AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

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June 5, 2024

VIA REGULATIONS.GOV FILING

Competition Policy and Advocacy Section, Antitrust Division
U.S. Department of Justice
950 Pennsylvania Ave., N.W.
Suite 3337
Washington, DC 20530

RE: Request for Information on Consolidation in Health Care Markets

The American Association of Hip and Knee Surgeons (AAHKS) appreciates the opportunity to submit comments to the United States Department of Justice's Antitrust Division (DOJ), the Federal Trade Commission (FTC), and the Department of Health and Human Services (HHS) collectively referred to as "the Agencies" in response to their Request for Information on Consolidation in Health Care Markets (the "RFI")[1].

AAHKS is the foremost national specialty organization of more than 5,200 physicians with expertise in total joint arthroplasty (TJA) procedures. Many of our members conduct research in this area and are experts on the evidence-based medicine issues associated with the risks and benefits of treatments for patients suffering from lower extremity joint conditions. AAHKS is guided by four principles:

- Payment reform is most effective when physician-led;
- Reductions in physician reimbursement by public and private payers drives provider consolidation;
- The burden of excessive physician reporting on metrics detracts from care; and
- Patient access, especially for high-risk patients, and physician incentives must remain a focus.

AAHKS specifically writes to respond to the RFI's solicitation of comments regarding the underlying causes of consolidation in health care and to provide the agencies with specific feedback from the experiences of their nationwide membership. Our membership remains clear on this issue: *reimbursement reduction combined with increased costs of staff and inflationary pressures leave private practice physicians with increasingly difficult financial decisions about how to continue operations while maintaining a high level of care for their patients.*

[1] Department of Justice, Department of Health and Human Services, Federal Trade Commission Docket No. ATR 102 Request for Information on Consolidation in Health Care, March 5, 2024.

I. EFFECTS OF CONSOLIDATION

There is a misconception that consolidation happens because retiring physicians want to sell their practices to "cash out." Instead, for many physicians, selling to private equity (PE), a large health system or to a private payer is the only means to continue to practice medicine in the face of reimbursement cuts and cost increases.[2] Our members are clear, private practice surgeons by definition would like to remain independent and the ONLY reason consolidation occurs is because running a practice with this level of reimbursement coupled with inflation is financially unfeasible. Unfortunately, according to the American Medical Association (AMA), the numbers of doctors owning their practices has declined drastically in recent years.[3]

a. LOSS OF AUTONOMY FOR PROVIDERS AND THE DOWNSTREAM DISRUPTION OF THEIR TALENT AND WORKFORCE PIPELINE ARE THE TWO PREDOMENENT NEGATIVE CONSEQUENCES OF CONSOLIDATION

Loss of autonomy: Selling to maintain a practice's ability to serve patients without a disruption in service or reduction in quality often leads to a physician group losing autonomy over the practice. This is not ideal for the physicians because this necessarily includes other parties into what was previously solely the direct doctor-patient relationship. Many physicians have made the difficult decision that staying open and continuing to care for their patients via an infusion of capital is more important than having their preferred business structure for their independent practice.

Disruption of the downstream talent and workforce pipeline: For junior partners at practices that sell, consolidation often stifles their own practice. This impacts both the physician's career and professional development as well as their patients and their own doctor-patient relationships. Without guardrails to protect and mentor junior partners at practices that sell, fewer junior physicians receive training and mentoring on how to run and operate an independent practice. Negative impacts for these junior physicians could mean a reduction in talent for the profession as a whole. This could also impact patients' timely access to care.

b. PAYOR PURCHASES OF PROVIDERS ARE UNIQUELY PROBLEMATIC

Payor-owned providers are a uniquely problematic form of consolidation in health care. A payor-owned practice may have exclusive arrangements with certain hospitals, specialists, or

[2] "Responses to the 2022 Benchmark Survey indicated that the need to better negotiate favorable (higher) payment rates with payers, better manage payers' regulatory and administrative requirements, and improve access to costly resources were the most important motivations for private practices selling to hospitals or health systems." AMA 2022 Policy Research Perspectives

