xv A more recent study from researchers at the University of California, Berkeley and UC College of the Law shows that cross-market mergers – those occurring between two providers operating in different geographic markets – result in price increases of 13% at the acquiring hospitals; prices increase more than 21% when the market share of the acquired
hospital was larger than the acquirer’s.\textsuperscript{xvi} Other research has found similar price effects, though the UC researchers’ work was the first to find that cross-market mergers had no impact on several key quality metrics.\textsuperscript{xvii} An average year of hospital mergers raised health spending on the privately insured in the year following the merger by $204 million between 2010-2015.

As other forms of consolidation increase, hospital mergers and acquisitions continue to occur – particularly the “acquisition[s] of multiple hospitals, or the merger of smaller and mid-size systems into larger, mega-health systems.”\textsuperscript{xviii} While we applaud the Administration’s efforts in recent years to limit the impact of this consolidation, there is more policymakers and regulators can do to limit further consolidation among hospitals or – in already consolidated markets – take steps to infuse competition back into markets, as outlined below.

**Vertical Consolidation Between Hospitals and Physicians.** In more recent years, vertical consolidation between hospitals and providers has increased substantially. Between 2012 and 2022, the share of physicians affiliated with hospitals or health systems rose from 29% to 41%.\textsuperscript{xx} While less is known about the impact of vertical integration (VI) relative to horizontal hospital consolidation, existing evidence consistently shows that VI between hospitals and physicians leads to higher prices. However, research to date on the impact on quality is more mixed. On average, prices increase 14.1% after physicians are acquired by a hospital.\textsuperscript{xxi} Research also indicates that price increases post-acquisition are greater when the acquiring health system is larger.\textsuperscript{xxi}

While there are multiple factors driving hospital-physician vertical integration, one driver is the financial incentives created by the lack of site-neutral payments in Medicare and the commercial markets, where hospitals charge higher prices for routine outpatient care and/or charge extra facility fees when they purchase outpatient facilities, such as a physician’s office. It is also worth noting that while vertical consolidation between hospitals and physicians has typically been in the form of an ownership relationship, newer contractual relationships – structured as “affiliations” between hospitals and providers (or even between multiple hospitals) – may have similar price effects.

There is also growing concern that 340B is spurring nonprofit hospitals to acquire physician practices and use contract pharmacies to generate bigger profits from the program, leading to further consolidation that ultimately raises commercial prices.\textsuperscript{xxiii}

**Vertical Consolidation Between Health Plans and Providers.** To counter vertically integrated health systems, a new trend is emerging where insurers are acquiring physician practices and ambulatory surgery centers (ASCs), among other types of providers. As of 2022, UnitedHealth’s Optum was the largest employer of physicians in the country, employing about 60,000 physicians (though this number has been disputed more recently\textsuperscript{xxiv}).\textsuperscript{xxv} CVSHealth, Elevance, and Humana have made significant acquisitions of physicians in the last few years as well.

This trend raises concerns about the potential effects of additional consolidation on health spending, but there has been minimal research on plan-provider integration and its impact on health care prices to date. On the one hand, by purchasing these provider types, insurers have more control over the health care spending of their enrollees and can ensure patients are referred to lower-priced facilities for common surgeries, potentially lowering health care spending as well as increasing the profits for the insurance companies. On the other hand, acquiring providers may also give insurers more market power and allow them to demand higher prices from other insurers contracting with the providers they own. It is unclear whether physicians owned by one insurer charge different prices for their own enrollees than they charge...
competitor plans, for example, and whether this type of integration, which insurers argue is aimed at countering the market power of integrated health systems, is actually increasing health care costs.

There are a number of unanswered questions about how consolidation between plans and providers might affect the acquiring plan’s prices, competitor plans’ prices, patient referral patterns, and the distribution of market power. Moreover, it is unclear if health insurers are relying on the same strategy used by private equity firms and hospitals during these acquisitions (and therefore can be regulated similarly), or if they are using different tactics entirely. Understanding these dynamics would be helpful for informing policy development and antitrust enforcement to address the harms of this consolidation.

