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Getting Medicare right

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VIA ELECTRONIC SUBMISSION

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

The Medicare Rights Center (Medicare Rights) appreciates this opportunity to comment on the **Request for Information on Consolidation in Health Care Markets (RFI)**. Medicare Rights is a national, nonprofit organization that works to ensure access to affordable and equitable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to over three million people with Medicare, family caregivers, and professionals.

Consolidation and market concentration impact many aspects of the U.S. health care system. Our comments focus on the consequences for Medicare and its enrollees. We discuss opportunities for the agencies and other policymakers to better protect older adults, people with disabilities, and the range of public programs that support their access to care.

As the agencies note in the RFI, this request complements the recent Medicare Advantage (MA) data RFI from the Centers for Medicare & Medicaid Services (CMS).[1] As reflected in our comments below, we agree that more transparency is needed around consolidation and the market distortions that result from and compel it. To a large degree, collecting, collating, and publicizing data on ownership, financial ties, and any other links between consolidated entities would make it easier to find and eliminate pernicious incentives in a timely manner. This is critical given the scalable nature of both these practices and their associated harms. While consolidation is concerning writ large, major conglomerations of insurers and providers can have a worrisomely rapid and cumulative effect on key market forces like favorable selection and risk adjustment. And at every level, consolidation can drive up costs for beneficiaries, taxpayers, programs, and the system. Accordingly, along with strengthening oversight and enforcement, we urge the agencies to use new and supplementary data to inform policymaking that disincentivizes these behaviors and limits their damage.

I. Private Equity

A. Problems

In Medicare, researchers have linked consolidation with worse care and outcomes.[2] Evidence suggests this may be especially true when private equity (PE) buyouts are involved. Such acquisitions are disproportionately associated with negative care quality and access.[3] And they are on the rise: Non-hospital corporate ownership of physician practices increased 86% between 2019 and 2021 alone.[4]

Some Medicare services—hospice,[5] home health care,[6] and durable medical equipment (DME)[7]—appear especially attractive to investors, to the detriment of beneficiary health. For example, PE involvement with DME suppliers has been shown to create delays and legal hurdles as beneficiaries attempt to obtain or repair vital equipment.[8] These are significant barriers to care that can prevent older adults and

[1] Centers for Medicare & Medicaid Services, "Medicare Program; Request for Information on Medicare Advantage Data" (January 30, 2024), https://www.federalregister.gov/documents/2024/01/30/2024-01832/medicare-program-request-for-information-on-medicare-advantage-data.
[2] Thomas Koch, *et al.*, "Physician Market Structure, Patient Outcomes, and Spending: An Examination of Medicare Beneficiaries" (January 2018), https://onlinelibrary.wiley.com/doi/10.1111/1475-6773.12825.
[3] Atul Gupta, *et al.*, "Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes" (February 2021), https://bfi.uchicago.edu/wp-content/uploads/2021/02/Does-Private-Equity-Investment-in-Healthcare-Benefit-Patients.pdf; Robert Siefert, "Doctored by Wall Street: Policy Solutions for Private Equity in Healthcare" (July 2023), https://ourfinancialsecurity.org/wp-content/uploads/2023/07/AFREF-Doctored-by-Wall-Street-PRIMARY-final.pdf.
[4] Hayden Rooke-Ley, "Medicare Advantage and Vertical Consolidation in Health Care" (April 2024), https://www.economicliberties.us/wp-content/uploads/2024/04/Medicare-Advantage-AELP.pdf.
[5] Rebecca Anhang Price, *et al.*, "Association of Hospice Profit Status With Family Caregivers' Reported Care Experiences," JAMA Internal Medicine, Volume 183, No. 4, pages 311-318 (April 2023), https://www.rand.org/pubs/external_publications/EP70209.html.
[6] Anna Claire Vollers, "Private equity's growing footprint in home health care draws scrutiny" (January 31, 2024), https://stateline.org/2024/01/31/private-equitys-growing-footprint-in-home-health-care-draws-scrutiny/.
[7] Private Equity Stakeholder Project & National Disability Rights Network, "Private Equity in Durable Medical Equipment" (November 2023), https://pestakeholder.org/wp-content/uploads/2024/02/PESP_Report_Medicare_Advantage_Feb2024.pdf.
[8] *Id.*

people with disabilities from accessing the supports they need to live safely in their homes and communities.

