AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

Statement of the American Academy of Family Physicians

By

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To

U.S. Senate Committee on Finance

On

Consolidation and Corporate Ownership in Health Care: Trends and Impacts on Access, Quality, and Costs

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Chairman Wyden, Ranking Member Crapo, and members of the Committee: My name is Shawn Martin, and I am the Executive Vice President and Chief Executive Officer of the American Academy of Family Physicians (AAFP). I am honored to be here today representing the 129,600 physicians and student members of the AAFP.

I would like to begin my testimony by stating that family physicians – in fact, all physicians – are at their best when they are in service to their patients and communities, not the interests of institutions or corporations. Furthermore, the foundation of our health care system is the human interaction between patients and physicians inside exam rooms, not the business decisions made by executives in board rooms.

The focus of today's hearing is timely and important. Consolidation is transforming our health care system in negative and positive ways. In my comments, I will focus on the impact of vertical consolidation in primary care and the challenge of sustaining comprehensive, continuous primary care that is connected to the people and communities it serves in the midst of the extensive consolidation we see happening today.

Specifically, I will highlight:

- The principal factors and policy decisions that have led to the increasingly consolidated market of primary care practices;
- The urgent need to reform fee-for-service payment, which has chronically underinvested in and undervalued primary care;
- How well-designed, sustainable value-based payment models can support practices of all sizes in providing continuous, comprehensive, and coordinated primary care; and
- Opportunities for Congress to address misaligned incentives that reward consolidation and allow primary care to be leveraged to maximize profits rather than patient care.

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. These new models are creating opportunities for primary care delivery organizations to not only survive but thrive as many of these groups bring important new resources to practices and are enabling primary care to be more readily available to historically underserved communities and populations. What distinguishes many of these organizations is that their revenue model is built primarily around expanding and investing in primary care – a space where our health care system has not performed well over the past several decades.

Many of the most successful primary care delivery innovations are led by primary care physicians. A growing body of evidence demonstrates that physician-led accountable care organizations (ACOs) achieve greater savings than their hospital-led counterparts.[1] One key driver of success is primary care: more primary care physicians and visits lead to greater savings.[2] Meanwhile, hospital-led ACOs may be unwilling to direct revenues away from hospital services to bolster primary care and perform better in ACO models.

The motivation behind the integration of primary care practices into larger, consolidated models is the same for both hospitals and insurers – control of cash flow. Vertical integration can allow primary care to become a leverage point for the pursuit of maximizing savings or profit somewhere upstream. For payers, controlling primary care allows them to oversee and manage care across a patient's care team and across care settings. For hospitals, it allows them to refer patients to their other employed specialists or seek treatments in their facilities that produce higher profit margins while also ensuring the patient's care (and costs) stay within a defined health system. In both situations, these organizations use primary care to meet other financial goals, redirecting revenue away from primary care and failing to invest in the primary care teams that patients benefit from

most. Both hospitals and insurers are achieving their financial goals, but the patients and their primary care physicians, in many instances, are not benefiting from these financial windfalls.

It is important to note that there are large health systems and health plans that are committed to the mission of longitudinal, person-centered primary care and are not only interested in leveraging primary care as a source of high-margin revenue. There are companies focused on bolstering primary care capacity, access, and investment in order to improve health outcomes for all populations and address equity within underserved communities. These organizations invest revenue into primary care, provide primary care teams with clinical autonomy, and are focused on meeting the needs of the communities they are located in.

There may be circumstances in which vertical integration is beneficial. However, the research on the impact of these trends and consolidation more broadly has become increasingly clear. **Evidence has shown vertical integration leads to higher prices and costs, including insurance premiums, without improving quality of care or patient outcomes.**[3] One study found that hospital-owned practices incurred higher per-patient expenditures for commercially insured individuals when compared to physician-owned practices.[4] Site-of-service payment differentials play a significant role in these inflated costs, as current payment policies allow hospitals to charge facility fees for outpatient services.

Despite these data, we continue to prop up a health care system with misaligned financial incentives that reward maximizing profits through consolidation when we should be significantly increasing our investment in primary care. This will require thoughtful implementation of well-designed, sustainable, value-based primary care payment models that support and ensure the success of practices of all sizes and ownership types, not just large practices owned by health systems and health plans with substantial capital.

Introduction

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. They serve as a trusted first contact for health concerns with training to address most routine health care needs. 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. Primary care is person-centered, team-based, community-aligned, and designed to achieve better health, better care, and lower costs.

Primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes, leading the National Academies of Sciences, Engineering, and Medicine (NASEM) to call it a common good.[5] Evidence clearly demonstrates that improving access to longitudinal, coordinated primary care reduces costs, improves utilization of recommended preventive care, and reduces hospitalizations. Yet the United States has continuously underinvested in primary care, which only accounts for a mere five to seven percent of total health care spending in the country.[6,7]

Our national, systemic underinvestment in primary care, coupled with overwhelming administrative burden and rising practice costs, has placed many independent practices in an unenviable position, struggling to envision a viable future where they can remain just that: independent. I acknowledge that independent practice is becoming increasingly challenging to define in today's market - but at its core, we're talking about practices that are primarily owned and led by physicians, whether it be solo clinics or a group or network of physician-owned practices that align themselves. Physicians are often forced to choose between the stability offered by health systems,

payers, or other physician employers, and the autonomy and community focus of independent practice. Increasingly, family physicians report that independent practice is simply unsustainable. The available evidence supports their experiences: our current environment is driving and rewarding consolidation while at the same time draining resources from primary care.

Data confirms that physician employment is increasing and physician practice acquisitions have accelerated in recent years, including by vertically integrated systems, payers, and private equity companies. A 2017 study found that from 2010 to 2016, the share of primary care physicians working in organizations owned by a hospital or health care system increased by a dramatic 57 percent—while the shares in independent solo practice or organizations owned by a medical group decreased.[8] A subsequent study published in 2020 found the share of primary care physicians affiliated with vertically integrated health systems increased from 38 percent to 49 percent from 2016 to 2018. In 2018, more than half of all physicians were affiliated with a health system.[9]

Similar data shows that hospitals and corporate entities, including health plans and private equity, now own over half of physician practices (hospitals own 26.4 percent and other corporate entities own 27.2 percent). From 2019 to 2021, there was a 43 percent increase in the number of corporate-employed physicians and an 86 percent increase in the percentage of corporate-owned physician practices.[10] In 2021, UnitedHealth Group – which already owns the nation's largest commercial heath plan – became the largest employer of physicians in the country through its subsidiary company, Optum.[11]

The proportion of family physicians who are employed continues to grow each year, with 73 percent of all AAFP members and 91 percent of new family physicians (one to seven years post-residency) working as employees in a wide range of organizations from small independent practices to Fortune 100 employers. This shift is dramatic considering only 59 percent of AAFP members reported being employed in 2011.

Family physicians who wish to remain in independent practice have transitioned into one of three practice models: physician-led care delivery organizations, physician-enabled care delivery organizations, or Direct Primary Care (DPC) practices. We discuss the physician-led and physician-enabled care delivery organizations earlier in our statement. In the DPC model, practices contract directly with employers and patients to provide a broad range of primary care services in exchange for a monthly fee. Many family physicians have chosen DPC because it provides more stable, comprehensive payments for primary care than fee-for-service and enables them to spend significantly more time with patients by eliminating many administrative tasks. DPC can effectively alleviate many of the pressures that are undermining primary care practices and driving consolidation but remains out of reach for many patients who rely on their employer, Medicaid, CHIP, or other programs to make health care affordable. More comprehensive solutions are needed to bolster primary care practices and make primary care accessible for all.

For family physicians, choosing independent practice or employment by a health plan or health system should be just that – a choice. Unfortunately, our current system rewards consolidation through misaligned financial incentives and undermines community-based primary care. This means many primary care physicians become employed by a health plan or health system not because they want to, but because it feels like their only option.

Drivers of Consolidation and Vertical Integration in Primary Care

The principal factors fueling primary care integration with health systems and corporate entities such as insurers are financial instability, staffing challenges, administrative burden, and the need for more resources and capital. Consolidation, in primary care and family medicine specifically, in the post-Balanced Budget Act of 1997 context, can be traced back to a set

of legislative and regulatory policies:

- Physician Quality Reporting Initiative/System (PQRI/PQRS) “Value Over Volume”
- Health Information Technology for Economic and Clinical Health (HITECH) Act
- Medicare Access and CHIP Reauthorization Act (MACRA)
- Medicare Physician Fee Schedule

It is now clear that the economic pressures associated with complying with these policies, coupled with systemic underinvestment in primary care via the Medicare Physician Fee Schedule, initiated and continues to drive the loss of independent practices.[12,1314] Over the past decade, most practices that have consolidated did so not from a position of opportunity, but to avoid economic ruin.

