



May 6, 2024

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

RE: Docket ATR 102; Request for Information on Consolidation in Health Care Markets

Dear Ms. Lee:

On behalf of the American Speech-Language-Hearing Association (ASHA), I am responding to a request for information issued by the Department of Justice, the Department of Health and Human Services, and the Federal Trade Commission regarding consolidation in health care markets.

ASHA is the national professional, scientific, and credentialing association for 234,000 members, certificate holders, and affiliates who are audiologists; speech-language pathologists (SLPs); speech, language, and hearing scientists; audiology and speech-language pathology assistants; and students.

Our members provide critical health care services to patients across the lifespan in a variety of practice settings, including hospitals, skilled nursing facilities (SNFs), home health, and private practices. They have experienced a variety of impacts associated with consolidation in health care markets, including challenges accessing insurer provider networks, lower payment rates, and administrative mandates that dictate care delivery decisions that negatively impact the quality and outcomes of care for their patients. We appreciate the administration's continued focus on these issues and have highlighted our concerns in previous comments including those in response to the fiscal year (FY) 2023 SNF prospective payment system (PPS) proposed rule.¹

I. Transactions Conducted by Private Equity Funds or Other Alternative Asset Managers

The agencies state an interest in learning more about the impact of transactions involving health care providers, facilities, or ancillary products or services conducted by private equity (PE) funds or other alternative asset managers.

The Medicare Payment Advisory Commission (MedPAC) has outlined serious concerns regarding the impact of private equity in health care, particularly in the SNF industry. According to the June 2021 MedPAC Report, approximately 11% of nursing homes are owned by PE firms. The report noted that many PE firms use management strategies designed to improve profitability, often to the detriment of the Medicare program and patients, such as:

- increasing volume;

- cherry-picking patients that comprise their patient case-mix (e.g., excluding Medicaid patients, limiting certain diagnoses, excluding patients entering from community settings);
- horizontal integration among companies owned by the PE firm (e.g., requiring the SNF to purchase personal protective equipment from another entity owned by the PE firm);
- reducing staff or changing the composition of staff (e.g., using assistants or aides rather than a therapist or nurse); and
- performance-related pay, which might spur inappropriate service delivery.

SNF-based SLPs have reported examples to ASHA that support these conclusions, including:

- Productivity standards that do not support quality patient care but instead focus on reimbursable time. For example, these standards often do not include time spent documenting in the medical record or multidisciplinary team care planning which could prevent adverse health events by proactively identifying risk factors that might lead to an unplanned admission or readmission to a hospital.
- Incentives to discharge patients quickly or provide unnecessary services to patients. For example, in an effort to increase payments, ASHA members are sometimes told to evaluate every patient who enters the SNF even when it's contraindicated.
- Administrative mandates that dictate how many treatment sessions a patient may receive, or which clinical specialty may treat a particular patient, regardless of the evaluating or treating clinician's professional judgement. For example, SLPs are often told that they are allowed a total of three treatment sessions in an episode of care for a SNF patient, that they can only provide 30-minute treatment sessions, or that SLPs cannot treat patients with cognitive impairments, which is within their scope of practice.

According to the summarized findings of research included in the MedPAC report, the impact of PE ownership can be mixed but correlates with increased mortality, worsening mobility, elevated use of antipsychotic medications, declines in nurse availability per patient, and declines in compliance with federal and state standards of care.² The current administration has also highlighted the relationship between PE ownership and problematic trends that deserve attention, including:

- residents in nursing homes acquired by PE firms were 11.1% more likely to have a preventable emergency department visit and 8.7% were more likely to experience a preventable hospitalization when compared to residents of for-profit nursing homes not associated with PE;
- PE ownership increased mortality for residents by 10%, increased prescription of antipsychotic drugs for residents by 50%, decreased hours of frontline nursing staffing by 3%, and increased taxpayer spending per resident by 11%; and
- PE-backed nursing homes' COVID-19 infection rate and death rate were 30% and 40% above statewide averages, respectively.³