B. Solutions

These care quality and access issues can be reduced by reforming the ecosystem that allows them to flourish. We recommend making PE buyouts less attractive by increasing oversight of facilities, eliminating overpayments throughout the system, bolstering required staffing ratios, and enhancing ownership and financial transparency.[9] Such policy shifts should be coupled with efforts to discourage provider consolidation more generally, including through rigorous anti-monopoly interventions and other strategies to reduce the upward pressure that springs from concentrated markets.[10]

I. Medicare Advantage Overpayment

A. Problems

Overpayments to private plans are negatively impacting Medicare's finances and long-term sustainability, as well as driving up beneficiary premiums and taxpayer costs. The Medicare Payment Advisory Commission (MedPAC) projects that MA plans will be paid 123% of fee-for-service Medicare costs in 2024 through a combination of favorable selection and coding.[11] MedPAC also estimates that these higher payments will increase Part B premiums by $13 billion in 2024.[12]

MA plans, including those owned and supported by PE, have used some of this "extra" money to generate further overpayments. One common approach is to roll up providers as well as health risk assessment and data scraping companies in order to boost paper-only enrollee diagnoses and, therefore, risk adjusted payments.[13] Vertically consolidated MA organizations (MAOs) are shown to engage in greater coding intensity than other MAOs, indicating widespread intentionality.[14] The plans may also pass these "upcoding" incentives on to physicians and other partners via payment arrangements and work directly with them to capture even more phantom diagnoses and overpayments in the future.[15]

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[9] Robert Siefert, "Doctored by Wall Street: Policy Solutions for Private Equity in Healthcare" (July 2023), https://ourfinancialsecurity.org/wp-content/uploads/2023/07/AFREF-Doctored-by-Wall-Street-PRIMARY-final.pdf.
[10] Robert A. Berenson, "Addressing Health Care Market Consolidation and High Prices: The Role of the States" (January 2020), https://www.urban.org/sites/default/files/publication/101508/addressing_health_care_market_consolidation_and_high_prices_1.pdf.
[11] Stuart Hammond, *et al.*, "The Medicare Advantage program: Status report" (January 12, 2024), https://www.medpac.gov/wp-content/uploads/2023/10/MedPAC-MA-status-report-Jan-2024.pdf.
[12] Stuart Hammond, *et al.*, "January 2024 Public Meeting Transcript," (January 11, 2024), https://www.medpac.gov/wp-content/uploads/2023/10/January-2024-meeting-transcript.pdf.
[13] Richard Gilfillan & Donald M Berwick, "Medicare Advantage, Direct Contracting, And The Medicare 'Money Machine,' Part 1: The Risk-Score Game" (September 29, 2021), https://www.healthaffairs.org/content/forefront/medicare-advantage-direct-contracting-and-medicare-money-machine-part-1-risk-score-game.
[14] David Meyers, *et al.*, "Provider Integrated Medicare Advantage Plans Are Associated with Differences in Patterns of Inpatient Care" (May 2020), https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00678; Michael Geruso & Timothy Layton, "Upcoding: Evidence from Medicare on Squishy Risk Adjustment" (March 2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7384673/.
[15] Stuart Hammond, *et al.*, "The Medicare Advantage program: Status report" (January 12, 2024), https://www.medpac.gov/wp-content/uploads/2023/10/MedPAC-MA-status-report-Jan-2024.pdf; Richard Gilfillan & Donald M Berwick, "Medicare Advantage, Direct Contracting, And The Medicare 'Money Machine,' Part 1: The Risk-Score Game" (September 29, 2021), https://www.healthaffairs.org/content/forefront/medicare-advantage-direct-contracting-and-medicare-money-machine-part-1-risk-score-game.