[3] With regard to employment status, 44.0 percent of physicians were owners in 2022, 49.7 percent were employees, and 6.4 percent were independent contractors. This is in great contrast to 2012 when 53.2 percent of physicians were owners and, even more so, to the early and mid-2000s, when around 61 percent of physicians were owners (Wassenaar and Thran 2003; Kane 2009), and the early 1980s when the ownership share was around 76 percent (Kletke, Emmons, and Gillis 1996). AMA 2022 Policy Research Perspectives

suppliers, constraining patients in their choices and decreasing competition. Further, care and outcomes could be negatively impacted if the payor creates a significantly narrowed network or attempts to control medical decision making through methods such as the pre-authorization denial process. In short, payors that own private practices can exert even more control than other buyers leading to fewer protections around the doctor patient relationship.

c. CASE STUDY: MAINE

General Overview: The State of Maine has a population of nearly 1.4 million people. Of the 30 hospitals in the state, 20 are part of one of the two major health systems that have 12 and 8 hospitals respectively.

Consolidation overview: In 2011 there were no hospital employed physicians in Maine. By 2012, one hospital employed group had emerged. Now, in 2024, there are two hospital employed groups made up of a merger of several private physician groups that recently partnered with a private equity group. Such significant consolidation over the last 12 years has impacted both physicians and patients as follows.

Consolidation impact on physicians:

- This trend of consolidation has limited the negotiating power of physicians during contract negotiations due to lack of alternative ways to preserve financial feasibility.
- Neither of the two major health systems owns an ambulatory surgery center (ASC), resulting in inflated hospitals payments and margins, due to lack of lower acuity facilities for simpler, outpatient surgeries. Further, because the State is a certificate of need (CON) law state, it is difficult for physicians to open new ASCs and provide local patients with more options for treatment. Without competition among providers, there is little incentive for health care systems to improve upon current procedures.
- Perhaps due to consolidation, these hospital systems have minimal engagement with Value Based Care (VBC) or Alternative Payment Models (APMs).

Consolidation impact on patients:

- Patients in Maine now have fewer options in types of providers.
- Patients also are experiencing longer wait times for care.
- Prices have also increased for elective surgical options due to very few orthopedic ASCs in the state (only four).

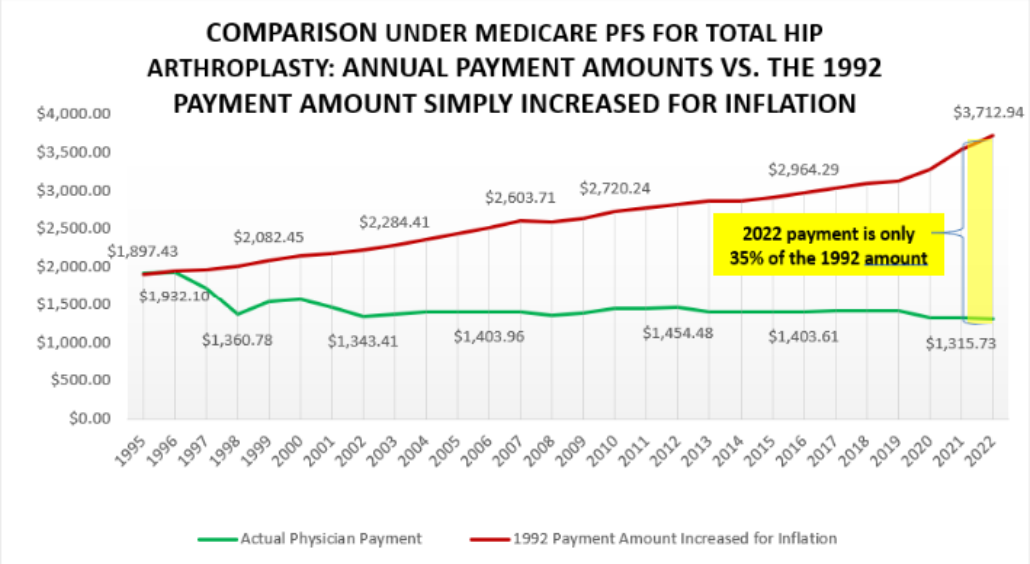
II. CLAIMED BUSINESS OBJECTIVES FOR TRANSACTIONS:

a. OUTSIDE CAPITAL ADDRESSES THE CHALLENGE OF SUSTAINED LONG-TERM REIMBURSEMENT DECLINE

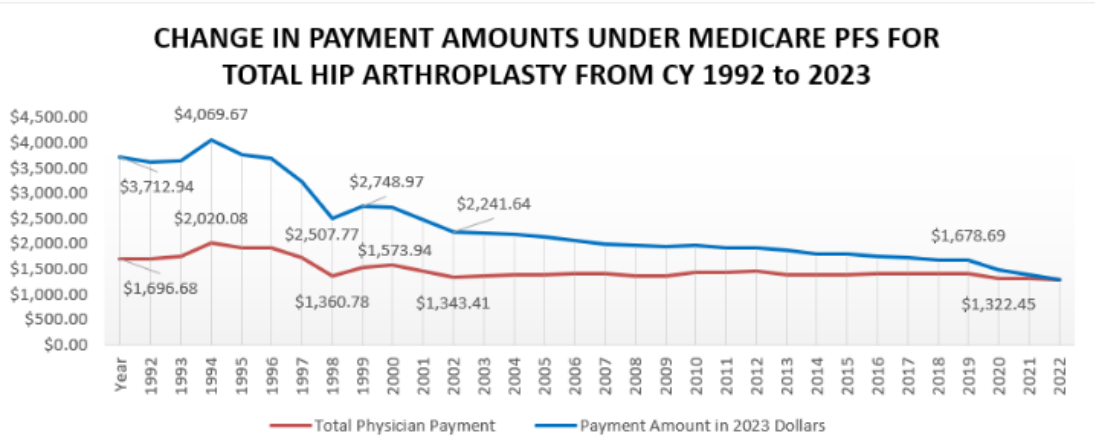
As discussed above, acquisition by PE, a large health system, or private payor is now often the only way for physicians to continue their practice in a financially practical manner.

Continued Medicare cuts to physician reimbursement for total hip and knee arthroplasty, which have drastically outpaced overall cuts to the physician fee schedule over the past 30 years, is the primary factor driving health care consolidation in orthopedic surgery and the growing inability of physicians to maintain an independent practice. These declining reimbursement rates, particularly a 65% cut in real dollar Medicare rates over 30 years, make maintaining an independent practice financially unfeasible.

For example, current Medicare reimbursement to physicians for total hip arthroplasty is only 35% of the amount it would have been if adjusted for inflation each year since 1992.

