AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

May 3, 2024

The Honorable Jonathan Kanter
Assistant Attorney General
Antitrust Division
U.S. Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Lina M. Khan
Chair
U.S. Federal Trade Commission
600 Pennsylvania Ave, NW
Washington, DC 20580

Re: Docket No. ATR 102: Request for Information on Consolidation in Health Care Markets

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

On behalf of the American Academy of Family Physicians (AAFP), representing more than 130,000 family physicians and medical students across the country, I write in response to the Request for Information (RFI) on Consolidation in Health Care Markets posted on March 5, 2024. The Departments seek information on the effects of transactions consolidating health care providers and related services, the intended aims of these transactions, and the actual effects on providers, patients, and others in the health care market. The AAFP greatly appreciates the opportunity to share information which will be used to inform future actions or enforcement priorities for the Departments.

Background

Family physicians are uniquely trained to care for patients across the lifespan, regardless of gender, age, or type of problem, be it biological, behavioral, or social. The foundation of family medicine is primary care, defined as the provision of integrated, accessible health care services by physicians and their health care teams who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

As a trusted first contact for health concerns, family physicians are the focal point of care for patients and provide referrals to other health care services and sites when necessary. They have significant influence over the services and settings in which patients seek care and coordinate care patients receive beyond their office. The trust placed in family physicians and other primary care clinicians by their patients makes them an appealing acquisition target for hospitals, health systems, and private

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payers. Hospitals are often motivated to acquire or control primary care practices to maximize the financial success of their organizations by securing referrals to high-margin services or facilities. Private payers and other firms leverage them to manage care across settings, or to direct patients to other services the firm owns.

Consolidation or private investment in primary care is not inherently bad. There is a tremendous amount of innovation taking place inside primary care, allowing primary care physicians to expand their capabilities, provide high-quality care to their patients and create a more rewarding practice environment. There are a number of private equity-backed firms noted for making investments and providing resources that enable primary care practices to successfully participate in the rapidly expanding value-based payment landscape. These firms offer primary care practices the ability to not only survive but thrive in many instances. What distinguishes many of these organizations is that their revenue model is built primarily around expanding and investing in primary care to support value-based payment success.

Despite broad agreement on the importance of a strong primary care foundation to a high-performing health care system, the US investment in primary care continues to lag well behind other nations that produce much better outcomes at a lower level of overall spending[1]. A recent analysis of primary care investment across a range of measures confirms that things are not getting better.[2] The persistent and troubling underinvestment in primary care, coupled with overwhelming administrative burden and rising practice costs, have made maintaining an independent primary care practice unsustainable for most family physicians. As a result, most primary care practices are now owned by larger entities, the majority of which are hospitals or health systems. This trend accelerated in the last decade. In 2016, 38 percent of primary care practices were affiliated (either by common ownership or joint management) with a hospital; in 2021, the proportion jumped to 51 percent.[3,4] With fewer opportunities to join an independent primary care practice, 74 percent of primary care physicians are employed by hospitals or corporations (53 percent by hospitals, and 20 percent by corporate entities).[5]

In June 2023, the AAFP provided testimony to the U.S. Senate Committee on Finance with payment-related policy recommendations to address the drivers of primary care consolidation. We urged Congress to address the issues fueling consolidation, including site neutral payment, billing and price transparency, and limited anti-trust enforcement authorities. Because most family physicians practice in settings where consolidation has already occurred, we hope to inform the agencies' approach to restoring competition in health care, as well as preventing anti-competitive behaviors.

Our comments provide information on health care consolidation, including the positive and negative impacts to physicians as well as the impacts to the patients and communities they serve. We provide information on the expected benefits and actual results of transactions involving physician practices, health systems, private insurers, and private equity-backed firms. We encourage the agencies to use their full authorities, or work with Congress to gain the authority, to do the following:

- Increase funding and resources available to the agencies for monitoring and enforcement activities to block anticompetitive behavior.
- Expand merger review requirements to include smaller transactions that are currently exempt from reporting, with special considerations for the total of multiple acquisitions or "roll-up" transactions.