A range of research to address these questions (as well as the implications in Medicare Advantage – see below) is forthcoming from academics and policy experts that could inform appropriate oversight and regulation of plan acquisitions of providers and its effects. There is also a need to understand other potential benefits and harms of this type of integration beyond spending – as there is some recognition that VI between plans and providers may result in improvements in care delivery or improve efficiency and practice administration.

**Vertical Consolidation Between Pharmacy Benefit Managers and Insurers.** Pharmacy benefit managers (PBMs) administer drug benefits on behalf of their clients (insurers and employers) by creating formularies, forming pharmacy networks, negotiating prices, and reviewing utilization. There are three large PBMs, each merged with a larger insurer, that cover 80 percent of the outpatient drug market and fall within the top 15 Fortune 500 companies. Mergers in the PBM industry have created a highly concentrated market which can exacerbate issues of transparency and create conflicts of interest across markets. Each of the three large PBMs serve insurers as clients but also compete with those same insurers in the marketplace. This creates an incentive for the merged PBM-insurer entity to charge competing health insurers more for its standalone PBM services.

**Vertical Consolidation Between PBMs and Pharmacies.** The top three specialty pharmacies are owned by the largest PBMs, which can create a conflict of interest across markets. The PBMs’ profits increase with the volume and price of prescriptions dispensed through its own specialty pharmacies—which does not align with the interest of its clients. Furthermore, the actual net cost of the specialty drugs purchased through pharmacies that are consolidated with PBMs creates transparency issues since price concessions can come in the form of lower acquisition costs (rather than rebates from the manufacturer) which may not be reported to the PBMs’ client.

**Private Equity.** Beyond hospital and health plans, other corporate actors, such as private equity firms, have increasingly entered health care markets to acquire health care providers and generate revenue. A wide and growing body of research shows that private equity’s acquisition of providers and the resulting consolidation often results in increased prices (for physician specialties) and changes in quality (for nursing homes/post-acute care providers – see more below); news stories also continue to highlight how private equity ownership can harm patient care and access. A 2022 JAMA study from Hopkins researchers finds that “private equity-acquired physician practices exhibited an average increase of $71 (+20.2%) charged per claim and $23 (+11.0%) in the allowed amount per claim.” Another 2022 JAMA study from Cornell researchers finds that private equity-employed anesthesiologists’ prices were over 2.5 times higher than non-PE-employed anesthesiologists.

Beyond price increases, private equity-backed providers also use other tactics to generate revenue, such as engaging in egregious out-of-network billing prior to the passage of the No Surprises Act (and continued
abuse of the law’s independent dispute resolution process used to determine payments) or closing down or selling off essential, but unprofitable service lines or facilities.

Roll-Up Acquisitions. “Roll-up” acquisitions – also known as “stealth consolidation” or “buy-and-build” – consist of the rapid acquisition of smaller entities (e.g., physician practices) to consolidate market power that escapes antitrust scrutiny because the transactions are typically smaller than those required to be reported to federal regulators under the Hart Scott Rodino threshold. They are used to horizontally consolidate physician practices, raising health care prices. Roll-ups have also dominated the dialysis market.

Private equity is particularly fond of “roll-ups”, as their model is focused on entering and existing a market in a relatively short time period (typically 3-7 years); rapid small transactions can quickly maximize the value of an entity/firm when the private equity company sells it. From 2012 to 2021, only 423 of 7,839 (approximately 5%) private equity deals were known to have exceeded the HSR threshold. U.S. Anesthesia Partners (USAP), Inc., who has recently been challenged by the FTC, was created as a platform by Welsh, Carson, Anderson, & Stowe to roll up anesthesiology practices; between 2012 and 2018, USAP purchased at least 17 practices. As of 2020, USAP employed 3,500 professionals in 8 states.