Further, MA plans that acquire related businesses can circumvent Medical Loss Ratio (MLR) rules by funneling money through linked businesses to build in excess profits.[16]

Vertical consolidation can also increase quality bonus program payments by giving plans more control over physicians' documentation of and performance on measures included in Star Ratings. For example, plans may urge clinicians to change prescribing patterns to make their patients appear more compliant, inflating both quality ratings and the associated payments.[17]

Finally, deep-pocketed entities with stakes in MA plans can easily fund practices like broker steering and predatory marketing that boost enrollment. And once established and profitable, PE startup plans can be sold to other players in the MA market, transitions that may disrupt enrollee care continuity and affordability.[18]

B. Solutions

Vertical consolidation drives MA overpayment, which drives vertical consolidation. Agencies should tackle this issue comprehensively, by preventing the rollups that increase consolidation as well as the behaviors that make such consolidations profitable.

Every layer of MA payment determination has built-in distortions and significant reforms are needed. We urge greater oversight of and data collection from MA plans to combat gaming and other harmful practices fueled by for-profit interest and engagement. This includes modernizing MA's risk adjustment model to account for recorded diagnoses that are not reflected in the beneficiary's care plan and do not result in additional care / plan spending. We support excluding such diagnoses from chart reviews and health risk assessments[19] and increasing review, and disregard, of discretionary and other diagnoses that disproportionately appear in MA coding as compared to OM coding.[20] All diagnoses collected by plan-related or financially linked entities should be subject to heightened scrutiny.

We also urge CMS to conduct more frequent and widespread plan financial reviews. Audits are a proven way to identify the recording of fraudulent diagnoses.[21] While the finalized Risk Adjustment Data Validation (RADV) rule[22] does enhance the effectiveness of plan audits, it does not intensify their

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[16] Richard G Frank & Conrad Milhaupt, "Medicare Advantage Spending, Medical Loss Ratios, and Related Businesses: An Initial Investigation" (2023), https://www.brookings.edu/articles/medicare-advantage-spending-medical-loss-ratios-and-related-businesses-an-initial-investigation/; Stuart Hammond, *et al.*, "The Medicare Advantage program: Status report" (January 12, 2024), https://www.medpac.gov/wp-content/uploads/2023/10/MedPAC-MA-status-report-Jan-2024.pdf.

[17] C. Annette DuBard, *et al.*, "Why The Star Ratings Medication Adherence Measures Must Go" (January 10, 2024), https://www.healthaffairs.org/content/forefront/why-medicare-star-medication-adherence-measures-must-go.

[18] Mary Bugbee, "How Private Equity Gets its Cut from Medicare Advantage," Private Equity Stakeholder Project (February 2024), https://pestakeholder.org/wp-content/uploads/2024/02/PESP_Report_Medicare_Advantage_Feb2024.pdf.

[19] US Dep't of Health and Human Services Office of Inspector General, "Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments To Disproportionately Drive Payments" (September 2021), https://www.oig.hhs.gov/oei/reports/OEI-03-17-00474.pdf.

[20] Centers for Medicare & Medicaid Services, "Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies: Principle 10-Focused Clinical Updates" (February 1, 2023), https://downloads.regulations.gov/CMS-2023-0010-0001/attachment_1.pdf.

[21] US Dep't of Justice, "Government Intervenes in False Claims Act Lawsuits Against Kaiser Permanente Affiliates for Submitting Inaccurate Diagnosis Codes to the Medicare Advantage Program" (July 30, 2021), https://www.justice.gov/opa/pr/government-intervenes-false-claims-act-lawsuits-against-kaiser-permanente-affiliates.

[22] 88 Fed. Reg. 6643.

frequency or expand their reach.[23] Correcting for this could substantially improve oversight and compliance.

We also recommend the collection and publication of additional relevant data.[24] For example, by making existing beneficiary-level risk score data available to researchers, the agencies would enable more independent, comprehensive assessments of risk score manipulation, including among integrated MAOs. This information should be granular, regularly reported, and used to guide MA and program-wide reforms.