- Clarify existing authority or grant explicit authority to the Federal Trade Commission's (FTC) to apply and enforce antitrust laws evenly across the health industry, to all organizations without regard to their tax status.
- Eliminate site-based payment differentials that incentivize consolidation in favor of site-neutral payment policies.
- Remove budget-neutrality requirements and reform Medicare payment policy to ensure physician payment rates keep pace with practice costs.
- Set Medicaid payment rates for primary care services to at least Medicare levels.
- Increase participation opportunities and resources to ensure primary care practices benefit from value-based payment models, such as extending the Advanced Alternative Payment Model (AAPM) bonus, giving CMS the authority to modify AAPM qualifying participant thresholds, and ensuring CMS has the authority to ensure primary care payments reach primary care practices
- Expand reporting requirements for highly consolidated entities to make the long-term effects of consolidation transparent, including public reporting of data which would allow researchers to assess the effects of health care consolidation over time on outcomes of interest, such as pricing, quality, access, equity, and patient experience.

<u>Transactions involving health systems</u>

The agencies seek information on the impact of health system consolidation and define "health system" as "including at least one hospital and at least one group of physicians who share common ownership or joint management." They seek information on the effects of vertical integration (e.g., when a physician practice is acquired by a hospital or health system) and horizontal integration (e.g., hospital acquired by a health system).

Effects of health system consolidation on physicians and patients

Providing high-quality, patient-centered primary care requires a multi-disciplinary team, technology that facilitates advanced data aggregation and population health analytics, and practice management staff to support traditional practice management functions such as patient communication, scheduling, and billing. All of this requires practices to make significant financial investments and commitments to remain competitive. While large health systems with revenue stream benefitting from multiple service lines and profit centers may be able to afford these escalating practice costs, many independent primary care practices struggle to make ends meet as today's physician payment system has failed to keep pace with the escalating demands and costs placed on primary care practices. Many have already made the difficult decision to sell their practice with the majority of those acquisitions being made by hospital-based health systems. While some family physicians have reported positive experiences after being acquired by a health system or corporation, citing access to advanced tools and technology, additional administrative support, and other expertise, many more physicians experience moral injury as they continue to face being under-resourced with staff and technology while also coping with the loss of clinical autonomy and requests that prioritize organizational needs over those of their patients.

In March 2024, the AAFP conducted a survey of members requesting information about their experiences with health care consolidation. Thirty percent of respondents said their practice or employer had been impacted by a merger, acquisition, or sale. Within this group, approximately eighty percent represented a hospital or health system transaction.

When asked specifically about the impact on compensation and benefits, responses were mixed, with 40 percent saying their compensation and benefits were somewhat or much better, 29 percent reporting no change, and 25 percent claiming compensation was worse or much worse after the transaction. In the comments, we found that respondents who sold their independent practice to a hospital generally felt compensation improved because of the transaction because their salary was more reliable, compared to experiences in independent practice when they were unable to draw salary due to economic events (such as the COVID-19 pandemic or delayed payments, including the recent cyberattack on Change Healthcare). A 2021 study found that physicians in independent primary care practices acquired by a hospital or health system saw, on average, no difference in income after integration.[6]

We asked respondents about the impact of consolidation on other aspects of practice, including staffing, management, clinical autonomy, access to resources such as health IT infrastructure, administrative and coding requirements, and reimbursement. **Overall, most physicians felt some positive impact on their ability to access resources such as health information technology, billing and patient portals, and telehealth tools. However, these benefits come at a high cost, such as a loss of clinical autonomy and a drop in job satisfaction.** Some respondents cited examples of how post-transaction administrative policies prevented them from offering needed patient care. For example, comments described scheduling mandates that prevent physicians from providing same-day visits to acute patients and result in month-long (or more) wait times for appointments. Several physicians felt that while their own personal productivity metrics increased, overall access and availability to patients decreased. Physicians also cited frustration with restrictions on referrals outside the health system. Other commenters noted that acquisition by a health system resulted in centralized management decisions made without local primary care physician or practice input, resulting in increased administrative burdens, reduced quality, or in some cases, both.

