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Congress of the United States

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August 30, 2018

Francis J. Crosson, M.D.
Chairman
Medicare Payment Advisory Commission
425 I St, NW
Suite 701
Washington, DC 20001

Dear Chairman Crosson,

We request the Medicare Payment Advisory Commission (MedPAC) conduct research examining questions regarding the market trend of hospital consolidation and the degree to which such consolidation increases cost to the Medicare program and beneficiaries, including the costs for prescription drugs. We request the Commission undertake this research as it clearly builds upon the work of the Commission in recent years.

Hospital Consolidation Is A Market Dynamic

The Energy & Commerce Committee (the Committee) appreciates that there are many economic and business reasons animating hospital consolidation today, including economies of scale to serve patients, access to capital, improved coordination of care, increased leverage against payers, reducing duplicative services through common electronic medical records, and many other rationales. We also appreciate that there can be horizontal hospital consolidation, in which hospitals consolidate into larger systems—as well as vertical hospital consolidation, in which hospital systems acquire other systems or physician practices.

Today, hospital care is the single largest category of spending on medical care as outlined in the National Health Expenditure data.[1] One recent media report noted that while drug pricing

[1] The Office of the Actuary in the Centers for Medicare & Medicaid Services annually produces projections of health care spending for categories within the National Health Expenditure Accounts, which track health spending by source of funds (for example, private health insurance, Medicare, Medicaid), by type of service (hospital, physician, prescription drugs, etc.), and by sponsor (businesses, households, governments). The latest projections begin after the latest historical year (2016) and go through 2026. They are available online at:

has received a lot of attention in recent years, "hospitals cost the health care system far more."[2] Certainly, hospitals play an important role in the ultimate cost of drugs that patients pay. Given that the 2018 Medicare Trustees Report identified hospitals receiving $197.9 Billion from Medicare in FY2017[3] it is essential that Congress benefit from a careful, data-driven, nonpartisan analysis regarding to what degree consolidation trends in the hospital industry have the potential to increase or decrease costs for beneficiaries and taxpayers.

Data shows that the trend of hospital consolidation has been increasing over the last decade. The Government Accountability Office (GAO) found that the number of vertically consolidated hospitals increased by 21% from 2007 through 2012.[4] The hospital industry has the most federal horizontal merger litigation in front of the Federal Trade Commission (FTC) currently,[5] and the rate of hospital merger and acquisition transactions is only expected to increase in the coming years, with some estimating that one in five hospitals will be realigned during the next decade.[6]

Consolidation in the hospital industry certainly appears to be part of a larger trend of consolidation in the health care market more generally.[7] Hospitals play a significant role in the health care market and are thus likely to have a role in influencing health care costs, particularly as it relates to the Medicare program.

Expert Testimony Has Focused on Different Impacts from Hospital Consolidation

There is conflicting information, however, on the impact hospital consolidation has on health care costs for patients. For example, a 2016 report suggested that consolidation can help reduce costs by 15 to 30 percent.[8] On the other hand, some studies conclude that "Hospital consolidation generally results in higher prices…This is true across geographic markets and different data sources…the price increase can be dramatic, often exceeding 20 percent."[9] Even more concerning is a study that suggested merging hospitals resulted in 40% higher prices than non-merging hospitals.[10]

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https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html

[2] "Think Drug Costs Are Bad? Try Hospital Prices," Axios article by Bob Herman, July 25, 2018, available online at https://www.axios.com/hospitals-drug-prices-trump-pharma-223585c8-f085-454d-8e17-078177274d24.html

[3] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf

[4] https://www.gao.gov/assets/680/674950.pdf

[5] Gowrisankaran, G., Nevo, A., & Town, R. (2015). Mergers When Prices Are Negotiated: Evidence from the Hospital Industry †. American Economic Review, 105(1), 172–203. doi:10.1257/aer.20130223

[6] Philip Betbeze, "M&A Forecast: 1 in 5 hospitals to realign over next decade," HealthLeaders Media, Jan. 25, 2013. Gerald Adolph, Gary D. Ahlquist, Anu Sharma, and Brett Spencer, "The coming surge in health provider M&A: How historical forces and healthcare reform will combine to drive activity," Strategy&, 2012.

[7] Fulton, B. D. (2017). Health care market concentration trends in the united states: Evidence and policy responses. Health Affairs, 36(9), 1530-1538. doi:http://dx.doi.org/10.1377/hlthaff.2017.0556

[8] https://www.strategyand.pwc.com/reports/size-should-matter

[9] Gaynor, M., & Town, R. (2012). The impact of hospital consolidation. ().The Robert Wood Johnson Foundation.