We appreciate CMS's steps to date to bolster ownership transparency in health care settings.[25] We support similar and stricter policies in the consolidation space. Better information on facility ownership and the financial incentives it creates, as well as greater price transparency around payments between entities with overlapping ownership or other financial ties could help identify MLR gaming and other deceptive tactics.

Changes are also needed to strengthen Star Ratings metrics. Excluding those that are vulnerable to manipulation could reduce the gamification of the quality program and its role in incentivizing consolidation. Wholesale replacement of the current quality program and stronger controls on profitable utilization management could also disincentivize gaming while additionally giving the public and policymakers greater insights on MA quality and plan actions.[26]

II. Medicare Advantage Market Concentration

A. Problems

Over the past decade, the number of MA plans has grown sharply. During open enrollment for 2024, the average beneficiary had 43 different MA plans from which to choose compared to 17 plans in 2014.[27] One-third of beneficiaries had a choice of at least 50 plans, a stunning increase over the 1% who had so many options in 2019. The abundance is even greater in 29 counties, where eligible beneficiaries could choose from more than 75 plans, with a high of 87 plans available in Akron, Ohio.

[23] Travis Williams, *et al.*, "Medicare Advantage Audit Changes Let Plans Keep Billions In Overpayments" (February 27, 2023), https://www.healthaffairs.org/content/forefront/medicare-advantage-audit-changes-let-plans-keep-billions-overpayments.
[24] Medicare Rights Center, "Response to Medicare Advantage Data Request for Information" (May 29, 2024), https://www.medicarerights.org/policy-documents/medicare-rights-center-response-to-medicare-advantage-data-request-for-information.
[25] *See, e.g.*, Centers for Medicare & Medicaid Services, "Biden-Harris Administration Continues Unprecedented Efforts to Increase Ownership Transparency in Health Care Settings" (December 20, 2022), https://www.cms.gov/newsroom/press-releases/biden-harris-administration-continues-unprecedented-efforts-increase-ownership-transparency-health.
[26] Medicare Payment Advisory Commission, "Chapter 3: Replacing the Medicare Advantage quality bonus program" (June 2020), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun20_ch3_reporttocongress_sec.pdf.
[27] Meredith Freed, *et al.*, "Medicare Advantage 2024 Spotlight: First Look" (November 15, 2023), https://www.kff.org/medicare/issue-brief/medicare-advantage-2024-spotlight-first-look/.

The number of plans offered is a result of many different factors, including booming profits.[28] KFF estimated that MA plans in 2021 had per person gross margins of more than double those seen in other markets.[29]

Importantly, the number of plans is not a good indication of the amount of competition in the market since many companies offer multiple plans per county.[30] Nationwide, much of MA enrollment is highly concentrated among a handful of firms, with two companies, UnitedHealthcare and Humana, accounting for 47% of total MA enrollment in 2023, and at least 75% in some counties.[31]

Some of this is the result of policy choices to relax regulations that required companies to demonstrate a "meaningful difference" between various plan offerings. In 2019, CMS eliminated this requirement and has since allowed individual companies to sell plans that vary only slightly.[32] Since then, the average number of plans has gone from 20 to 43 while the average number of companies offering plans in each market has only gone from 6 to 8.[33]

This concentration is significant because the number of MA plans and the often slight but important variances across each can hinder sound beneficiary decision-making.[34] Beneficiaries may become overwhelmed and select or continue with a plan that does not meet their needs or correspond with their preferences. This experience aligns with qualitative evidence[35] and is supported by behavioral economics research, which suggests individuals who face a wide range of choices may have more difficulty making decisions, make poorer choices, or fail to act at all.[36] Indeed, few people with Medicare evaluate their options annually or switch plans from one year to the next.[37] This inertia, and any underlying sub-optimal enrollments, can have detrimental impacts, like higher costs, care disruptions, and problems accessing preferred providers. Enrollees who arguably have the most at stake—those who