Our survey results align with other external reports indicating physicians experience a drop in clinical autonomy and feel patient care declines post-acquisition. A 2023 survey conducted by NORC found that more than half of employed physicians experienced reductions in the quality of patient care as a result of a practice acquisition.[7] Nearly half of survey respondents attributed the changes to reduced clinical autonomy and requirements that prioritize financial performance. [8] The same survey found 61 percent of physicians felt they had moderate to low autonomy to make referrals to care outside the health system,[9] which is reinforced by research showing hospital ownership of a physician practice dramatically increases the likelihood a patient will be admitted to the owning hospital.[10]

Many respondents commented on the impact of health system consolidation on patient access. As noted above, most comments cited additional barriers or delays to appointments which reduced access. Physicians in our survey observed that health system consolidation of hospital facilities often led to service line closures which reduced access to local care. This is supported by a growing body of evidence that consolidation of rural hospitals leads to service line closures, particularly in obstetric care.[11,12 ,13,14] These closures cause pregnant people to travel a significant distance to receive care. Comments from our survey further align with research demonstrating health system integration has a negative impact on patient experience without evidence of improved

quality.[15] Other research suggests the negative impacts of health system consolidation include reduced patient access and physician autonomy.[16]

In the RFI, the agencies expressed concern regarding the potential for reduced competition caused by system policies that prioritize referrals to services within the health system. Our survey results suggest health system consolidation impacts where physicians direct referrals. There is also research to indicate primary care physician referral patterns change after health system acquisition, resulting in increased referrals within health systems and higher spending.[17] A 2021 study also found diagnostic testing and imaging referrals increased within the health system post-acquisition.[18] In addition to changes in referral patterns, research indicates health system consolidation results in increased prices that impact patients through rising premium costs.[19,20]

Claimed business objectives for transactions

Our survey respondents primarily cited financial reasons or objectives for the acquisitions which they had experienced, including increased revenue to fund new physician hires or other staff. Some physicians said they believed integration would lead to improvements in care delivery as a result of greater coordination. Survey results indicate physicians rarely think care improvement aims are achieved but are satisfied with the financial results of integration into the health system.
Health systems claim several reasons for physician ownership: better coordinated care leading to improved quality at a lower cost, sufficient scale to participate in risk-based contracting, and increased operating efficiencies that reduce cost.[21] While not promoted publicly, interviews with C-suite executives also suggest that increased leverage with payers and increased volumes or market share (through reduced competition) are also common motivations. [22]

Despite stated aims, there is no strong evidence that health system consolidation improves clinical outcomes or leads to lower cost.[23] Survey comments align with the research that points to primary care physician leadership as a contributor to success under value-based payment. For example, there is evidence that demonstrates independent physician-led Accountable Care Organizations (ACOs) achieve greater savings than hospital-led ACOs.[24,25] Unfortunately, comments from our survey indicate that once acquired, physicians lose autonomy over unexpected aspects of practice management, such as scheduling systems and/or processes, as the health system seeks to prioritize productivity over continuity or access. Changes that may seem small on the surface can have harmful effects, such as a loss of continuity, one of the foundational elements of high-quality primary care. Further, hospitals focused on short-term financial results have an incentive for patients to visit an emergency room which generates greater revenue than an outpatient office. Reduced physician autonomy and competing financial priorities are likely reasons why hospital-led ACOs often fail to achieve the same results as physician-led ACOs.

