AAOS
American Association of Orthopaedic Surgeons

Addressing Healthcare Consolidation: Strategies to Improve Competition for Higher Quality Care

American Association of Orthopaedic Surgeons (AAOS)

April 2024

Consolidation Trends in the U.S. Health Care System

Hospital markets are experiencing unprecedented consolidation as large hospitals devour smaller facilities and independent physician practices at record rates, raising concerns about the creation of monopolies that could drive up healthcare costs and limit patient choice. The stress of running a medical practice, including amplified financial pressures and administrative burdens, is causing one in five physicians to consider leaving private practice within two years.[1] The pandemic also contributed to accelerating consolidation in the healthcare market as independent physician practices faced decreases in revenue and utilization and increases in operating costs.[2] Now, according to an estimate by the Physicians Advocacy Institute (PAI), nearly 70 percent of the U.S. physician workforce is employed by a hospital or corporation.[3] Unfortunately, the negative impact of the rising costs of running a medical practice disproportionately impacts small, independent practices, rural physicians, and those serving low-income and marginalized communities increasing the risk of access to care issues for some of our country's most vulnerable patients.

The PAI's study also estimates there was a 25 percent increase in hospital and corporate-owned practices from 2019 to 2021 and at the completion of the study, 48 percent of all physician practices in the United States were under the ownership of hospitals and corporate entities.[4] This isn't surprising, given the declining Medicare reimbursements and sharp inflation rate that are driving doctors to seek employment at

[1] https://www.mcpiqojournal.org/article/S2542-4548(21)00126-0/fulltext
[2] https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/
[3] https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/Revised-6-8-21_PAI-Physician-Employment-Study-2021-FINAL.pdf?ver=K6dyoekRSC_c59U8QD1V-A%3d%3d
[4] https://www.fiercehealthcare.com/practices/practice-consolidation-private-practice-departures-skyrocketed-during-covid-19

larger health systems, thus accelerating consolidation and giving some hospital groups monopolistic control over large shares of the market. Private equity firms and insurance companies are also buying up independently owned physician practices at unprecedented levels. One study estimates that private equity now owns over 30 percent of physician practices in a third of metropolitan areas across the United States.[5] With the increasing corporatization of medicine, there are rising concerns about the potential impacts on patient care and choice, sustainability of independent physician practices, and lack of competition in the health care market due to monopolistic forces.

Consolidation Leads to Higher Costs and Lower Quality of Care

Despite promises of increased productivity and reducing redundancies, consolidation has not resulted in the lower costs and better care promised by the massive U.S. health care systems. Rather, research shows that increased consolidation has led to higher health care prices across the board. The consolidation of practices and integration with hospital systems can lead to increased prices for common orthopaedic procedures and decrease competition and opportunities among independent practices in the same market. For example, the cost for knee replacement and lumbar spine fusion were approximately 30 percent higher in concentrated markets versus competitive markets.[6] More broadly, A New York Times analysis in 2018 found that average hospital prices increase dramatically following mergers.[7] Other studies have reported similar findings, including a 2015 study published in the Journal of the Missouri State Medical Association stating that hospitals that merge impose prices that are 40 to 50 percent higher compared to what they would charge without consolidating.[8] Additionally, a 2015 working paper published by the National Bureau of Economic Research emphasizes that hospitals with a regional monopoly charge prices 12 percent higher than those in

[5] https://www.antitrustinstitute.org/wp-content/uploads/2023/07/AAI-UCB-EG_Private-Equity-I-Physician-Practice-Report_FINAL.pdf
[6] JC Robinson. Hospital Market Concentration, Pricing, and Profitability In Orthopedic Surgery and Interventional Cardiology. Am J Managed Care 2011; 17(6):e241-e248
[7] https://www.nytimes.com/2018/11/14/health/hospital-mergers-health-care-spending.html
[8] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6170097/

markets with four or more competitors.[9] This data amplifies the concerning trend that consolidation has consistently led to higher costs for patients and payers, undermining affordability and access to care.

