Charles N. Kahn III
President and CEO

June 5, 2024

The Hon. Jonathan Kanter
Assistant Attorney General
Department of Justice
Antitrust Division
950 Pennsylvania Ave., NW
Washington, DC 20530

The Hon. Xavier Becerra
Secretary
Dept. of Health and Human Srvs.
200 Independence Ave., SW
Washington, DC 20201

The Hon. Lina Khan
Chair
Federal Trade Commission
600 Pennsylvania Ave., NW
Washington, DC 20580

Re: Request for Information; Docket No. ATR 102 (Mar. 5, 2024)

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

The Federation of American Hospitals (FAH) appreciates this opportunity to submit comments to the Department of Justice Antitrust Division (DOJ), the Department of Health and Human Services (HHS), and the Federal Trade Commission (FTC) (collectively, the Agencies) regarding the *Request for Information on Consolidation in Health Care Markets*, Docket No. ATR 102, released March 5, 2024 (the Request for Information or RFI).

The FAH is the national representative of more than 1,000 tax-paying hospitals throughout the United States. The FAH's members provide patients and communities with access to high-quality, affordable care in urban and rural areas across 46 States, Washington DC, and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals, which provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services to patients in diverse communities across the country.

The Request for Information seeks comments about the effects of mergers and acquisitions of healthcare providers. As the national representative for tax-paying hospitals, we offer these comments to provide our perspectives on the critical role that hospital networks and health systems play in ensuring that patients have access to, and are provided with, quality healthcare services when and where they need it around the clock – whether it is routine, emergency, elective, trauma, or any other type of medical care. Hospitals and healthcare systems are foundational for a resilient, solvent healthcare delivery system that can meet the needs of millions of patients across the United States (US) at any time, day or night.

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Hospital and Healthcare System Mergers and Acquisitions Bring Critical Value and a Strong, Resilient Foundational Structure to the US Health Care Delivery System

Across business models and ownership structures, hospitals and health systems engage in mergers and acquisitions to invest in new services and increase capacity, promote resilient hospital infrastructures, grow opportunities available for caregivers, and connect a hospital or small network system to a national system of medical specialists. These systems add value to our healthcare delivery system and ensure care delivery on a daily basis and over the long-term in communities across the US. The benefits of these systems were seen by larger systems' abilities to weather unprecedented public health emergencies, like COVID-19 , and other system-wide crises, such as the recent Change Healthcare cyberattack.

Hospitals and health system mergers and acquisitions promote a broad range of benefits for patients, workers, communities, and health care delivery overall. Importantly, these systems offer a steady, reliable capital funding source and long-term commitment that is an anchor, and often a lifeline, to other hospitals that may be struggling or simply can benefit in terms of improved patient care and services that it can offer to the local community, including rural and underserved communities. With a stable capital financing foundation, as well as a long-term commitment to patients and the community, an acquiring health system can bring diversification and innovation to acquired hospitals, thus strengthening these hospitals and improving care, access, and service lines offered by the individual hospital and the services of the system as a whole, for example, through the use of remote patient monitoring. In addition, providers and clinicians at the acquired hospitals have new resources to transform operations to meaningfully solve complex patient issues. As one example, larger networks may be better able to leverage capital resources to build a behavioral health platform as a model that can then be replicated across multiple hospitals, accounting for nuanced regulatory costs and requirements that otherwise hinder the development of such services. This also can help absorb the often overwhelming needs of behavioral health patients in that system's acute care hospitals.

This support is in stark contrast to a struggling individual or small hospital network that is left to manage growing expenses and operational and medical complexities in an increasingly competitive economy. These hospitals often need the support of a strong, resilient, efficient, and more sophisticated system – to better manage mounting challenges. These challenges include, spiraling drug costs, chronic labor shortages, and increasingly complex and demanding regulatory and operational structures, such as ensuring the confidentiality of patients' health information, promoting quality metrics, complying with routine daily billing systems and revenue cycle management, protecting against sophisticated global cyberattacks, and launching a hospital's ability to adopt new technology (e.g., electronic interoperability and artificial intelligence (AI)) that can dramatically transform patient lives and increase operational efficiency. All of this occurs against the backdrop of not only Medicare and Medicaid payments that fall short of the cost of care, but also concentrated health insurer consolidation.[1] This environment fuels aggressive practices to inappropriately deny or downgrade medical care or engage in payment delay tactics. These practices are seen in excessive pre-payment audits and requests for more information, and arbitrary denials of payment for medically necessary care,

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[1] Competition in Health Insurance: A comprehensive study of U.S. markets, American Medical Association (2023 Update).

deemed unnecessary by medical clinicians without training or expertise in the medical specialty they are reviewing, or worse, by computer software and AI programs.