[28] Jared Ortaliza, *et al.*, "Health Insurer Financial Performance in 2021" (February 28, 2023), https://www.kff.org/medicare/issue-brief/health-insurer-financial-performance/.
[29] For more on MA payment and overpayment, *see, e.g.* Medicare Payment Advisory Commission, "Medicare Payment Policy: Report to the Congress," (March 2022), https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf; Medicare Rights Center, "The Overpayment Cycle: Payments to Medicare Advantage" (July 17, 2023), https://www.medicarerights.org/policy-documents/the-overpayment-cycle-payments-to-medicare-advantage.
[30] Meredith Freed, *et al.*, "Medicare Advantage 2024 Spotlight: First Look" (November 15, 2023), https://www.kff.org/medicare/issue-brief/medicare-advantage-2024-spotlight-first-look/.
[31] Nancy Ochieng, *et al.*, "Medicare Advantage in 2023: Enrollment Update and Key Trends" (August 9, 2023), https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/.
[32] 83 Fed. Reg. 16440, 16490.
[33] Gretchen Jacobson, *et al.*, "Medicare Advantage 2018 Data Spotlight: First Look" (October 13, 2017), https://www.kff.org/medicare/issue-brief/medicare-advantage-2018-data-spotlight-first-look/.
[34] Allison Rizer, "Is Too Much Choice a Bad Thing?" (July 26, 2021), https://www.arnoldventures.org/stories/is-too-much-choice-a-bad-thing.
[35] *See, e.g.*, KFF, "Chartpack: Seniors and the Medicare Prescription Drug Benefit" (November 2006), https://www.kff.org/medicare/poll-finding/chartpack-seniors-and-the-medicare-prescription-drug/; KFF, "Seniors' Knowledge and Experience With Medicare's Open Enrollment Period and Choosing a Plan: Key Findings from the Kaiser Family Foundation 2012 National Survey of Seniors" (October 2012), https://www.kff.org/medicare/issue-brief/seniors-knowledge-and-experience-with-medicares-open/.
[36] Medicare Payment Advisory Commission, "Report to the Congress: Medicare and the Health Care Delivery System" (June 2023), https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch3_MedPAC_Report_To_Congress_SEC.pdf.
[37] *See, e.g.*, Meredith Freed, *et al.*, "More Than Half of All People on Medicare Do Not Compare Their Coverage Options Annually" (October 29, 2020), https://www.kff.org/medicare/issue-brief/more-than-half-of-all-people-on-medicare-do-not-compare-their-coverage-options-annually/; Nancy Ochieng, *et al.*, "A Relatively Small Share of Medicare Beneficiaries Compared Plans During a Recent Open Enrollment Period" (November 01, 2022), https://www.kff.org/medicare/issue-brief/a-relatively-small-share-of-medicare-beneficiaries-compared-plans-during-a-recent-open-enrollment-period/; and Jeannie Fuglesten Biniek, *et al.*, "Medicare Beneficiaries Rarely Change Their Coverage During Open Enrollment" (November 01, 2022), https://www.kff.org/medicare/issue-brief/medicare-beneficiaries-rarely-change-their-coverage-during-open-enrollment/.

are older, have lower incomes, are living with cognitive impairments, or have serious health needs—are also the least likely to review and change their coverage.[38]

B. Solutions

More robust MA market competition and improved beneficiary plan selection could be addressed by reducing market clutter through limits on the number of plans offered by each MA organization, reinstating the "meaningful difference" requirement, and standardizing plans and supplemental benefits. Agencies should also explore exercising federal authority against monopolies and better support informed consumer decision-making by adequately funding State Health Insurance Assistance Programs (SHIPs) and modernizing tools such as Medicare Plan Finder.

