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Hearing On:

Consolidation and Corporate Ownership in Health Care:

Trends and Impacts on Access, Quality, and Costs

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Introduction
Good morning, Mr. Chairman Wyden, Mr. Ranking Member Crapo, and members of the committee. My name is Dr. Karen Joynt Maddox, and I am a practicing cardiologist at Washington University in St. Louis as well as a health policy researcher with expertise in Medicare payment policy. It is an honor for me to be speaking with you today, and I will preface my remarks by stating that what I say today is my own opinion, and not the official position of my employer or institution.

Opening Statement
The issue I have been asked to address today is corporatization in health care, with specific attention given to issues around the growing presence of private equity in health care markets. Private equity is an arrangement in which firms raise capital, invest in private companies, sell or "exit" these investments, and reap the financial benefits.

The data on private equity acquisitions in health care are more sparse than one might hope, but can be summed up as follows. In the hospital industry, PE makes up 5-10% of the market, and the effects of acquisition on quality, costs, and outcomes are relatively minor – small increases in financial performance, and mixed evidence on quality and outcomes. In the nursing home industry, PE makes up more than 10% of the market, and at least more recent data suggest that acquisitions are associated with a decrease in staffing and worse health outcomes, including ED visits and mortality. In the physician practice sector, the data are hardest to come by, but PE is likely only 1-2% of the total market; data suggest that PE-acquired practices tend to shift towards care provided by advanced practice providers and increase volume and price. However, this is changing very rapidly, and our data are limited. In Medicare Advantage, PE plays a role in several ways, including in insurers themselves (Oscar, Clover) but also in a number of companies that provide services to manage patients, whether in primary care, home-based care, or post-acute care. While this makes it harder to quantify market impact and outcomes, data suggest a 2-5% market penetration overall.

Given the broad involvement of PE in health care, there is no "going back" in which we remove PE from the economic milieu. Indeed, while private equity is the latest major entrant, our health care system is broadly based on corporate, profit-maximizing strategies, across sub-sectors of the market, even among ostensibly non-profit actors.

Instead, we should pursue an updated policy response and strategy to steer profit motives so that competition can make things better rather than worse. Taking a broad, structural approach to change would ensure that not only private equity, but whatever form of corporatization comes next, operates within a statutory and regulatory environment that prioritizes keeping people healthy, well, and out of the hospital.

To accomplish these goals, we may need sector-specific fixes, but broadly, policy in each sector should include two things.

The first strategy is to create a modernized data system by which to measure ownership and costs, as well as quality and access. For the former, there is opportunity within the hospital and nursing home sectors to revise the Medicare Cost Reports, a burdensome system of data collection that manages both to collect more information than it needs and simultaneously fail to collect much of the information that it should. For quality and outcomes measurement, we should move from a model of claims or EHR data collection and release that is slow and reactive to one that is streamlined and proactive. As long as insurers and hospital systems outpace CMS on data and strategy, we will continue to see both groups try to win by gaming rather than by making serious investments in health.

The second strategy is continued movement towards models of value-based payment that create clear guard rails and equity-centered, longer-term financial incentives. The increasing corporatization of health care drives an even more urgent need to continue to shift payment towards population health. Rather than having the young, brilliant minds of the private equity firms around the country focus on ways to win at fee-for-service, they should be at work finding ways to win at population health management. This requires improvements in quality and equity measurement, changes to risk adjustment, explicitly rewarding access to care, and, of course, as I've already mentioned, modernizing underlying data infrastructure to make it capable of meeting these needs.

Finally, both of these objectives need to be pursued with careful attention to clinician burden and burnout, and above all else, centered around patients and their needs. But they are feasible and tangible strategies. As a country, we need an updated policy response to ensure that corporate interests are leveraged in the most positive ways possible.

Written Testimony

I. Introduction

Corporatization in health care is not new, but has reached new heights over the past decade. In part, this is due to the recent growth in the involvement of private equity (PE) in health care. Private equity is an arrangement in which investment firms raise capital, invest in private companies, improve their financial performance, and then sell or "exit" these investments, reaping the consequent financial benefits. PE firms, unlike other types of for-profit involvement in health care, typically have defined (5-7 year) investment cycles, requiring that they achieve profits in a relatively short amount of time.

There has been a great deal of concern raised about PE involvement in health care, particularly in regards to the fundamental tension between patients' health and corporate profits. The need for short-term profit can lead to cost-cutting strategies that could be harmful, such as decreasing necessary staffing or discontinuing low-margin yet essential service lines. It may also incent dubious strategies for increasing revenue such as surprise billing, creating local monopolies to raise payment rates, or increasing the delivery of high-margin but less-essential health care services like certain high-tech imaging procedures. Various legal aspects of PE

acquisitions, including a lack of accountability for debt, also create concern about whether PE investments are creating patient-centered, sustainable value in their pursuit of short-term profit.