In previous comments, ASHA recommended that the Centers for Medicare & Medicaid Services (CMS) monitor changes in quality reporting scores and the number of adverse

health events and determine if these changes followed a change of ownership. CMS has also noted that since FY 2020, payments to SNFs have exceeded their costs significantly; therefore, CMS imposed across-the-board negative payment adjustments to better align payments and cost. However, ASHA has argued that CMS should use the data at its disposal to target these negative payment adjustments to SNFs that do not comply with regulatory requirements or might be engaged in practices that could be considered fraud, waste, and/or abuse. Many of the practices of PE firms—such as staffing changes or increasing volume of medically unnecessary care—could be associated with fraud, waste, and abuse and should be closely scrutinized.

Based on our members' experiences, ASHA remains concerned that a consolidated health care market jeopardizes professional autonomy and patient care. We often hear from our members working in SNFs or home health agencies (HHAs) that are acquired by regional or national chains who share concerning details about how their work environments and practice patterns change dramatically. Once acquired, the corporate offices of these chains make drastic changes to care delivery patterns—often informing the clinicians working in the SNF or patient's home that they can only provide a select number of visits for a specific amount of time per visit—regardless of the patient's diagnosis or the plan of care developed by the multidisciplinary care team who evaluated the patient and reviewed the patient's medical record.

ASHA is concerned that consolidation, which is being driven by profit-focused PE firms, could further shrink health plan provider networks. We routinely hear from our members that they are rejected because the network is closed. PE firms might use narrow networks to tightly manage how and when care is provided; thereby, jeopardizing access to care for patients. However, patients should have robust provider networks to ensure timely and appropriate access to care.

II. Transactions Conducted by Health Systems

The agencies state an interest in learning more about the impact of mergers and other transactions involving health care providers, facilities, or ancillary products or services conducted by health systems. While these mergers claim to lower the cost of care, this is not always the case. Prices for services in acquired physician practices increase by 14.1% on average according to a 2018 study in the *Journal of Health Economics*.⁴ Vertical integration provides an opportunity for practices to bundle under the hospital or facility, resulting in higher charges to insurance companies.⁵

ASHA members also report that these mergers often lower provider pay and patient access to services. Providers report these mergers result in inappropriate administrative mandates reducing service times, directives to engage in inappropriate billing practices (e.g., unbundling or code stacking), and requirements to perform additional unnecessary services. Health Services Research found that patient satisfaction decreased after hospital acquisitions of private practices.⁶

Providers choosing to remain in independent private practice cite frustrations with the dramatic difference between their reimbursement rates and facility-based rates. Their negotiating power is minimal in comparison to the larger health care entities, which has resulted in stagnant and diminishing reimbursement rates for private practice owners. This could drive more independent private practices to consider merging with larger health care

entities, even if that results in an increase in health care costs and a decrease in patient satisfaction. ASHA strongly encourages the agencies to evaluate the impact that significant pay differentials between facility rates and outpatient rates have on independent and private practices—which are often small businesses—and consider solutions (e.g., shrinking the payment differential) to encourage market competition, protect independent practices, and reduce the cost of post-merger services.

Similarly, current and emerging value-based care models require significant investment in electronic health records technology, data analytics, and population health management tools. They also require the funding and analytical power of a finance team to support cashflow changes and increased financial risk while transitioning from fee-for-service to value-based care. This presents challenges to small independent practices who are functionally left out of these payment models unless they merge with larger health care entities. To facilitate a smooth transition from fee-for-service to value-based care without forcing providers and practices into consolidation, ASHA urges the agencies to consider making upfront investments to providers who wish to participate in emerging models.

