Attachment—Additional Questions for the Record

Senate Committee on the Judiciary, Subcommittee on Competition Policy, Antitrust, and Consumer Rights, hearing entitled
"Antitrust Applied: Hospital Consolidation Concerns and Solutions"
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The Honorable Michael S. Lee (R-UT)

1) Two days after our hearing, the New York Times reported that some hospitals may be using funds they received under the CARES Act Provider Relief Fund to buy up their competitors.[1] I am concerned that the government has yet again directly facilitated consolidation in the hospital industry. Do you share these concerns, and how can policymakers avoid such mistakes in the future?

I share these concerns. A large portion of the CARES Act Provider Relief Funds[2] were provided without a specific requirement as to use, did not screen providers as to geography (rural, urban, suburban), or assess differential need. Distribution was frequently based total net patient revenue and partially on Medicare fee for service revenue . Consequently, many large and already financially stable health systems such as the Cleveland Clinic[3] and the Mayo Clinic[4] received CARES Act funds while reporting record 2021 operating income during the pandemic. For example, the Mayo Clinic raised over $1 billion in philanthropy[5] despite having over $18 billion in investment asset[6] and despite this received and subsequently returned half of its CARES Act funds.[7] At the same time, the Cleveland Clinic had over $12 billion in long term investments[8] and even during the height of the pandemic had a $650M million credit line and $447 million in investment income, yet turned a net profit due to CARES Act funds.[9] It is unclear why such institutions needed or need financial support from the federal government.

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[1] https://www.nytimes.com/2021/05/21/health/covid-bailout-hospital-merger.html
[2] "The Provider Relief Fund: Frequently Asked Questions." *CRS* April 7, 2022. Available from: https://sgp.fas.org/crs/misc/R46897.pdf
[3] https://www.beckershospitalreview.com/finance/cleveland-clinic-s-operating-income-more-than-triples-in-2021.html
[4] https://www.beckershospitalreview.com/finance/mayo-clinic-operating-income-jumps-to-1-2b.html
[5] https://newsnetwork.mayoclinic.org/discussion/mayo-clinics-2021-achievements-affirm-bold-forward-strategic-vision-staff-dedication/
[6] https://cdn.prod-carehubs.net/n7-mcnn/7bcc9724adf7b803/uploads/2022/02/2021-Mayo-Clinic-Consolidated-Financial-Report.pdf
[7] https://www.beckershospitalreview.com/finance/mayo-clinic-returns-nearly-half-its-federal-covid-19-aid.html
[8] https://my.clevelandclinic.org/-/scassets/files/org/about/financial-statements/cchs-2021-w-ob-nonob.pdf?la=en
[9] https://www.fiercehealthcare.com/hospitals/cleveland-clinic-posts-49m-profit-for-first-nine-months-2020-as-covid-19-hampers-finances

Subsequent corporate action denotes that business continued as usual with respect to expansion of specialty services, growth, and mergers. In the case of Mayo, the corporation purchased 288 acres around its existing site to expands it specialty footprint.[10] The Cleveland Clinic purchased a hospital from the Sisters of Mercy Health System in the Clinic's home Ohio market of December of 2020,[11] and opened a private hospital in London in 2022.[12] Other health systems engaged in similar corporate behavior, with CommonSpirit Health, a large West Coast health system, expanding its existing Washington state presence through its purchase of Virginia Mason.[13]

In order to future mistakes, any direct federal funding/subsidization should be specifically required to be used for direct clinical uses in the future, with policymakers strictly enumerating use of funds similar to the following: clinical labor, information technology infrastructure, existing facility improvements, and purchase of medical equipment for existing medical facilities directly for the provision of emergency care in a pandemic or for the creation of emergent, temporary medical care sites reasonably expected to be used for less than 180 days. Policymakers should add specific language that funds should be not be utilized for the purchase of new facilities, long-term investment projects, or executive compensation. Finally and arguably most importantly, inclusion of specific language denoting eligibility through an assets test with specific requirements (e.g. long-term investment assets must be less than $500 million or 25% of the annual gross operating expenses average over the prior 3 years, whichever is lower) would ensure that any funds go to the facilities that need it most.

The Honorable Thomas Tillis (R-NC)

1. One concern that arises from hospital mergers is the impact it has on the prices insurers, and ultimately, consumers and taxpayers, pay for care. Can you share your perspective on the impact mergers and acquisitions of hospitals, particularly local, community-based hospitals, have on the cost of care?

