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Re: Request for Information on Consolidation in Healthcare Markets, Docket No.: ATR-102

Dear Assistant Attorney General Kanter, Chair Khan, and Secretary Becerra,

Americans for Financial Reform Education Fund (AFREF) commends your agencies for their concern about the effects of consolidation in health care markets and is pleased to offer our comments on this request for information. AFREF is a nonpartisan and nonprofit coalition of more than 200 civil rights, consumer, labor, business, investor, faith-based, and civic and community groups dedicated to advocating for policies that shape a financial sector that serves workers, communities and the real economy, and provides a foundation for advancing economic and racial justice.

AFREF's response to the RFI focuses on transactions by private equity (PE) funds which, by treating health care facilities and companies as financial instruments, have inflicted damage on health care businesses, communities, and individuals. PE leveraged buyouts have driven economic consolidation and concentration over the past 15 years, and these takeovers increased an average of 10 percent annually over that period, despite contractions and slowdowns during the financial crisis, the pandemic, and the recent inflationary period. PE buyouts tripled from about 2,300 deals in 2008 to over 7,000 deals in 2022 and the total value of buyout deals more than tripled to over $800 billion in 2022. PE deals in health care more than quadrupled from 329 in 2008 to 1,542 in 2021, before dropping to 1,317 in 2022. The value of the deals similarly increased, reaching over $200 billion in 2021. From 2008 to 2023, there were over 11,000 PE deals in health care, with an aggregate value of $1.1 trillion.[1] And PE's footprint across health care sectors is broad, including facilities such as hospitals and nursing homes; specialty physician practices such as orthopedics, gastroenterology, anesthesiology, and ophthalmology; emergency room physicians; ambulance services; behavioral health, autism services, hospice, dentistry, travel nurses, durable medical equipment, pharmaceuticals, billing and collections, and more.[2]

In the following comments, AFREF responds to the RFI's questions by detailing PE's activities in health care, in terms of:

- **Effects of consolidation** on patients, clinicians and other health care workers, providers, and the patients and communities they serve;
- PE's **claimed business objectives** for acquisitions in the health care sector, and their fundamental incompatibility with the purpose and goals of health care;
- **Notable transactions** that illustrate PE's malign impact on health care; and
- The **need for government action** to protect the public's health and prevent the further degradation of the health care system.

1. Effects of Consolidation

Health care is attractive to PE investors for a number of reasons. The system is complex and fragmented, with payment loopholes and operating inefficiencies that can be exploited by actors seeking a quick profit. Prices for services are distorted by asymmetric information, the presence of third-party payers, and prices being divorced from underlying costs and quality. Demand for services is

[1] Pitchbook. "U.S. Private Equity Breakdown: 2023 Annual" and data summary. January 2024.
[2] KFF Health News, "Patients for Profit: How Private Equity Hijacked Health Care." https://kffhealthnews.org/private-equity/

growing because of an aging population and expansion of insurance coverage. Many practices and providers are small, undercapitalized, and disconnected, and as much as one-quarter of spending in the health care system is waste,[3] presenting opportunities for streamlining and revenue enhancement that PE firms seize on to produce financial returns – but not necessarily improvements in systems or outcomes.

A central feature of the private equity model is that transactions are highly leveraged, with debt financing as much as 70 percent of an acquisition, and the acquired entity bearing the debt burden. PE firms also frequently add to the financial burden on their portfolio companies by requiring the payment of hefty management fees, and through arrangements like the sale and leaseback of facilities. Debt service and fees can threaten patient care, as revenue for staffing, services, equipment, and technology is instead diverted to these expenses. This is particularly disruptive in markets where there is little choice of providers, such as when consolidation has reduced the number of competitors in a market.

PE firms often seek to consolidate markets using the tactic of sequential "roll-up" transactions, acquiring a platform or company and then buying up other companies in the same market segment. This strategy enables a PE firm to accumulate market power while evading antitrust regulatory scrutiny because each individual transaction falls below the Hart-Scott-Rodino Antitrust Improvements Act (HSR) notification threshold.[4] Because a PE firm typically takes operational control of its companies, there is a great opportunity for a high degree of coordination across markets. The Department of Justice and Federal Trade Commission 2023 Merger Guidelines identify the potentially anticompetitive impact of serial acquisitions that substantially lessen competition or tend to create monopoly and can be unlawful under the Clayton Antitrust Act.[5]

PE strategies may consolidate markets in less straightforward ways as well. About one-fifth of PE deals are investments in minority stakes in businesses. This tactic allows PE firms to exert control through management and governance channels, by, for example, selecting board members. Some firms place the same person, or members of a close-knit group, on several boards to coordinate business strategies.[6]

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[3] William H. Shrank, Teresa L. Rogstad, and Natasha Parekh, "Waste in the US Health Care System: Estimated Costs and Potential for Savings," JAMA 322, no. 15 (October 15, 2019): 1501–9, https://doi.org/10.1001/jama.2019.13978.

