Submitted Electronically through Regulations.gov

June 5, 2024

The Honorable Merrick Garland
Attorney General
U.S. Department of Justice
950 Pennsylvania Ave. NW
Washington, DC 20530-0001

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

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

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

Dear Attorney General Garland, Secretary Becerra, and Chair Khan:

On behalf of our members and partners, including not for profit and other mission-driven organizations, LeadingAge offers the following comments in response to the Request for Information on Consolidation in Health Care Markets ("RFI") issued by the Department of Justice ("DOJ"), Department of Health and Human Services ("HHS"), and Federal Trade Commission ("FTC") (collectively, the "Agencies"). LeadingAge member organizations and partners serve individuals and communities across the entire field of aging services, including nursing homes, assisted living, hospice, home health care, PACE, adult day, and affordable housing, and we appreciate the opportunity to provide feedback.

I. Consolidation and Private Equity

Among other issues, the RFI seeks input on transactions in the healthcare market conducted by private equity funds. While the Agencies will already be familiar with the literature addressing these issues, we note the following examples of studies and reports that have addressed the prevalence and impact of private equity ownership.

Nursing Homes: According to a November 2023 report by the HHS Assistant Secretary for Planning and Evaluation ("ASPE")[1], private equity investment in nursing homes increased from 2013 through 2017 but declined to represent around 5% of all facilities as of 2022, the last year of the study period. For purposes of the report, ASPE defines private equity entities as publicly or non-publicly traded companies that collect capital from large investors and rely heavily on debt financing to purchase an ownership share of a provider and collect capital from their investments.

[1] Trends In Ownership Structures Of U.S. Nursing Homes And The Relationship With Facility Traits And Quality Of Care (2013-2022).

While more research is needed to understand fully what impact private equity ownership has on the delivery of nursing home services, two recent studies have identified associations between private equity ownership and increases in short-term mortality of Medicare patients and declines in other measures of patient well-being, and that, given the pressure to generate high short-term profits, private-equity-owned nursing homes might reduce staffing, services, supplies, or equipment, which could adversely affect quality of care.[2]

Hospice and Home Health Care: A 2023 report from the Center for Economic Policy & Research ("CEPR") references a study by Braun, Stevenson, and Unruh (2021) examining the increase in the number of hospice providers operating in the U.S. and consolidation of the industry between 2011 and 2019: "Over the eight years covered by the study, the authors found that the number of hospice agencies increased from 3,162 to 5,615. Private equity ownership of hospice agencies increased between 2011 and 2019 from 106 agencies to 303; ownership by publicly traded companies grew from 93 to 151." The CEPR report also observes that almost three-quarters of private equity transactions over the study period were acquisitions of agencies that were previously nonprofit, meaning this is one driver of consolidation of hospice agencies and transformation from nonprofit to for-profit providers in the hospice industry.[3]

Other reports have noted that home health care, one of the fastest-growing markets in the healthcare sector, also has attracted significant interest from private equity investors.[4]

In terms of impact, a 2022 Private Equity Stakeholder Group report relating case studies about private equity in the home health care and hospice industries[5] observed that the private equity business model, which often includes cutting costs to increase cash flow, may exacerbate quality issues that for-profit home health care and hospice companies already face, including insufficient investment in staffing and operations.

LeadingAge has closely followed trends relating to private equity ownership of nursing homes, home health care, and hospice. While not all private equity arrangements cause concerns, we agree that these transactions raise policy questions that are important to understand and address, and we appreciate the Agencies' study of these matters.

II. Business Objectives for Transactions

The Agencies have specifically requested information about the goals and objectives of business combinations and related transactions that tend to increase consolidation in the health care market.

Academic research, case studies, and other reporting shows that excessive provider consolidation can have negative effects, such as resulting in higher costs for Medicare and commercial insurers. As the

[2] Atul Gupta, Sabrina T. Howell, Constantine Yannelis, and Abhinav Gupta, Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes, 2020; Robert Tyler Braun, Hye-Young Jung, Lawrence Casalino, et al., JAMA Health Forum, 2021.

[3] https://cepr.net/report/preying-on-the-dying-private-equity-gets-rich-in-hospice-care/

[4] See, e.g., The Growth of Private Equity Ownership in the Home Healthcare Market; and Private Equity in U.S. Healthcare: Trends in 2023 Deal Activity (describing activity in both home health care and hospice).

[5] https://pestakeholder.org/wp-content/uploads/2022/03/Home-Healthcare-and-Hospice-report.pdf

Agencies consider policy options, however, we believe it is important to acknowledge that many aging services providers enter into business combinations and affiliations with positive goals and objectives and in pursuit of results that benefit consumers and communities.