Strategies to Improve Competition in the U.S. Healthcare System

Stabilizing Medicare Reimbursement for Physicians

Our nation's physicians are currently grappling with yet another cut to the Medicare Physician Fee Schedule (MPFS). Coupled with medical practice costs which are projected to increase by 4.6 percent this year, even the reduced cut of 1.69 percent that Congress implemented in its recent appropriations package is financially straining physician practices past their breaking point. While the gap between rising physician costs and stagnant or declining reimbursement has grown more volatile in recent years, the economic uncertainty it creates for physicians has been slowly building for decades. The projected 4.6 percent increase clinicians' input costs for CY 2024—as measured by the Medicare Economic Index (MEI)—is the highest it's been this century, beating last year's record of 3.8 percent. In fact, since 2001, the cost of running a medical practice has increased 39 percent, but the Centers for Medicare & Medicaid Services (CMS) has only increased reimbursement for physicians by 11 percent.[10] Unlike hospitals and nursing homes—physicians and other health care professionals do not receive an automatic increase to help keep up with the rate of inflation. As a result, when adjusting for inflation in practice cost, Medicare physician pay dropped by 20 percent over the past two decades.[11]

Given this economic climate, it should come as no surprise that many practices are forced to choose between closing their doors or consolidating with larger healthcare institutions that can provide the kind of economic stability needed to continue treating patients. Increasing physician reimbursement to keep pace with hospital reimbursement is one very tangible way that Congress can alleviate the economic conditions that lead to consolidation and ultimately higher costs for health care. Providing physicians with a full inflationary update

[9] https://www.nber.org/papers/w21815
[10] https://www.ama-assn.org/system/files/medicare-pay-chart-2021.pdf
[11] https://www.ama-assn.org/sites/ama-assn.org/files/2022-09/medicare-updates-inflation-chart.jpg

tied to MEI is a necessary first step to further stabilize the MPFS. For this reason, we urge Congress **to pass H.R. 2474, the Strengthening Medicare for Patients and Providers Act**, which would accomplish this goal.

Physicians are not only struggling to keep up with inflation, but they also face Medicare reimbursement cuts year-after-year due to budget neutrality constraints. The Omnibus Budget Reconciliation Act of 1989 contained a provision which mandated that any upward payment adjustments or the addition of new procedures that will increase spending by $20 million or more must be offset by cuts elsewhere in the MPFS. As a result, the various medical specialties are pitted against each other in competition over the size of their respective pieces of the MPFS pie, creating even more uncertainty for physicians. It is not uncommon for a physician in one specialty to see their payments reduced because of policy decisions aimed at a completely different specialty that have little to do with their day-to-day practice of medicine. In fact, roughly 60 percent of the original 3.37 percent cut that CMS proposed in this year's MPFS can be attributed to one such policy decision – the implementation of the G2211 add on code that is primarily directed towards primary care and other office/outpatient evaluation and management (E/M) intensive specialties. A good first step would be to raise the MPFS budget neutrality threshold and index it to inflation going forward, as well as providing statutory guard rails to limit the year-over-year changes to the conversion factor.

Unless we make long-term, structural changes to how Medicare—and by extension, how the rest of the private market, which often adjusts its rates based on changes to Medicare—values the services physicians provide, the idea of the independent, private practice physician will continue to fade from our health care system. For that model of health care delivery to be a financially viable option for physicians, they must have some sense of long-term financial security that the current patchwork of yearly payment fixes fails to provide to those who aren't salaried employees of a larger institution. While we appreciate Congress' efforts to mitigate the annual cuts, short-term legislative fixes only kick the can down the road without addressing the underlying stability. Next year, when both the 1.25 percent statutory adjustment from the Consolidated Appropriations Act, 2023 and the additional 1.68 percent relief from this year's appropriations package are set to expire, physicians are set to face yet another cut of 2.93 percent for 2025.

