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Advancing Health in America

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December 2, 2019

Francis J. Crosson, M.D.
Chairman
Medicare Payment Advisory Commission
425 I Street, N.W., Suite 701
Washington, DC 20001

Dear Dr. Crosson:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the Medicare Payment Advisory Commission's (MedPAC) discussions on consolidation within the health care field as well as graduate medical education. As the Commission continues its deliberations, we would like to share some observations related to both of these issues.

Regarding your November discussion, we have several concerns related to hospital consolidation. Specifically, we are concerned that:

- **The discussion presented a myopic view of the purported dangers of hospital mergers to the exclusion of their many benefits;**
- **The analysis of hospital mergers was flawed and oversimplified;**
- **Contrary to what was reported at the meeting,**
    - **the Federal Trade Commission (FTC) has not under-enforced the antitrust laws in hospital mergers, and**
    - **physician integration with hospitals does benefit patients; and**
- **The review of the current research on hospital consolidation was oversimplified.**

Regarding your September discussions on potential modifications to the Indirect Medical Education (IME) program, we continue to:

- **Be concerned that the proposed changes to the IME program would result in considerable payment decreases for a substantial number of teaching hospitals, limiting their ability to carry out critical functions.**

- **Urge MedPAC to share additional information and analysis on the effects of its proposals, in light of limited information provided during the meeting.**
- **Urge the Commission to give due consideration to teaching hospitals' essential function as a crucial source of inpatient care and medical training, and to adequately maintain financial support to ensure high-quality care at these organizations.**

We thank you for your consideration of our comments. Please contact me if you have questions or feel free to have a member of your team contact Erika Rogan, senior associate director of policy, at (202) 626-2963 or erogan@aha.org.

Sincerely,

/s/

Ashley B. Thompson
Senior Vice President
Public Policy Analysis and Development

MEDPAC'S DISCUSSION ON HOSPITAL CONSOLIDATION

During the November meeting, MedPAC staff presented work on its congressionally-mandated report on hospital consolidation. Our concerns related to this work are outlined below.

MedPAC has presented a myopic view of the purported dangers of hospital mergers. MedPAC raises concerns that hospital mergers increase bargaining leverage with health insurers, leading to higher commercial reimbursement rates. But MedPAC focused on inpatient services only while the health care field is transitioning to provide the majority of care on an outpatient basis.[1] It is myopic to focus on only inpatient services when evaluating the impact of hospital mergers. Providers face far lower and fewer barriers to entry or expansion on outpatient services as compared to inpatient services. Providers of outpatient services are strong competitors to hospitals and do not have the high cost structure of operating an inpatient facility. Recent examples of entry in the outpatient space include Optum – a division of insurer UnitedHealth Group – acquiring Surgical Care Affiliates, a large national outpatient services provider, and CVS's acquisition of Aetna, which was followed by announced plans to make CVS drugstores destinations for outpatient care with a goal of reducing hospital admissions.[2]

MedPAC uses a flawed (and oversimplified) analysis of hospital mergers. MedPAC's analysis of hospital mergers relies heavily on hospital merger concentration levels, based on the Herfindahl-Hirschman Index (HHI). The HHI is calculated by squaring the market share of each hospital competing in the market and then summing the result. A merger that produces an HHI above 2,500 points with a change greater than 200 points will likely raise antitrust concerns. But HHI calculations depend entirely on market definition and, at best, are the beginning of the analysis of the impacts of concentration but not the end point on which to base a conclusion. Furthermore, an HHI calculation in a geographic or product market that has not been properly defined is not valid.

MedPAC has not properly defined the market for hospital mergers. It used Core Based Statistical Areas for the geographic markets in which to calculate market shares for the HHI assessment. That approach is not consistent with the reliability that the courts and antitrust agencies insist upon in defining markets for assessing mergers and

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[1] *See, e.g.*, Medicare Payment Advisory Commission: Medicare Payment Policy: Report to the Congress. March 2019, pp. 69-73, http://www.medpac.gov/docs/default-source/reports/mar19_medpac_entirereport_sec.pdf (showing that between 2007 and 2017 the number of inpatient discharges declined while outpatient visits and outpatient spending increased substantially); United States Ambulatory Surgery Center Market Report 2019, Research & Markets, Oct. 2019, https://www.prnewswire.com/news-releases/united-states-ambulatory-surgery-center-market-report-2019-300945571.html ("The ambulatory surgery center (ASC) market is estimated to grow by up to $52-55 billion by 2025").