The Affordable Care Act (ACA) also contributed to the reshaping of our delivery system. While the ACA created mechanisms for consolidation, the law itself was significant in its support for community-based primary care practices in three ways: 1) Medicare Incentive Payments to primary care physicians; 2) Medicaid to Medicare payment parity for primary care; and 3) the Medicare Shared Savings Program (MSSP) which created a pathway for groups of physicians to aggregate outside of vertical integration options. Of those policies, only the MSSP program remains.

Together these policies took steps to advance value-based payment and electronic health record adoption and interoperability, but they also increased the cost of doing business for primary care practices without meaningfully addressing rising hospital prices and spending.

Providing high-quality, patient-centered primary care requires a care team, advanced data aggregation and analytics tools, and practice management staff and software. Each of these requires practices to make significant financial investments and commitments, but today’s physician payment system fails to provide such support. Instead, independent practices struggle to make ends meet. Family physicians in private practice report months where they couldn’t bring home a paycheck, ultimately succumbing to acquisition to avoid financial ruin. While some family physicians have reported positive experiences with being acquired by a health system or corporation, citing access to advanced tools and technology, additional administrative support, and other experts, many more physicians experience moral injury as they cope with loss of clinical autonomy and requests to prioritize organizational priorities over those of their patients.

For example, family physicians have experienced a narrowing of their scope of practice when their practice is acquired, or they become employed. An administrator or executive makes decisions about what services will be offered based on profitability, volume, and other factors, instead of considering how best to serve their patients and community. Family medicine is, at its core, about providing continuous, comprehensive care – limiting the scope of services offered by family physicians negatively impacts timely, equitable access to care and undermines family medicine’s value and ability to meet patients’ needs.

Workforce challenges also contribute to the state of financial insecurity for many independent practices. It is projected that we will face a shortage of up to 48,000 primary care physicians by 2034,[15] and recruitment of clinical staff remains a struggle, at a time when physicians and their staff are dedicating nearly two business days just to completing burdensome administrative processes like prior authorization.[16,17] In 2021, more than 20 percent of respondents in a primary care survey reported they were paying staff a salary above what they can afford to retain them.[18]

The shadow of student debt (on average $200,000 not including undergraduate studies)[19] looms over medical students and incentivizes them to pursue higher paid specialties. Payment

differentials among specialties have shown many fields receive two to two and a half times more income than primary care physicians, causing many medical students to choose subspecialty fields over primary care. Independent practices face significant challenges in recruiting newly trained physicians given the lack of financial resources to provide loan repayment and salary guarantees that larger health systems and employers can provide. **Congress should consider graduate medical education (GME) program reforms and increased funding for existing loan forgiveness programs, such as the National Health Service Corps, for primary care physicians who chose to join independent practices in rural and other underserved areas as one solution for addressing these challenges.**

Reforming Fee-for-Service Physician Payment

The piecemeal approach fee-for-service (FFS) and the Medicare Physician Fee Schedule (MPFS) take to finance primary care undermines and undervalues the whole-person approach integral to primary care. The damage caused by the historical under-investment in primary care and the failure of the MPFS and the sub-regulatory bodies who influence the valuation of physician services have undermined the stability of primary care practices and worsened consolidation. Across payers, physicians must document several unique screening codes, vaccine administration, other preventive services and counseling codes, an office visit, care management codes, integrated behavioral health codes, and several other services to justify payment for typical, comprehensive primary care, even though these services are all foundational parts of primary care. In addition to being administratively burdensome, this approach encourages carve-outs of behavioral health, telehealth, and other services that are more accessible and effective when integrated in and coordinated within the patient's usual source of care.

FFS also undervalues the component parts of primary care, like care management and integrated behavioral health, and therefore fails to account for the complexity of primary care. The Medicare Payment Advisory Commission (MedPAC) has long advised policymakers to address the underpricing of primary care services in FFS and the NASEM consensus report confirmed that FFS does not adequately value or support the longitudinal, person-centered care that is the hallmark of primary care. For example, many patients benefit from regular care management and coordination services that are not billable under FFS. **Together, the failings of FFS are jeopardizing many community-based primary care practices, driving consolidation, and eroding patients' timely, affordable access to primary care in their own neighborhood.**

Statutory budget neutrality requirements make matters even worse by requiring Medicare to offset increased investment in one area of medicine with cuts to others, pitting primary care and other specialties against each other instead of enabling Medicare to pay appropriately for all types of care. This dynamic has only exacerbated our underinvestment in primary care within the fee-for-service payment system: primary care's voice is drowned out as organized medicine competes for arbitrarily limited resources without adequate focus on the services that would drive population health improvements and health equity.