On the other hand, proponents of PE in health care point out that PE can bring needed innovation, access to capital, the potential for leveraging partnerships, deep knowledge of operational efficiency and best practices, and a track record of creating value across a wide range of industries. PE firms may bring a nimbleness and creativity to health care delivery that more established institutions can't or won't pursue.

The broader context of corporatization in health care should also be noted. While PE has been a focus of concern recently, it is entering health care markets in an existing milieu that includes for-profit entities, both as individual hospitals or facilities as well as organized into larger chains. As has been covered by other witnesses at this hearing, both vertical and horizontal consolidation are increasing, challenging our definitions of health care markets and changing market dynamics. To be clear, corporatization isn't going away, and even if future regulations were put in place by the Federal Trade Commission, Department of Justice, or others, the vast majority of the existing infrastructure of our health care system is built on profit motives. This is why we have shiny new hospitals in wealthy suburbs and crumbling, abandoned buildings in highly segregated urban areas and in disproportionately minority and poor rural areas.

It is well-documented that the United States, despite spending more than any other country on health care, has health outcomes that are suboptimal and highly inequitable. The mismatch between what profit motives in health care yield and what we value as a society are stark, but this mismatch is in part the result of policy that has failed to set appropriate guard rails and create the market circumstances that lead to the results we want. Health care is not a functional market in and of itself; the patient voice is the weakest at the bargaining table and loses time and again to the health systems and the insurers. It is the job of the government and of smart regulation to set the conditions for competition that help align incentives back where they belong – with the patient.

II. Data on the Effects of Private Equity Acquisition

Due to data limitations, which are discussed in more detail below, much of the existing data regarding the effects of PE acquisitions of hospitals, nursing facilities, and physician practices has been done retrospectively, using large private or public claims databases. In some emerging sectors, such as long-term care and hospice, there is little evidence of the ultimate effects of acquisition because of the recent nature of most of the events. Other limitations, in addition to the retrospective and sometimes cross-sectional nature of the studies, include difficulty in ascertaining when and by whom acquisitions are made, especially for smaller deals that fall below required reporting levels; distinguishing between different ownership models; and compiling data on proprietary elements such as negotiated prices.

In the hospital sector, from 2003-2017, 42 private equity deals led to the acquisition of 282 unique hospitals across 36 states.[1] Evidence generally suggests that PE-acquired hospitals raise list prices and charges, and improve financial performance, but have little consistent change in quality or outcomes of care, with studies finding small improvements in quality for some conditions and decrements for others.[2-5] Though less-well studied, 91 PE-backed acquisitions of ambulatory surgical centers from 2011-2014 were similarly not associated with consistent differences in quality or outcomes.[6]

Evidence from the nursing and long-term care facility sector is more extensive, and perhaps more concerning. Though studies are mixed,[7,8] some evidence suggests that PE acquisition of nursing homes may be associated with significant decreases in staffing, 1-2 percentage point increases in emergency department visits and hospitalizations,[9] and a 1-2 percentage point increase in mortality.[10] Another recent study reported that PE-owned nursing homes performed comparably to other facilities during COVID, however, in terms of cases or deaths.[11] One issue that complicates interpretation of the nursing facility literature is the high proportion of for-profit chains in this industry (~70%) and the high degree of variability in size, patient sociodemographic and case mix, market conditions, and capacity across the nursing facility landscape.[12] Further, because the majority of care in nursing facilities is paid by public payers (Medicare and Medicaid), pricing is less variable, and pursuing cost-cutting approaches may be a more dominant strategy.

The physician practice sector is the most difficult to summarize because it is the most variable in terms of structure, organization, and personnel, but evidence suggests that PE investment in this space is growing.[13,14] In some specialties, such as ophthalmology, dermatology, gastroenterology, and urology that are both lucrative and highly fragmented, PE has made rapid inroads. By gaining market share or even local monopoly power, increasing charges, streamlining operations, cutting costs, changing staffing, and/or increasing the volume of high-margin procedures, there is ample opportunity for PE firms to achieve short-term profits.[15-21] However, there are scant data on the effects of PE acquisition of physician practices on patient outcomes. In urology, there is evidence that acquisition is associated with worse access to care for patients insured by Medicaid.[22] In other fields, such as anesthesiology and emergency medicine, surprise billing was a common strategy to increase revenues prior to recent legislation to curb this practice.[23] In primary care or larger multispecialty practices, strategies may focus on population health and care redesign more broadly, though again outcomes data are largely lacking.[24]

III. Policy Responses and Recommendations

In order for Congress to achieve its goals of improving affordability, accessibility, quality, and ultimately health outcomes for the American people, there are at least two important policy responses that are feasible in the near term.