Implications of Consolidation Beyond Prices. Evidence suggests consolidation also impacts patient choice and access and has implications for health care workers – in terms of wages and job choices, as well as clinician autonomy. As consolidation increases, ownership of facilities and providers shrinks, narrowing patient’s ability to choose among them or receive care from independent competitors. Service line and facility closures also appear to occur in both urban and rural markets, following consolidation. For example, Wellstar – an Atlanta-area nonprofit – announced it was closing two of eleven hospitals, both of who served predominantly lower income and Black communities, following the purchase of said hospitals just several years prior. In rural areas, some consolidation may help rural hospitals remain open, though evidence suggests that key services (e.g., primary care, obstetrics, neonatal, non-emergency outpatient services, surgery, and diagnostic imaging) are reduced at rural hospitals following acquisition by larger systems. These reductions may exacerbate challenges in access to care, including increasing travel distances or wait times.

Research also indicates that consolidation reduces wages for certain health care workers (e.g., nurses) and limits health care worker autonomy. In 2018, 45% of primary care physicians were subject to noncompete clauses in hospital employment contracts, which limit physician choice in employment and ability to change jobs over time; consolidation may also impact clinical autonomy.

Effects and Drivers of Consolidation Affecting Public Payers
Public payers largely control prices, thus consolidation manifests differently in the Medicare and Medicaid programs, but the effects are equally detrimental and important. For example, consolidation may result in increased costs to the government, increased utilization, or an exploitation of the rules established by government actors, all in the interest of maximizing the profits of the parent company. Fewer resources may be available to care for people enrolled in the programs and other program priorities can be crowded out altogether. Additionally, market consolidation can enhance the political power of certain owners, which has effectively been used to argue against government cost containment and oversight efforts over time. It’s important therefore that any efforts to address consolidation also include efforts to identify and address its impact to public payers.
**Vertical Consolidation Between Medicare Advantage Plans and Providers.** Similar to vertical integration affecting the commercial market, vertical integration between Medicare Advantage (MA) insurers and physician practices is increasing with implications for the Medicare program.\textsuperscript{48} Several MA insurers including UnitedHealth Group, Humana, and CVS have all invested resources in acquiring physician practices over the last few years, and health system ownership of plans remains prevalent.\textsuperscript{49,50} These transactions signal that acquiring entities see significant financial advantages to becoming vertically integrated, some of which stem from MA payment policy. MA plans will argue that vertical integration enables more efficient care delivery, but there is no clear evidence this is occurring. There is emerging evidence, however, to suggest this kind of consolidation in the health care system has harmful effects that erode competition and increase costs for taxpayers and beneficiaries through several mechanisms including:

**Risk Score Gaming.** Under the current MA payment system, MA plans receive risk-adjusted payments based on coded diagnoses of their enrollees that are intended to account for differences in enrollee health status and expected costs. Research consistently shows that MA plans abuse the system by engaging in more intensive coding which makes their enrollees appear less healthy and inflates payments to plans.\textsuperscript{51,52} The evidence suggests that vertically integrated MA organizations have greater coding intensity and are better able to engage in risk scoring gaming and this is likely a significant driver of MA insurer acquisition of physician practices.\textsuperscript{53,54,55} Integrated plans can pass coding incentives to physicians via payment arrangements and work directly with physicians to capture additional diagnoses.\textsuperscript{56,57,58} These tactics enable integrated plans to generate higher payments and give them important competitive advantages. Because higher payments enable MA insurers to offer more generous extra benefits that influence beneficiaries’ plan choice, this may drive more beneficiaries to their plans and increase enrollment concentration. Overall, the existing evidence suggests this type of vertical integration decreases competition and increases costs for the federal government.\textsuperscript{59}