Fee-for-service is not the future of primary care - but it is the present. Federal policymakers must ensure the current FFS system appropriately and sustainably compensates physicians to make more meaningful progress toward the future – one that rewards quality of care over volume of services. Independently practicing physicians need an environment that allows them to thrive, but inadequate payment rates threaten their long-term viability. This is especially true in rural and medically underserved communities, where simply participating in Medicare and Medicaid is economic detrimentally to independent practices. However, backing out would mean that these patients – who make up the greatest portion of a panel – are unlikely to access care elsewhere.

Rural communities are disproportionately impacted by insufficient FFS payments and the other pressure points fueling consolidation. They have smaller patient volumes that are older and more likely to have chronic illnesses, multiple health concerns, and be low-income. Rural areas see higher rates of uninsured and Medicare and Medicaid patients, meaning significantly lower payment rates and more expensive, uncompensated care. Because of the less-profitable patient population, studies have indicated that market concentration is higher in low-income areas. [20] For small, rural practices and hospitals, the effects of consolidation may be different. Mergers and acquisition can play an important role in preserving existing sites of care (and oftentimes, the only site) with insufficient margins. However, it also often results in the closure of service lines not deemed highly profitable – including primary care – and may worsen equitable access to care in these communities.[21]

One family physician in the Midwest shared his experience of trying to keep the doors open for his rural community practice. For more than 20 years, he provided care in the community he called home. He spent 50 percent of his time working in the emergency department at the local hospital simply to try and keep his primary care practice financially afloat. Unfortunately, it wasn't enough. In 2020, he closed his practice not due to COVID, but due to the financial instability, and left primary care entirely to seek refuge in the emergency department.

The Academy strongly urges the Committee to consider legislative solutions, including reforms to MACRA, that would address unsustainable FFS payment rates for physicians and promote community-based primary care, rather than incentivizing consolidation.

MACRA permanently repealed the sustainable growth rate (SGR) and set up the two-track Quality Payment Program (QPP) that emphasizes value-based payment. While the elimination of the SGR was lauded by the physician community at the time, **MACRA has left the majority of Part B clinicians in a similar state of financial insecurity as Medicare payment rates failed keep pace with practice costs amid a dearth of value-based payment model options.**

According to the American Medical Association's analysis of Medicare Trustees report data, Medicare physician payment has been reduced by 26% when adjusted for inflation over the past 20 years.[22] Practically speaking, this means that physicians are struggling to cover the rising costs of employing their staff, leasing space, and purchasing supplies and equipment - let alone make investments to transition into new payment models. In 2023, Medicare pays $33.89 ($33.8872) per relative value unit under the Medicare physician fee schedule, which is less than the $36.69 ($36.6873) it paid when Medicare moved to a single conversion factor in 1998. If the 1998 amount had simply kept pace with inflation, it would be $68.87 today.

Both MedPAC and the Board of Trustees have recently raised concerns about rising costs for physician practices and impacts on patient care, with each body recommending Congress provide payment updates for physicians. Specifically, the Board of Trustees warned that, without a sufficient update or change to the payment system, they "expect access to Medicare-participating physicians to become a significant issue in the long term."[23]

Congress should heed these warnings. **The AAFP strongly urges the Committee to pass legislation that would provide an annual update to the Medicare Physician Fee Schedule based on the Medicare Economic Index (MEI).** This annual update is an important first step in reforming Medicare payment to help practices keep their doors open, resist consolidation, and ensure continued access to care for beneficiaries.

Since the passage of MACRA, it has become clear that stable, adequate fee-for-service payments are also a vital component to the value-based care transition, particularly for practices serving

rural, low-income, and other underserved communities. Physician practices that struggle to keep their doors open cannot possibly transition into alternative payment models or hire care managers and behavioral health professionals. Practice transformation and quality improvement require significant investment in practice capabilities including technology, people, and new workflows.

Statutory budget-neutrality requirements and the lack of annual payment updates to account for inflation will, without intervention from Congress, continue to hurt physician practices, slow the adoption of value-based payment models, accelerate consolidation, and jeopardize patients' access to care. In October 2022, the Academy submitted robust recommendations to Congress on reforming MACRA to address challenges affecting our members and their patients. The AAFP urges Congress to expeditiously consider additional reforms to MACRA and Medicare physician payment, such as relief from budget neutrality requirements, to modernize Medicare fee-for-service payments.