Notable transactions

In exchange for valuable tax exemptions, non-profit health systems are required to provide charitable contributions to the community. Without adherence to these essential requirements, tax-exempt organizations have an unfair advantage that creates an uneven playing field and stifles fair competition in health care markets. Tax exemptions for hospitals, which generated an estimated value of $28 billion in 2020, provide them with even greater capital and financial resources to purchase physician practices.[26] Recently, the FTC clarified that organizations with 501(c) status with the Internal Revenue Service “are not categorically beyond the Commission’s jurisdiction.[27] We ask

the agencies to use their full authorities and jurisdiction to ensure all eligible entities are subject to federal antitrust enforcement and oversight of anticompetitive behaviors.

Anecdotal comments from the survey cited disconnects between the stated mission of non-profit health systems and decisions to close local services that were less profitable. Survey comments expressed physician views that centralized decisions from health system leaders prioritized profits over patient care. Research indicates non-profit hospitals have higher operating margins than for-profit hospitals, and these surpluses are used to increase cash reserve balances, not to provide charity care.[28] The same study found that a one dollar increase in profit was not associated with a statistically significant increase in charity care for non-profit hospitals, while for-profit hospitals had a four-cent increase in charity care for every additional dollar of profit. [29]

Hospital financial reserves can help non-profit health systems maintain solvency during downturns or emergencies, such as the COVID-19 public health emergency.[30] However, some large systems direct cash reserves to launch venture capital funds.[31,32] There is no evidence that gains from these investment funds are used to maintain or expand charity care during economic downturns. For example, one system reporting operating losses in 2023 cited significant gains in an associated investment fund, but funding for charity care was still cut that year.[33] **We urge the agencies to increase monitoring of tax-exempt health systems to ensure profits are used to reinvest in it the organization's stated mission to provide care, not channeled to speculative investments.**

Survey comments from physicians in practices acquired by religious health systems noted concerns about the loss of services due to the forced adoption of Ethical and Religious Directives (ERDs). ERDs are often applied to non-religious hospitals and health systems acquired by religious systems.[34] Several commenters said they were no longer able to offer the full range of reproductive health services they are trained to furnish – blocking them from delivering the same care they offered prior to the merger and decreasing their scope of practice. External reports echo this concern: physicians in a non-religious hospital were no longer permitted to provide tubal ligations during caesarean section surgeries or provide birth control.[35]

Increasingly, religious systems are acquiring or merging with non-religious hospitals which may reduce access to reproductive services. The AAFP believes that no physician or healthcare professional shall be required to perform actions that violate moral and ethical beliefs. The AAFP also strongly believes that there is an ethical obligation to provide complete and accurate medical information and referrals for desired services for all patients, and to ensure that when referrals are made, they are made for appropriate evidenced-based services. Consolidation by religious health systems have the additional effect of prohibiting access to the full range of appropriate evidence-based services. Further, research suggests religious-based health systems conduct more multi-state transactions than other health systems and are more consolidated than non-religious systems.[36] We ask the agencies to consider policies and regulations to protect patients' ability to access all evidence-based care in compliance with Federal and State laws.

Need for government action

By acquiring or merging with physician practices or other hospitals, health systems gain increased leverage with payers and reduce competition with other health systems, allowing them to increase prices post-transaction.[37] In addition to increased market power, health systems are directly rewarded when acquiring physician practices, freestanding ambulatory surgical centers, and other

lower cost outpatient care settings by charging a facility fee for services that can be safely performed in the ambulatory setting as allowed under current Medicare rules. The hospital uses this differential to acquire physician practices which also increases out-of-pocket costs for patients..[38] Site-of-service differentials also make it difficult for independent practices to compete with hospitals for new physician hires because hospitals are able to leverage other higher margin sources of incomes, including facility fees, to offer a higher salary than independent practices.[39] One model found that primary care physician reimbursement could increase by as much as 78 percent when integrated into a health system due to the disparity in payment between sites.[40] **We strongly support site-neutral payment policies that eliminate these misaligned incentives which are created by the ability for hospitals, regardless of tax status, to charge excess costs in the form of facility fees.**