Budget Neutrality

Budget neutrality requirements under Medicare Part B have resulted in significant payment cuts to physicians, which in turn makes it increasingly difficult for physicians to keep their practices financially viable. AAOS is supportive of legislation led by Reps. Greg Murphy (R-NC), Brad Wenstrup (R-OH) and Michael Burgess (R-TX), **"The Provider Reimbursement Stability Act of 2023,"** which would reform budget neutrality and provide much needed stability within the MPFS for orthopaedic surgeons and the larger physician community.[12] As written, the legislation would provide a full inflationary update to the MPFS and limit positive or negative adjustments to Medicare reimbursements to 2.5 percent. AAOS believes this legislation is another great step that Congress can take towards more comprehensive payment reform.

Site Neutral Policies

For years, Medicare has implemented varying payment models based on where patients receive care – be it a hospital, clinic, surgery center, or doctor's office. This site-specific approach stemmed from the notion that reimbursement should align with the total resources utilized in delivering healthcare services. Such facility-dependent payments have long been woven into the fabric of Medicare and Medicaid, exemplified by systems like the MPFS.

However, this payment variation is not without its shortcomings. On one hand, it has bred inefficiencies and fueled a wave of physician practice acquisitions by hospital networks. On the other, it has significantly impacted patient choice by creating payment disparities - with hospital outpatient departments receiving markedly higher reimbursements for the same services offered at independent physician offices. Such policies incentivize these consolidations, gradually restricting patient access to more affordable community-based care settings. Study after study has highlighted the adverse effects of such acquisitions on healthcare costs and access.

To counter this, the Centers for Medicare & Medicaid Services (CMS) and Congress have mulled over transitioning to site-neutral payments that disregard facility types. AAOS broadly endorses initiatives to

[12] https://www.congress.gov/bill/118th-congress/house-bill/6371/text?s=1&r=2

minimize these site-based payment differentials for identical services. Extending site-neutral policies to cover office visits, in-office procedures, and ambulatory surgical center services could further curb inefficiencies, promote patient choice, and stimulate much-needed competition within the healthcare landscape. However, it is crucial that any cost savings generated from reforms to site neutrality are reinvested into physician payment reform to ensure long-term stability and address the inherent advantages that large healthcare companies have over independent physicians and smaller practices.

Revisiting the In-Patient Only List

In January 2018 and 2020 respectively, CMS removed total knee arthroplasty (TKA) and total hip arthroplasty (THA) from the inpatient-only (IPO) list. This meant that Medicare would now reimburse for a TKA or THA performed in either the inpatient or outpatient setting. While removing a procedure from the IPO should not mean it should no longer be done in an inpatient setting, many of our members face increased scrutiny from the hospital. Over half of our hip and knee surgeons reported in 2018 that their hospital had instructed them to default all TKA surgeries to outpatient status. AAOS later worked with CMS to release a special MLN Matters article that intended to clarify that the admissions status for TKA is still controlled by the surgeon.

Many patients can safely receive the care they need in an outpatient setting, but not all. This is particularly true in the Medicare population. There are many factors a surgeon should consider when determining the best setting of care for their patient. Specifically, we support the following social factors to consider when determining the best setting for musculoskeletal procedures: “lives alone,” “pain,” “prior hospitalization,” “depression,” “functional status,” “high-risk medications,” and “health literacy.” In some cases, a patient may be clinically stable but lack the resources to care for themselves once they go home. This can lead to an increased risk for adverse events or accidents that end in hospital readmission. Congress must consider these criteria and social determinants when forming guardrails around the performance of procedures in the outpatient setting.

Further, AAOS believes many musculoskeletal procedures cannot currently be performed safely in an outpatient setting, no matter the profile of the patient. These include complicated procedures from major trauma, such as pelvic, acetabulum, hip and fragility fractures, and amputations that are mostly done with heavy inpatient monitoring. AAOS recommends that the IPO list not be eliminated for these complicated procedures until there is peer-reviewed objective data on allowing these procedures in an outpatient setting.

Moving care to an outpatient setting also creates an additional burden for the patient, the surgeon, and their staff. Patients receiving care in an outpatient setting meant an increase in out-of-pocket expenses, the potential to run into challenges with post-op medication, and no eligibility for a skilled nursing facility payment following outpatient surgery. The surgeon faces increased administrative and documentation time and increased work associated with rapid discharge for both the surgeon and the staff.

