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May 30, 2024

VIA ELECTRONIC DELIVERY
U.S. Department of Justice
Department of Health and Human Services
Federal Trade Commission
Washington, DC 20530

RE: Docket No. ATR 102
RFI on Consolidation in Health Care Markets

On behalf of the American Independent Medical Practice Association ("AIMPA"), we appreciate the opportunity to respond to the Department of Justice's ("DOJ"), Department of Health and Human Services' ("HHS") and Federal Trade Commission's ("FTC") (collectively, the "Agencies") Request for Information on Consolidation in Health Care Markets. AIMPA agrees with the Agencies that "robust competition in health care markets promotes lower health care costs and improved working conditions, while fostering high-quality patient care and driving innovation across the health care system."[1] We submit this RFI response to offer our perspective on why it is critical that federal policy support—and not undermine—the ability of independent practices to serve as critical access points for the delivery of high quality, cost-effective care and as a robust, competitive counterbalance to care delivered in hospitals, health systems, vertically-integrated payors, and other institutional employers.

AIMPA is a physician-led, national advocacy organization representing more than 8,700 physicians in approximately 550 independent medical practices in 43 States and the District of Columbia. Each year, these independent practices care for 20 million patients in the fields of primary care, internal medicine, cardiology, dermatology, emergency medicine, gastroenterology, hematology/medical oncology, nephrology, neurosurgery, ophthalmology, orthopedic surgery, otolaryngology, radiation oncology, urology, and women's health.

[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 Markets," pp. 1, 3 (Feb. 29, 2024), *available at* https://content.govdelivery.com/attachments/USDOJOPA/2024/03/05/file_attachments/2803589/DOJ-FTC-HHS%20HCC%20RFI%20-%2003.04.24%20-%20FINAL.pdf (last accessed April 22, 2024) ("2/29/24 RFI").

AIMPA's mission is to promote and protect high-quality, cost-efficient care furnished in the independent medical practice setting.

Our RFI response focuses on three main issues:

- In Part I, we examine the drivers of health care market consolidation and the implications of that consolidation on patient access to affordable health care in the independent practice setting.

- In Part II, we discuss one of the ways in which independent medical practices have been able to preserve their independence from an ever-consolidating hospital, health system, and vertically-integrated payor landscape. That mechanism for maintaining independence—through collaborations with private equity-backed management services organizations ("MSOs")—has enabled independent practices to drive innovation, expand access to high quality and affordable health care services, including in previously underserved communities, and remain a robust, competitive counterbalance to care delivered in other sites of service.

- In Part III, we urge federal policymakers and regulators to ensure that independent medical practices continue to have access to the tools needed to compete on a level playing field with hospitals, health systems and payors that are acquiring medical practices at an ever-accelerating pace.

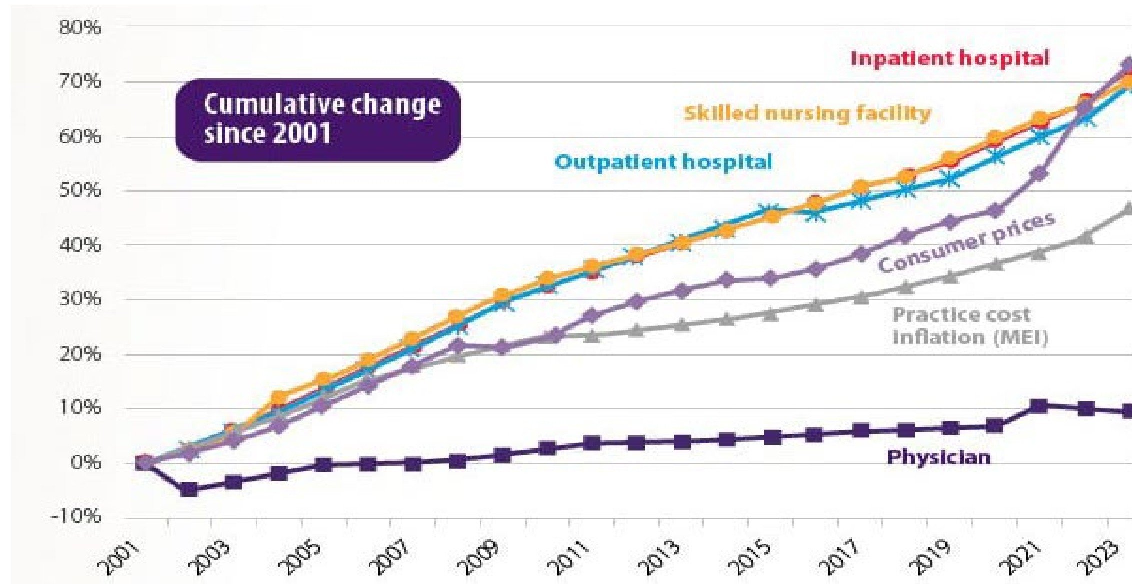
I. Drivers of Health Care Consolidation and the Implications for Patient Access to High Quality, Affordable Health Care in the Independent Practice Setting.