**Medical Loss Ratio (MLR) Gaming.** There is also emerging evidence that MA plan acquisition of related businesses (i.e., physician practices, supplemental benefits providers) enable them to evade MLR rules intended to limit plan profits. (MLR regulations require plans to spend at least 85% of their premium revenue on patient care versus other items such as administrative expenses or profit.) Because related businesses are not subject to the MLR, parent companies can structure favorable intercompany financial arrangements that circumvent the MLR to maximize profits for the integrated plan. For example, parent companies can direct their MA plan to purchase services from related businesses under the parent company at prices that exceed market-level prices, which side-steps the MLR rules by increasing the amount of revenue spent on patient care while at the same time boosting the overall profitability of the parent company.\textsuperscript{60,61} As part of the bid process, CMS requires that MA plans’ report arrangements with related businesses and establish that pricing is reasonable including by comparing prices paid to what the prices would be without such arrangements. Despite this, payments to acquired businesses (e.g., owned physicians) may still include a margin that enables profits to flow to the parent company and boost its profitability even though the insurer is meeting the MLR requirement. This highlights the need for stronger regulation and oversight of MA plans’ financial relationships with related businesses (discussed below).\textsuperscript{62}

**Star Rating Gaming.** Evidence suggests that MA’s quality bonus program has not led to meaningful improvements to quality and is a key driver of overspending in the Medicare program.\textsuperscript{63} These issues may be exacerbated in the context of integrated plans. The quality bonus program’s Star
Rating rewards plans for physician performance on a range of metrics including process-based clinical measures (e.g., breast cancer screening, medication reconciliation, flu vaccination, etc.).\(^1\) This creates an incentive for MA insurers to integrate with physician practices so they can have more control on physicians’ documentation of and performance on these measures.\(^{\text{lv}}\) Increases to the Star Ratings can mean that MA plans receive higher payments which they can use to fund more generous benefit packages that attract enrollees into their plans. To the extent this allows integrated MA organizations to effectively boost their star ratings, this enables a competitive advantage to integrated plans and increases costs to the government.

**Horizontal and Vertical Integration of PBMs and Medicare Part D Premiums.** Horizontal mergers involving PBMs that increase market concentration are of great concern across markets. The merger of Express Scripts and Medco in 2012 contributed to the highly concentrated PBM market that we have today. Additionally, mergers between large PBMs and large insurers have increased concentration in the Medicare Part D market.

One study found that when CVS (both a large PBM and a large sponsor of Part D plans) doubled its presence in the Part D market by merging with a plan sponsor in 2011, Part D premiums increased.\(^{\text{li}}\) Within Medicare Part D, one study found that the market share of vertically integrated insurer-PBMs increased from 30% to 80% between 2010 and 2018. This contributed to a 78% increase in premiums between 2010 and 2018 for smaller Medicare Part D plans that were using a larger rival’s PBM services.\(^{\text{lvii}}\)

**Private Equity in Nursing Homes and Other Medicare and Medicaid Providers.** People who use nursing homes are a driver of both Medicare and Medicaid spending, and this population experiences worse outcomes that are avoidable.\(^{\text{lxviii}}\) Given this, we have focused much of our exploration of the impact of non-hospital consolidation at the provider level on nursing homes to date, but we believe many of the findings are translatable to other provider types, especially those where Medicare and Medicaid are their predominant revenue source. An estimated 5% of nursing home facilities are owned by private equity, and private equity ownership has been shown to lead to worse outcomes for patients and have an impact on government spending.\(^{\text{lxix}}\) More specifically, in these facilities private equity ownership has been found to:

- Increase utilization of potentially unnecessary or avoidable services—stays in private equity-owned facilities are associated with a 4% increase in total quarterly per patient Medicare costs yet the outcomes for this additional spending did not improve,\(^{\text{lx}}\)
- Lead patients to experience worse outcomes such as:
  - Increase the likelihood of short-term mortality by 2-11% dependent on patient composition,\(^{\text{lxii}}\)
  - Decrease in mobility by 6.2%,\(^{\text{lxii}}\)
  - Increase the likelihood of developing a pressure ulcer by 8.5%,\(^{\text{lxiii}}\)
  - Increase in pain intensity by 10.5%,\(^{\text{lxiv}}\)
  - Increase the likelihood of an emergency department visit by 11%,\(^{\text{lxv}}\)
  - Increase the likelihood of a hospitalization by 8%,\(^{\text{lxvi}}\) and
  - Increase a person’s health deficiency score by 14% (i.e., worse).\(^{\text{lxvii}}\)

Private equity acquisitions are also associated with staff reductions and a relative decrease in skilled staff compared to less-skilled staff in nursing facilities. This is not only bad for patient outcomes but puts