If Congress wishes to make significant changes to the IPO list—including removal altogether—AAOS encourages Congress to work with stakeholders to develop appropriate policy and to consider clinical, financial, social, and administrative implications to all stakeholders. All stakeholders should participate and influence any future decisions and implementation regarding removal of Medicare procedures from the IPO list.

Medicare Advantage Reform

As Medicare Advantage (MA) plans continue to grow in popularity across the United States, there is an increasing need for heightened oversight and scrutiny to safeguard beneficiaries and ensure reasonable cost savings. While traditional fee-for-service Medicare is subject to stringent regulations, MA plans operated by private insurers have faced criticism for potential abuses, including overpayments from the government, narrowing of provider networks to an extent that may restrict patient access to care, and burdensome overuse of prior authorization. In 2016, Medicare beneficiaries who switched from traditional to MA plans had a 13 percent lower average spending on Parts A and B compared to those who remained in traditional Medicare.[13]

[13] https://www.kff.org/report-section/do-people-who-sign-up-for-medicare-advantage-plans-have-lower-medicare-spending-issue-brief/

However, Medicare is at risk of overpaying MA plans between $1.3 trillion and $2 trillion over the next decade.[14] MedPAC also estimated that MA plans would be overpaid by $27 billion in 2023 alone.[15] Auditing and monitoring MA practices and use of taxpayer funds is crucial to ensuring that Medicare funds are being properly utilized and patients can access quality care. More accurate estimations of utilization rates and payments may allow Congress to reallocate any cost savings in Medicare Part C to other areas of the Medicare Program, such as Part B to stabilize the MPFS.

Physician-Led Hospitals

Physician-led hospitals are an important component and competitive force within the American healthcare system that ensures that patients receive the highest quality care at the lowest cost. Yet, current law prohibits new construction or expansion of these hospitals to meet growing community demand. The moratorium on building new or expanding existing physician-led hospitals must be lifted to address the above concerns of a rapidly consolidating market to drive down health care costs and improve quality of care. The moratorium on building new or expanding existing physician-led hospitals must be lifted to address the above concerns of a rapidly consolidating market to drive down health care costs and improve quality of care.

In fact, physician-led hospitals are among the most cost-effective and efficient providers of healthcare in the country, providing complex medical care at rates far below those charged by non-physician-led hospitals. According to a May 2023 study published in the Journal of the American Medical Association (JAMA), commercial negotiated prices are 33.7 percent lower and cash prices are 32.7 percent lower for the same procedures at physician-led hospitals compared to other hospitals.[16] Not to mention, health care economists from Avalon Health Economics analyzed CMS data and found that physician-owned hospitals saved Medicare $3.2 billion over a 10-year period, including over $258 million in 2014 alone.[17]

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[14] https://www.americanprogress.org/press/release-cap-releases-2-new-reports-to-strengthen-medicare-and-end-overpayment-in-medicare-advantage/#:~:text=CAP%20outlines%20several%20policy%20recommendations,Medicare%20benchmark%20or%20the%20local

[15] https://healthpolicy.usc.edu/article/overpayments-to-medicare-advantage-plans-could-exceed-75-billion-in-2023-usc-schaeffer-center-research-finds/

[16] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2806510

[17] https://www.haynesboone.com/news/publications/reigniting-the-debate-about-restrictions-on-physician-owned-hospitals

For these reasons, the AAOS supports the **Patient Access to Higher Quality Health Care Act of 2023 (H.R. 977/S. 470)**, which would repeal the ban on the expansion of existing and creation of new physician-led hospitals. Once repealed, physician-led hospitals can help increase patient choice and inject much-needed competition into the health care market to drive down health care costs, and we urge Congress to swiftly pass this legislation.