III. Site Differentials

A. Problems

Hospitals have historically had higher overhead expenses than physician's offices and ambulatory care centers.[39] Medicare payment rules account for this by applying different rates in different settings, ultimately paying more for a service because it is performed in a hospital. Specifically, for reimbursement purposes, hospital outpatient departments (HOPDs) are considered part of the hospital and can therefore bill Medicare through the Outpatient Prospective Payment System (OPPS)—which pays for hospital operating costs—in addition to the Physician Fee Schedule (PFS), which pays health care professionals for delivering services. The combination of these two payments is typically higher than the single PFS reimbursement doctors would receive for performing the same services in-office,[40] often two to three times more, even when the care provided is otherwise indistinguishable.[41]

Since there is money to be made at these higher-paid sites, hospitals have responded rationally through vertical consolidation—by buying up physician practices and designating them as HOPDs. Today, more physicians work for hospitals and health systems than in independent practice[42] and more services are being delivered—more expensively—in HOPDs.[43]

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[38] Nancy Ochieng, *et al.*, "A Relatively Small Share of Medicare Beneficiaries Compared Plans During a Recent Open Enrollment Period" (November 01, 2022), https://www.kff.org/medicare/issue-brief/a-relatively-small-share-of-medicare-beneficiaries-compared-plans-during-a-recent-open-enrollment-period/.

[39] Frederick Isasi, *et al.*, "Gaming the System: How Hospitals Are Driving Up Health Care Costs by Abusing Site of Service" (June 2023), https://familiesusa.org/wp-content/uploads/2023/06/Gaming-the-System-How-Hospitals-Are-Driving-Up-Health-Care-Costs-by-Abusing-Site-of-Service.pdf.

[40] *See, e.g.*, Jackson Hammond, "Site-neutral Payments" (May 4, 2023), https://www.americanactionforum.org/insight/site-neutral-payments/; American Medical Association, "Payment variations across outpatient sites of service" (2023), https://www.ama-assn.org/system/files/issue-brief-pay-variations-outpatient-sites.pdf; Medicare Payment Advisory Commission, "Outpatient Hospital Services Payment System" (November 2021), https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_opd_final_sec.pdf; and Loren Adler, "Testimony of Loren Adler, MS Associate Director and Fellow, USC-Brookings Schaeffer Initiative for Health Policy Economic Studies, Brookings Institution" (April 26, 2023), https://www.brookings.edu/wp-content/uploads/2023/04/2023-04-26-EC-Competition-Transparency-Testimony-Final.pdf.

[41] Medicare Payment Advisory Commission, "Chapter 6: Aligning fee-for-service payment rates across ambulatory settings" (June 2022), https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch6_MedPAC_Report_to_Congress_SEC.pdf.

[42] Avalere Health, "COVID-19's Impact On Acquisitions of Physician Practices and Physician Employment 2019-2021" (April 2022) (https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI%20Avalere%20Physician%20Employment%20Trends%20Study%202019-21%20Final.pdf.

[43] Medicare Payment Advisory Commission, "Chapter 6: Aligning fee-for-service payment rates across ambulatory settings" (June 2022), https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch6_MedPAC_Report_to_Congress_SEC.pdf.

Such shifts increase industry profits as well as costs to Medicare and to beneficiaries, who typically pay 20% coinsurance. From 2012 to 2022, Medicare and beneficiary spending on hospital outpatient services grew by 73%, an average of 5.6% per year.[44] MedPAC estimated that inflated site-based payments raised beneficiary costs by nearly $1.7 billion and Medicare's by $6.6 billion in 2019 alone.[45]

In addition, hospitals often charge opaque "facility fees" for care provided in their outpatient departments. These amounts can increase a patient's bill by thousands of dollars, effectively padding hospital payment rates and further encouraging consolidation at enrollee, taxpayer, and Medicare's expense.[46]

B. Solutions

Site neutrality is the policy of paying the same rate for the same service, regardless of where it is provided. Higher cost facilities are the appropriate setting for some services and should be compensated accordingly. But such facilities should not be overused, over-incentivized, or overpaid. Better aligning Medicare payment rates across settings could help reduce these abuses.

Policymakers have attempted to reduce problematic payment differences in the past,[47] but have not yet fully done so.[48] For example, although current rules aim to pay new off-campus HOPDs at PFS rates, this approach is overly narrow, applying to less than 1% of hospital outpatient spending.[49] Extending this policy to all off-campus HOPDs would save approximately $40 billion over 10 years.[50] Coupling it with other changes would have an even bigger impact. For instance, limiting HOPD reimbursement for certain low-complexity services to the lower PFS rate[51] could generate another $100 billion in savings.[52] Some independent analysts estimate similar site neutrality changes could save Medicare $141 billion over 10 years,[53] while others put the number slightly higher at $153 billion, including $94 billion in lower beneficiary costs.[54] Spillover effects may benefit other payers who would be able to leverage Medicare's changes. We support exploring these strategies and adopting promising improvements.