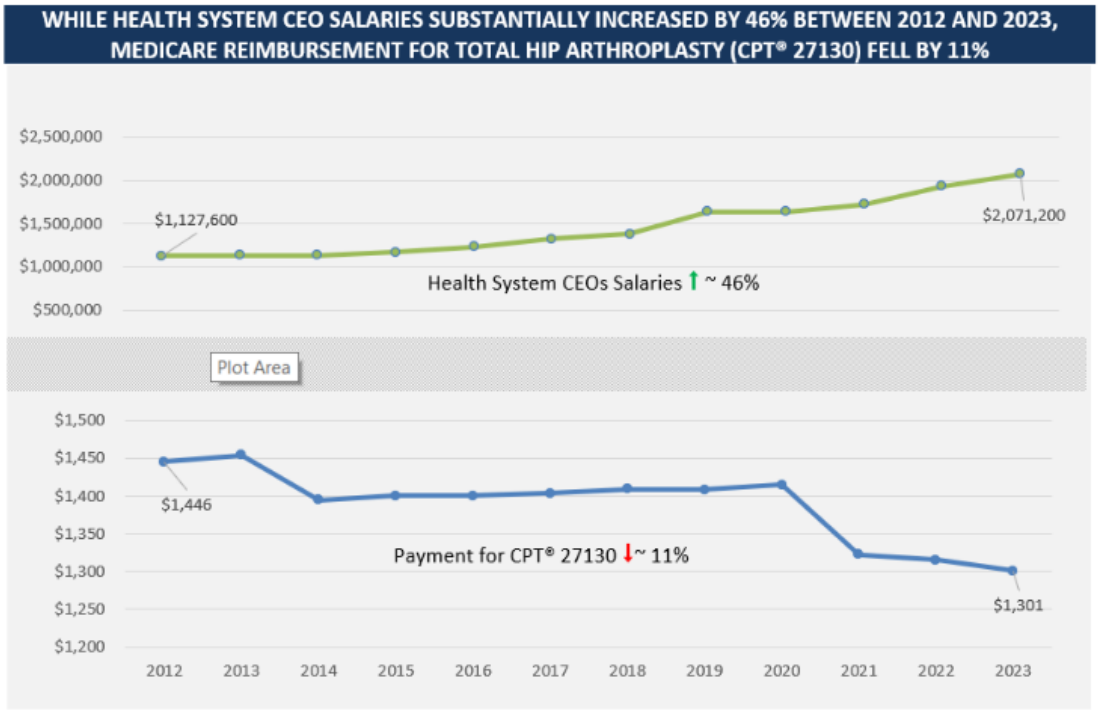


Illustrated another way, current Medicare reimbursement to physicians for total hip arthroplasty has fallen 22% since 1995. When adjusted for inflation, current Medicare reimbursement to physicians for total hip arthroplasty has fallen 65% since 1995. Such sustained cuts inarguably make it financially unfeasible for our members to afford to practice independently.



Our understanding is that TJA reimbursements have been a disproportionate target of physician fee schedule reductions because TJA is among Medicare's highest volume and highest value procedural code. There is urgent demand for our members' surgical interventions as Americans are increasingly burdened with comorbidities that accelerate end-stage osteoarthritis and necessitate total hip and knee replacements.

Advancements in patient care, pioneered by many of our members, have drastically reduced hospital patient days for TJA, improved recovery times, reduced use of opioids and have consistently saved substantial money for the Medicare program.[4] To be clear, ongoing TJA physician reimbursement cuts *undermine* the goal of improving care and reducing costs and drive consolidation of providers. The fact of reductions in physician reimbursement is particularly frustrating when compared with trends in health care executive compensation more broadly.



DATA NOTES: Health system executive compensation data was obtained from Modern Healthcare's analysis of the SullivanCotter Annual Executive Compensation Survey. Data for CYs 1992 – 1999 for Current Procedural Terminology (CPT®) code 27130 (Total Hip Arthroplasty/Total Hip Replacement) reflects the applicable Physician Fee Schedule publication. Data for CYs 2000 – 2023 reflects CMS' data compilation from the CMS Physician Fee Schedule Lookup Tool. The payment amount calculation reflects payment for total hip arthroplasty procedures performed in a facility. The payment amount does not take into account any particular MAC locality or Medicare Geographic Practice Cost Index (GPCI) adjustments.

[4] "CJR episode payments decreased by 3.7% more in the first two years of the CJR model. This represents a $146.3 M gross savings." Comprehensive Care for Joint Replacement (CJR) Model Evaluation of Performance Years 1 and 2 (2016 – 2017)

b. OUTSIDE CAPITAL ADDRESSES THE INCREASES IN STAFF COST AND INFLATIONARY INCREASES GENERALLY

Staff shortages and increased cost: For all of the blowback about PE, for better or worse, the PE model offers a unique funding opportunity to help with increased staff salaries and inflationary costs while also providing funding to allow for the transition to value-based care.[5]

Capital infusion is crucial for enhanced scale and technology optimization and all of these components are critical for the survival of private practice orthopedic programs and their ability to compete with large healthcare systems.

As staffing shortages continue to hurt the healthcare industry, medical group practices face surging expenses for facilities, supplies, IT and more. Research by the Medical Group management Association (MGMA) indicates that the cost of many non-labor expenses have increased significantly including drug supply (36%), information technology (24%), facilities (17%) and administrative supplies (15%). [6]

As was discussed by provider witnesses at the Senate Finance Committee hearing on April 11, 2024, entitled *Bolstering Chronic Care through Medicare Physician Payment*, if the capital infusion is utilized properly, these transactions can improve patient care coordination, and enhance staff satisfaction and professional growth through a thriving healthcare program.

Physician-led practices are key in making sure that the clinical program quality and patient care remain the paramount factors in determining care and treatments. Ensuring that these critical partnerships are formed only through transactions that are physician-led preserves clinical program quality and patient care.

The predominant worry our members have expressed is that they will be pressured to take financial repercussions into account when making clinical decisions and that those pressures will ultimately harm patient care and outcomes.

Inflationary Pressures: Our members report that staffing and supply costs continue to rise, and mandatory reporting and electronic medical costs continue to grow. These challenges coupled with the cuts to reimbursement outlined above put real financial strain on our members and their independent practices.