Consolidation of the health care industry is well-documented, but the reason for that consolidation—"the why"—is often overlooked or misunderstood, particularly when it comes to the challenges faced by physicians caring for patients in independent medical practices and *especially* with respect to those independent practices that choose to pursue transactions with private equity-backed MSOs. Understanding the "why" is a critical foundation for any meaningful discussion about how to tackle the topic of consolidation from a policy-making perspective. In this Part I, we address that issue, which dovetails with Question 2 in the RFI in which the Agencies ask for feedback on the "claimed business objectives for transactions."[2] We broaden our response so that we not only address the "business" objectives of transactions but also the more important, patient-focused objectives of these transactions.

We start with a fundamental flaw with the economics of health care delivery in this country. Over the last 23 years (2001-2023), Medicare reimbursement rates in the physician office setting have declined, on an inflation-adjusted basis, by approximately 30 percent, dramatically outpaced by the Medicare Economic Index ("MEI") and by even larger increases in payment rates in the

[2] 2/29/24 RFI p.10.

hospital setting (including in provider-based clinics) and in consumer prices, as illustrated in the following graph:[3]



Competition is skewed when reimbursement in one site of service—independent medical practices—so dramatically trails reimbursement in the outpatient hospital setting and practice expenses as measured by the MEI. Simply put, a more than 20-year decline in reimbursement, on an inflation adjusted basis, is not a sustainable model for physicians who want to continue delivering care to their patients in independent medical practices.

But the structure of Medicare reimbursement only tells part of the story.

Hospitals, health systems, academic medical centers ("AMCs") and vertically-integrated commercial payors ("pay-viders") enjoy a massive competitive advantage in the marketplace as compared to individual independent medical practices by virtue of their economies of scale, volume purchasing power, physician recruitment and facility development resources, information technology platforms, data analytics, regulatory expertise, and value-based care capabilities. It is implausible to think that independent practices can survive—let alone thrive—when they are at such a competitive disadvantage as compared to physician groups owned by hospitals, health systems, AMCs, and pay-viders with their robust infrastructures that dwarf the business support and financial resources of even the largest independent medical practices.[4]

[3] Sources: Federal Register, Medicare Trustees' Reports, Bureau of Labor Statistics, Congressional Budget Office. See also American Medical Association, Economic and Health Policy Research, September 2022 (noting that for 2001-2022, when adjusted for inflation in practice costs, Medicare physician payment declined 22 percent), *available at* https://www.ama-assn.org/sites/ama-assn.org/files/2022-09/medicare-updates-inflation-chart.jpg (last accessed April 26, 2024).