Medicaid payment improvements are critically needed, as well. On average Medicaid pays just 66 percent of the Medicare rate for primary care services and can be as low as 33 percent in some states.[24] This severely reduces the number of physicians who participate in Medicaid and limits access to health care for children and families enrolled in Medicaid, which has seen record high enrollment in recent years.

Evidence has indicated that increasing Medicaid payment rates improves access to care for beneficiaries. From 2013 to 2014, appointment availability increased following the ACA's increased Medicaid payment for primary care services, but decreased after Congress failed to reauthorize it.[25] States that had larger payment increases also had more improved appointment availability and child health outcomes.[26] **Therefore, the AAFP urges Congress to pass legislation to permanently raise Medicaid payment rates for primary care services to at least Medicare levels to better support physicians and their patients' access to care.**

Value-based Payment and Alternative Payment Models

Some independent primary care practices have found refuge in value-based payment. 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.

Central to our principles is the idea that value-based payment for primary care should not be piecemeal codes and billing requirements for specific services as in fee-for-service but should rely primarily on population-based payments that provide predictable, prospective revenue streams capable of supporting continuous, comprehensive, and coordinated primary care delivered in the context of the community it serves. It is essential that policymakers and others recognize that this kind of primary care is not delivered exclusively in an exam room – whether that "room" is in person or virtual. Primary care physicians who are finding success under value-based payment talk about the importance of the "in-between spaces" and that the patient who's not on your visit schedule that day may be the one who needs you most. Successfully navigating these in-between spaces requires physician-led care teams enabled by actionable and timely data and information.

Finally, with many primary care practices contracting with seven to ten 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. Models that heed these recommendations will more effectively support independent practices through continuous investment in primary care. **Federal policymakers should increase participation opportunities in primary care models that align with these principles and meet practices where they are, allowing them to gain a foothold in value-based payment. As a starting point, Congress should support CMMI demonstrations consistent with our principles, extend the Advanced Alternative Payment Model (AAPM) bonus, and provide CMS with authority to modify AAPM qualifying participant thresholds to ensure independent practices are not left behind.**

However, primary care practices face significant barriers to entering value-based payment models, even when aligned with our principles. Practices must ensure compliance with ever-changing federal regulations, negotiate value-based contracts with multiple commercial payers, establish and maintain a robust panel of attributed patients, acquire and effectively use data aggregation and analysis software to track patient utilization, treatment adherence, and identify outstanding needs. This creates an immediate high barrier to entry, forcing physicians to choose between remaining independent and stuck in a fee-for-service environment that fails to support the full scope of comprehensive, longitudinal primary care, or join with a larger practice, health system, or payer that can provide them with the tools and support they need to thrive in value-based arrangements. Federal policymakers should increase participation options in APMs that provide upfront or advance payments to enable the infrastructure investments and practice transformations necessary to succeed in value-based payment.

For these reasons, the AAFP has consistently advocated for Congress and CMS to bolster support for new practices entering APMs. For example, CMMI provided practices participating in the Comprehensive Primary Care Plus (CPC+) model with a robust data dashboard and other technical assistance that enabled new practices to join the model and successfully reduce hospitalizations. CMMI also partnered with state Medicaid agencies and commercial payers to drive alignment in the regions it was testing CPC+, which in turn provided practices with greater financial support across their contracts and accelerated care delivery innovations. Without these kinds of supports built into model participation, small primary care practices face significant barriers to entry and will be unable to move into value-based care. **Congress could consider providing CMMI with additional authority and funding specifically directed to supporting independent primary care practices entering into value-based payment arrangements.**

In the Medicare Shared Savings Program (MSSP), many independent primary care practices have successfully partnered with aggregators to remain independent and successfully participate in value-based payment models, in part because aggregators assist practices in aligning their contracts across payers and effectively reinvesting financial incentives into practice improvements. Aggregators are companies that bring independent practices together, typically to form an Accountable Care Organization (ACO), and provide technical support in model enrollment and compliance, data analytics, and practice improvement and care management. They do not own the practices they work with. Aggregators are also increasingly assisting practices in securing value-based contracts with commercial payers and managed care organizations that align with the Medicare Shared Savings Program. These aggregators share in the savings accrued by the practices they partner with but enable practices to benefit from their tools and support, often without requiring upfront payment. Given the significant upfront investment, as well as new competencies and skills required to successfully participate in APMs, aggregators offer a viable pathway to remaining independent and financially operational for many practices.