[4] The Federal Trade Commission has proposed changes to the HSR notification process that addresses the unique problems of serial roll-up acquisition that would require pre-notification of smaller transactions that are in the same industry as prior transactions. *See* Federal Trade Commission (FTC). "FTC 16 CFR Parts 801 and 803 Premerger Notification; Reporting and Waiting Period Requirements." 88 Fed. Reg. 124. June 29, 2023 at 42178 et seq.

[5] U.S. Department of Justice and Federal Trade Commission. "2023 Merger Guidelines." December 18, 2023 at 23.

[6] Americans for Financial Reform Education Fund. Comment letter on Merger Guidelines 2023 of U.S. Department of Justice and the Federal Trade Commission [Hereafter "AFR Comments on Merger Guidelines"]. September 18,

These minority stakes and interlocking strategic alignment allow purported competitors to coordinate marketing, pricing, geographies, and service quality that can disadvantage patients, workers, and communities. The 2023 Merger Guidelines address the anticompetitive effects and potentially unlawful practices of these kinds of coordinated partial ownership practices.[7]

Vertical mergers of upstream suppliers and downstream buyers are another form of consolidation. PE firms frequently have portfolios that include such configurations that have the capacity and incentive to offer services to their other portfolio companies on more favorable terms than they offer to their rivals or foreclose access in ways that disadvantage potential rivals. These vertical combinations allow PE firms to incentivize their portfolio companies to purchase services or products from other companies in their portfolio.[8] This can raise concerns that self-referrals or transactions between affiliated PE firms can inflate prices or otherwise overbill for public programs like Medicare and Medicaid.

Another consolidation tactic is the acquisition of portfolio companies in complementary, adjacent markets. One example is Global Medical Response (GMR), owned by the PE firm KKR. GMR is effectively a cluster product market of emergency services. Its nationwide network has 8,000 ground ambulances, 375 helicopters, 123 medical airplanes, and 174 fire trucks with almost 400 air bases, 60 communication centers, and 51 fire stations.[9] While many of these emergency services are not direct competitors (fire trucks and organ transport, for example), GMR's presence in adjacent markets amplifies its market power in ways that can disadvantage its rivals, increase prices, suppress wages, and undermine competition.[10]

PE firms have also taken advantage of the increasingly common practice among hospitals and other institutions to outsource key clinical and administrative services. Forty percent of hospital emergency departments are overseen, staffed, or managed by PE-owned companies, according to one estimate.[11] Many health care organizations also outsource their billing and collections, called "revenue cycle management," and PE firms have shown a great interest in these businesses, executing 18 add-on

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2023.
https://ourfinancialsecurity.org/2023/09/letters-to-the-regulators-letter-in-support-of-proposed-merger-guideline/

[7] 2023 Merger Guidelines at 28.

[8] Mills, Ryan and Melanie Payne. (Mills & Payne). "Neglected: Florida's largest nursing home owner represents a trend toward corporate control." Naples (FL) Daily News. May 31, 2018; Rau, Jordan. "Care suffers as more nursing homes feed money into corporate webs." *New York Times*. January 2, 2018.

[9] Global Medial Response. About Overview. Accessed September 2023.

[10] AFR Comments on Merger Guidelines

[11] Gretchen Morgenson, "Senate investigating whether ER care has been harmed by growing role of private-equity firms." NBC News, April 1, 2024. https://www.nbcnews.com/health/health-care/senate-questions-private-equity-hospital-emergency-departments-peters-rcna145909, accessed May 30, 2024.

transactions and three buyouts in 2022 alone.[12] This approach gives PE firms the opportunity to consolidate vital services and sell them to institutions that may not be in consolidated markets themselves. It may also increase the opportunities for and incidence of related party transactions, as PE buyouts proliferate across numerous subsectors.

PE's consolidation strategies have numerous negative effects. They begin with how PE typically funds acquisitions – with large amounts of debt, which the acquired company bears responsibility for servicing. When the company in question is a health care organization, large debt repayment obligations can result in staff reductions, increased prices, and revenues that might otherwise go to improving care instead being used to pay down debt. This can affect patient care and ultimately destabilize a community's health care resources. The bankruptcies of Envision Healthcare and Steward Healthcare—affecting millions of patients—underscore the damage that the combination of consolidation and PE's irresponsible financial practices cause for people who need health care and the professionals who provide it.[13]