During COVID-19, the benefits of consolidation were readily apparent as larger integrated hospitals and health systems had greater success in addressing and adapting to the pandemic and providing care to patients. In addition, as discussed above, amid the ongoing fallout from the Change Healthcare cyberattack, larger systems have had a greater ability to "absorb the shocks" from a system-wide crisis that has left hospitals and many other providers, while continuing to provide care to patients throughout the crisis, without an ability to bill or receive payment for those patient care services. The payment gap, resulting in billions of dollars in unpaid claims to hospitals and many other providers, reportedly left certain smaller providers and non-system entities to teeter on the edge of closure or ability to treat patients timely. Hospital systems have multiple tools at their disposal that are all geared toward improving patient care and the patient experience both in the short- and long-term, as well as bringing benefits to hospital and health system workers and the broader community.

Another example of the benefits of an acquisition, rooted in our tax-paying members' experiences, occurs when a tax-paying hospital system acquires a smaller not-for-profit hospital or smaller network of hospitals that may operate in an underserved, rural community. As discussed above, this acquisition may occur so that a smaller hospital has access to greater services or because a smaller system is financially or otherwise struggling to meet the specific needs of its patients and the surrounding community. Upon closing the acquisition, the hospital system brings its capital, expertise, and innovation to the smaller not-for-profit operation. Upon closing the acquisition, the new hospital system makes investments in talent, for example, adding residency programs and bringing new physicians, nurse training programs and fellowships to a rural community to help develop a much needed workforce pipeline and the next generation of caregivers. Moreover, while continuing to serve the uninsured through charity care programs, the tax-paying entity contributes to the tax base through income, property, sales, and other state and local taxes, as well as federal corporate income taxes. Also, in this type of acquisition, transaction proceeds often are used to fund a new not-for-profit charitable foundation that is operated independently from the health system and offers additional community benefits.

In short, hospital and health system acquisitions enable the investment of hundreds of millions of dollars in new services and increasing hospital capacity, growing the opportunities available for caregivers, and connecting the individual hospital or smaller network of hospitals to a national system of medical specialists, all while providing additional community benefits.

Improvements and Benefits for Patients, Communities, and Health Care Workers

The foregoing discussion and examples are broadly illustrative of our members' experiences and show that mergers and acquisitions can create net value for all stakeholders – patients, caregivers, communities, and the healthcare delivery system more broadly – consistent with the Agencies' mission to ensure competition that protects and enhances consumer health. Of course, every transaction is different, and the benefits that follow from one transaction may not be exactly replicated in another. Therefore, we briefly summarize a non-exhaustive list of

specific benefits that often come from hospital and health system mergers and acquisitions – and all of which feed into improved patient access and care:

- Saving a financially struggling provider from cutting services or hours, laying off staff, or closing its doors entirely;
- Providing capital to fund investments in service lines, staff, amenities, health information technology, or growth;
- Connecting a small, siloed provider with an integrated continuum of caregivers, to provide efficient, coordinated, financially aligned care;
- Centralizing underutilized clinical programs into a single site to ensure that cases are handled by physicians, nurses, and other allied clinicians who have the critical mass of experience necessary to provide a high clinical quality;
- Bringing world-class clinical and administrative expertise to a small, community hospital through telemedicine visits, specialist consultations, or specialty physician rotations from a larger, more sophisticated system into a local community;
- Improving rebates and discounts for procuring drugs, supplies, or professional services;
- Managing with precision and enabling efficiencies by consolidating duplicative back-office or administrative functions;
- Allowing the capital and scale needed to replicate successful initiatives, business models, and best practices across a broader footprint;
- Bringing the experience, sophistication, and platform needed to navigate the byzantine processes of appealing improper denials of claims or prior authorizations (a well-documented problem, especially with certain Medicare Advantage (MA) and managed Medicaid plans, as discussed further below), ensuring patients access to the care and benefits they deserve;[2]
- Diversifying a portfolio of assets (regardless of ownership model) to include new service lines and geographies, allowing the organization to better absorb shocks and providing stability in times of disruption or crisis;
- Building enrollment in healthcare coverage through community outreach, leading to better coverage and the right care at the right place at the right time;
- Providing charitable care and other financial assistance provided to patients;
- Contributing significantly to the local and federal tax base; and
- Preserving and creating hundreds or thousands jobs for communities, while providing healthcare workers the benefits of a large, national employer, including competitive compensation packages and broader benefits (*e.g.*, long-term disability insurance or employee stock purchase plans), relocation options, flexibility to work in different regions during different seasons, ability for professional and career expansion,