Hospital mergers drive consolidation and raise prices. Research shows that mergers result in higher prices for health care services.[14] Higher prices resulting from hospital mergers are then reflected in higher insurance premiums for consumers.[15,16] Despite these broad national studies

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[10] https://ktar.com/story/4811192/mayo-clinic-buys-288-acres-for-expansion-around-phoenix-hospital/
[11] https://www.fiercehealthcare.com/hospitals/cleveland-clinic-makes-deal-sisters-charity-to-acquire-mercy-medical-center
[12] https://www.fiercehealthcare.com/providers/cleveland-clinic-opens-private-london-hospital-near-buckingham-palace
[13] https://www.fiercehealthcare.com/hospitals/chi-franciscan-virginia-mason-finalize-acquisition-deal-and-roll-out-new-name
[14] Cooper Z, Craig SV, Gaynor M, Van Reenen J. The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured. *Quarterly Journal of Economics* 2019;134(1):51-107. doi: 10.1093/qje/qjy020
[15] Boozary AS, Feyman Y, Reinhard UE, Jha AK. "The Association Between Hospital Concentration And Insurance Premiums in the ACA Marketplaces." *Health Affairs* 2019;4:668-674. doi: 10.1377/hlthaff.2018.05491
[16] Trish EE, Herring BJ. How Do Health Insurer Market Concentration and Bargaining Power with Hospitals Affect Health insurance Premiums? *J Health Econ* 2015;42:104-11. doi: 10.1016/j.jhealeco.2015.03.009

and summaries thereof,[17] local evidence suggests a similar story. In 2018, both UNC and Atrium Health considered merging, with the State Attorney General questioning whether such a transaction would raise prices and create a monopoly.[18] The transaction was later abandoned based upon these and other concerns.[19] More recent examples include HCA's acquisition of Mission Health, now the subject of suits alleging monopolization resulting in higher prices for consumers[20,21] and state oversight concerns into how the deal was undertaken.[22] Outside of nonpartisan academic and policy research, research conducted for the purposes of investigative journalism reveals the effects of local mergers in various geographies: higher prices for consumers.[23]

2. I am particularly interested the impact mergers have on the cost of healthcare for rural and underserved communities. Can you share your thoughts on the costs mergers may impose on rural and underserved communities?

Mergers raise costs regardless of their locality. Many merging rural entities utilize a "failing firm thesis," that a merger is necessary in order to save an otherwise failing business. Yet, a study characterizing 380 rural hospital mergers in the early 2000s denoted that some hospitals closed post-merger.[24] Long standing academic and policy research denotes that competition reduces costs and improves quality in the market for health care services. Ensuring that rural and underserved communities benefit experience and from competition for critical health care services is even more important.

3. Is it possible that government regulations actually caused the consolidation of hospitals?

Absolutely. Many government policies drive consolidation of hospitals and health care delivery in general. From 2010 to 2017, there were over 778 hospital mergers,[25] with research denoting that now over 90% of hospital markets are now considered consolidated.[26] The last several decades of hospital mergers coincided with a wave of accelerating hospital acquisition of

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[17] https://www.rwjf.org/en/library/research/2012/06/the-impact-of-hospital-consolidation.html
[18] https://www.fiercehealthcare.com/finance/atrium-health-university-north-carolina-merger-ag-wants-details
[19] https://www.fiercehealthcare.com/finance/atrium-health-unc-health-care-merger-talks-suspended
[20] https://www.citizen-times.com/story/news/2021/08/10/hca-mission-anti-trust-class-action-lawsuit-claims-higher-prices-lower-quality/5544976001/
[21] https://www.fiercehealthcare.com/providers/hca-healthcare-faces-another-antitrust-lawsuit-tied-2019-mission-health-merger
[22] https://www.northcarolinahealthnews.org/2022/03/20/hca-deal-was-rigged-ag-office-concerned/
[23] https://www.nytimes.com/2018/11/14/health/hospital-mergers-health-care-spending.html
[24] https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2018/08/Rural-Hospital-Mergers.pdf
[25] Shwartz K, Lopez E, Rae M, Neuman T. "What We Know About Provider Consolidation." *Kaiser Family Foundation* September 2, 2020. Available from: https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/
[26] Fulton BD. Health Care Market Concentration Trends In the United States: Evidence And Policy Response. *Health Affairs* 2017;36(9):1530-1538. doi: 10.1377/hlthaff.2017.0556

physician practices, driving vertical consolidation of care delivery.[27] Multiple federal policies drove and continue to drive both horizontal and vertical consolidation in care delivery.