Other effects of the impact of PE-driven consolidation are well documented. Studies of nursing homes owned by PE firms found both worse quality of care – increased probabilities of emergency department visits, hospitalizations, and deaths – and increased costs and Medicare claims.[14,15] A recent study raised further concerns about safety at PE-owned facilities, finding that PE ownership of hospitals was associated with increases in falls and hospital-acquired central-line infections.[16] And the malignant effects of PE ownership of nursing homes is difficult to elude. It is estimated that private equity firms own 11 percent of nursing homes nationally, including some of the largest nursing home chains.[17] In addition to the restriction of choice resulting from horizontal consolidation, as many as 75 percent of nursing homes are also integrated vertically, doing business with "related parties" – real

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[12] Mary Bugbee, Eileen O'Grady, & Michael Fenne. "Recent Trends in Private Equity Healthcare Acquisitions/" Private Equity Stakeholder Project, February 2023.
[13] Envision Healthcare, "Who We Are," accessed June 4, 2024, https://www.envisionhealth.com/about/who-we-are.
[14] Atul Gupta et al., "Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes," accessed November 7, 2022, https://bfi.uchicago.edu/insight/finding/does-private-equity-investment-in-healthcare-benefit-patients-evidence-from-nursing-homes/.
[15] Robert Tyler Braun et al., "Association of Private Equity Investment in US Nursing Homes With the Quality and Cost of Care for Long-Stay Residents," *JAMA Health Forum* 2, no. 11 (November 19, 2021): e213817, https://doi.org/10.1001/jamahealthforum.2021.3817.
[16] Sneha Kannan, Joseph Dov Bruch, and Zirui Song, "Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition," *JAMA* 330, no. 24 (December 26, 2023): 2365–75, https://doi.org/10.1001/jama.2023.23147.
[17] Eileen O'Grady, "Pulling Back the Veil on Today's Private Equity Ownership of Nursing Homes." Private Equity Stakeholder Project, July 2021.

estate companies, management and staffing companies, therapy providers, and others – in which they have an ownership interest.[18]

A study by AFREF and the American Antitrust Institute found that PE roll-ups of home health care companies yielded a disproportionate level of Medicare payments for these companies.[19] PE companies can hinder access to health care by closing facilities and practices in areas where they are needed, often in marginalized communities – examples are the closure of Hahnemann Hospital in Philadelphia[20] and the bankruptcy of the Center for Autism and Related Disorders[21] – and by increasing the burden of medical debt through higher prices and the vertical integration of revenue cycle management companies that pursue aggressive bill collection activities on behalf of their clients.[22] And consolidation can be life-threatening: a study of the dialysis industry found that acquisitions that were exempt from the HSR pre-merger notification requirement resulted in higher hospitalization rates and lower survival rates. The study concluded that requiring merger notification of these dialysis transactions would have saved thousands of lives.[23]

Not to be minimized is the effect PE ownership has on the well-being of practicing physicians and on their future in the profession. A recent survey of physician perspectives found that PE-employed physicians were less likely to report high professional satisfaction and autonomy compared with their non-PE counterparts, and fewer PE-employed physicians said they were likely to remain with their employer.[24]

An important feature of PE-driven consolidation is that it is one-directional and engenders further consolidation. The roll-up strategy and the short-term exit strategy typical of PE virtually ensure that subsequent buyers will be other PE firms or large corporations executing their own consolidation strategies. Steward Health Care's physician group, Stewardship Health, is a case in point. A product of PE-driven acquisitions, Steward's physicians practice in 30 hospitals across nine states. Optum, the

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[18] "Related Party Transactions and CMS's Role in Regulation." The National Consumer Voice for Quality Long-Term Care, February 2024.
[19] Moss, Diana L. and Oscar Valdés Viera. American Antitrust Institute and AFREF. "The Growth of Private Equity Ownership in the Home Healthcare Market." June 6, 2023.
[20] Chris Pomorski, "The Death of Hahnemann Hospital," *The New Yorker*, May 31, 2021.
[21] Eileen Appelbaum, keynote address, "Private Capital, Public Impact: An FTC Workshop on Private Equity in Health Care." March 5, 2024.
[22] Quynh Chi Nguyen and Mark Rukavina, "A Path Toward Ending Medical Debt: A Look at State Efforts" (Boston, MA: Community Catalyst, December 2021).
[23] Thomas G. Wollmann, "How to Get Away with Merger: Stealth Consolidation and Its Effects on US Healthcare," Working Paper, Working Paper Series (National Bureau of Economic Research, May 2020), https://doi.org/10.3386/w27274.
[24] Jane M. Zhu et al., "Physician Perspectives on Private Equity Investment in Health Care," JAMA Internal Medicine 184, no. 5 (May 1, 2024): 579–80, https://doi.org/10.1001/jamainternmed.2024.0062.