Another facet to consider is the rise of accountable care organizations (ACOs). While some evidence suggests they are associated with lower costs and higher quality, they also incentivize provider consolidation for the reasons listed above. A 2019 Health Affairs analysis demonstrated that counties with the highest ACO penetration showed a decline in small practices and an increase in large practices.⁷ This is concerning as CMS has set the strategic goal that all Medicare fee-for-service beneficiaries and a vast majority of Medicaid beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030. This could have the unintended consequence of accelerating consolidation without addressing the challenges that consolidation brings, namely lower quality and higher prices.

III. Transactions Conducted by Private Payers

The agencies have requested information about the impact of transactions involving health care providers, pharmacies, facilities, or ancillary products or services conducted by private payers. Like the claims made by health systems acquiring practices, private payers promise efficiency and lower cost of care. Unfortunately, this often comes at the expense of provider pay and patient care. Private payers are incentivized to seek profits in a market-based system, a model which often does not align with optimal patient outcomes and sustainable health care models. They often push for shorter sessions to increase the number of patients seen per day and require additional paperwork, such as prior authorizations, that limit and delay access to care.⁸ Not only does this impact patient satisfaction and outcomes, but it also increases the burden to providers by forcing additional work for the same (or less) pay.

This is more challenging for some provider specialties like audiologists and SLPs who have consistently report reductions in reimbursement rates and more burdensome prior authorization requirements in recent years. Their patient populations are typically more clinically complex with multiple comorbidities, and their fee schedules rarely include payment for tasks that support patient care, such as multidisciplinary team care planning or care coordination; whereas, physicians often get paid for such services.

In addition, practices that are owned or managed by entities associated with private payers may be more incentivized to find ways to reduce the cost to the insurer, but these costs

often fall to the providers or patients. For example, if a payer denies a prior authorization request, the patient becomes responsible for paying for these services. Private payers are seeing significant profits, which are increasing with their acquisitions.^{9,10} However, our members are reporting decreases in their reimbursement rates, additional paperwork burdens, and challenges securing coverage for their patients' services. Patients and providers are entitled to data that shows where premiums and other revenue are going (e.g., marketing, payer employer salaries, beneficiary benefits) and explains why more money is not being directed toward patient services and provider payments. ASHA asks the agencies to identify ways to track private payer profits and spending to ensure that patients are receiving adequate care and providers are receiving adequate payment for the services they provide.

IV. Effects of Consolidation on Patients

As noted above, consolidation that involves PE firms has significant impacts on patients. MedPAC found that SNFs with private equity investments had higher rates of patient mortality, worsening mobility, elevated use of antipsychotic medications, and declines in clinical staffing availability per patient.¹¹

Consolidation poses risks to robust provider networks, which can limit access to care for patients who either face long wait times to access a clinician or cannot access anyone at all. Patients might also have to drive long distances to appointments, requiring extensive travel costs, caregiver burden, and lost wages due to time off from work. Consolidation also limits competition, which in turn reduces incentives to offer competitive rates. This might lead to increased health care spending by insurers, including Medicare and Medicaid, and patients through higher patient cost-sharing obligations.

V. Effects of Consolidation on Providers

As previously noted, consolidation often leads to dictated changes to clinical practice that are not always in the best interest of patients. The increased workload and undermining of providers' judgement leads to increased stress and burnout. Administrative mandates also place providers in difficult positions where they either violate their clinical and ethical obligations or lose their employment. Providers should never be put in a situation where they are forced to decide between 1) doing what is right and what they are ethically and legally bound to do for their patients or 2) following their employer's mandates to keep their job.

VI. Need for Government Action


As noted above, ASHA believes changes in ownership should be scrutinized to determine if adverse events occur after a merger or acquisition. Examples could include, but are not limited to:

- Changes in the number and/or types of clinical staff. For example, replacing therapists with assistants or overall staffing level decline.
- Costs decrease but payments to the facility increase.
- Increase in patient complaints regarding the experience, quality, or outcomes of care. These complaints could come through 800-Medicare, the Medicare ombudsmen, or other sources.