The AAOS is also supportive of the discussion draft led by Rep. Michael Burgess (R-TX), to ease the current restrictions on physician-led hospitals and allow existing POHs to expand.[18] In addition, this legislation would allow physicians in rural areas to refer patients to POHs over a 35-mile drive from a traditional or critical access hospital. We were encouraged to see a recent study found that physician-led hospitals generated approximately $1.1 billion in savings in 2019 compared to traditional hospitals, when examining the total cost of care for 20 of the most expensive conditions.[19] As debates around healthcare reform continue, physician-led hospitals must be considered as a cost-effective option to promote competition and expand patients' access to care.

Investing in the Next Generation of Physicians

Establishing a pipeline of future physicians is crucial to maintain patients' access to high-quality cares. However, the rising cost of medical education and the subsequent burden of student loan debt pose significant challenges that deter talented individuals from pursuing careers as physicians. Student loan debt for graduating medical students continues to rise due to yearly tuition increases. The Association of American Medical Colleges estimates that 70 percent of the 2023 medical school graduating class graduated with an average debt of nearly $207,000.[20] Meanwhile, the average first-year resident makes just $60,000.[21] Orthopaedic surgeons have a 5-year residency often followed by 1-2 year fellowship in a specialty, during which time the accrual of interest can add tens of thousands of dollars to their overall loan. Studies have

[18] https://burgess.house.gov/news/documentsingle.aspx?DocumentID=403810
[19] https://www.beckersasc.com/asc-transactions-and-valuation-issues/physician-owned-hospitals-could-save-1b-per-year.html
[20] AAMC. (October 2023). Medical Student Education: Debt, Costs, and Loan Repayment Fact Card for the Class of 2023. Retrieved from https://store.aamc.org/medical-student-education-debt-costs-and-loan-repayment-fact-card-for-the-class-of-2023.html
[21] https://www.ama-assn.org/medical-students/specialty-profiles/6-things-medical-students-should-know-about-physician

linked this financial burden to increased stress and burnout and poorer quality of life in the surgical resident population.[22]

As such, the AAOS is supportive of legislative remedies aimed at easing the burden of student loan debt for aspiring physicians. The **Resident Education Deferred Interest (REDI) Act (H.R. 1202/S. 704)** would provide relief by allowing interest-free deferment on student loans for borrowers serving in a medical or dental internship or residency program. Additionally, the **Specialty Physicians Advancing Rural Care (SPARC) Act (H.R. 2761/S. 706)** could alleviate the debt burden by authorizing a loan repayment program for specialty physicians practicing in rural communities that are facing a workforce shortage. Specialty physicians participating in this program will be eligible to have up to $250,000 of their student loan debt repaid over six years. While not a comprehensive fix, these legislative efforts are a step in the right direction to ease the burden of student debt for those choosing to become physicians.

Excessive student loan debt risks turning bright, qualified students away from becoming physicians — negatively impacting access to care for patients. According to one recent study, 25 percent of medical students in the U.S. reported that they have thought about quitting their studies, and 61 percent of medical and nursing students said they plan to work in roles that do not involve patient care.[23] Addressing the issue of student loan debt is inextricably linked to the need for solutions that tackle the root causes of financial constraints, such as consolidation and disparities in reimbursement rates. Without comprehensive reform, the ability to attract and retain top talent in the medical field will continue to diminish, ultimately compromising patient care in the long run.

Conclusion

In summary, consolidation in the health care market is costly and detrimental to patients' access to quality care. There are a variety of possible solutions such as providing an inflationary update to the MPFS, rethinking budget neutrality, implementing site neutral policies, revisiting the In-Patient Only list, reforming

[22] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8826965/pdf/jagrr-6-e21.00276.pdf
[23] https://www.medpagetoday.com/hospitalbasedmedicine/workforce/107118

the MA program, and repealing the ban on physician-led hospitals. If implemented effectively these proposed solutions will provide meaningful, long-term reform that will drive down the cost of medicine while also allowing physicians to better serve their patients. Thank you for your attention to these critical issues that deeply impact physicians and their ability to provide quality care to patients. The AAOS looks forward to working with you and your colleagues on the ideas outlined above. Please feel free to contact Catherine Hayes (hayes@aaos.org) if you have any questions or if the AAOS can further serve as a resource to your office.