[2] Allison Kodjak, CVS Looks to Make Its Drugstores a Destination for Health Care, NPR, Feb. 21, 2019 https://www.npr.org/sections/health-shots/2019/02/21/695216345/cvs-looks-to-make-its-drugstores-a-destination-for-health-care.

acquisitions, including hospital mergers. Market definition is not a one-size-fits-all approach. Instead, it requires a fact-based approach that fully understands the unique aspects of each market examined.[3] Otherwise it is entirely unreliable.

A proper geographic market must encompass the arena of effective competition where insurers can turn for alternative sources of supply. The key question when defining geographic markets is whether a hypothetical monopolist controlling all of the hospital services in that area could profitably implement a small but significant non-transitory increase in price. If so, then the area is a relevant geographic market. MedPAC does not undertake a proper analysis before defining markets and, as a result, its findings are unreliable.

Even if markets were defined properly, HHIs are not particularly useful as a means to evaluate the competitive effects of hospital mergers. HHIs measure market concentration levels and are most useful to understand the likelihood for enhanced coordination among remaining market participants after a merger. It would be extremely difficult for hospitals to engage in successful coordination because their services are not homogenous.

MedPAC's concerns focus entirely on increases in bargaining leverage for network inclusion with insurers from lost head-to-head competition between merging hospitals. But HHIs do not estimate the degree of competition between hospitals in this context.

The FTC has not under-enforced the antitrust laws in hospital mergers. MedPAC suggests that there has been "minimal change in antitrust regulation since 1980." That is incorrect and a fundamental misunderstanding of antitrust law and policy. Antitrust analysis is a fact based analytic framework that has withstood the test of time for many different fields and industries; it is not a regulatory exercise.

The changes in antitrust analysis and enforcement reflect changes in economic analysis and market circumstances. The FTC has continued to refresh its approach to hospital merger enforcement.[4] In a letter to the FTC in 2018, we criticized the FTC's approach to reviewing hospital mergers because its approach was flawed and resulted in over-

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[3] See In the Matter of ProMedica Health System, Inc., Docket No. 9346, Opinion of the Commission (citing U.S. Dep't of Justice & Federal Trade Comm'n, Horizontal Merger Guidelines § 1), https://www.ftc.gov/sites/default/files/documents/public_statements/promedica-opinion-commission-commissioner-julie-brill/120328promedicaopinion.pdf, ("[M]erger analysis should not consist of uniform application of a single methodology…. [T]he fact-specific nature of merger review necessarily entails a flexible analysis tailored to the nature of the market under examination, and there are a range of analytical tools that can be applied to the evidence to evaluate the competitive concerns from a transaction.").

[4] In the Matter of Evanston Northwestern Healthcare Corporation, Docket No. 9315, https://www.ftc.gov/enforcement/cases-proceedings/0110234/evanston-northwestern-healthcare-corporation-enh-medical-group.

enforcement not under-enforcement.[5] This over-enforcement has undoubtedly discouraged hospitals from attempting mergers that may draw FTC scrutiny.

MedPAC suggests, however, that the FTC under-enforces the antitrust laws against hospital mergers because it only challenges "2-3 percent of mergers a year." That again, is a misunderstanding of how the FTC investigates hospital mergers. The reality is that the FTC has many tools to derail any merger it believes *may* be problematic, including onerous second requests and the threat of its own administrative review, both of which would consume a vast amount of time and resources and therefore discourage nearly any hospital from pursing a transaction to which the FTC objected, regardless of the merits for doing so.[6]

Federal policy incentivizes hospital-physician consolidation. We agree with several MedPAC commissioners that federal policy encourages hospital-physician mergers. For example, the Stark law and the Anti-Kickback statute make routine, efficient transactions that occur in other sectors of the economy problematic – or even felonies – when undertaken between independent physicians and hospitals. These statutes push hospitals to acquire physicians so they can operate more efficiently while avoiding the often draconian penalties imposed for violations of Stark law, the Anti-Kickback statute and the False Claims Act.

Physician integration with hospitals benefits patients. The presentation at the November meeting indicated that hospital-physician integration leads to increases in prices and Medicare spending. However, the evidence for such a sweeping conclusion is contradicted by other studies.[7] It also fails to account for the facts that both the regulatory requirements associated with providing care in a hospital and the characteristics of patients treated in a hospital (older, sicker) are principally responsible for increased costs.