[2] *See generally* Department of Health and Human Services, Off. of Inspector Gen., *High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care* (July 2023); Department of Health and Human Services, Off. of Inspector Gen., *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care* (Apr. 2022); Department of Health and Human Services, Off. of Inspector Gen., *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials* (Sept. 2018).

nursing programs and scholarships, and the peace of mind of having a financially solvent employer.

Multiple studies corroborate these benefits. Specifically, in 2013, the Center for Healthcare Economics and Policy released a comprehensive analysis of hospital integration studies, including 75 studies spanning the years 1996-2013, as well as 36 primary sources. The Center's analysis outlines improvements, such as those listed above, in healthcare for communities that result from mergers.

In addition, the American Hospital Association (AHA) has released numerous studies indicating that hospital mergers and acquisitions benefit patients by providing higher quality care at a lower cost. A 2021 study reinforced the conclusions of previous reports: hospital acquisitions benefit patients by providing access to higher-quality care at a lower cost.[3] This followed a previous 2018 study found that mergers of hospitals within 30 miles of each other generated savings of more than $6.6 million in annual operating expenses at acquired hospitals.[4] The studies also determined that hospital acquisitions lead to improvements on key indicators of quality.

Moreover, a study published in JAMA Network Open concluded that hospital mergers improve health outcomes in rural hospitals.[5] The researchers, who are affiliated with IBM Watson Health and the Agency for Healthcare Research and Quality, compared data from 172 merged rural hospitals and 266 comparison hospitals and found that in-hospital mortality rates were lower after the rural hospitals completed mergers. Researchers noted, "Mergers may enable rural hospitals to improve quality of care through access to needed financial, clinical, and technological resources, which is important to enhancing rural health and reducing urban-rural disparities in quality."

Given all of the critical benefits that mergers and acquisition transactions infuse into the marketplace, we submit that the Agencies should consider each transaction on a case-by-case basis, in light of all relevant facts and circumstances, regardless of ownership structure.

Ownership Structure is the Incorrect Lens for Competitive Analysis

The RFI seeks comments specifically about the effects of mergers and acquisitions of healthcare providers "conducted by private equity funds or other alternative asset managers, health systems, and private payers." The RFI echoes the FTC's March 5, 2024 "Workshop on Private Equity in Health Care" (Workshop). Although the RFI and Workshop seem intended to distinguish among the different types of hospital and health system ownership structure, we urge the Agencies to reframe their approach to these issues.

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[3] Hospital Merger Benefits: An Econometric Analysis Revisited, conducted by economists at Charles River Associates, Sean May, Monica Noether and Ben Stearns, August 2021, and sponsored by the American Hospital Association.

[4] In Hospital Mergers: Foundation for a Modern, Efficient and High-Performing Health Care System of the Future, conducted by Charles River Associates, 2018, and sponsored by the American Hospital Association.

[5] Jiang HJ, Fingar KR, Liang L, Henke RM, Gibson TP. Quality of Care Before and After Mergers and Acquisitions of Rural Hospitals. JAMA Netw Open. 2021;4(9):e2124662. doi:10.1001/jamanetworkopen.2021.24662.

The lens of "ownership structure" has no place in law enforcement or competition policy. The terms "for-profit," "non-profit," "private equity," and "alternative asset manager" do not appear in the newly revised *Merger Guidelines*, and for good reason. Ownership structure has no relevancy to the statutory question of whether a transaction may have the effect of "substantially … lessen[ing] competition, or … tend[ing] to create a monopoly."[6]

Instead, the Agencies should evaluate each potential transaction individually, on a case-by-case basis, considering ***all*** of the relevant facts at hand. And the Agencies' ***competition*** policy should be driven by data and facts, not anecdotes.[7] Condemning an entire business model based on individual outlier scenarios would be unempirical and incorrect to the point of undermining the rule of law – and it would be a missed opportunity to identify true root causes that need to be addressed.