UnitedHealth Group subsidiary that is the largest employer of physicians in the country, is moving to acquire Stewardship, thereby strengthening the power of United, the nation's largest health plan, to exploit its vertical consolidation in the market. Another example is Oak Street Health, a primary care company that serves Medicare and Medicare Advantage beneficiaries. Founded in 2012, Oak Street attracted private equity investors to fuel growth and went public in 2020, with PE firms still holding a majority of shares. Finally, in 2023, CVS Health acquired Oak Street Health in a $10.6 billion transaction, which, following CVS Health's acquisition of Aetna in 2018, added to CVS Health's national dominance as a vertically integrated "payvider."[25]

2. Claimed Business Objectives

The contention that mergers and consolidation creates efficiencies that will improve competition and reduce consumer price are not supported by empirical evidence. The FTC's and DOJ's 2023 Merger Guidelines treat this claim with the skepticism it deserves, requiring merger-specific, verifiable evidence that the purported efficiencies would be passed on to consumers and not just be captured by the merging parties.[26]

In fact, PE's objective in health care, as it is in other markets, is to generate large revenue for its general partners, and profits for its investors over a short time period. PE firms view health care facilities and practices as financial commodities to be bought and sold, and from which resources can be extracted to benefit the PE firm and its investors.

This business approach is fundamentally incompatible with health care. The high levels of debt, short time horizons, and lack of expertise conflict with what is needed for a well-functioning health care system that responds to the needs of its community and seeks to improve through the development and application of clinical and administrative best practices. Patients, providers, health care workers, and the public's health overall are the worse for it.

[25] Andrew Grant, "CVS Health's Acquisition of Oak Street Health Reconfirms Market Viability of Private Equity Investment in Value-Based Payment Models for Primary Care," *American Journal of Law & Medicine* 49, no. 1 (March 2023): 120–27, https://doi.org/10.1017/amj.2023.20.
[26] U.S. Department of Justice and Federal Trade Commission, "Merger Guidelines." December 18, 2023.

3. Notable Transactions

As we review above, the harmful consequences of PE transactions in health care are widespread and varied. Several examples from diverse health care sectors provide illustrations.

Debt obligations and asset extraction leave rural communities without hospital services. Audrain Community Hospital, in Mexico, Missouri, was acquired by Noble Health in March 2021. Noble, which also acquired nearby Callaway Community Hospital, was launched by the private equity firm Nueterra Capital little more than a year earlier. Noble was led by executives without experience in hospital administration, including co-founder Donald Peterson. Peterson had earlier been accused of Medicare fraud and was on an exclusion list barring him for five years from Medicare, Medicaid, and other federal programs.

Within a year, Noble had suspended hospital services at Audrain and Callaway, furloughed 181 employees, and agreed to sell the two hospitals to Platinum Neighbors. In the foregoing year, Noble had taken on $45-50 million in debt, accumulated $4 million in unpaid bills, was paying employees erratically, and had stopped paying for employee insurance benefits, leaving many employees who thought they were insured with 5- and 6-digit medical bills.[27] While apparently struggling, Noble also received $20 million in federal COVID-19 relief funds, including $4.8 million in paycheck protection funds, during this period.

Platinum sold the hospitals to Clifford Sullivan on December 7, 2022; a local legislator said of Platinum's brief ownership, "There is a question as to whether Platinum Health ever had any intention to operate the hospitals."[28] The hospital property – hospital and clinic buildings, as well as the equipment inside them – is still owned by Noble's subsidiary, Noble Health Real Estate II, LLC,[29] but the prospect of reopening seems remote. The hospital's current owner, Ziva Medical, laid off the hospital's skeleton staff in January 2024.[30] Mexico, the small city where Audrain once operated, has

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[27] Sarah Jane Tribble, "Buy and Bust: Collapse of Private Equity-Backed Rural Hospitals Mired Employees in Medical Bills," Kaiser Health News (blog), August 16, 2022, https://khn.org/news/article/noble-health-private-equity-rural-hospitals-missouri-employees-medical-bills/.

[28] Matt Pilger, "Mexico and Fulton Hospitals New Owner Denied Extension of Suspended Operating License," The Mexico Ledger, accessed January 17, 2023. https://www.mexicoledger.com/stories/mexico-and-fulton-hospitals-new-owner-denied-extension-of-suspended-operating-license

[29] "Audrain Community Hospital 'Sold' Again?" https://www.kwwr.com/2023/01/06/audrain-community-hospital-sold-again/, accessed January 20, 2023.

[30] Dennis Sharkey, "Ziva Medical shuts down operations amid uncertainty." The Mexico Ledger, accessess May 29, 2024. https://mexicoledger.com/stories/ziva-medical-shuts-down-operations-amid-uncertainty,66890

been without a hospital for over two years. The closest acute care hospitals to Mexico are in Columbia, Missouri, nearly 30 miles away.