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\(^1\) MA’s quality bonus program measures, reports, and rewards quality at the contract-level. This can mask variation in quality across plans within the contract and lead to strategic consolidation of plans within a contract to boost quality ratings.
increased pressure on existing staff. For example, research on nursing homes shows that private equity acquisitions result in a 12% decrease in registered nursing hours per resident compared to other for-profit entities. Given that evidence shows that staff ratios have an impact on patient outcomes, it’s not surprising that these facilities have relatively lower quality scores than other for-profit facilities.\textsuperscript{lxviii}

Outside of nursing homes, consolidation through private equity has also been shown to make it harder to access medically-necessary services. For example, now the durable medical equipment industry is dominated by just a few private equity-backed companies. Anecdotally, these companies have used their consolidated power to quash efforts by patients to seek timely repairs to their medical equipment. Furthermore, these companies’ efforts to cut costs have been linked to slow response times for equipment repairs that people with disabilities and other complex needs rely on to function and participate in society.\textsuperscript{lxxix}

\textit{Related Party Transactions.} Parent company ownership of related businesses can provide the opportunity for the parent company to control funding flows in a way that hides true profits and gives them a competitive advantage. There is evidence that this occurs in the context of MA where plan acquisition of related businesses enables them to circumvent MLR requirements (discussed above), and there is also evidence that this occurs in the context of corporate ownership of nursing homes.

CMS cost reports submitted by nursing homes indicate extremely low or even negative profits among these facilities. However, other indicators of an industry’s financial health portray these facilities in a different light. Between 2000 and 2020, 46.6% of nursing homes reported profit losses, yet the rate of facilities closing is relatively small. It’s estimated that there was a 0.95% annual exit rate during this period of time. For comparison purposes, the U.S. Census Bureau estimates that the national exit rate across all industries was 8.5% in the same time period. Furthermore, losses have not stopped the entrance of private equity into the market or mergers and acquisitions.\textsuperscript{lxxx}

A recent study identified another cause of these “losses”, related party transactions or “tunneling.” It was found that 63% of nursing home profits were “tunneled” in hidden to other businesses owned by the same corporate entities.\textsuperscript{lxxxi} Similarly, another analysis found instances where nursing homes’ payments made to related parties exceeded the reported costs by nearly 1200%.\textsuperscript{lxxii}

Similar to behavior seen in the Medicare Advantage market, parent companies may own many of the affiliated operational or care related entities and set prices above market rates, which enables them to inflate and hide profits. For example, corporate entities can charge nursing homes above market rates for the services, artificially inflating expenses and permitting the parent company to hide true profits. This also applies to the real-estate associated with the facilities—for example, a nursing home sells its real estate, commonly to a real estate investment trust (REIT), which can be owned by the same parent company. The parent company then charges the nursing homes above market rates for rent. These real-estate investment trusts are now estimated to exist in just shy of 10% of all nursing facilities\textsuperscript{lxxxiii} These tactics also can shield the nursing home’s assets in the instance of litigation, making obtaining appropriate settlements in cases of wrongdoing that much more difficult.

These examples highlight that there is little transparency regarding complex corporate structures in health care sectors, and how government funding flows through them. At the same time, the evidence from corporate ownership of nursing homes suggests that the parent companies leveraging these strategies are associated with poor outcomes. Increased transparency related to ownership structures, in particular when linked to actual outcome data, is important to assist policymakers and other stakeholders in...
determining how best to address any harms these tactics might create. It can also assist policymakers with weighing trade-offs associated with setting payment and establishing new requirements. For example, despite the evidence of hidden profits in nursing homes, the industry continuously pushes a narrative that it is underfunded through the Medicaid program in particular and needs higher reimbursement levels. Industry has also strongly pushed back on proposed CMS regulations that would mandate nursing home facilities meet certain minimum staffing requirements because their reimbursement rates are inadequate, calling the ratio requirements “unfunded mandates.”