The lack of site neutral payment, or paying the same amount for the same service provided, regardless of where it is provided, drove hospital acquisition of many other components of care delivery, resulting in the creating of large health system oligopolies or even monopolies covering hospital care, ambulatory care, and home health.

Secondly, the 340B drug pricing program is a significant driver of consolidation, both horizontal and vertical. While well-intentioned when created in 1992 – it provides access to low cost pharmaceuticals intended for underserved patients – both the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and the Patient Protection Affordable Care Act expanded scope of eligibility. Currently, over 50,000 clinical sites[28] including over 2,500 hospitals[29] participate in the program.

At its core, the 340B program allows safety net hospitals (now comprising a universe of hospitals far broader than that) to purchase pharmaceuticals at an artificially low price, yet has no restrictions on their use. That is, the drug does not have to follow the patient, and discounted drugs can be administered to patients regardless of their ability to pay or insurance coverage. Understandably, this has driven consolidation across the care delivery supply chain.

Research has demonstrated that expanded facility eligibility for the 340B program is not associated with increased provision of charity care.[30] Other work has demonstrated how the growth of the 340B program has driven hospital acquisition of physician practices in hematology/oncology and ophthalmology without engendering expanded access to care for low-income populations.[31] Still other work has suggested that the program exists primarily as a wealth transfer from the pharmaceutical industry to the hospital industry in addition to being a potential driver of consolidation.[32]

In summary, policymakers should look to close payment policy arbitrage loopholes, or opportunities for the health system to buy various components of care delivery and bill higher for the same service or product based upon arbitrary rules. Policymakers should remove the government's foot from the accelerator driving consolidation.

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[27] Nikpay S, Richards MR, Penson D. "Hospital-Physician Consolidation Accelerated In the Past Decade In Cardiology, Oncology." *Health Affairs* 2018;37(7):1123-1127.
[28] Mulligan K. "The 340B Drug Pricing Program: Background, Ongoing Challenges and Recent Developments." *USC Leonard D. Schaeffer Center for Health Policy and Economics* October 14, 2021.
[29] Fein A. "New HRSA Data: 340B Program Reached $29.9 Billion in 2019; Now over 8% of Drug Sales." *Drug Channels* June 9, 2020. Available from: https://www.drugchannels.net/2020/06/new-hrsa-data-340b-program-reached-299.html
[30] Desai SM, McWilliams JM. 340B Drug Pricing Program and hospital provision of uncompensated care. Am J Manag Care. 2021 Oct;27(10):432-437. doi: 10.37765/ajmc.2021.88761.
[31] Desai S, McWilliams JM. Consequences of the 340B Drug Pricing Program. N Engl J Med. 2018 Feb 8;378(6):539-548. doi: 10.1056/NEJMsa1706475

[32] Conti RM, Bach PB. The 340B drug discount program: hospitals generate profits by expanding to reach more affluent communities. Health Aff (Millwood). 2014 Oct;33(10):1786-92. doi: 10.1377/hlthaff.2014.0540

4. Looking past antitrust remedies and enforcement, are there are other laws we should consider modifying and changing? In other words, looking holistically at our healthcare system, what statutory changes should we consider making in order to deal with the issue of hospital mergers and acquisitions?

There are multiple levers that the government can use to improve enforcement and promote market entry, the latter representing unorthodox levers. First, to improve enforcement, policymakers can provide the Federal Trade Commission (FTC) statutory authority for addressing anti-competitive practices by non-profit hospitals. Currently, these cases are handled by the Department of Justice Antitrust Division due to a lack of FTC authority over these non-profit entities, despite the FTC handling and having experience with related merger enforcement in hospital and health system merger cases. Correcting this would ensure efficiency in antitrust oversight and enforcement.