We offer the following examples for your consideration:

Evolving Consumer Preferences: Consumer preferences for when, where, and how they receive long-term services and supports have been evolving for many years. While longer-term residence in nursing homes is and will remain an essential service that supports well-being and quality of life, many consumers will seek out community-based services, if they are able, to receive care and support in the places they call home. Many aging services providers have grown and expanded their service offerings with the goal of meeting these needs and preferences, as an extension of their missions to serve their communities. This growth may occur without consolidation, but organizations may also view an acquisition or affiliation as the most desirable pathway to serve a community where there is demand for a given service.

Preservation or Expansion of Access: In many instances, an acquisition by a nonprofit aging services provider of another provider, or an affiliation with another provider, is driven a desire to ensure preservation of access to services available from an organization that is financially distressed and at risk of closing its operations. In other words, the goal of consolidation and integration often is to preserve and maintain access to services for vulnerable populations.

Support of an Organization's Overall Mission: Acquisitions and affiliations often are motivated by a desire to extend the mission of a nonprofit organization. In some instances, like those noted above, this entails continuing and preserving the mission of another organization that is struggling. But not all affiliations involve financial distress. An organization that is financially strong may also seek affiliation or merger, because the benefits of greater scale would support the ability to fulfill its mission in a way that going it alone may not.

Efficiencies, Economies of Scale, and Expertise: Consolidation may allow providers to operate more efficiently or achieve important economies of scale. Business combinations can increase purchasing power for products and services, for example, and insurance coverage provides one illustration: when coverage for multiple sites of service is bundled, costs can be reduced. Investments in technology are another example, creating opportunities to invest in a manner that supports multiple sites of service and lines of service to deploy technologies that support outcomes for those being served, and to protect the organization against cybersecurity risks. Business combinations or expansions can also support the employment of greater numbers of subject matter experts – both in terms of clinical and other service delivery and in administrative matters, such as regulatory compliance, revenue cycle management, and contracting/partnership development (e.g. with managed care organizations and accountable care organizations).

Integration and Value Based Payment Opportunities: Organizations may also be motived by the goal of creating integrated care networks, partnering or consolidating with other organizations to achieve clinical and financial integration that reduces costs and improves quality, including in management of care transitions from one setting to another (e.g. acute care to post-acute care) or from post-acute care to home.

In sum, aging services providers need continued flexibility to pursue strategic opportunities and partnerships, as they seek to strengthen access to high-quality, cost-effective care and innovate for the future, and we urge the Agencies to bear in mind the worthy goals and objectives that motivate many acquisitions and other business combinations or affiliations.

III. Government Actions

In response to the request for feedback about policy options that might address issues raised in the RFI, LeadingAge offers the following observations and recommendations.

A) Ownership Transparency

LeadingAge and our nonprofit, mission-driven members support efforts to ensure that older adults and families receive quality care, including the goals of transparency with respect to ownership and operations.

LeadingAge members are transparent in their ownership structure and board governance and are held accountable to their local communities and government at all levels. Nonprofit providers have always disclosed ownership and management information as required by federal tax law on Internal Revenue Service Form 990s that are open to public inspection.

Transparency promotes excellence and strengthens our organizations and the communities that we serve, and also affords opportunities for data analysis that informs public policy decisions. Recent ASPE analyses, for example, illustrate how ownership and change of ownership data allow for examination of how consolidation may impact access to care, care quality, and prices.[6]

In the CY2023 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule, LeadingAge commented in support of transparency on mergers, acquisitions, consolidations, and changes of ownership for Medicare certified home health agencies and hospices in order to improve transparency and provide researchers with the tools to analyze the impact of ownership on the quality of care beneficiaries receive. This data was subsequently released in April 2023.

Additionally, in response to the Centers for Medicare & Medicaid Services ("CMS") proposed rule on Disclosures of Ownership and Additional Disclosable Parties Information for Skilled Nursing Facilities and Nursing Facilities (CMS-6084-P), we supported the incorporation of data elements that identify private equity status, which will facilitate further research and analysis on how and to what extent ownership types affect and correlate with outcomes and the quality of care.

As noted in our comment on the nursing home disclosures rule, however, we also believe that CMS policies and systems requiring data submission, and publication of data for public use, should be tailored and targeted to achieving the underlying goals of accountability and quality improvement, balancing the

[6] Examples of and links to ASPE reports are available at https://aspe.hhs.gov/topics/long-term-services-supports-long-term-care/health-health-care/skilled-nursing-facilities-snfs.

pursuit of those goals with the importance of not creating unduly burdensome reporting requirements.