**Need for Government Action: Policy Recommendations**

Arnold Ventures is supportive of a range of policies that would help address the issues and challenges outlined above and improve health care market competition to lower costs and improve quality of and access to care. Our recommendations are focused on:

1. Strengthening ownership and related party transaction data;
2. Limiting health care provider consolidation and improving competition;
3. Limiting the effects of vertical integration between insurers and providers in Medicare Advantage; and
4. Encouraging cross-administration data sharing and coordination.

**Strengthen Ownership Transparency and Related Party Transaction Data and Ensure Accuracy of Data**

We appreciate the Administration’s efforts to release hospital and nursing home ownership, mergers, and changes in ownership data. These data can help researchers and policy experts analyze health care competition issues, highlight trends, and identify the nuances to inform policy development and enable appropriate oversight and regulation of health care markets and public programs. Specifically, these data can be particularly useful in providing transparency over certain types of owners—such as private equity—that evidence suggests are using specific tactics or loopholes (e.g., vertical integration or out-of-network billing) to generate revenue at the expense of patient care, quality, and affordability. This level of transparency can be used to validate the existing evidence and ultimately hold the parent company (e.g., the private equity company) accountable for poor outcomes in the organizations they invest in when it’s appropriate. It can also be used to shed light on newer trends in vertical consolidation (e.g., hospital-provider and plan-provider) and inform other future policy development.

However, current ownership transparency data—mostly housed within the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) data—is incomplete and hard to access by policymakers and researchers, and there is limited information on the ownership linkages between different types of facilities in the PECOS data (such as providers owned by one private equity firm). For example, even in the nursing home industry which has undergone significant transparency efforts around ownership in the last several years undertaken by the CMS, the data is still poor. In their recently improved ownership database, CMS still failed to identify an estimated two-thirds of private equity investments and four fifths of Real Estate Investment Trusts (REIT) investments identified in comparable private data. Further, there are no publicly available data that provide a comprehensive view of ownership relationships between MA plans, physicians, and related business entities which prevents systematic investigations into the effects of such relationships on competition, federal spending, and other key outcomes.
**Enhance Ownership Transparency**

The federal government has significant authority within the Medicare and Medicaid programs to require reporting of ownership and corporate structure data. We encourage the Administration to enhance ownership transparency across health care sectors, including by:

- Beyond hospital and nursing home data, release merger, acquisition, and changes in ownership data for physician practices with more than 25 physicians; physician practices owned by hospitals, health plans, or private equity or venture capital firms; and ambulatory surgical centers and freestanding emergency departments.
- Extract and release additional ownership data in the PECOS data set to more clearly indicate type of owner beyond the entity name and provider type, including for profit, nonprofit, and other corporate (private equity, venture capital, etc.) ownership. Specifically, we recommend developing a specific “private equity indicator” to convey private equity ownership, as this information can only currently be determined by piecing together secondary sources, such as merger databases, news articles, press releases, and S&P market trackers.
- To further enhance understanding about roll-up acquisitions and the role of parent companies (i.e., which should include private equity actors where applicable), create a specific indicator or identifier number for parent companies operating chains of facilities or practices, as names alone (as self-reported in PECOS) are an inconsistent and unreliable method for linking together broader provider networks. The ability to assess the linkages between facilities through parent companies can provide information on the true magnitude and market power of certain actors. AV-funded work notes, “Experts who were able to access PECOS explained the only way to link chains of facilities together by ownership is by manually comparing the name of the owner from text fields. The trouble with this, experts explained, is that names are inconsistent in PECOS, likely due to the information being self-reported with no consequence for inconsistency.” Tax identification numbers or CMS certification numbers could be used as identifier numbers.
- Collect ownership information (e.g., name, corporate structure, tax status, etc.) about related third parties connected to the reporting entity. These entities should also have a unique identifier that can be linked across various facilities, including real-estate investment trusts.
- Release merger, acquisition, and changes in ownership data for hospitals, nursing homes, and the additional provider types outlined above at least annually moving forward. Additionally, when possible, publicly release analyses of trends in horizontal and vertical consolidation for these provider types at least annually moving forward.
  - Any data release should also explicitly highlight changes in ownership from for profit to nonprofit ownership, given the tax benefits nonprofit health care entities receive.
- Ownership data should be collected and shared in such a way that would allow it to be linked to other sources and tools that CMS uses in particular to collect payment, spending, and quality outcomes in Medicare and Medicaid data. Researchers and policymakers should be able to look at outcomes associated with a particular private equity investor, for example, across investments. Ownership data should be able to be linked, for example, to nursing home cost reports, medical loss ratio reporting, and hospital cost reports.