On a final note regarding ownership structure, although the Agencies' focus is in part on private equity, there is not any long-established, uniform legal definition of the term "private equity company." In previous regulatory initiatives, definitions of a private equity company have been so broad and ambiguous as to potentially encompass entities that are not typically considered a "private equity company." And in our members' experiences, certain private equity companies bring the same long-term commitment to patient care and communities with crucial capital resources needed to achieve all of the benefits that a larger hospital and health system can bring to patients, workers, communities, and the healthcare delivery system overall when acquiring a smaller individual hospital or smaller network of hospitals, as discussed above. Thus, this further highlights that while ownership structure may vary, the hospitals and health systems discussed above, regardless of ownership structure, are essential for maintaining a nationwide health system with a strong, resilient, long-term foundation for healthcare delivery.

Healthcare Payer Abuses and Impact on Patients

We close by noting a larger issue for which the RFI requests public comment. On March 5, 2024, as the RFI was issued, hospitals and other providers were already well into the aftermath of the unprecedented crisis stemming from the Change Healthcare cyberattack.[8] Two weeks earlier, on February 21, Change Healthcare, the nation's largest processor of medical claims – and a subsidiary of UnitedHealth Group, the nation's largest commercial health insurer – was the victim of a catastrophic cyberattack. This cyberattack left Change Healthcare, which processes

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[6] 15 U.S.C. § 18; *see also FTC v. Univ. Health, Inc.*, 938 F.2d 1206, 1214 n.15 (11th Cir. 1991) ("Section 1 of the Clayton Act defines 'persons' as all corporations, including nonprofit corporations."); *Cmty. Blood Bank v. FTC*, 405 F.2d 1011, 1018 (8th Cir. 1969) ("[Sections 7 and 12 of the Clayton Act] not only make no distinction between business and nonprofit corporations as does the FTC Act, but they contain no language whatsoever that would limit jurisdiction to particular types of corporations.").

[7] We echo comments that Commissioner Slaughter made at the Workshop: "we're talking a lot about private equity and the model that private equity uses, but it's a model that could be picked up by anyone else and [we should be] making sure that the enforcement efforts we take, the policy solutions we act [sic] are agnostic or are equally applicable to anyone employing the same rapacious business model." Transcript of *Private Capital, Public Impact: an FTC Workshop on Private Equity in Health Care* [hereinafter *FTC Workshop*], at page 43 (remarks of Hon. Commissioner Slaughter) (with mis-transcriptions at 3:12 corrected).

[8] *See generally* Dan Diamond & Daniel Gilbert, *Officials Rush to Help Hospitals, Doctors Affected by Change Healthcare Hack*, WASH. POST (Mar. 5, 2024); Dept. of Health and Human Services, Press Release, *HHS Statement Regarding the Cyberattack on Change Healthcare* (Mar. 5, 2024).

15 billion claims[9] totaling more than $1.5 trillion a year[10] and handles 50 percent of all medical claims in the United States,[11] unable to perform basic functions essential to hospital operations, including coverage verifications, clinical decision support, or the submission and payment of claims. The fallout for the hospital sector was severe. An American Hospital Association survey conducted that week found that 94 percent of hospitals had suffered some financial impact (of which more than half reported an impact that was "significant or serious"), 74 percent reported a direct impact on patient care, and nearly 40 percent reported that patients were having difficulties accessing care because of processing delays.[12]

It was with this backdrop that the Agencies issued the RFI and hosted the Workshop. Though the RFI and Workshop cautioned against "intermediaries that act as middlemen between you and your doctor"[13] and "financialization in the healthcare industry,"[14] the Change Healthcare cyberattack – the most pressing, existential threat facing the healthcare system at that particular moment – was not mentioned. Nevertheless, UnitedHealth Group's experience with Change Healthcare is directly relevant to any policy discussion about the potential effects of mergers and acquisitions in healthcare.

No discussion of competition policy in healthcare can be complete without considering the roles of private healthcare insurers.[15] Insurers are the quintessential "intermediaries" and financial "middlemen" that stand between patients and their medical providers. Insurers dictate which providers a patient may see, what services those providers may perform, how much those providers will be paid, and what hoops the providers will have to jump through to care for their patients. Mergers and acquisitions involving insurers therefore potentially raise complex issues of horizontality, verticality, entrenchment, platform effects, monopsony, or myriad other competitive issues. In particular, insurer acquisitions of healthcare providers can raise grave questions of whether the combined organization will have the ability and incentive to disadvantage rival insurers and/or the ability and incentive to disadvantage rival providers.