[4] See, e.g., "UnitedHealth Group Profits Eclipse $5.4 Billion as Optum and Health Plans Roll Despite Rising Costs," Forbes (stating that UnitedHealth Group's medical provider business, Optum, reported second quarter revenues soared 25% to $56.3 billion and operating earnings grew 13% to $3.7 billion, led by Optum Health) (July 14, 2023), *available*

Given all the headwinds they confront—particularly physicians in small independent medical practices—it is not surprising that 74,500 physicians became employees of hospitals from 2019 through 2023.[5] As of January 2024, hospitals and health systems employed more than half of all physicians (55.1%), with the percentage of hospital-employed physicians increasing by 5.9% over just the last two years.[6] This is a remarkable figure considering that a little more than a decade earlier, only a quarter of physicians (25.8%) were employed by hospitals or health systems.[7]

Whether to leave one's own medical practice for hospital or health system employment presents physicians with a Hobbesian choice, because moving into a larger institutional provider setting often leads to a loss of autonomy and, in most instances, shifts care into a higher-cost setting for patients and our health care system as a whole.

So again, we return to the question of "why." Why do some physicians in independent practice elect to remain in independent practice and partner with an MSO that is often financially backed by private equity? These doctors are consciously choosing not to sell their practice to a hospital or health system or to become affiliated with another larger institutional provider.

Instead, these physicians want to remain in an independent practice setting where they maintain their autonomy and, yet, they want resources that help them open new office locations in underserved communities, build ambulatory surgery centers where procedures can be done for a fraction of the cost as compared to the hospital setting, compete for the best and brightest physicians coming out of residency and fellowship programs, aggregate data across a broader platform of practices in their own specialties to develop clinical guidelines and other best practices to enhance the quality of care they deliver, and bring into community practices state-of-the-art technologies to diagnose and treat patient injuries, illnesses, and diseases that hospitals, health systems, and vertically-integrated "pay-viders" are able to obtain by virtue of their scale and financial resources.

That objective—delivering better, faster and more cost-efficient care to patients in an economically-viable independent practice setting—is at the heart of why some independent practices collaborate with private equity-backed MSOs. As we now show, that objective is being realized across medical specialties and in communities across the country for the benefit of patients and our health care system as a whole.

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at https://www.forbes.com/sites/brucejapsen/2023/07/14/unitedhealth-group-profits-eclipse-54-billion-as-optum-and-health-plans-roll-despite-rising-costs/?sh=648e2f194e72 (last accessed April 27, 2024).

[5] Physicians Advocacy Institute, "Updated Report: Hospital and Corporate Acquisition of Physician Practices and Physician Employment 2019-2023, slide 11 (April 2024) ("4/24 PAI Report") , *available at* https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI-Avalere%20Physician%20Employment%20Trends%20Study%202019-2023%20Final.pdf?ver=uGHF46u1GSeZgYXMKFyYvw%3d%3d (last accessed April 26, 2024).

[6] 4/24 PAI Report, slide 14.

[7] 4/24 PAI Report, slide 5.

II. The Positive Impacts of Independent Medical Practice Collaborations with Private Equity-Backed Management Services Organizations.

The Agencies ask in Question 1 of the RFI how transactions involving health care providers and private equity funds affect patients and providers and, relatedly, in Question 2, whether the claimed goals and objectives of these transactions have been realized post-transaction.[8] We present here the perspective of physicians who care for patients in independent practices that receive business support from private equity-backed MSOs.

We start with an important clarification about the nature of the transactions whose effects we will discuss. Contrary to the false narrative that private equity-backed MSOs are designed to circumvent bans on the corporate practice of medicine or force physicians to prioritize investor profits over patient care, the MSO model preserves physician control over patient care. Practices remain physician-owned and physician-led. Clinical decisions remain the prerogative of physicians. In the experience of physicians whose independent practices are part of AIMPA, private equity-backed MSOs have provided the business resources that enable physicians to focus on what they do best—providing great care for patients in a high-quality, convenient setting that costs patients and our health care system less than if the identical services were furnished in a hospital.