Secondly, policymakers can undertake multiple efforts at the federal level to promote hospital and health system market entry with an aim to improving competition. This does not discount the need for state level reforms, such as addressing Certificate of Need processes that restrict facility entry at the local levle. First, as part of the ACA, a statutory prohibition on new physician-owned hospitals (POH)s from participating in the Medicare program was implemented. Further, existing POHs were prohibited from expanding. POHs exist in two primary markets: general acute care or community hospitals and specialty hospitals (cardiac, orthopedic, and general surgical). Recent evidence demonstrates that physician-owned cardiac hospitals have similar costs and higher quality to their community hospital competitors, while physician-owned orthopedic specialty hospitals have lower costs and higher quality. Physician-owned community hospitals are similar in cost and quality performance to their non-physician owned (i.e. non-profit and for-profit) community hospital counterparts.[33] In order to improve competition by promoting the creation of new hospitals, policymakers could reverse the ban on new or expanded POHs from Medicare, building off of evidence that competition improves quality and lowers costs.

Stark Law reform offer a final opportunity to promote market entry. With early research demonstrating concerns that physicians engaged in inappropriate self-referral – a form of fraud, waste and abuse that policymakers rightly sought to avoid – researchers supported and policymakers enacted a series of reforms enshrined in statute and subsequent rulemaking prohibiting physicians from making referrals for designated health services to an entity in which they have a financial relationship and subsequently billing Medicare. Notably, corporate self-referral is frequently a soft or hard requirement as part of clinical practice when physicians are employed as part of a health system, with an aim to support integrated and coordinated high quality care. While a series of exceptions to Stark Law remain, including recent efforts by the prior administration, Stark Law remains a statutory impediment to value-based contracting for all market participants and to the creation of physician-owned and -operated integrated care

[33] Cho T, Meshnick AB, Ehrenfeld JM, Miller BJ. "Cost and Quality of Care in Physician-Owned Hospitals: A Systematic Review." *Mercatus Center at George Mason University* Arlington, Virginia. September 7, 2021.

delivery enterprises. The payment world of today is vastly different from that of the 1980s and 1990s when Stark Law was passed: nearly 76% of Medicaid beneficiaries are part of a managed care program with 46% enrolled in risk-adjusted capitated managed Medicaid[34] while nearly half Medicare beneficiaries are enrolled in Medicare Advantage, a risk-adjusted capitated public-private program. Unlike fee for service Medicare and Medicaid, these managed care programs have built in utilization review tools to identify, manage, and combat fraud, waste, and abuse.

Thus, re-examining the challenges and benefits of self-referral <u>for all market participants</u> is needed, along with the creation of either exceptions, modifications, or wholesale repeal of Stark Law (noting that providers would still be subject to anti-kickback statutes, which have criminal liability).

5. How have federal government healthcare policies—again, looking at them holistically—influenced the closure of hospitals in rural and underserved areas?

Rural hospitals frequently operate in economically depressed regions and have a less favorable payer mix (i.e. higher share of Medicaid and Medicare). Thus, with fewer financial resources, such institutions are more sensitive to the cost of regulation and compliance. For example, it is well-documented that rural areas suffer from a shortage of mental health care (psychiatrists, psychologists, and both clinics and hospitals) in addition to a significant burden of unmet mental health needs.[35] Yet, at the same time, compliance costs are significant, with a study denoting that 62 inpatient facilities spent an estimated 4.8% of annual revenue on compliance.[36] For a business section with operating margins in the 0 – 3% range, the costs of regulatory compliance can mean the difference between being a going concern or filing for bankruptcy.

Each type of regulation adds an additional cost from preparation, process, consulting, and auditing. CMS and other agencies frequently add new requirements without simultaneously examining whether prior regulations are still meaningful and necessary, thus increasing costs for hospitals. While industry estimates of the cost of regulatory are likely overestimated at $1,200 per patient admission,[37] the concern that costs are real and significant is valid and is one of several significant drivers of rural hospital financial distress.

6. Can you explain the impact hospital mergers and acquisitions have on the quality of care for patients? I am particularly interested in the impact on care for rural areas.