B) Program Integrity

We support CMS's application of existing program integrity requirements to address some of the issues that underlie the Request for Information. In January 2023, for example, LeadingAge and other national hospice organizations submitted 34 hospice program integrity recommendations to CMS, and we have appreciated the opportunity to explore and advance these ideas collaboratively with CMS leadership.

We also note that, in the CY2024 Home Health Prospective Payment System Rate Update, CMS extended the "36-month rule" to hospices, meaning that a hospice is prevented from undergoing a change in majority ownership of more than 50%, within 36 months of the hospice's Medicare enrollment or its most recent change in majority ownership. This rule is also in effect for home health care. CMS might consider offering technical assistance to these agencies during such ownership transitions, to assist with quality assurance.

C) Assess and Address Systems Issues That Drive Consolidation

More broadly, as the Agencies assess consolidation and integration activities, we believe it is important to recognize, consider and address systemic environmental conditions, such as outside revenue pressures, that may affect provider decisions to grow, merge, consolidate, sell certain assets, or discontinue providing certain services. Many organizations pursue business combinations or affiliations from a position of strength and motivated by the goals described in Section II of this letter above. However, mergers, acquisitions and other transactions are often driven by the realities of operating in the current environment and factors that present challenges for independent or other providers that lack economies of scale. Addressing these systemic issues would bolster providers' ability to fulfill their missions, which in turn would help sustain a competitive marketplace.

Payment Rates

Aging services providers are heavily dependent on public healthcare programs to reimburse them for the services they deliver, at rates established by a federal agency or by a state, depending on the program. Unfortunately, Medicaid funding is inadequate to cover the full cost of delivering care for many services in many states. And while Medicare rates are higher than Medicaid for many services, Medicare payment rates present challenges too, with home healthcare rates being subject to baseline cuts, for example, including under a payment rule CMS finalized for implementation in calendar year 2024. Sustainable fee-for-service rates that cover the continually rising costs of delivering care are of critical importance.

Medicare Advantage

Outside revenue pressures such as lower reimbursement rates from managed care plans, reduced units of service through accountable and managed care organizations, and an increasing need to be an organization of a certain size in order to contract with managed care organizations and accountable care organizations are also factors that drive consideration of consolidation options.

Ensuring provider access to Medicare Advantage ("MA") plan networks and ensuring payment adequacy to providers under this program is essential. While some of the reforms we seek would require Congressional action, we nevertheless wish to highlight the issues here.

According to an August 2023 report from KFF, for the first time in Medicare's history, more than half of all eligible people with Medicare, or 30.8 million people, are enrolled in private MA plans. MA enrollment has more than doubled since 2010 and is projected to grow from 54% of the eligible population in 2024 to 60% by the end of this decade.[7]

As we noted in our 2023 white paper – Fulfilling the Promise: Medicare Advantage – low provider payment rates are the number one concern of LeadingAge members in relation to Medicare Advantage, including skilled nursing facilities and home health agencies. Payments from MA plans have diminished over the past 5-10 years, at the same time as enrollment in MA has grown significantly, which may increase pressure on providers to consolidate.

The sticking point is that MA plans largely control which providers are in their networks and the nature of the contracts. Section 1854(6)(B)(iii) of the Social Security Act limits the authority of HHS in this regard: "NONINTERFERENCE.—In order to promote competition under this part and part D and in carrying out such parts, the Secretary may not require any MA organization to contract with a particular hospital, physician, or other entity or individual to furnish items and services under this title or require a particular price structure for payment under such a contract to the extent consistent with the Secretary's authority under this part." The intent of this provision was to promote competition. However, it was drafted in a time when MA comprised only a small fraction of the marketplace.

The provision is out of step with current developments and enrollment patterns, and LeadingAge advocates for Congress to amend the language to permit and direct HHS to establish a rate floor (such as equivalency with Medicare fee-for-service rates) that plans must pay unless the plan can negotiate a pay for performance or other value-based arrangement ("VBA") with the provider.

Network adequacy is also important, alongside payment adequacy. We advocate for CMS not to allow plans to exclude providers simply based on size and to consider, for example, an any-willing-provider clause to ensure access to smaller models offering person-centered experiences (e.g. Green House models) or those whose size is limited by provider type.

On a related topic, CMS on March 4 announced the end of the Value Based Insurance Design ("VBID") Hospice Benefit Component as of December 31, 2024, "after careful consideration of recent feedback about the increasing operational challenges of the Hospice Benefit Component and limited and decreasing participation among Medicare Advantage Organizations that may impact a thorough evaluation." While the program is ending, we note that, in response to CMMI's earlier Request for Information for the VBID program, LeadingAge strongly advised CMMI to exert extreme caution regarding closed networks for hospice providers and strongly opposed any change to current prior authorization restrictions for the VBID Hospice Benefit Component. This is counter to many practices used by Medicare Advantage Organizations to control utilization of other benefits like skilled nursing

[7] Medicare Advantage in 2023: Enrollment Update and Key Trends

and home health care and could be identified as one of the factors leading to reduced plan participation in the demonstration.