We want to emphasize this point. **No corporate entity—whether a private equity firm, an MSO, a hospital, or insurance company—should interfere with the clinical judgment of physicians or otherwise control health care decisions.** The appropriate role of an MSO, regardless of whether it is financially backed by a private equity fund, is to provide resources to independent practices to expand access to high quality, cost-efficient care while physicians in those practices exercise their own clinical judgment about the appropriate course of care for their patients.

We now provide concrete examples of how partnerships between independent practices and private equity-backed MSOs "promote[] lower health care costs and improved working conditions, while fostering high-quality patient care and driving innovation across the health care system."[9]

Reducing the Total Cost of Care ("TCC"). The TCC in the independent practice setting is far less than in other settings. A recent study found that the cost of services in the hospital setting was 12% to 26% higher than the cost in the independent practice setting.[10] The same has long held true when comparing the cost of care for procedures in independent ambulatory surgery centers ("ASCs") versus hospital outpatient departments ("HOPDs").[11] The furnishing of infusion services

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[8] 2/29/24 RFI, pp. 8-9, 10.

[9] 2/29/24 RFI, p. 1, 3.

[10] Beaulieu ND, Chernew ME, McWilliams JM, et al. Organization and Performance of US Health Systems. JAMA. 2023;329(4):325–335. doi:10.1001/jama.2022.24032, *available at* https://jamanetwork.com/journals/jama/article-abstract/2800656 (last accessed April 25, 2024).

[11] Commercial Insurance Cost Savings in Ambulatory Surgery Centers, Healthcare Bluebook, Ambulatory Surgery Center Association, HealthSmart (review of commercial medical-claims data found that U.S. healthcare costs are reduced by more than $38 billion per year due to the availability of ASCs as an appropriate setting for outpatient procedures as an alternative to HOPDs with more than $5 billion of the cost reduction accruing to patients through lower deductible and coinsurance payments), *available at* https://www.ascassociation.org/asca/about-ascs/savings/private-payer-data/shifting-procedures-to-ascs/commercial-insurance-cost-savings-in-ascs (last accessed April 25, 2024).

provides an additional example of the profound cost differential between identical services furnished in independent practices as contrasted with HOPDs.[12]

In addition to facilitating care in lower-cost, convenient settings, private equity-backed MSOs provide independent medical practices with access to data analytics, clinical decision support tools, innovative technologies, and centralized support services that reduce the TCC while improving patient outcomes. These MSOs provide specialty-focused data aggregation and analytics capabilities to drive down avoidable utilization of diagnostic tests, hospital services and expensive prescription drugs—an endeavor that most independent practices do not have the human capital or financial resources to replicate without MSO support. By way of example:

- In partnership with an MSO supporting independent dermatology practices, physician leaders created a Medical Advisory Board ("MAB") to oversee the integrity and quality of the independent practices' clinical program. The MAB, which is staffed exclusively by physicians, established clinical guidelines for its providers that not only improve the quality of care but reduce its cost. The MAB also developed evidence-based guidelines for the prescribing of medicines and tests. These guidelines have resulted in the practice of better, safer medicine and reduced costs for patients.

- An MSO supporting independent gastroenterology practices assists physicians in monitoring CMS's ASC-9 Quality Measures and implementing the quality measure, "Endoscopy/Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients." In furtherance of the practices' value-based contracts, the MSO assisted the practices in tracking patients considered average risk for colorectal cancer who have a negative colonoscopy with a good bowel prep and are recommended for a repeat colonoscopy at 10 years rather than 5 years, thereby avoiding unnecessary colonoscopies.

- An MSO supporting independent oncology practices assisted a partnered practice in creating genetic tumor marker tests to identify cancers, access the latest therapy protocols, and expand the practice's bone marrow service to provide stem cell transplants for patients. At the same time, the MSO brought laboratory and pathology support to independent medical practices that improved the physicians' ability to diagnose patients efficiently and promptly, resulting in cost savings of approximately 40% for patients and eliminating lengthy wait times for results.