[10] Dafny, L. (2009). Estimation and Identification of Merger Effects: An Application to Hospital Mergers. Journal of Law and Economics, 52(3), 523–550. doi:10.1086/600079

Through its public hearings, the Committee has heard differing views from experts on the extent to which consolidation is a cost driver in the Medicare program and the degree to which payment policies of the Medicare program encourage such consolidation. Some have questioned the merit of concerns over consolidation and have instead highlighted the beneficial efficiencies and economies of scale that can be accomplished through consolidation. For example, in testimony before the Energy and Commerce Health Subcommittee on May 21, 2014, during a hearing entitled "Keeping the Promise: Site-of-Service Medicare Payment Reforms," which examined various site-neutral prospective policy changes, one witness argued that site-neutral payment policies could not be viewed in a vacuum and instead must be viewed along with the totality of services provided, populations served and recognizing that "hospitals are subject to significant regulatory and quality requirements."[11]

However, other witnesses have made data-driven arguments that much hospital consolidation can increase spending for the program and patients. For example, on February 14, 2018, the Oversight and Investigations Subcommittee of the Committee on Energy and Commerce held a hearing on consolidation in the health care industry. One witness highlighted how "extensive research evidence shows that consolidation between close competitors leads to substantial price increases for hospitals, insurers, and physicians, without offsetting gains in improved quality or enhanced efficiency."[12] The witness noted that "evidence shows that patient quality of care suffers from lack of competition" and suggested "policies are needed to support and promote competition in health care markets [which] includes policies to strengthen choice and competition, and ending distortions that unintentionally incentivize consolidation."

Some Medicare Payment Policies Which Incentivize Consolidation Have Been Modified

Bipartisan concern over the degree to which Medicare payment policy may be accelerating hospital consolidation and negatively impacting the Medicare program has been present in Congress for some time. This concern in part animated bipartisan policy changes in recent years to try to mitigate, in part, the impact that payment differentials may have had in driving these recent trends in consolidation.

For example, the Bipartisan Budget Act of 2015 (BBA, P.L. 114-74) was signed into law on November 2, 2015. Section 603 of this bipartisan law made changes to certain Medicare hospital reimbursements on a prospective basis. The policy within Section 603 established a site neutral payment policy for newly-acquired, provider-based, off-campus hospital outpatient departments (HOPD) after November 2, 2016, within the Medicare program. At the time, Congress was reacting to findings such as those reported by GAO that Medicare paid $58 to $86 more when an evaluation and management visit was performed in an HOPD compared to a

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[11] Written Testimony of Dr. Reginald W. Coopwood on behalf of the American Hospital Association, "Keeping the Promise: Site-of-Service Medicare Payment Reforms," Available online at http://docs.house.gov/meetings/IF/IF14/20140521/102250/HHRG-113-IF14-Wstate-CoopwoodR-20140521.pdf.

[12] Committee on Energy and Commerce, Oversight and Investigations Subcommittee, Hearing: "Examining the Impact of Health Care Consolidation," February 14, 2018. Available online at https://energycommerce.house.gov/hearings/examining-impact-health-care-consolidation/ Testimony from Martin Gaynor, E.J. Barone University Professor of Economics and Health Policy in Heinz College at Carnegie Mellon University.

physician office, depending on the HCPCS code[13] billed, even though these beneficiaries were no sicker than those seen in a physician's office.[14] Many had pointed to such findings and raised concerns that this payment inequity was or had the economic incentive to, drive the acquisition of stand-alone or independent practices and facilities by hospitals, resulting in higher costs for the Medicare system and taxpayers, and also resulted in beneficiaries needlessly facing higher cost-sharing in some settings than in others.

Data-Driven Analysis From MedPAC Helps Inform Considerations

The Committee understands the vital role hospitals play in the American healthcare system, including, but not limited to, providing emergency room services, general nursing, surgery, inpatient drugs, and other services and supplies that 58.4 million Medicare beneficiaries rely upon.[15] Simply put, the Committee recognizes that hospitals are an essential part of the Medicare benefit and guarantee.

At the same time, as stewards of the taxpayers' dollars and the Medicare beneficiaries and the Hospital Insurance Trust Fund, we feel more work by the Commission in this space can only benefit Congress. We note that the Medicare Hospital Insurance Trust Fund was most recently projected to be depleted in 2026, which is three years earlier than the 2017 Trustees Report.[16] Accordingly, it is imperative the Committee receive additional analysis from MedPAC regarding the degree to which current Medicare payment policies may encourage hospital consolidation and may also lead to higher drug spending for the program and patients.