Administrative burden also drives independent practices to seek integration with a health system or corporate entity, as they lack the resources or staff to manage a growing administrative workload. For example, a single family physician practice frequently interacts with ten or more payers.[41] Practices must navigate the rules for each payer, forcing them to spend countless hours reviewing documents, checking boxes to meet requirements for each health insurance plan, and complying with federal, state, and local regulations. The average physician practice completes an average of 45 prior authorizations per physician per week and 35 percent of physicians employ staff who are dedicated to managing prior authorization-related tasks.[42] **Policies and regulations to address administrative burden are necessary to enable physicians to remain in or return to independent practice.**

Survey responses and external reports provide anecdotes regarding the use of direct contracting with patients or purchasers to exit hospital employment and transition to independent practice.[43] The AAFP supports physician and patient choice to provide and receive healthcare in any ethical healthcare delivery system model, such as the Direct Primary Care (DPC) practice-setting. DPC can effectively alleviate many of the pressures that are undermining independent primary care practices and driving consolidation, but it remains out of reach for many patients who rely on their employer, Medicaid, CHIP, or other programs to make health care affordable. **The AAFP asks the agencies to consider policies that would bolster physician and patient choice to, respectively, provide and receive healthcare in any ethical delivery system model, including the DPC setting.** This includes proposals to remove the legal barriers to allow patients with health savings accounts (HSAs) to pay for DPC arrangements, which we support.

Some independent primary care practices have found a sustainable financial model and reduced administrative burden in value-based payment arrangements. Alternative payment models, when well-designed and implemented to meaningfully support primary care, provide practices with predictable, stable revenue streams that provide the financial flexibility to provide truly patient-centered care. The AAFP has developed a set of Guiding Principles for Value-based Payment as a reference point for physicians and other stakeholders to evaluate whether primary care alternative payment models (APMs) are designed to meet their stated goal: improving patient health outcomes through quality improvement with accountability for health care spending.

Additionally, **we ask the agencies to work towards increasing participation opportunities in primary care models that align with these principles and meet practices where they are, allowing more independent practices to benefit from well-designed and implemented value-based payment arrangements.** Models must support practices' ability to make continuous investment in care (not create barriers to up-front investment in practice transformation) and align multiple payers to reduce administrative burden. This may include providing access to capital at a

reasonable interest rate, affordable reinsurance to mitigate the risk of outlier patients, and programs or requirements to facilitate risk-sharing contracts with private payers, who might otherwise be unwilling to spend the time necessary to establish risk-based contracts with smaller, independent groups. With many primary care practices contracting with ten or more different payers, there should be alignment across public and private payers on important aspects of value-based payment, including measures of performance, data collection, and reporting requirements, to reduce unnecessary administrative burdens on practices. Building the infrastructure and staff required to provide comprehensive, coordinated primary care takes significant investment and time.

While value-based payment can and should be used to buoy primary care practices, health systems will continue to enter these models seeking safe harbor from antitrust laws that prohibit the use of primary care to reduce competition and increase profit. **We urge the agencies to take actions to ensure that value-based payment is being used as a tool to significantly increase our nation's investment in primary care, not as a leverage point to increase profits in other business areas.** In other words, payments and financial rewards from APMs should be directed into the primary care practice, not redirected to other service lines. **We also urge the agencies to enhance monitoring and enforcement efforts to ensure independent practices can successfully operate in already consolidated markets.** This includes investigation and action to reduce anticompetitive behaviors including anti-tiering, anti-steering, gag clauses, and most favored nations contracts which stifle competition. Further, ensuring implementation of patient-facing transparency could help to highlight the competitive advantage of non-hospital-owned practices that do not charge facility fees, making them a less expensive option for patients compared to health systems.