- An MSO supporting independent gastroenterology practices provides those practices with access to an FDA-approved, AI-powered polyp detection system that enables physicians to detect colorectal polyps through enhanced visualization during screening colonoscopies. This technology increases adenoma detection rates ("ADR") by 14.4%—and each 1% increase in ADR decreases the risk of interval cancer by three percent. Without access to capital, most independent medical

[12] The 2024 Medicare reimbursement rate for CPT Code 96413 (chemo administration; intravenous infusion; up to 1 hour) is $322.68 in hospital outpatient departments and only $129.16 in an in-office setting.

practices could not afford this technology, which saves lives while reducing the cost of care.

- Other independent medical practices supported by MSOs have implemented multimillion-dollar linear accelerators that expand access to radiation therapy treatment outside the more expensive hospital setting (urology), total joint programs in the lower-cost ASC setting (orthopedic), and genetic testing centers for cancer patients (urology)—all of which would have been difficult, if not impossible, but for MSO access to capital and support.

Private equity-backed MSOs also provide expertise and resources to facilitate independent medical practices' participation in value-based care models, further reducing the TCC for patients and payors:

- An MSO supporting independent gastroenterology practices enabled the practices it supports to enter value-based payer contracts with quality and community engagement metrics and to earn performance incentives.

- An MSO supporting independent oncology practices facilitated practice participation in value-based care initiatives by incorporating quality and utilization metrics and utilizing sophisticated reporting and analytics tools. The practices earned shared savings performance payments in the first two years of the program. These oncology practices are often very small, and the MSO is able to help those practices develop and implement more than 20 value-based payment arrangements among the independent practices, including the development of analytics and data reporting necessary to operationalize complex value-based contracts.

Likewise, private equity-backed MSOs help independent practices navigate the labyrinth of MIPS reporting requirements. As but one example, an MSO supporting an independent oncology practice helped that practice better understand how to transcribe data in the practice's electronic medical record into the required fields for MIPS reporting that, by itself, resulted in more accurate MIPS reporting from a quality category performance of 53.55% and an overall MIPS score of 65/100 to a quality score of 95% and an expected overall MIPS score of 100/100.

In sum, private equity-backed MSOs help independent medical practices reduce the TCC by providing access to capital and facility development services that allow practices to provide care in lower-cost settings while also providing sophisticated technologies, data analytics, and other business support that foster value-based care.

Improving Quality and Patient Outcomes. Private equity-backed MSOs provide data aggregation and analytics capabilities, information technology platforms, and other business expertise that enable physicians to standardize clinical guidelines and implement quality initiatives. These initiatives produce quality/outcomes improvements and often a correlating decrease in the TCC, positively impacting the patient care experience.

- Independent women's health practices supported by an MSO have educated their providers on how to perform procedures safely in the medical office setting that do

not need to be performed in an ASC or hospital. This shift to office-based procedures lowered costs and improved patient experience, with an office-based procedure rate more than twice industry average—59% vs. 27%. These independent practices also have a primary cesarean section rate of 16%—six percentage points lower than the industry average. With the MSO's support, these independent practices launched an initiative incorporating consistent, guideline-driven behavioral health screening, treatment, and referral resources, with more than 300,000 women screened for behavioral health disorders and over 5,000 women referred for collaborative care, which integrates the provision of behavioral health services with primary care and facilitates communication among providers. Nearly nine in ten patients in this collaborative care program experience a significant improvement in their behavioral health screening scores.

- An MSO supporting independent emergency medicine practices was able to help physicians who furnish clinical care in 90 different emergency departments ("ED") substantially improve key quality and operational results. Overall, these practices reduced ED door-to-clinician wait times by 34% and ED door-to-hospital admit times by 21%, resulting in faster treatment and better patient outcomes. To do so, the MSO utilized a Clinical Leadership Council to develop and operationalize tools, resources, best practices, and solutions, together with a data warehouse and analytics to improve clinical flow and related outcomes for a variety of ED settings. Not surprisingly, patient satisfaction has increased, with more than two-thirds of patients giving the highest possible rating.