Overuse and upselling in specialty physician practices. Some PE-driven consolidation has focused on specialty practices that offer expensive services and are paid on a fee-for-service basis. Revenue grows with volume, and PE-backed companies increase volume in a number of ways:

- Adding acquisitions to a platform practice, which often has the additional effect of raising prices by reducing competition;
- Acquiring companies that offer lucrative subspecialties, for example Mohs surgery in dermatology, so that referrals may be kept in-house;
- Using staff with less training , such as physician assistants and nurse practitioners, to perform procedures, often with minimal or no supervision from a physician.

Dermatology has been the most sought after specialty for PE firms. From 2012 to 2021, there were 376 deals in dermatology, resulting in increased market concentration and higher prices.[31] Dermatology is a specialty where volume-enhancing tactics are common, often leading to the overuse of services, putting patients, many of whom are frail and elderly, at risk for complications. An investigation by the New York Times found an increase in unnecessary skin biopsies and procedures performed by physician assistants and nurse practitioners on patients near the end of life, and found that one-fifth of Mohs procedures paid for by Medicare were performed on a patient aged 85 or older. The investigation also found that 75 percent of the patients treated for skin problems by three physician assistants and one nurse practitioner employed by Bedside Dermatology in Michigan had been diagnosed with Alzheimer's disease.[32] Bedside Dermatology is owned by Advanced Dermatology and Cosmetic Surgery, the nation's largest dermatology company and the eighth-most active PE-backed acquirer of specialty physician practices from 2012 to 2021.[33]

Monopolistic price gouging in ambulance services. Private equity firms began buying up emergency ambulance firms and non-profits in the wake of the financial crisis, and the roll-up of air ambulances and ground ambulances has continued even following enactment of the No Surprises Act.[34] Ambulance patients are captive consumers — they get the ambulance that shows up and some

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[31] Richard M Scheffler et al., "Monetizing Medicine: Private Equity and Competition in Physician Practice Markets" (American Antitrust Institute, Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, University of California, Berkeley, and Washington Center for Equitable Growth, July 10, 2023).

[32] Katie Hafner and Griffin Palmer, "Skin Cancers Rise, Along With Questionable Treatments," The New York Times, November 20, 2017.

[33] Scheffler at al., "Monetizing Medicine."

[34] Webb, Olivia. "Private equity chases ambulances." American Prospect. October 3, 2019

patients are not even conscious — and are especially vulnerable to companies that use their market power to impose price hikes. KKR built Global Medical Response from a series of smaller mergers and the acquisition of large companies including Air Medical Group Holdings, CALSTAR, and Air Medical Resource Group. GMR's creation resulted in nearly 75 percent of air ambulances being provided by just three for-profit companies, two of which were PE firms.[35] Such market concentration usually leads to price increases, and this has been the case in air ambulance services: the average price of an airplane ambulance trip increased 75 percent from 2012 to 2021, and the average price of a helicopter trip increased 84 percent (prices for medical care overall rose about 26 percent during this period[36]). About one-quarter of these trips were out-of-network in 2021.[37]

Home Health Care. Home health is a rapidly growing field, as the population ages and more people seek post-acute care and long-term services and supports in home-based rather than facility based settings. It is a potentially lucrative area of health care, with Medicare and Medicare Advantage plans as primary payers. Home health care has been increasingly attractive to PE: in 2023, PE owned 492 home health providers, representing about 5.7 percent of all providers, rolled up into 37 PE-owned or backed parent companies. Five of the parent companies accounted for 63 percent of Medicare revenue collected by PE-backed companies in this sector and 57 percent of their locations. Rising levels of concentration and increasing interest from PE firms invite concern about the companies' ability to increase prices and cut costs in ways that can harm patients. PE's typical practice of rapidly exiting markets after maximizing its gain potentially jeopardizes the quality of care home health clients receive, as similar behavior has done in the nursing home industry.[38]

4. Need for Government Action

The foregoing has pointed to the risk and damage that PE-driven consolidation can and does cause among health care businesses. The cost is financial, but it is also measured in terms of people's health and lives. The three agencies have policy levers at their disposal to reduce the incentives PE firms have for expansion and consolidation and to address the negative consequences of PE ownership and consolidation. These recommendations focus on actions the agencies can take within their current

[35] Americans for Financial Reform Education Fund,
[36] U.S. Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers: Medical Care in U.S. City Average [CPIMEDSL], retrieved from FRED, Federal Reserve Bank of St. Louis; https://fred.stlouisfed.org/series/CPIMEDSL, June 4, 2024.
[37] John Hargraves and Linsay Sarfo, "Ambulance Trends of 10 Years (2012-2021)." Health Care Cost Institute. October 12, 2023.
[38] Diana L. Moss and Oscar Valdes Viera, "The Growth of Private Equity Ownership in the Homes Healthcare Market." American Antitrust Institute and Americans for Financial Reform Education Fund, June 2023.

regulatory and enforcement authority. Comprehensive reform will require complementary legislation as well, which is beyond the scope of this RFI.