First, Congress should support the development of an updated, modernized data system that allows CMS and the government more broadly to track quality, access, costs, and consolidation

in a proactive and timely fashion. Second, Congress should continue to support moves towards value-based and alternative payment models that incentivize population health.

A. Updating and Modernizing Data Collection and Use

Tracking costs and ownership

One current system that could be leveraged to create the data collection and transparency that are needed to monitor the impact of corporatization on costs and consolidation in health care is the Medicare Cost Reports. The Cost Reports are financial reports that Medicare-certified entities (including hospitals and nursing facilities) are required to provide on an annual basis, and include information on utilization, costs and cost centers, and facility characteristics. These reports provide minute detail on many elements of hospitals' spending and revenue, and are highly burdensome for hospitals and other entities to complete. They are also rarely audited, often missing data, and collected on different schedules based on hospitals' unique definitions of their fiscal years.

At the same time, the Cost Reports fail to collect information on crucial elements that are necessary for policymakers to know, including ownership, and spending is not collected in a way that allows for the consistent or comparable measurement of administrative costs or other key "buckets" such as electronic health records. These reports are overdue for an update, which provides an opportunity to simultaneously reduce burden and increase the utility of what is collected. A list of example measures is shown in Table 1.

Table 1: Cost and Ownership Measures

Domain	Examples
Ownership	What is the ownership stake of PE or other for-profit entities in each facility? What are the related "parent" organizations, if any?
Administrative waste	Do facilities or practices improve their internal cost structure in various domains of administrative waste?
Service provision	Do facilities stop providing low-margin services such as maternity care or mental or behavioral health care? Do they add high-margin services?

Many important results of PE acquisition, such as the specific negotiated fees commanded by providers, or the degree to which patients' out-of-pocket costs change with PE acquisition, are much harder to monitor, and would require additional data collection. Further, there is currently no equivalent data source to the Cost Reports for physician practices, which is a major gap though an understandable one given concern for reporting burden. However, with a modernized approach to the Cost Reports, policymakers would have a window on an annual basis into key elements of health care costs and organization. This would allow a proactive approach to tracking acquisitions, as well as mergers, which could then be evaluated on a range of policy-relevant elements, selected for their importance.

Tracking quality and outcomes

Data collection and transparency should also be modernized in terms of quality and outcomes. The state of the knowledge on the impact of PE acquisitions on quality and outcomes, as outlined above, is largely based on retrospective studies conducted in the past 2-3 years,

looking back at financial transactions from the early 2010s. We are 10 years too late to the game, and that is both unacceptable and avoidable.

If one were to log on to Hospital Compare right now, in June 2023, the quality and safety measures that one would see reported there reflect data collected in 2019-2021. But on the CMS research portal, Medicare patient data from December 2022 are already available. Indeed, CMS can access data from last week. The data already exist to proactively monitor hospital performance, but are not being optimally used. While claims data are processed within weeks, they are not used for monitoring quality or safety for years, and there is no proactive monitoring program set out to detect deviations in care that could follow acquisitions or other status changes at hospitals. A list of measures that could be monitored are shown in Table 2.

There is no technological reason that policymakers shouldn't be able to review data on hospital quality and outcomes on a quarterly basis. Our progress towards using electronic data for quality measurement has been far too slow, despite the technological infrastructure existing broadly. No other industry would be satisfied with performance data that are so old, particularly when the stakes are so high.

Table 2: Quality and Outcome Measures	
Domain	Examples
Processes of care	Do facilities maintain safe practices and meet high expectations of fidelity to guidelines and appropriate care?
Outcomes of care	Do facilities maintain excellent outcomes across a range of metrics, including preventable acute-care use?
Experience of care	Do facilities or practices improve patient experience?

Tracking access and equity

Finally, as data collection and basic use are modernized to change *how* we measure key elements of the US health care system, we must also update *what* we measure. Glaringly missing from our monitoring systems are measures of equity and access. If we want to improve the health of our nation, we must begin to include these crucial factors as part and parcel of what we measure – and ultimately reward – within our systems. Though

Table 3: Access and Equity Measures	
Domains	Examples
Physical access to health care	Are existing physical locations closed, or new ones opened? How does this impact geographic access for key groups?
Adequate workforce	Do facilities maintain safe levels of staffing, and do they retain staff?
Access to basic services (also listed above)	Do facilities stop providing maternity care or mental health care because they are not profitable?
Access for all people	Do facilities stop providing care to people with Medicaid or those who cannot pay? Does patient racial or ethnic mix change?
Equity in outcomes	Are existing equity gaps based on income or race narrowed, or widened? Are outcomes for marginalized groups improved, or worsened?

this is an area where a great deal more work is needed in measure development and validation, examples of access and equity measures are shown in Table 3.