- With the help of its MSO partner, an independent gastroenterology practice instituted an initiative to ensure that all laboratory stains meet national benchmarks (i.e., no over-staining), formed physician-driven quality and peer review committees, and instituted standardization of bowel preps (down from over 90 forms of prep among practices supported by the MSO to a handful of best-practices), resulting in higher quality colonoscopies and better patient experiences.

- An MSO supporting independent ophthalmology practices created an Innovation Center that centralizes quality assurance, patient safety, education, and research functions for affiliated practices. The Center includes a clinical data warehouse that draws on electronic health records across practices, allowing for physician monitoring of patient outcomes and the development of best practices.

- An MSO supporting independent gastroenterology practices analyzed data from nearly three million patients to develop a clinical dashboard and comprehensive care management program that is leading to better health outcomes and lower costs by minimizing unplanned episodes of care—such as ED visits. The MSO is expanding the data in the dashboard to include laboratory and radiology data to provide more robust outputs to help further improve patient care and prepare the practices for value-based care initiatives at national scale. The MSO allows gastroenterology practices across the country (not just the practices supported by

the MSO) to access the dashboard and metrics, promoting the cost-effectiveness of care across the specialty.

- An MSO supporting independent oncology practices aided in the recruitment of a molecular pathologist and Ph.D. to support the on-demand interpretation of highly complex, difficult-to-read genomic tests for all physicians whose practices are supported by the MSO. These experts are available for immediate consultation to all physicians supported by the MSO. They can review gene alterations present in tumor specimens and discuss which standard therapies might be appropriate and which clinical trials would most likely benefit the patient.

Expanding Access to Care. Private equity-backed MSOs help independent medical practices expand care delivery options in urban settings and create additional access points for high-quality, lower-cost care in rural and other underserved communities. This comes in the form of access to capital and facility development expertise to open additional clinic sites and develop ASCs as well as greater infrastructure to recruit physicians and advanced practice providers ("APPs") to the independent medical practice setting. All these efforts result in expanded access to lower-cost care than in the institutional setting. This support is often most profound in rural and underserved communities, enabling independent practices to offer more highly specialized services and obviating the need for patients to travel substantial distances for specialty and sub-specialty care.

- In the past two years, an MSO supporting independent urology practices helped one of the practices recruit four urologists. Adding those doctors directly benefited patients by reducing wait times for appointments from as many as eight weeks to two weeks or less. In some cases, the practice is seeing patients the same day. With additional doctors, the practice was able to open clinics in three historically underserved communities lacking state-of-the-art urologic care.

- An independent oncology practice, with the assistance of its MSO partner, expanded its geographic reach and access to cancer care into northern Georgia and rural areas in Tennessee by recruiting additional physicians into these previously underserved communities.

The partnerships between independent practices and private equity-backed MSOs have expanded access to care in other ways beyond the recruitment of physicians to rural and other underserved communities.

- MSOs have sponsored virtual tumor boards and virtual grand rounds, bringing leading experts from the nation's most highly respected AMCs into a virtual setting through which physicians in independent medical practices across the country—in more remote communities as well as major metropolitan areas—can benefit.

- Similarly, MSOs have helped independent medical practices expand access to clinical trials and thereby offer patients access to innovative therapies. Traditionally, clinical trials were the domain of AMCs. Today, a network of independent medical practices supported by an MSO creates a single point of access to a large number of providers so that their patients can participate in clinical trials.

> The MSOs also serve as a single point of contact to ease administrative burdens associated with clinical trials. This has meant that patients outside of urban areas can enroll in clinical trials. In turn, clinical trial enrollment better represents diverse communities to ensure the therapy is safe and effective for all subpopulations. This democratizes clinical trials by creating more equitable access to those trials.