To ensure robust reporting and data accuracy, these data should be regularly audited, and the federal government should consider tying Medicare payment to compliance with these requirements. Both tactics – audits and connection to payment – have been identified anecdotally as best practices in states that collect this data to improve the reported data’s accuracy, ensuring true transparency is achieved.
Increase Transparency into PBM Contracting
Consolidation between PBMs as well as between PBMs, insurers, and pharmacies created a highly concentrated industry, which can exacerbate issues of transparency and create conflicts of interest that result in higher costs to patients, taxpayers, and employers. We are supportive of policies to address misaligned incentives in the PBM market (such as enhanced transparency and required reporting for PBMS, among other solutions\textsuperscript{xcii}) to mitigate some of the drivers of higher health care costs resulting from consolidation and related lack of transparency in this market.

Limit Further Health Care Provider Consolidation and Improve Provider Competition
Enhance Site-Neutral Payments. Because the Medicare program currently pays higher rates for services provided in a hospital setting rather than independent physician offices – even for routine services or those often and safely provided in a physician office – hospitals are incentivized to acquire physician offices to generate higher payments. Payment differentials based on the site of service result in care shifting from lower cost physician offices to higher cost hospital settings, leading to increased spending in Medicare and the commercial market.\textsuperscript{xciii} Arnold Ventures strongly supports the steps CMS as taken to date to advance site neutral payments, which pay the same amount for certain services regardless of setting. We encourage the Administration to use its authority to further expand site neutral payments in the Medicare program by:\textsuperscript{xciii}

- Narrowing the definition of free-standing emergency departments to those that function truly as an emergency department, such as those that provide most services on an unscheduled basis.
- Expanding site-neutral payments by eliminating grandfathering for existing off-campus departments and applying site neutral payment for all evaluation and management visits to all on-campus departments.
- In the absence of eliminating grandfathering for existing off-campus departments, releasing data on how many grandfathered locations exist and utilization trends for grandfathered vs. non-grandfathered locations to understand the impact and magnitude of eliminating the grandfathering exception.
- Updating CMS claims forms by adding additional modifiers to the “Place of Service” codes to better understand additional information about the provider when a facility fee or higher payment rate is being billed on provider claims. Modifiers could include “owned by” or “affiliated with” to indicate when a provider is potentially charging an additional site related fee, even if in an office-based setting. Adding these modifiers will be a foundational step in helping researchers and policymakers understand these billing practices and how frequently facility-related fees are being assessed, the magnitude of these fees, the prices being billed for the services, and which types of providers might be charging such fees and high prices. Because many plans use these forms for their commercial claims as well, this information can also help inform facility fee analysis and spending in the commercial market.

We are also supportive of similar policies to directly address prices in the commercial market; prohibiting providers from charging facility fees for services provided at hospital outpatient departments and standalone emergency rooms when the same service is commonly provided in a physician’s office can also reduce the incentives for vertical consolidation.

Strengthen Antitrust Enforcement. We applaud the Administration’s work to date to aggressively take on health care consolidation and take steps to strengthen oversight tools – including through the publication of this Request for Information. The FTC’s action over hospital mergers in Rhode Island\textsuperscript{xciv} and North Carolina\textsuperscript{xcv}, for example, release of updated merger guidelines, and litigation against US Anesthesiology Partners are all important steps for limiting the detrimental impacts of health care consolidation. We
support strong, continued antitrust enforcement and oversight by the FTC and the Department of Justice (DOJ) to prevent the continued growth of monopolies—particularly in less explored areas, such as vertical integration, sub-HSR mergers and roll-ups, and cross-market mergers. Maximizing the FTC’s authority over nonprofit providers is also an important step in improving provider competition, and we are engaged with the Congress in support of extending FTC’s authority to oversee nonprofit hospital conduct. We also recognize the need for additional resources for the FTC and DOJ to enhance their ability to engage more robustly in oversight and regulation of health care consolidation.