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[5] See Federal Trade Comm'n, Overview of FTC Actions in Health Care Services and Products, June 2019, pp. 51-84 and Re: Federal Trade Commission Hearings on Competition and Consumer Protection in the 21st Century – Project P181201 – Comments from the American Hospital Association on Defects in the Models Used for Evaluating Hospital Transactions https://www.aha.org/system/files/2018-12/181217-let-ftc-defects-in-models-used-for-evaluating-hospital-transactions.pdf

[6] Prepared Statement of FTC Chairman Joe Simons to Senate Committee on Judiciary for hearing on "Oversight of the Enforcement of the Antitrust Laws", Sept. 17, 2019. https://www.ftc.gov/system/files/documents/public_statements/1544480/senate_september_competition_oversight_testimony.pdf (noting that the FTC recent successful effort to block a healthcare provider merger in the Eighth Circuit marked the "fifth straight appellate victory involving health care provider consolidations, [which] has solidified in case law the agency's analytical approach to these mergers, strengthening our ability to block anticompetitive mergers among health care providers.").

[7] For example, one recent study found that physician participation on the hospital board is associated with lower hospital expenditures when hospitals acquire and integrate physicians. *See* Na-Eun Cho, Sejoong Lee, & Joonwhan David Lee, *Economic Evaluation of the Impact of Physician-Hospital Integration and Physician Boards on Hospital Expenditure Per Patient: A 5-Year Longitudinal Study*, Med. 97(41): e12812, Oct. 2018, https://www.researchgate.net/publication/328211350_Economic_evaluation_of_the_impact_of_physician-hospital_integration_and_physician_boards_on_hospital_expenditure_per_patient_A_5-year_longitudinal_study.

Moreover, the discussion appears to ignore the significant patient benefits from hospital-physician integration. These benefits include:

- Promoting better coordination of care between hospitals and physicians, reducing wasteful medical expenditures and increasing quality of care.
- Improving access to care for underserved populations. Physicians employed by hospitals do not have a financial incentive to treat patients without commercial insurance. But when physicians join large health care systems, they routinely are required to (and do) provide care to all patients, regardless of ability to pay.
- Stabilizing physician group practices by providing them with the financial resources and infrastructure to provide top-notch care in the community.
- Enabling the physicians to engage in more risk-based contracting that provides financial incentives to providers who help patients avoid costly procedures.
- Facilitating the recruitment of more physicians to the community so patients have better local access to care.

Insurer acquisitions of physician groups (e.g., United-Optum) do not provide the same benefits. Most insurer-acquired practices do not provide assured access or free services to the uninsured, as hospitals do. Physicians employed by insurers likely will be discouraged from treating patients who do not have commercial insurance. Thus, insurer acquisitions of physician groups likely will diminish access to care for the uninsured and even those covered by Medicaid and Medicare.

MedPAC's review of the current research on hospital consolidation was oversimplified. MedPAC staff definitively concluded that historical research has proven that consolidation leads to higher commercial prices for hospital care. Although staff did not provide specific examples during the discussion, we find that observers who are typically predisposed to an antagonistic perspective rely on the same flawed studies from critics such as Zack Cooper, Martin Gaynor, Leemore Dafny and Chapin White. None of these studies reach a causal conclusion about the relationship between hospital consolidation and prices, rather they typically find an association. In addition, none of the studies to date have combined an analysis of harm with an analysis of benefits. Moreover, all of these studies lack data from Blue Cross plans, which dominate virtually every market – a serious omission that is typically not addressed by the studies. The AHA has expressed concerns about drawing nationwide conclusions

with significant policy implications from these studies, each of which are flawed in significant ways.[8,9,10,11] Some examples of these studies and their flaws include:

- "The Price Ain't Right?" report[12] is based on old and incomplete data, none of which include the payer with the biggest share in most markets, and with highly uneven geographic representation. The authors rely on old claims data (2008 – 2011) from the Health Care Cost Institute, which is comprised of employer-sponsored data for just three large payers, Aetna, Humana and United. These data represent just 13.5% of covered lives.

- Similarly, authors of the "Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely" report[13] drew nationwide conclusions from a sample representing just 2% of all covered lives, and claims that represented just 1% of all hospital expenditures. And 73% of allowed amounts analyzed in the study came from just three states: Colorado (48%), New Hampshire (15%) and Michigan (10%).