- Increases in adverse health events such as falls, hospitalizations, rehospitalizations, and emergency room visits.
- Lower quality scores through programs like the Medicare quality reporting and value-based purchasing programs.
- Decrease in patient experience measures such as Home Health Consumer Assessment of Healthcare Providers & Systems/Consumer Assessment of Healthcare Providers & Systems (HCAHPS/CAHPS).
- Increased citations through the Medicare survey and certification processes and complaints to state insurance commissioners or other state officials.
- Increased complaints to the Department of Justice or the Department of Health and Human Services Office of Inspector General by clinicians raising concerns of unethical or illegal practices.
- Increased appeals filed by patients when care is denied.
- Shifting costs to patients and providers, such as increasing cost-sharing, reducing payment to providers, and imposing utilization management techniques that inappropriately delay or deny access to care.

Thank you for considering ASHA's comments. If you or your staff have additional questions, please contact Sarah Warren, MA, ASHA's director for health care policy for Medicare, at swarren@asha.org or Meghan Ryan, MSL, ASHA's director for health care policy for private health plans, at mryan@asha.org.

Sincerely,



Tena L. McNamara, AuD, CCC-A/SLP
2024 ASHA President

¹ American Speech-Language-Hearing Association. (2022, June 9). ASHA Comments Regarding Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2023; Request for Information on Revising the Requirements for Long-Term Care Facilities to Establish Mandatory Minimum Staffing Levels. <https://www.asha.org/siteassets/advocacy/comments/asha-comments-to-cms-on-snf-pps-fy2023-060922.pdf>.

² Medicare Payment Advisory Commission. (2021). Report to Congress. Chapter 3: Private Equity and Medicare. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/default-document-library/jun21_ch3_medpac_report_to_congress_sec.pdf.

³ White House. (2022). White House Fact Sheet: Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes. <https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/28/fact-sheet-protecting-seniors-and-people-with-disabilities-by-improving-safety-and-quality-of-care-in-the-nations-nursing-homes/>.

⁴ Capps, C., Dranove, D., & Ody, C. (2018). The effect of hospital acquisitions of physician practices on prices and spending. *Journal of Health Economics*, 59, 139–152. <https://doi.org/10.1016/j.jhealeco.2018.04.001>.

⁵ Baker, L., Bundorf, M., & Kessler, D. (2014). Vertical Integration: Hospital Ownership Of Physician Practices Is Associated With Higher Prices And Spending. *Health Affairs*. <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2013.1279?journalCode=hlthaff>.

⁶ Hanson, C., Herring, B., & Trish, E. (2019). Do health insurance and hospital market concentration influence hospital patients' experience of care? *Health Services Research*, 54(4), 805–815. <https://doi.org/10.1111/1475-6773.13168>

⁷ Kanter, G., Polsky, D., & Werner, R. (2019). Changes In Physician Consolidation With The Spread Of Accountable Care Organizations. *Health Affairs*. 38:11, 1936-1943.

⁸ (2024). Corporate Giants Buy Up Primary Care Practices at Rapid Pace. *The New York Times*.
<https://www.nytimes.com/2023/05/08/health/primary-care-doctors-consolidation.html>.

⁹ Mathews, A. (2020, February 23). Physicians, Hospitals Meet Their New Competitor: Insurer-Owned Clinics. *The Wall Street Journal*. <https://www.wsj.com/articles/physicians-hospitals-meet-their-new-competitor-insurer-owned-clinics-11582473600?ns=prod/accounts-wsj>.

¹⁰ (2023, October 8). Who profits most from America's baffling health-care system? *The Economist*.
<https://www.economist.com/business/2023/10/08/who-profits-most-from-americas-baffling-health-care-system>.

¹¹ Medicare Payment Advisory Commission. (2021). Report to Congress. "Chapter 3: Private Equity and Medicare."
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