Recruitment and Impact on the Workforce. Private equity-backed MSOs help independent practices compete against health systems and AMCs for physician talent while increasing access in rural and other underserved communities. As a physician in an independent gastroenterology practice stated:

> We hired six providers in Colorado in the last six months. This allowed us to increase access for our patients by decreasing wait times to see a provider. We could not have done this without a dedicated MSO partner investing in recruiting. We have been able to serve rural communities in Wyoming, as well as improve access in Colorado Springs. Recruiting to a place like Wyoming is exceedingly difficult, yet we are investing in patients by investing in more physicians to improve access so that patients in Wyoming receive the care they deserve while cutting down on drive times that could be as much as six hours to a major metropolitan city. We can hire transplant hepatologists and interventional endoscopists to smaller cities, which again increases access and quality of care in a lower cost setting. We are expanding the types of services offered, while providing treatment that was previously unavailable in many communities in Colorado and Wyoming.

Similarly, an ophthalmologist whose independent practice is supported by an MSO explained:

> We have several rural communities that are difficult to recruit to and whose size makes it difficult to cover the cost of a full-time health care provider. However, we have expanded services to smaller and rural communities—such as in North Topeka, Kansas and Festus, Missouri—by having ophthalmologists rotate through some of the many optometric offices in these areas. As a result, we can locally provide additional in-office services, including chalazion debridement, lid biopsies, tarsorrhaphies, intravitreal injections, and diabetic lasers.

Physicians are not the only providers who benefit from additional resources to support the care they offer patients. APPs benefit from enhanced training programs that small practices often lack the resources to provide.

- An MSO supporting independent oncology practices created an APP committee that spent a year developing a curriculum and framework that any of its partnered practices can use to educate their newly-hired APPs. The MSO helped launch an "APP Academy" in January 2024 that currently has 15 APPs participating.

- In partnership with a national medical society, an MSO supporting independent gastroenterology practices developed a comprehensive training curriculum for APPs and a virtual library of lectures that is available for free to all APPs across the country, regardless of the medical practice in which they work.

MSOs support independent medical practices' clinical teams with the management of recruiting and onboarding of employees, payroll services, employee relations, legal compliance efforts, and employee engagement. With respect to non-clinical employees, MSOs have expert recruiting professionals who screen applicants for interviews, train managers on best practices in interviewing with role-specific interview guides, attend job fairs, and ensure overall vacancy rates are kept as low as possible. All this business management support—to which physicians employed by hospitals, health systems, AMCs and pay-viders are accustomed—enables physicians in independent practices to devote more time to caring for their patients.

III. Federal Policymakers and Regulators Should Ensure that Independent Medical Practices Have Access to the Tools Needed to Compete on a Level Playing Field with Hospitals, Health Systems and Payors that Acquire Medical Practices.

AIMPA supports the Agencies' desire to promote robust competition and ensure sufficient transparency to identify transactions that, due to market consolidation, adversely impact patients, communities, payors, employers, providers, health care workers, and businesses.[13] However, transactions involving private equity funds, such as transactions between independent medical practices and private equity-backed MSOs, do not warrant more robust reporting requirements or more rigorous review than transactions involving other health care market participants. To the contrary, as the information provided in this RFI response demonstrates, private equity-backed MSOs bolster the ability of independent medical practices to compete against institutional providers by providing high quality care in a lower cost and more convenient setting.

The Agencies should not take action that further tilts the playing field in favor of care delivery in HOPDs, health systems, or vertically integrated pay-viders. Instead, federal policy—whether through legislation or regulation—should be developed in a way that ensures that physicians in independent medical practices have the resources they need to remain a robust competitive counterbalance to large institutional providers.

AIMPA appreciates the opportunity to respond to the Agencies' RFI and would be more than happy to engage in further discussions with the Agencies on how independent medical practices continue to improve patient outcomes, expand access to high quality care, and lower costs by serving as a critical part of our country's health care delivery system.

Sincerely,

Paul Berggreen, MD
AIMPA, President

Jack Feltz, MD
AIMPA, Chair, Federal Health Policy

[13] See 2/29/24 RFI, p. 11 (Question 4).