Value-Based Payment and Integrated Care Delivery

We recommend that CMS develop a combination of incentives and tools that create greater opportunities for post-acute care providers to enter into VBAs with plans and other payers, including the development of guidelines or templates that establish a roadmap for an array of VBA payment options and milestones. VBA templates specific to post-acute care could broaden adoption of VBAs by plans and CMMI model participants by making it easier to implement. A standardized template may incentivize plans to upgrade their systems to support such arrangements. Templates should offer an array of VBAs from minimum risk (e.g. pay for performance) to full risk, allowing for a phased in approach so that both providers and plans can learn and adapt.

LeadingAge, along with other provider groups and the National Association of Accountable Care Organizations, collaborated to identify some actions necessary to improve access to accountable care models for beneficiaries and remove barriers to nursing home participation. One such recommendation was to develop a skilled nursing facility-led nested bundle payment within the ACO that allows the SNF to be financially rewarded for the savings it generates through care redesign efforts.

To the extent the Agencies may have questions or concerns about accountable care organizations or other integrated care models, which some may consider "soft" forms of consolidation, we wish to voice our support for such arrangements, particularly when post-acute or long-term care providers are in a position to lead or meaningfully partner in such efforts and be rewarded for the value they are creating, such as through development of Institutional Special Needs Plans. We urge the Agencies to consider actions, including updated antitrust guidance to replace the guidelines DOJ and FTC recently withdrew, that will support aging services providers to participate and succeed under these models, even though integration or consolidation is a necessary ingredient.

LeadingAge also continues to advocate at the Congressional level for legislation proposal that would provide financial incentives to Medicare participating long-term and post-acute care providers (skilled nursing facilities, long-term care hospitals, inpatient rehabilitation facilities, home health agencies, and hospices) to acquire or upgrade existing health information technology and implement interoperable electronic health record technology. The goal of the incentive program is to provide for bidirectional interoperability between post-acute care providers, acute care providers of services, and health care suppliers, including physicians and non-physician practitioners, to ensure a cross-continuum of interoperable electronic information exchange and alignment among these providers of services and suppliers.

D) Medicare Advantage Market Concentration and Ownership Transparency

With MA enrollment now exceeding the 50% mark nationally, and even higher percentages in certain markets, LeadingAge believes now is the time to collect data and conduct an analysis of the impacts to beneficiaries and providers. Questions that may be asked include: What effect, if any, does MA market concentration have on provider payments, contracting pressure and financial solvency; beneficiary premiums, plan supplemental benefit offerings, network quality and plan complaints? Are there any trends in the types of plans that dominate markets (e.g., for-profit vs. nonprofit, vertically integrated,

managed care led vs. provider led, national vs. regional)? At what threshold of market concentration, are negative impacts observed? Policymakers need to understand this information to set appropriate policies.

We also believe MA plan ownership should be more transparent. CMS produces monthly reports that update MA enrollment by county and state and plan. As MA organizations merge, or as one organization acquires another MA plan in a given market, we have observed that the plan names do not change and therefore, when data is reported, it is less obvious which MA organizations control a market. For example, if United Health Group ("UHG") owns the United Healthcare plans with 30% market share but also the Sierra Health plans with 15% market share in a given market, the combined 45% concentration is important to provider decision making on which plans or MA organizations with which to contract and could affect beneficiaries decision-making or access to care or benefits. In addition, if a beneficiary has a bad experience with a particular plan, they should know which other available plans are also managed by that same MA organization. To assist both providers and beneficiaries, we recommend that parent company data of a specific MA plan should be displayed on the Medicare plan finder; and that CMS report MA enrollment data also by county and state rolled up to parent organization level.

* * * * *

We appreciate the opportunity to provide input on these important issues and thank you for your consideration.

Sincerely,

Jonathan Lips

Jonathan Lips
Vice President, Legal Affairs

LeadingAge represents more than 5,400 nonprofit and mission-driven aging services providers and other organizations that touch millions of lives every day. Alongside our members and 36 partners in 41 states, we use applied research, advocacy, education, and community-building to make America a better place to grow old. Our membership encompasses the continuum of services for people as they age, including those with disabilities. We bring together the most inventive minds in the field to lead and innovate solutions that support older adults wherever they call home. For more information visit leadingage.org.