We appreciate the robust analysis that MedPAC routinely provides to Congress. We appreciate MedPAC has previously conducted some rigorous analysis that examines the degree to which Medicare payment policies that reimburse providers differently for identical services provided at different location types may encourage provider behaviors that can ultimately increase costs to the Medicare program and beneficiaries. Certainly, such dynamics can play a role in pressures to consider consolidation.

The Commission has produced meaningful work on the merits of aligning payments based on the site of service dating back well over a decade. In testimony before the Health Subcommittee on December 9, 2014, MedPAC Executive Director, Mark Miller Ph.D., stated: "In principle, the Medicare program should pay the same amount for the same service, regardless of the setting in which it is provided, unless payment differentials are justifiable by differences in

[13] Health care Common Procedure Coding System is a set of health care procedure codes based on the American Medical Association's Current Procedural Terminology (CPT).
[14] GAO-16-189, "Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform." Available online at http://www.gao.gov/products/GAO-16-189
[15] https://www.medicare.gov/coverage/hospital-care-inpatient.html#1367
[16] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf

patient mix, provider mission (e.g., maintaining stand-by capacity for emergencies), or other justifiable factors."[17]

More recently, in the June 2017 Report to Congress, MedPAC noted that consolidation can increase costs to the Medicare program and beneficiaries. For example, MedPAC noted, "horizontal hospital consolidation can contribute to higher commercial prices and therefore contribute to the growing gap between the prices paid by Medicare and those paid by commercial insurers. In addition, high commercial prices can induce higher hospital costs and, in turn, pressure the Medicare program to increase its prices."[18] MedPAC also found that "physician–hospital vertical consolidation can also result in higher costs for Medicare and commercial insurers." MedPAC provided a broad analysis of provider consolidation that recognized hospital markets are already highly consolidated. As such, MedPAC recommended three specific policy options: (1) restrain Medicare prices rather than follow increases in commercial prices to promote higher savings in response to horizontal consolidation; (2) implement site-neutral pricing in response to vertical consolidation, ending financial incentives for hospitals to purchase physician practices; and (3) synchronize payment rates for MA plans, ACOs and FFS to create a level playing field in response to provider and insurance consolidation."[19]

Some Federal Policies Appear to Incentivize Consolidation Which Can Increase Costs for Patients

The Committee would also like the Commission to look closely at how Medicare patients may face higher drug costs due to hospital consolidation. For example, in recent years, MedPAC has conducted an analysis examining the role of the 340B drug discount program and its intersection with the Medicare program.[20] In a June 2017 report to Congress, MedPAC noted that "over half of the Medicare Part B drug spending in HOPDs in 2015 was attributable to hospitals that participate in the 340B Drug Pricing Program."[21] MedPAC also reported that the availability of 340B discounts is among a number of reasons that have been cited by stakeholders for physicians' interest in selling to hospitals and hospitals' interest in acquiring physician practices. [22]

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[17] Written Testimony of Dr. Mark E. Miller on behalf of MedPAC, "Context for Medicare Payment Policy and Recommendations," Available online at http://docs.house.gov/meetings/IF/IF14/20141209/102787/HHRG-113-IF14-Wstate-MillerM-20141209.pdf.

[18] June 2017 *Report to the Congress: Medicare and the Health Care Delivery System*, Chapter 10, "Provider Consolidation: The Role of Medicare Policy," page 289 and following. Available online at: http://www.medpac.gov/docs/default-source/reports/jun17_ch10.pdf?sfvrsn=0

[19] June 2017 *Report to Congress*, Chapter 2, "Medicare Part B Drug Payment Policy Issues," available online at http://www.medpac.gov/docs/default-source/reports/jun17_ch10.pdf?sfvrsn=0

[20] MedPAC website listing references to 340B work is available online at http://www.medpac.gov/search-results?indexCatalogue=searchresultsindex&searchQuery=340B&wordsMode=0

[21] June 2017 *Report to Congress*, Chapter 2, "Medicare Part B Drug Payment Policy Issues," available online at http://www.medpac.gov/docs/default-source/reports/jun17_ch2.pdf?sfvrsn=0

[22] June 2017 *Report to Congress*, Chapter 2, "Medicare Part B Drug Payment Policy Issues," available online at http://www.medpac.gov/docs/default-source/reports/jun17_ch2.pdf?sfvrsn=0, see page 58

The Committee's own analysis has suggested that the 340B program may be increasing hospital consolidation in some cases – which has an impact on Medicare costs for patients, including for covered outpatient drugs. For example, in the Committee's January 2018 oversight report of the 340B program, the Committee noted many of the hospitals participating in the 340B program have multiple associated "child sites" which can extend the footprint of the 340B program—and the number of child sites has increased significantly over time.[23] While part of the increase in the number of child sites may be due in part to changes in how such sites are registered,[24] the Committee report also found "the dramatic growth in 340B child sites can be attributed in part to the issue of consolidation, or the practice of 340B hospitals acquiring private practices and registering those practices as child sites."[25]