FTC should investigate, regulate, and enforce.

The Federal Trade Commission (FTC) should use its investigative, enforcement, and regulatory powers to minimize the damage that private equity inflicts on health care. First, the FTC has broad authority to demand information from market participants to prepare reports on issues of concern, even without a specific law enforcement purpose. The FTC should use its authority to investigate: (1) billing practices by health care entities, including revenue cycle management companies, owned or managed by private equity companies; (2) the impact of private equity-backed company MultiPlan on payment amounts to out-of-network providers, including the impact on smaller providers and out-of-pocket costs for patients;[39] (3) collection actions against patients by health care practices owned or managed by private equity; (4) quality of care at health care entities owned or managed by private equity companies; (5) the use of affiliated PE-owned providers of services or products; (6) the impacts and prevalence of PE-investor/ owners use of sale-leaseback arrangements with health care facilities; (7) the reliance of PE-owned health care entities on federal health programs including Medicare, Medicaid, and Indian Health Services; and (8) the ownership structures and interrelation with medical real estate investment trusts. The FTC should also make recommendations to Congress for legislative action to address the risks of private equity in health care.

Second, the FTC should bring enforcement actions and issue rules regarding unfair practices by health care entities owned or managed by private equity companies. The FTC should consider whether the following practices are unfair to patients and providers: sale-leaseback transactions that strip hospitals, nursing homes, or other health care facilities of valuable assets and require exorbitant rent payments; understaffing at nursing homes, hospitals and other health care entities owned or managed by private equity companies; upcoding by health care entities owned or managed by private equity companies; and the payment of management or advisory fees to private equity firms for minimal or nonexistent services that siphons money away from patient care; the use of affiliated providers of goods or services; or any other practice that undermines the quality of care, reduces workers' wages or benefits, or threatens the solvency of federal health programs.

Third, the FTC should take enforcement action and issue rules to prevent "unfair methods of competition" in health care by private equity companies. The FTC has confirmed that its authority on unfair methods of competition reaches beyond antitrust law to encompass "various types of unfair

[39] The New York Times, "In Battle Over Health Care Costs, Private Equity Plays Both Sides," April 7, 2024, https://www.nytimes.com/2024/04/07/us/health-insurance-medical-bills-private-equity.html.

conduct that tend to negatively affect competitive conditions."[40] The FTC should continue to apply this authority to challenge "roll-up" acquisitions by private equity companies.

Fourth, the FTC should study the impact of serial private equity roll-ups across the health care sector and evaluate the extent to which these transactions have amassed market power and the impact on patients, workers, and public healthcare programs.

DOJ should prosecute health care fraud and cease contracting with private equity companies for health care in correctional facilities.

The DOJ should investigate and prosecute health care fraud by private equity companies. The DOJ recovered $2.2 billion from 351 False Claims Act (FCA) settlements in 2022, and 77 percent of that amount came from health care-related businesses.[41] The sum could have been higher if the DOJ had pursued the maximum treble damages in these cases; typically, the DOJ seeks an amount closer to double damages.[42] PE owners may view these settlements as a cost of doing business. Prosecutors should pursue maximum penalties to more effectively deter illegal practices.

Further, the Stark Law's prohibition against self-dealing permits an exception for in-office ancillary referrals within a "group practice," as defined by the law. A portfolio of vertically-related PE-owned companies may find it difficult to meet this definition, which requires a group practice to be a single legal entity, not "separate group practices under common ownership or control through a physician practice management company… or other entity or organization."[43] Transactions between entities with common PE-owners are thus potential violations of the Stark Law, and worthy of close attention and investigation.

To address quality of care concerns in health care entities owned or managed by private equity companies, the DOJ should continue to pursue FCA cases for substandard care (*e.g.*, "worthless services"). To address concerns about higher billing by health care entities owned or managed by private equity companies, the DOJ should continue to pursue FCA cases for upcoding and other inflated claims, including inflated billing related to affiliated service providers. The DOJ should use HHS data on ownership or management by private equity companies to investigate patterns of

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[40] *E.g., Fed. Trade Comm'n v. U.S. Anesthesia Partners, et al.*, 4:23-cv-03560 (S.D. Tex.).
[41] "2022 False Claims Act Enforcement Data Shows DOJ's Continued Focus On Healthcare Fraud, Successful Year For Whistleblowers Who Go It Alone," The National Law Review, February 9, 2023, https://www.natlawreview.com/article/2022-false-claims-act-enforcement-data-shows-doj-s-continued-focus-healthcare-fraud.
[42] Erin C. Fuse Brown and Mark A. Hall, "Private Equity and the Corporatization of Health Care," *Stan. L. Rev.* 76 (Forthcoming 2024).
[43] 42 C.F.R. § 411.352(a).

substandard care or improper billing across multiple providers owned or managed by the same private equity firm.