A recent study in the New England Journal of Medicine completed a study of hospital mergers using Medicare claims and Hospital Compare data. The study authors found no difference in

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[34] Total Medicaid MCO Spending. *Kaiser Family Foundation* 2019. https://www.kff.org/other/state-indicator/total-medicaid-mco-spending/

[35] https://rupri.org/wp-content/uploads/Behavioral-Health-in-Rural-America-Challenges-and-Opportunities.pdf

[36] https://www.nabh.org/wp-content/uploads/2019/03/The-High-Cost-of-Compliance.pdf

[37] https://www.aha.org/system/files/2018-02/regulatory-overload-report.pdf

quality subsequent to mergers as measured by 30-day readmission or 30-day mortality rates, and unfortunately did find a decrement in patient experience.[38]

A subsequent study looking at specifically rural hospitals in the open access journal JAMA Network Open found small but significant improvements in quality associated with rural hospital mergers.[39] *Unfortunately, this study suffers from several critical flaws that undermine the policy significance of its results and are noted by the authors:*

1. *Imbalances in the two groups (merged v. non-merged) hospitals persisted after matching merged hospitals to non-merged controls. This suggests that the comparison groups were not the same. Denoted in Supplement eTable 1,*[40] *merged hospitals were on average larger, less likely to be a critical access hospital, and more likely to be a private nonprofit as opposed to a public hospital. These differences were significant, for example 19.8% of the merged hospitals group were public hospitals as opposed to 54.3% of the initial comparison hospitals. These and other characteristics suggest that the groups were starkly different, and that statistical adjustment after the fact does not account for what is a wholly inaccurate comparison.*

2. *Another important challenge noted by the authors is that their study spans the change from ICD-9 to ICD-10 diagnostic coding, which affects use and measurement of quality indicators. This is a significant confounder of quality improvement analyses.*

3. *Finally, the authors note that after mergers, hospitals could curtail service lines or transfer high risk patients to urban centers driving the appearance of higher quality of rural facilities when in fact risk is shunted. As transfers and service line reductions were not measured, this is a significant draw back to this study.*

   In response to this study, other researchers studied and found that high risk / high mortality service lines such as surgery and obstetrics/gynecology services were closed after mergers and correlated with increasing demand in neighboring areas, lending credence to the aforementioned concern.[41]

7. Do mergers actually improve patient access to comprehensive, integrated care? For example, a merger between two local hospitals may reduce choice, but the consolidation might also allow the new merged hospital to commit resources to the development of

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[38] https://www.nejm.org/doi/full/10.1056/NEJMsa1901383

[39] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2784342

[40] https://cdn.jamanetwork.com/ama/content_public/journal/jamanetworkopen/938760/zoi210722supp1_prod_1631288531.09998.pdf?Expires=1665695460&Signature=K77vinGPc2lZylxRavFCH2WyRdtXuSFMsn6p~M5ougmE~wSmtt6hgEM1V4i21HX4n2P1xXvO3BWyXekJDTwlgeEIi29cD9zyPmo1kEKxULPDaKJ23aUn6V6o8LOn1bYGRFbxOmSawALWJwX1vPqvqVKOwsH8K3dSD0e68JKfCPMjt15rCiPa3822PmL-60Ws56AuYMtxMp2LIyESAa9jEJo4tyG6PIPsd6SDOY7RmuhMkPdrzc0bIi~HL9yfUEhSqm4g6fQoejUST7UXNlvKRSwmNpjvcWVZmuZqzcoeKJgoymBuEzTWG-zcQ87QX7fLhh7Bj~~HG6oURgnQj7pY~g__&Key-Pair-Id=APKAIE5G5CRDK6RD3PGA

[41] *https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2021.00160*

more comprehensive treatment methods and specialties. How do mergers affect access to more comprehensive, integrated treatment?

Many mergers are purported to increase access to comprehensive, integrated care as a tradeoff between reduced choice. However, access to comprehensive, integrated care can be achieved by other mechanisms such as contracting, joint ventures, or other tools to improve clinical alignment.

For example, consider two local hospitals looking to improve access to integrated care for joint replacements. Instead of merging two separate hospitals, both hospitals could together create a joint venture to create an ambulatory surgery center for outpatient total hip and knee replacements. The joint venture surgery center could contract with a local orthopedic group for surgical coverage or create its own independent medical group for staffing. A physical therapy clinic could be purchased, built from the ground up, or contracted. Home care coverage for after-surgical care such as home physical therapy could come from one of many local, regional, or national home care companies. For patients with rheumatologic diseases, orthopedic surgeons could refer such patients to rheumatologists at either hospital. Care coordination could be promoted by offering the joint venture surgical center and other physicians access to the same electronic health record platform and technological support through contracting or at preferred rates under a valued-based arrangement. Patients evaluated to need inpatient care after joint replacement could be referred to either hospital.

Such a hypothetical scenario would preserve competition and simultaneously promote coordinated, integrated care. Mergers are frequently not required to achieve clinical operational and population-level health goals.