Despite this insurer market power, a 2023 study conducted by the American Medical Association found that the majority of US health insurance and MA markets are highly concentrated.[16] Our members experience this power concentration every day through insurer practices that arbitrarily and inappropriately deny, limit, modify, or delay the delivery of or access to services and care for patients, including Medicare beneficiaries.

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[9] Diamond & Gilbert, *supra* Note 7.

[10] *Transforming Healthcare Through the power of Data,* CHANGE HEALTHCARE, https://www.changehealthcare.com/insights/transforming-healthcare-with-data.

[11] Leroy Leo, *UnitedHealth unit will start processing $14 billion medical claims backlog after hack,* REUTERS (Mar. 22, 2024).

[12] *See generally* American Hospital Association, *Change Healthcare Cyberattack Having Significant Disruptions on Patient Care, Hospitals' Finances* (Mar. 2024), *available at* https://www.aha.org/2024-03-15-aha-survey-change-healthcare-cyberattack-significantly-disrupts-patient-care-hospitals-finances.

[13] *FTC Workshop*, supra note 4, at page 4 (remarks of Hon. Assistant Attorney General Kanter).

[14] *Id.* at page 2 (remarks of Hon. Chair Khan).

[15] *FTC v. Penn State Hershey Med. Cent.*, 838 F.3d 327, 344 (3d Cir. 2016) ("The realities of the healthcare market … dictate that we consider the payors in our analysis.").

[16] Competition in Health Insurance: A comprehensive study of U.S. markets, American Medical Association (2023 Update).

In fact, their experience was affirmed by an Office of the Inspector General (OIG) April 2022 report, “Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care” (hereinafter, OIG Report).[17] The OIG Report identifies a pattern by which Medicare Advantage Organizations (MAOs) apply utilization controls to improperly withhold coverage or care from MA beneficiaries. Specifically:

- *Improper prior authorization denials.* The OIG found that thirteen percent of prior authorization requests denied by MAOs would have been approved for beneficiaries under original Medicare.
- *Improper denials for lack of documentation.* The OIG found that in many cases, beneficiary medical records were sufficient to support the medical necessity of the services provided.
- *Improper payment request denials.* The OIG found that eighteen percent of payment requests denied by MAOs actually met Medicare coverage rules and MAO billing rules.

FAH members have regularly observed that MAOs abuse prior authorization requirements, maintain inadequate provider networks, use extended observation care, retroactively reclassify patient status (i.e., inpatient versus observation), improperly down code claims, and deploy inappropriate pre- and post-payment denial policies, and even deny claims for previously approved services. These activities are often carried out by way of MAOs' downstream at-risk physicians and contracted hospitalists. All of these activities limit MA beneficiaries' access to the care to which they are entitled under the Social Security Act.[18]

Further, as outlined in a previous FAH letter,[19] there is growing evidence that MA enrollees experience significant disparities in access to high-quality and necessary care compared to traditional Medicare fee-for-service (FFS) beneficiaries. These disparities in access and quality are amplified due to the differences in the demographic distributions between the MA and FFS programs. The MA program has a significant population of racial and/or ethnic minority and dual eligible enrollees. Racial and ethnic minority beneficiaries make up a much higher proportion of the MA program than FFS. In 2019, the percentage of racial and ethnic minorities enrolled in MA was 32 percent, compared to 21 percent in traditional Medicare. This means that when MA plans limit enrollee access to high-quality care, these practices could increase disparities in care. Insurer consolidation must not go unchecked as the foregoing practices demonstrate that these abusive practices have an adverse impact on patient care.

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[17] Christi A. Grimm, U.S. Department of Health and Human Services Office of the Inspector General (“OIG”), OEI-09-18-00260, “Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care” (April 2022), https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

[18] For further detail, see Federation of American Hospitals letters re: “Inappropriate MAO Utilization Controls Limit and Delay Beneficiary Access to Care, May 19, 2022; attached hereto.

[19] For further detail see Federation of American Hospitals letter re: “Advance Health Equity”; August 31, 2022; attached hereto.

The FAH appreciates this opportunity to submit these comments. If you have any questions, or if there is any other way that we can assist the Agencies as they consider the Request for Information, please contact me or any member of my staff at (202) 624-1500.

Sincerely,