The DOJ should encourage providers and other staff at health care entities to come forward with allegations of substandard care or improper billing and establish a confidential portal for whistleblowers to report these claims. The DOJ should make public statements about the protections and incentives available for whistleblowers with knowledge of health care fraud. The DOJ should target this message at specialist physicians whose practices have been bought by PE companies, and at other employees and contractors at health care entities owned or managed by private equity.

The DOJ should forbid private equity-owned companies from providing healthcare and other services to those incarcerated in the federal prison system and provide incentives for state prison systems to eliminate private equity from their correctional health systems. Wellpath, which is owned by a private equity firm, is the largest prison health contractor in the country, serving patients in at least 34 states. Wellpath has been accused of routinely denying care, and monitors at one California jail found that 18 of the 19 deaths reviewed at the facility could have been prevented if Wellpath had provided timely and adequate treatment.[44] Incarcerated individuals have no choice of health care providers. Given Wellpath's record and the widespread concerns about private equity in health care, the DOJ should immediately cease contracting with private equity companies to provide health care at correctional facilities.

HHS (CMS) should expand its ownership transparency rules.

Ownership of health care facilities is often opaque, which is another weakness in the health care market that PE companies exploit for financial gain. PE-owned health care providers structure themselves to limit their legal liability, and providers with common owners can obscure the overlap with complex corporate structures. Understanding who or what entity owns a health care provider and what related businesses they own is essential for accountability, for monitoring financial stability and health care quality, for better understanding motives and strategies of owners and investors, and for enforcing anti-fraud laws and antitrust laws.

CMS took a significant step in addressing the need for greater transparency in the rule it adopted in November 2023, requiring Medicare institutional providers to report ownership and managing control by PE companies and real estate investment trusts (REIT) on the Medicare enrollment form

[44] Letter from Senators Warren, Durbin, et al. to Wellpath, Dec. 18, 2023. https://www.warren.senate.gov/imo/media/doc/2023.12.18%20Wellpath%20letter1.pdf.

CMS-855A. There are additional requirements for PE- and REIT-owned Medicare skilled nursing facilities.[45]

We urge HHS to build on this foundation with additional rules that promote transparency. Given PE's activity in acquiring and consolidating non-institutional providers, CMS should require the same level of disclosure of ownership among those Medicare providers as it now does for institutional providers, and provide assistance to state Medicaid agencies to do the same. Reporting requirements should include consolidated financial statements from all entities related by common ownership and control.[46] The Care Compare website should give users the ability to identify chains and common ownership interests across facilities.[47] CMS should create a national, on-line PE data base, to allow CMS and researchers to monitor the effects of PE ownership and consolidation on prices, quality, patient experience, and utilization.[48]

Transparency of ownership is directly tied to quality. In the nursing home sector, facilities with the worst quality of care were found to be more frequently bought and sold.[49] The federal government is slow to review ownership changes, however, and does not have specific standards for approving changes. In the interest of health system integrity and the safety of often very vulnerable patients, CMS should set specific minimum criteria for purchase, change of ownership, or management, to prevent ownership by entities with a history of low staffing, poor quality, or past fraud settlements.[50]

CMS should reduce Medicare Advantage overpayments.

More than half of the nation's Medicare beneficiaries are enrolled in Medicare Advantage (MA) plans. MA plans are paid through a capitation arrangement. Capitation is a response to the traditional, fee-for-service payment model, which pays providers for each service they provide, often leading to costly (and sometimes harmful) overutilization of services. Capitation in MA shifted some of the

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[45] CMS, "Medicare and Medicaid Programs; Disclosures of Ownership and Additional Disclosable Parties Information for Skilled Nursing Facilities; Medicare Providers' and Suppliers' Disclosure of Private Equity Companies and Real Estate Investment Trusts," Final Rule, 88 Fed. Reg. 221 at 80149 (Nov. 17, 2023).
[46] Charlene Harrington et al., "These Administrative Actions Would Improve Nursing Home Ownership And Financial Transparency In The Post COVID-19 Period," *Health Affairs Forefront*, accessed December 2, 2022, https://doi.org/10.1377/forefront.20210208.597573.
[47] "Nursing Homes: CMS Should Make Ownership Information More Transparent for Consumers," January 2023, https://www.gao.gov/assets/gao-23-104813.pdf.
[48] Erin Fuse Brown et al., "Private Equity Investment As A Divining Rod For Market Failure: Policy Responses To Harmful Physician Practice Acquisitions" (USC-Brookings Schaeffer Initiative for Health Policy, October 2021).
[49] David C. Grabowski et al., "Low-Quality Nursing Homes Were More Likely Than Other Nursing Homes To Be Bought Or Sold By Chains In 1993–2010," Health Affairs 35, no. 5 (May 2016): 907–14, https://doi.org/10.1377/hlthaff.2015.1042.
[50] Harrington et al., "These Administrative Actions Would Improve Nursing Home Ownership And Financial Transparency In The Post COVID-19 Period."