**Limit Anticompetitive Conduct.** Given that most hospital markets are already highly consolidated, we also support efforts to address anticompetitive behavior by powerful hospitals or physician groups. In particular, the recent launch of HealthyCompetition.gov to collect reports of unfair and anticompetitive health care practices is an important step to better identify these practices. We encourage the Administration to regularly release reports on the data submitted to the portal and support continued FTC and DOJ enforcement against specific anticompetitive actions identified through the portal. We are also working to advance legislative prohibitions on the use of anticompetitive contracting practices included in plan-provider contracts that limit plan negotiation power. This includes bans on tactics like all-or-nothing or anti-tiering/anti-steering clauses that are used by powerful hospitals to limit competition and charge higher prices, even in competitive markets.

**Limit the Effects of Vertical Integration Between Insurers and Providers in Medicare Advantage**

**Make Risk Score Data Available to Researchers.** CMS should make existing beneficiary-level risk score data (including for additional and more recent years) available to researchers to enable more comprehensive assessments of the extent to which integrated MA organizations are engaging in greater risk score gaming to inflate payments. These data are essential to understanding the impact of vertical integration in MA on competition in the MA market and federal spending.

**Mitigate Risk Score Gaming.** Given evidence indicating that integrated MA organizations are better able to engage in risk score gaming and have greater coding intensity, the Administration should limit the effects of vertical integration in MA on coding. Specifically, CMS should use its authority to apply a higher coding adjustment factor than what is minimally required of it in statute via an approach that takes into account variation in coding across MA organizations. For example, plans could be tiered based on their coding intensity. Plans in the highest tier would receive the largest coding adjustment while plans in the less intensive coding tier would receive a smaller adjustment, with the total adjustment across all MA organizations averaging to size of the difference in risk scores between MA and traditional Medicare.

**Protect Against MLR Gaming.** Given evidence suggesting that parent companies can structure intercompany financial arrangements to circumvent the MLR and increase profitability, greater oversight is needed to hold parent companies more accountable to MLR requirements. A first step that the Administration could take to protect against MLR gaming is to improve the transparency of transfer prices for related business entities and establish an approach for assessing whether transfer prices reflect reasonable market-level rates.xcvi

**Encourage Cross-Administration Data Sharing and Coordination**

We are pleased that the Administration has taken a number of steps to better coordinate among the Department of Health and Human Services (HHS), DOJ, and FTC to promote and strengthen health care competition. This will lead to stronger policies aimed at improving market competition and allow each agency to leverage its own regulatory authority more effectively. We encourage the Administration to continue this coordination and continue to:
• Pursue independent or joint investigations into anticompetitive conduct, consolidated markets, and other predatory or monopolistic practices pursued by powerful health care entities.

• Regularly collaborate and share hospital and provider data on ownership and consolidation. For example, while the FTC and DOJ are often at the forefront of health care consolidation issues, they are limited in both staff capacity and funding; providing this type of data could help to catalyze further enforcement efforts and identify new types of consolidation for investigation. This collaboration should include engaging across the Administration to understand what new or additional data would be helpful to the work of improving health care competition.

We thank the Departments and the Commission for your efforts to address health care competition. We look forward to working with you on this important issue and would be pleased to provide further information on the above. Please contact Andrea Noda (anoda@arnoldventures.org), Arielle Mir (amir@arnoldventures.org), and Erica Socker (esocker@arnoldventures.org), Vice Presidents of Health Care at Arnold Ventures, with any questions. Thank you again for the opportunity to respond to this Request for Information, and for your consideration of the above.

Sincerely,

Mark Miller
Executive Vice President, Health Care
Arnold Ventures


Andrew Witty testimony