[5] Private equity investments consistently support quality, affordable health care for patients across America. Private equity-backed hospitals employ a higher ratio of doctors, nurses, and pharmacists compared to their non-private equity backed counterparts, according to research from Indiana and Georgetown Universities. The same study found that wages increase significantly at private equity-backed hospitals." American Investment Council Letter to FTC Chair Lina Khan p2 March 4, 2024.

[6] Inflation, rising expenses for drugs, supplies, IT and facilities strain medical practice finances.

This experience of our members is backed by national statistics as well. According to the Kaiser Family Foundation, in March of 2024, "medical inflation was 2.2% from the same time last year. This was lower than inflation in the overall economy, which was 3.5%."[7]

III. NEED FOR GOVERNMENT ACTION

a. ENHANCED FTC SCRUTINY OF PRIVATE PAYER ACQUISION OF PRACTICES IS NEEDED

More focused scrutiny by the FTC of private payer acquisition of provider practices is needed to address consolidation concerns. Private payer acquisition of provider practices impacts choice in models of care and creates an insurmountable imbalance of power between providers and private payers. This imbalance of power leads to even more consolidation of health care than does the purchase of provider practices solely by entities like PE or a health system.

b. DECLINING MEDICARE REIMBURSEMENTS MUST BE ADDRESSED

Continued cuts to Medicare reimbursement make it more difficult for surgeons to sustain independent practices or have a realistic range of options for practice models. This leads to mergers and consolidation. Consolidation leads to fewer choices for consumers across the care continuum, higher prices, and decreased access to care—particularly in rural and underserved areas. In light of President Biden's *Executive Order on Promoting Competition in the American Economy*, CMS should evaluate whether its proposed reductions in Medicare physician rates promote competition in health care or if they facilitate consolidation.

AAHKS is optimistic for the future passage of H.R. 3284, *the Providers and Payers COMPETE Act of 2023*, which has been reported out of the House Committees on Energy & Commerce and Ways & Means, to require the Secretary of Health and Human Services (HHS) to assess and report to Congress on the impact of any Medicare reimbursement or regulatory changes on consolidation of healthcare providers and payers. Such reporting is an important step to better inform Congress and CMS on how not to exacerbate health industry consolidation through Medicare payment rates reductions.

c. MEDICARE REIMBURSEMENT MUST KEEP PACE WITH INFLATION AND FACILITY REIMBURSEMENT TO PREVENT INCENTIVE FOR PROVIDERS TO SELL

Continued Medicare cuts to physician reimbursement for total hip and knee arthroplasty, which have drastically outpaced overall cuts to the physician fee schedule over the past 30 years, is the primary factor driving health care consolidation and the growing inability of physicians to maintain an independent practice. As Congress and the agencies work to update the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to update the Physician Fee Schedule (PFS) and incentive payments for VBCs and APMs, we request that our members' experiences with consolidation based on reductions in reimbursement are addressed.

[7] Peterson-KFF Health System Tracker https://search.app/TjNdpx5YmUcm25dZA

d. REQUEST THE AGENCIES CONDUCT A REVIEW OF HOW CERTAIN STATE LAWS INCENTIVIZE HEALTHCARE CONSOLIDATION

We request that the agencies conduct a review of state specific data for any correlation between change of ownership rates and state laws impacting the leverage of facilities.

This research would help understand how state laws may be limiting competition among providers. For example, it is important to understand the impact of state certificate of need (CON) laws as well as state laws with aggressive non-compete provisions in employment contracts that may prevent physicians from opening new facilities or expanding their services.

Our members report that acquisitions are more likely in the presence of state laws that weaken physicians relative to health care systems and/or health plans. In our experience, facilities consolidate and exercise more market power when federal and state policies weaken physicians. Data on the correlation between such state laws and health care consolidation is crucial.

This review would help the agencies understand if there is a pattern on the rate of acquisitions in states with certain laws. Should there be a pattern, this would help the agencies advance federal law to prevent healthcare consolidation.

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AAHKS appreciates your consideration of our comments. If you have any questions, you can reach Mike Zarski at mzarski@aahks.org or Joshua Kerr at jkerr@aahks.org.

Sincerely,

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