financial risk of overutilization to commercial insurers and also included quality standards that need to be met to receive full payment. However, in the case of Medicare the intentions of this reform were largely frustrated because the methodology for calculating MA's capitation rate in fact results in per member per month payments to the insurers offering the plans which are much higher than CMS's fee-for-service-equivalent cost would be for MA members. The payment calculation rewards aggressive coding of diagnoses to game the risk adjustment methodology, turning MA into what former CMS Administrator Dr. Donald Berwick calls the "Medicare Money Machine."[51] A recent estimate is that MA overpayments due to coding intensity and favorable selection of healthier members amounted to $75 billion in 2023, and could cost the public an additional $810 billion to $1.6 trillion over the next decade.[52]

These pricing distortions attract profit seekers and especially private equity companies, which seek such opportunities to exploit through vertical integration of physician practices and MA plans, joint ventures, and consolidation of other MA-related businesses. The most popular of these businesses in recent years are marketing and brokerage companies, to which PE firms are attracted because of increasing Medicare enrollment, regulatory rollbacks during the Trump administration, and loopholes in maximum commission rules that allow companies to generate excessive profits. Another PE target has been in-home assessment companies, which can help MA plans take advantage of MA's favorable risk adjustment mechanics to increase capitation payment and then share in the windfall.[53]

CMS can use its current authority to weaken these incentives. The Medicare Payment Advisory Commission (MedPAC) estimates that, in 2024, CMS pays MA plans 22 percent more than it would have paid if the MA members were instead in the fee-for-service part of Medicare.[54] However, CMS applies only a 5.9 percent coding intensity adjustment, meaning that MA plans in aggregate reap a premium of about 16 percent over a baseline level of spending. We urge CMS to apply its coding intensity adjustment more assertively, to reflect the actual degree to which CMS overpays MA plans. Combining this policy change with scrutiny of individual contracts using Risk Adjustment Data

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[51] Richard Gilfillan and Donald M. Berwick, "Medicare Advantage, Direct Contracting, And The Medicare 'Money Machine,' Part 1: The Risk-Score Game," Health Affairs Forefront (blog), accessed April 12, 2023, https://www.healthaffairs.org/do/10.1377/forefront.20210927.6239/full/.

[52] Committee for a Responsible Federal Budget, "New Evidence Suggests Even Larger Medicare Advantage Overpayments-2023-07-17," July 17, 2023, https://www.crfb.org/blogs/new-evidence-suggests-even-larger-medicare-advantage-overpayments.

[53] Mary Bugbee, How Private Equity Gets Its Cut from Medicare Advantage. Private Equity Stakeholder Project, January 2024.

[54] Estimating Medicare Advantage coding intensity and favorable selection. MedPAC, Report to the Congress: Medicare Payment Policy, Chapter 13. March, 2024.

Validation audits would make a significant dent in MA overpayments and begin to dismantle the money machine that is MA capitation.

CMS should better regulate bad actors through use of the Medicare and Medicaid exclusions list.

Individuals and entities convicted of health fraud are legally excluded from participating in Medicare and Medicaid, and are listed on the HHS Office of Inspector General's (OIG) exclusions list. Working around a ban is not uncommon, however, and it is often up to employers and whistleblowers to report violations. When the FTC and DOJ enforce anti-fraud laws among PE firms, their subsidiaries, and other actors, CMS should be able to effectively exclude those and related actors from further profiting in health care markets. The value of the exclusions list could be strengthened by adopting the types of recommendations, addressing enhancing controls and assessing fraud risk, made to the Veterans Administration in a 2021 Government Accountability Office review.[55]

Conclusion

AFREF thanks the three agencies for undertaking this inquiry. The financialization of health care that PE's activities exemplify is bad for markets, patients, and communities. We urge the agencies to use their regulatory, investigative, and enforcement authority to strengthen policies that favor fair competition and good health for the many over profits for the few.

[55] Government Accountability Office, "Veterans Community Care Program: VA Should Strengthen Its Ability to Identify Ineligible Health Care Providers," December 2021, https://www.gao.gov/assets/gao- 22-103850.pdf