On the other hand, Charles River Associates (CRA) analyzed Medicare cost report data to better understand the effects of consolidation on revenue and costs.[14] MedPAC staff were quick to dismiss the study because it did not use actual price data. CRA was transparent in the data limitations and the goals of the study, which were not to examine the effects of hospital mergers on prices, but rather the net effect on revenue, which includes both inpatient and outpatient care and accounts for contractual allowances and other discounts given by the hospital. This study found that, relative to non-merging hospitals, hospital acquisitions were associated with a statistically significant 2.3% reduction in operating expense per admission and a statistically significant 3.5% decline in revenue per admission at the acquired hospitals. In addition, an August 2018 Health Affairs study found that higher premiums are associated with local health insurance monopolies while hospital market structure had relatively weak associations with premiums across markets.[15]

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[8] "AHA responds to RAND study on prices paid to hospitals by private health plans." https://www.aha.org/news/headline/2019-05-09-aha-responds-rand-study-prices-paid-hospitals-private-health-plans
[9] "'The Price Ain't Right' Ain't Right Again!" https://www.aha.org/news/blog/2018-05-21-price-aint-right-aint-right-again
[10] "New analysis finds recent RAND study misses the mark." https://www.aha.org/news/blog/2019-06-05-new-analysis-finds-recent-rand-study-misses-mark
[11] "Comments on Cooper et al. 'Hospital prices grew substantially faster than physician prices for hospital-based care in 2007-2014.'" https://www.aha.org/issue-brief/2019-02-14-comments-cooper-et-al-hospital-prices-grew-substantially-faster-physician
[12] "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured." https://academic.oup.com/qje/article-abstract/134/1/51/5090426
[13] "Prices paid to hospital by private health plans are high relative to Medicare and vary widely; Findings from an employer-led transparency initiative." https://www.rand.org/pubs/research_reports/RR3033.html
[14] "Charles River Associates report: Hospital merger benefits." https://www.aha.org/2019-09-04-charles-river-associates-report-hospital-merger-benefits
[15] ACA Marketplace Premiums Grew More Rapidly In Areas With Monopoly Insurers Than In Areas

Moreover, MedPAC staff are quick to dismiss the work of CRA because it was commissioned by the American Hospital Association. However, staff did not express similar skepticism about the work funded by the HCCI, or using the HCCI data, even though that organization is funded and supported in part by insurers. Meanwhile, horizontal and vertical consolidation among insurers continues unabated. For example:

- 75% of health insurance markets are highly concentrated.[16]
    - In 48% of markets, one insurer had a combined market share of 50% or greater.
    - The share of markets that are highly concentrated increased from 71% to 75% between 2014 and 2018.
- UnitedHealth Group reported that it employs, partners with, or contracts with 30,000 physicians in 2018, up from 22,000 physicians the year before, and has agreed to acquire DaVita Medical group, which employs another 17,000 physicians.
- Following the CVS/Aetna merger, the three largest pharmacy benefit managers are under insurance company ownership.

In addition to their econometric analysis, CRA interviewed hospital executives to better understand the purpose of hospital acquisitions and consolidation. The CRA study found that the priorities of hospital systems are increasingly focused on addressing the continuum of care needs in a value-based delivery system framework. Moreover, mergers allow health systems to achieve scale, reduce capital costs, standardize clinical protocols and guidelines, and enable health systems to bear risk for the cost of care. Critics of CRA's qualitative data collection wrongly suggested that the study could not be taken seriously because the interviewees were not selected randomly, but that is not standard practice.

Qualitative data should not be dismissed on the basis of who funded the work and who was interviewed, rather, these findings should be viewed within that context, so that the perspective the qualitative work brings can be carefully considered. Many unbiased institutions have found ways of incorporating qualitative research into their work. For example, the Medicaid and CHIP Payment and Access Commission leaned heavily on structured interviews with a variety of stakeholders as it explored Medicaid Delivery System Reform Incentive Payment programs, among other work it has done. Both the Government Accountability Office and MedPAC itself use structured interviews as a key component of program evaluation and policy analysis.

We urge MedPAC to take into account the issues identified above and work more closely with stakeholders as it continues its work on consolidation.