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[44] Medicare Payment Advisory Commission, "Health Care Spending and the Medicare Program," Chart 7-9 (July 2023), https://www.medpac.gov/wp-content/uploads/2023/07/July2023_MedPAC_DataBook_SEC.pdf.
[45] Medicare Payment Advisory Commission, "Chapter 6: Aligning fee-for-service payment rates across ambulatory settings" (June 2022), https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch6_MedPAC_Report_to_Congress_SEC.pdf.
[46] Frederick Isasi, *et al.*, "Gaming the System: How Hospitals Are Driving Up Health Care Costs by Abusing Site of Service" (June 2023), https://familiesusa.org/wp-content/uploads/2023/06/Gaming-the-System-How-Hospitals-Are-Driving-Up-Health-Care-Costs-by-Abusing-Site-of-Service.pdf.
[47] Pub. L No. 114-74.
[48] Government Accountability Office, "Medicare: Increasing Hospital-Physician Consolidation Highlights Need for Payment Reform" (December 18, 2015), https://www.gao.gov/products/gao-16-189.
[49] Loren Adler, "Testimony of Loren Adler, MS Associate Director and Fellow, USC-Brookings Schaeffer Initiative for Health Policy Economic Studies, Brookings Institution" (April 26, 2023), https://www.brookings.edu/wp-content/uploads/2023/04/2023-04-26-EC-Competition-Transparency-Testimony-Final.pdf.
[50] Congressional Budget Office, "Proposals Affecting Medicare—CBO's Estimate of the President's Fiscal Year 2021 Budget" (March 2020), https://www.cbo.gov/system/files?file=2020-03/56245-2020-03-medicare.pdf.
[51] Medicare Payment Advisory Commission, "Chapter 6: Aligning fee-for-service payment rates across ambulatory settings" (June 2022), https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch6_MedPAC_Report_to_Congress_SEC.pdf.
[52] Congressional Budget Office, "Proposals Affecting Medicare—CBO's Estimate of the President's Fiscal Year 2021 Budget" (March 2020), https://www.cbo.gov/system/files?file=2020-03/56245-2020-03-medicare.pdf.
[53] Government Accountability Office, "2023 Annual Report: Additional Opportunities to Reduce Fragmentation, Overlap, and Duplication and Achieve Billions of Dollars in Financial Benefits—Open Matters and Recommendations with Potential for Financial Benefits" (June 14, 2023), https://files.gao.gov/reports/106089/index.html#finding3.
[54] Committee for a Responsible Federal Budget Health Savers Initiative, "Equalizing Medicare Payments Regardless of Site-of-Care" (February 23, 2021), https://www.crfb.org/papers/equalizing-medicare-payments-regardless-site-care.

We also urge the elimination of facility fees for off-campus sites and on-campus primary care offices. While the Bipartisan Budget Act of 2015 reduced Medicare's payment for such fees,[55] they should be eliminated entirely. This may require greater transparency about and updating coding to determine the precise location of care for any services.

Conclusion

As these comments show, there are many opportunities to ensure consolidation and market concentration do not have a detrimental effect on older adults, people with disabilities, programs like Medicare, and taxpayers. We urge greater regulation and oversight of these areas, as well as enhanced plan transparency and accountability, to ensure all patients have access to the care they need to thrive.

Thank you again for the opportunity to provide comment. For more information, please contact Lindsey Copeland, Federal Policy Director at LCopeland@medicarerights.org or 202-637-0961 and Julie Carter, Counsel for Federal Policy at JCarter@medicarerights.org or 202-637-0962.

Sincerely,

Fred Riccardi
President
Medicare Rights Center

[55] Pub. L No. 114-74.