Finally, we urge the agencies to work with Congress to increase enforcement authorities and resources to meet today's health care consolidation challenges. Antitrust authorities are currently constrained in a number of ways, including limited available data and resources, as well as a high threshold of premerger notification. In 2023, pre-merger notification to federal antitrust authorities was required for transactions over $111.4 million, meaning that many acquisitions, particularly of physician practices, go unnoticed until the merger has been finalized.[44] Because significant research and evidence are required for the FTC to successfully block a mergers,[45] ongoing and continued study of the effects of health care consolidation are also needed to help the agencies identify trends before markets are consolidated. **HHS should also use its authority to collect and share data on quality, cost, access, and other impacts of consolidation with DOJ and FTC to address current, and prevent future, harmful effects of health care consolidation.**

The AAFP also supports legislation that advances billing transparency by requiring hospital outpatient departments to use distinct National Provider Identifiers (NPI) and claim billing forms from the hospital itself, as well as legislation to require hospital price transparency. Improving health care price transparency across all payers, including within the Medicare program ultimately provides policymakers, researchers, and other stakeholders with the tools they need to implement meaningful solutions. Understanding the environment and changing the incentives currently accelerating consolidation and acquisition of primary care practices is essential.

Finally, we note that over 40 percent of survey respondents impacted by health system consolidation said non-compete agreements were "somewhat worse" or "much worse" after the transaction. We applaud the FTC's final rule on noncompete clauses and urge the FTC to use its full authority, as described in the final rule, to prevent all eligible entities from engaging in unfair methods that restrain competition.[46]

Transactions involving private payers and private equity funds

The Departments seek information about the impact of transactions by private equity funds or other alternative asset managers, in addition to transactions by private payers. Because the revenue strategy driving these organizations to acquire primary care physicians is a strong indicator of the likely impacts of the transaction, we have grouped our comments on these two types of entities together, as they often share the same intent when acquiring or investing in or employing primary care physicians.

Effects of private payer and private equity-backed consolidation on physicians and patients

Our March survey on health care consolidation found that most family physicians are impacted by health system consolidation, but a small percentage were acquired by private payers or a private equity-backed firm. **Like physicians acquired by health systems, these respondents also said physician autonomy, job satisfaction, and patient access decreased after the transaction, and were more likely to report noncompete arrangements were "somewhat worse" or "much worse."** We again applaud the FTC's final rule on noncompete clauses which would allow many physicians to continue to serve patients in their community if they choose to leave corporate employment.

As noted above, comments from our survey suggest reduced patient access is an effect of consolidation by private equity and other corporate entities, similar to the effects of consolidation by health systems. Access reductions are linked to two kinds of post-transaction changes: the corporate entity implements policies that limit access to physicians via schedule reductions or administrative barriers to appointment scheduling, and/or the physician resigns from the practice due to poor working conditions, leaving patients without a physician. For example, there are reports of a local primary care practice implementing a half-day schedule to complete integration-related tasks, reducing appointment availability, while another practice implemented changes which made scheduling an appointment exceptionally difficult.[47,48] There are also reports of patients being turned away from the clinic entirely after their physician resigned unless they agreed to accept virtual health services or switch to a different insurer.[49, 50]

Loss of clinical and professional autonomy is significant driver of physician dissatisfaction and contributes to physicians choosing to leave clinical practice. Comments from our survey suggest physicians believe they will retain autonomy post-transaction as long as they are not acquired by a health system. However, a 2023 survey found that a third of physicians acquired by private equity firms or private payers have minimal to no input on practice management policies and decisions, including important staffing decisions that have a direct or indirect impact on patients.[51] Staff from one practice shared that a subsidiary of a private payer that acquired their practice reportedly fired and replaced employees with outsourced contractors who lacked the requisite skills to reliably courier samples to labs, causing delays in lab results and lost samples.[52] Physicians have also expressed frustration over increased documentation or coding requirements.[53] All of these changes ultimately impact the care and/or experience of patients and contribute to moral harm experienced by physicians. Because of noncompete clauses in their contract, many physicians face barriers to resign, such as a forced relocation to avoid geographic competition. In some cases, physicians stop practicing medicine entirely, further exacerbating the primary care physician shortage.