With More Competition, Health Affairs, August 2018. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2018.0054

[16] "Competition in health insurance research." https://www.ama-assn.org/delivering-care/patient-support-advocacy/competition-health-insurance-research

ANALYSIS OF MEDPAC'S PROPOSED IME PROGRAM MODIFICATIONS

In September, MedPAC commissioners discussed possible changes to the IME program including: shifting some IME funds to the outpatient setting; eliminating capital IME payments; and reducing aggregate IME payments in order to shift funds to a performance-based payment program. While total aggregate IME funds would remain the same, MedPAC acknowledged that there would be "substantial redistribution of IME payments" and that many teaching hospitals would see "material changes" in their IME payments. This redistribution also would have significant impacts on hospitals' total Medicare margins.

As noted in our previous letter, we appreciate MedPAC's recognition that more care is shifting to the outpatient setting. However, we support several MedPAC commissioners' concerns that the redistributive effects of the proposal could have a detrimental effect on the mission of teaching hospitals. These providers play essential roles in providing highly specialized care, serving the most complex and vulnerable patients, and training the next generation of practitioners. Given the costs associated with these activities, decreases in IME payments may substantially limit their capacity to carry out their critical roles. During the September meeting, MedPAC staff noted that 20% of teaching hospitals could see as much as *a 25% decrease* in their IME payments. Further, it was indicated that a number of hospitals could experience *a 5% or more decrease* in their total Medicare payments due to the proposed changes.

In light of the possibility of such significant payment changes, several commissioners requested a more granular assessment of the hospital-level impacts of the potential modifications to the IME program. **The AHA also has endeavored to examine the potential effects of MedPAC's IME program proposals.** We used the information discussed during the September meeting to model the proposal's effects using fiscal year (FY) 2017 Medicare cost report data, running several different models to infer parameters that were not discussed in the session.[17]

Given the challenges in estimating the impact of IME program modifications without detailed information, we continue to urge MedPAC to share additional information and analysis on the effects of its proposals. Nevertheless, based on our findings, we have become even more concerned that the proposed changes to the IME program would result in considerable payment decreases for a

[17] We modeled shifting some inpatient IME funds to outpatient, based on a resident-to-average daily total equivalent census (i.e., teaching intensity), and eliminating capital IME. Because features of the proposed performance-based system remain unknown, we were not able to account for how those funds would be redistributed (although we estimated the aggregate amount). We ran several models to, for example, determine an appropriate multiplier, which reflects the increase in payment relative to the increase in teaching intensity, and an appropriate coefficient, which reflects the relationship between teaching intensity and hospital costs. We utilized 12 months of data from the FY 2017 cost reports, for all hospitals that had both operating and capital IME payments. For those hospitals that did not have 12 months of data in their FY 2017 Medicare cost report, data were length inflated to equal 12 months.

substantial number of teaching hospitals, limiting their ability to carry out critical functions.

Our estimates suggest that cuts could be even more draconian than first reported. For example, more than a quarter of teaching hospitals would stand to lose *25% or more* of their IME payments. Among this group, more than one fifth would lose *at least 40% of their IME funds*, which would result in an approximately *4% decrease in overall Medicare margin* for these hospitals on average[18] – margins that already stand at negative 9.0%, on average, according to MedPAC's March 2019 report. Moreover, our analysis indicates that more than two thirds of public and non-for-profit teaching hospitals would experience losses as a result of MedPAC's proposed changes.

As the Medicare margins for teaching hospitals have been declining for nearly a decade, further decreases to Medicare payments could compromise the financial stability of these providers. **We continue to urge the Commission to give due consideration to teaching hospitals' essential function as a critical source of inpatient care and medical training, and to adequately maintain financial support to ensure high-quality care at these organizations.**

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[18] Importantly, as indicated above, the exact impact of MedPAC's proposals cannot be estimated without further information, including more detail about how the performance program would distribute funds. However, we believe our results are reasonable because, after trying to construct an inpatient plus outpatient measure of teaching intensity with only the very limited information provided in the September meeting, we arrived at aggregate payments across settings similar to those presented by MedPAC staff. As noted above, we reduced total aggregate IME payments by approximately $1 billion that would be presumably be redistributed according to some performance criteria; thus, our estimated IME payments represent a lower bound and may not necessarily reflect the actual payments to be received by providers under the proposed modifications. However, even if the program were to retain total aggregate IME payments by distributing the roughly $1 billion, the potential provider-level losses estimated in our analysis are very concerning given the reliance on teaching hospitals to care for the most complex patients and educate the next generation of practitioners.