The Committee report explored the growth of 340B and its impact on costs for patients with a particular focus on the acquisition of oncology practices. The report found that "regardless of the motivation for such consolidation, these acquisitions often result in higher cost of care to patients due to additional costs imposed by the hospital, such as facility fees."[26] While there are impacts to patients with private insurance, Medicare is impacted by such changes as well. The report explained that "not only do these acquisitions often result in higher cost of care for patients, GAO found that for Medicare Part B beneficiaries in particular, 340B DSH hospitals 'prescribed more oncology drugs, or prescribed more expensive oncology drugs,' than did non 340B hospitals treating Medicare Part B oncology patients."[27] This indicated that on average, those patients were prescribed either more, or more expensive drugs by 340B hospitals than by other hospitals.[28]

While the Committee has been clear that the 340B program is an important program that enjoys strong bipartisan support in Congress, the program appears to be having an unintended secondary effect in encouraging consolidation in some cases. In such cases, Medicare patients may face higher costs for drugs and other services or treatment.

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[23] "Review of the 340B Drug Pricing Program," report by the Committee on Energy and Commerce, January 2018, available online at https://energycommerce.house.gov/news/press-release/new-ec-report-examines-340b-drug-pricing-program/ The report noted, in 2011, GAO reported that the number of child sites had nearly doubled over the previous decade, reaching just over 16,500 registered sites at that time. However, as of October 1, 2017, there were 42,029 registered covered entity sites were participating in the 340B program, including 12,722 covered entity (parent) sites and 29,307 associated (child) sites participating in the program.

[24] "Review of the 340B Drug Pricing Program," report by the Committee on Energy and Commerce, January 2018, available online at https://energycommerce.house.gov/news/press-release/new-ec-report-examines-340b-drug-pricing-program/ see pages 44-45

[25] "Review of the 340B Drug Pricing Program," report by the Committee on Energy and Commerce, January 2018, available online at https://energycommerce.house.gov/news/press-release/new-ec-report-examines-340b-drug-pricing-program/ see page 66

[26] "Review of the 340B Drug Pricing Program," report by the Committee on Energy and Commerce, January 2018, available online at https://energycommerce.house.gov/news/press-release/new-ec-report-examines-340b-drug-pricing-program/ see page 67

[27] "Review of the 340B Drug Pricing Program," report by the Committee on Energy and Commerce, January 2018, available online at https://energycommerce.house.gov/news/press-release/new-ec-report-examines-340b-drug-pricing-program/ see page 68

[28] U.S. Gov't Accountability Office, Medicare Part B Drugs: Action Needed to Reduce Financial Incentives to Prescribe 340B Drugs at Participating Hospitals, GAO-15-442 (June 2015).

Request for Additional Analysis From the Commission

In conclusion, the Committee believes that MedPAC should continue to review the trends of hospital mergers to help improve our understanding of the impact of consolidation in the hospital industry. The Committee wishes to determine the impact consolidation has on patients, and if patients end up paying higher prices due to consolidation for no identifiable benefit to the beneficiary. In this light, we ask the MedPAC to examine the following:

1) Describe recent trends in hospital consolidation and to what degree current federal policies may accelerate consolidation.

2) What are the implications of hospital consolidation on hospitals' costs and on patients' costs?

3) Do markets with higher levels of hospital consolidation have higher commercial prices than markets with lower levels of hospital consolidation? Do markets with higher levels of hospital consolidation result in similarly-situated Medicare beneficiaries facing higher spending for drugs or other treatment and services?

4) How has integration between physicians and hospitals affected Medicare payments for physician services?

5) Under the 340B program, hospitals can acquire outpatient drugs at a substantial discount, leading to high profit margins on drugs for 340B hospitals, which has contributed to hospitals acquiring physician practices. Can the availability of 340B drug discounts create incentives for hospitals to choose more expensive products in some cases? If so, what would be the impact on Medicare patients' cost-sharing for such drugs in such cases?

We very much appreciate your careful attention to this request. We respectfully request a written response to this request within 30 days upon its receipt. If you have any questions regarding this request, please contact Josh Trent, James Paluskiewicz or Jennifer Barblan with the Energy and Commerce Majority staff at (202) 225-2927. Thank you for your prompt attention to this matter.

Sincerely,

Greg Walden
Chairman

Michael C. Burgess, M.D.
Chairman
Subcommittee on Health

Gregg Harper

Gregg Harper
Chairman
Subcommittee on Oversight
and Investigations

CC: James E. Mathews, Ph.D., Executive Director