To support independent practices' ability to participate in APMs that work for them, Congress should also consider providing CMMI with additional flexibility in how it evaluates the success of primary care models. Currently, federal statue only allows CMMI to expand models that reduce health care spending and maintain quality, or improve performance on quality metrics without increasing spending. Demonstrating savings in primary care often takes several years, as physicians build relationships with their patients, use data to better manage their care, and increase utilization of preventive and other high-value services, like care management.[27] The current statutory framework has prevented CMMI from making important model improvements or continuing to test models that do not show significant savings within a short model test period, ultimately causing more complexity and financial instability for participating physician practices. Further, all CMMI primary care model evaluations have been done at the national level, which may be masking regional model successes. Congress should consider enabling and encouraging CMMI to evaluate several other markers of success for primary care APMs, such as whether they successfully bring new physicians into value-based payment, improve patient experience measures, markedly improve care delivery transformation, enable more beneficiaries to access the behavioral health services they need, and when applicable, evaluate models both nationally and regionally. These additional criteria would allow CMMI to continue testing models that show early markers of success, as well as iterate upon them to meet current patient, clinician, and market needs.

While value-based payment can and should be used to buoy primary care practices, health systems, hospitals, payers, and other large companies will continue to enter these models. **Federal policymakers should take steps 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 reinvested back into the primary care practice, not redirected to other service lines or books of business. The AAFP increasingly hears from family physicians that their employers – whether they are health systems, health insurers, or another type of employer – are using primary care as a management tool and are failing to reinvest financial gains into their primary care practices and clinicians. This prevents primary care practices from reaping the full benefits of APM participation, including practice improvements that can advance quality and bolster patient health outcomes. **The AAFP urges Congress to examine additional guardrails to ensure that hospital systems, integrated payers, and other physician employers participating in primary care APMs are required to reinvest the payments and incentives earned from high-quality primary care back into the practices that are performing successfully.**

Realigning Incentives and Improving Enforcement

While value-based payment is one solution to which Congress should look in support of independent primary care, additional federal action is needed to address current policies and incentives that reward increasing consolidation and sap resources from independent practices.

Congress should advance site neutral payment, billing transparency, and price transparency legislation to address misaligned incentives that reward consolidation and undermine independent practices. Currently, hospitals are directly rewarded financially for acquiring physician practices, freestanding ambulatory surgical centers, and other lower cost care settings and moving services into the hospital or hospital outpatient department setting. Medicare allows hospitals to charge a facility fee for providing outpatient services that can be safely

performed in the ambulatory setting. Thus, the hospital increases its revenue by acquiring physician practices and beneficiaries are forced to pay higher coinsurance.[28] The AAFP has long advocated to advance site neutral payments as a vital tool for stemming vertical consolidation and reducing beneficiary cost-sharing.

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 transparency within the Medicare program ultimately provides policymakers, researchers, and other stakeholders with the tools they need to implement meaningful solutions. Understanding the environment that is currently accelerating consolidation and acquisition of primary care practices is essential.

Finally, Congress should improve federal regulators' enforcement authorities and resources to meet today's health care consolidation needs. Antitrust authorities are currently constrained in a number of ways, including limited available data and resources, as well as a high threshold of pre-merger 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.[29]

Relatedly, tax-advantaged hospitals are not currently subject to federal antitrust enforcement or oversight of anticompetitive behaviors. In exchange for valuable tax exemptions, hospitals are required to provide charitable contributions to the community. However, data has shown that the highest income-generating tax-advantaged hospitals provided the lowest amount of charity care.[30] 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.

Greater transparency and strengthened antitrust statutes could help reduce the amount of anticompetitive consolidation in health care. Congress should ensure oversight agencies have the resources needed to be effective in researching and pursuing new and developing issues related to health care consolidation and competition.

In closing, thank you again for the opportunity to provide this testimony. On behalf of the AAFP, I look forward to continuing to work with the Committee to advance policies that support physician practices, invest in high-quality primary care, and ultimately ensure a health care system that rewards value of care over volume of services.

Founded in 1947, the AAFP represents 129,600 physicians and medical students nationwide. It is the largest medical society devoted solely to primary care. Family physicians conduct approximately one in five office visits -- that's 192 million visits annually or 48 percent more than the next most visited medical specialty. Today, family physicians provide more care for America's underserved and rural populations than any other medical specialty. Family medicine's cornerstone is an ongoing, personal patient-physician relationship focused on integrated care. To learn more about the specialty of family medicine and the AAFP's positions on issues and clinical care, visit www.aafp.org. For information about health care, health conditions and wellness, please visit the AAFP's consumer website, www.familydoctor.org.

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