Claimed business objectives for transactions

Physician practices seek financial resources to sustain or grow their practice. Unanticipated economic events can be a tipping point that forces a practice to seek acquisition or capital partnership. For example, research indicates the COVID-19 pandemic was associated with 29,800 physicians leaving independent practice to become employees of a corporate entity.[54] There was also a sharp increase in the number of reported private equity investments in outpatient clinics between 2020 and 2021.[55] There are reports that the economic impact of the Change Healthcare data breach may have been associated with at least one accelerated practice acquisition, as one practice's limited cashflow during the crisis forced the State to bypass a full anti-trust review of the transaction.[56] Comments from our survey and external sources indicate physicians prioritized transactions with physician-led, private-equity backed entities because they expect to maintain some autonomy over the practice, and because they prefer management by a physician-led organization to health system management. When the initial transaction is signed, investors may agree to a minority share and grant physician leaders a majority of seats on the board of directors. However, there is no guarantee this arrangement will persist. In fact, research shows over half of private equity firms exit the investment within three years, and nearly all are resold to other private equity firms with more resources.[57]

Private equity firms and corporations view primary care physicians as a front door to a larger healthcare 'ecosystem' that often involves other products or services owned by the investor or corporation.[58] In addition to their ability to direct patients to other services the parent entity owns, such as an urgent care center or pharmacy, physicians can also coordinate care and control utilization which drive performance in risk-based contracting arrangements, including Medicare Advantage (MA).[59,60]

Need for government action

We support the agencies' recent implementation of the HealthyCompetition.gov portal to gather information and complaints about healthcare competition, and look forward to sharing this resource with members who have expressed strong interest in the agencies recent efforts regarding health care consolidation. This resource will provide physicians who are experiencing or witnessing anti-competitive actions a means to share their concerns; we applaud the agencies' effort to consider these reports for further investigation.

The AAFP increasingly hears from family physicians that their employers (whether health system, private insurer, or private-equity firm) are using primary care as a mechanism to drive success in other aspects of their business and are failing to invest in the infrastructure (e.g., technology and teams) needed to support high quality, comprehensive primary care practices and clinicians. This prevents primary care practices from making the practice improvements that can advance quality and bolster patient health outcomes. **The AAFP urges the agencies to identify, and as needed, work with Congress to implement additional guardrails to ensure that hospital systems, integrated payers, and other physician employers participating in primary care APMs are required to direct the payments and incentives earned from high-quality primary care directly into the practices that are performing successfully.**

There is insufficient research to fully assess the impact of private equity and corporate ownership in health care. More transparency about ownership, including pre and post-data on outcomes of

interest, would enable researchers and policymakers to better understand the effects of this type of consolidation.[61] Private equity and corporately owned practices face extreme pressures to demonstrate increased growth or profitability in a short period of time, which may result in staffing changes that diminish the quality of patient care, reduce access, and negatively impact the well-being and satisfaction of a shrinking primary care workforce. In some cases, private equity-backed entities serve as value-based payment enablers offer practices the resources and support necessary to develop and expand innovative primary care models that provide high-quality care to patients and create a more rewarding practice environment. Without greater transparency, it is difficult to tell the difference. We ask the agencies to use their authorities and work with Congress to make ownership and investment in health care more transparent, including requirements for private equity-backed or corporate entities to disclose debts, fees, and relevant performance metrics such as cost, quality, and access measures.

We appreciate that your agencies are jointly tackling this very important matter. Improving the quality and affordability of US health care cannot happen without well-resourced primary care delivery supported by a robust and growing workforce. The family physicians who make up the AAFP welcome innovation that enhances their ability to deliver high quality primary care to their patients. They commit every day to providing their best for their patients and communities. In order for this to remain viable, a level playing field for independent primary care practices as well as those employed by larger organizations is essential. Thank you again for the opportunity to provide these comments and we look forward to working with your agencies on these recommendations. For additional questions, please contact Julie Riley, Regulatory and Policy Strategist, at jriley@aafp.org.

Sincerely,

Tochi Iroku-Malize, MD, MPH, MBA, FAAFP
American Academy of Family Physicians, Board Chair

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