B. Moving Towards Aligned Financial Incentives

Second, Congress should continue to push our health system towards population health. As long as we operate within a fee-for-service system, the most nimble actors will bring out the worst elements of that system, finding ways to profit from charging for more and more services, some of dubious value. We need look no farther than surprise billing to recognize that predatory practices are always a risk. As such, the increasing corporatization of health care drives an even more urgent need to continue to shift payment towards population health.

We have an opportunity to leverage value-based and alternative payment models to align our societal goals of achieving better health with our payment models, and thus re-direct profit maximization in ways that are more closely linked to patients' health and wellbeing. These programs should be simplified and streamlined where possible, to reduce clinician burden as well as to reduce the incentives their burden and complexity create towards greater consolidation.

There is evidence that such incentives can lead to innovation in care delivery. For example, many PE-backed entrants into the primary care space are pursuing total costs of care models, including integration of mental and behavioral health and health-related social needs, betting on their ability to provide support and coordination to reduce unnecessary hospitalizations for disease progression or instability. This is the space in which we need people to think creatively and be willing to create new paradigms of care – and where financial incentives can help steer care delivery innovation in directions we think are most societally beneficial.

Different approaches might be needed in different sectors. In the hospital sector, it is likely that one reason PE acquisition has not been associated with a great deal of change is that the hospital market is already relatively mature. There are large, established systems also pursuing acquisitions, and the rules of the game in terms of value-based payment and other mandatory quality reporting programs are well-developed.

On the other hand, the nursing facility market is potentially much more problematic from a quality and outcomes standpoint. There are fewer established standards, and less auditing and monitoring; the patient population is also more vulnerable both medically and socially. There are over 15,000 nursing facilities, compared with around 6,000 hospitals (3,000 general medical acute-care hospitals paid under the Inpatient Prospective Payment System), ranging in size from a few beds to hundreds, and there is no equivalent of the Emergency Medical Treatment & Labor Act (EMTALA) to compel nursing homes to care for medically and socially complex patients. Better measurement and more targeted approaches to payment models are sorely needed, particularly as this sector grows with the aging population and their care needs.

In the physician practice sector, the effects of PE have varied quite a bit by specialty, and thus different approaches are probably needed in this regard. For highly fragmented markets like

ophthalmology and dermatology, the primary approach has been to create local monopolies to increase negotiating power, driving up prices. There is less of an obvious role for population-based payment models in this context. On the other hand, value-based and alternative payment models hold tremendous potential for increasing investment and innovation in the primary care space, where there is great opportunity to save money by improving patient outcomes if incentives are properly aligned. In this environment, PE firms may give primary care or group practices the support they need to resist vertical integration, instead protecting their independence; if that independence is coupled with strong financial incentives for health and wellness, these financial arrangements may prove more attractive for patients and clinicians alike.

For any continued transition to value-based care to be feasible, not just the payment models need to change, but the expertise and approach underlying them. That means making intentional and careful improvements in quality and equity measurement, advancing the science of risk adjustment to be more accurate, more equitable, and less game-able, explicitly rewarding access to care, and, of course, as outlined above, modernizing underlying data infrastructure to make it capable of meeting these needs.

C. Additional Considerations

Each of the policy strategies stated above need to be pursued with careful attention to burden, in particular clinician burden and burnout. Access to health care facilities means nothing if there are no clinicians to provide care. Health care is, at its core, an interpersonal, hyperlocal undertaking, and broad corporatization and consolidation threaten to further erode clinician well-being and autonomy. Clinician leadership should be prioritized, and strategies that both improve patient outcomes and release clinicians from burdensome micromanagement and utilization review should be studied and pursued where found to be fruitful.

IV. Conclusions

In conclusion, the ongoing corporatization of health care, including the rise of private equity across sectors, has the potential to increase costs and worsen quality, access, and outcomes. But it also presents an opportunity to modernize policy and create the data and payment infrastructure that can reorient profit-seeking behavior towards keeping patients healthy, well, and out of the hospital. Aligning incentives is the only way to move towards progress in our market-driven system, balancing competition and regulation in the most patient-centered way possible.

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