# Primary Care Payment Reform Collaborative Meeting

May 9, 2024

# Agenda

- Housekeeping & announcements
- Federal & state updates
- Market Dynamics - Private Equity
- Public comment

# Meeting Goals & Requested Feedback

## GOALS

- Establish baseline understanding of market-level forces impacting health care access, affordability, quality
- Identify/discuss implications for primary care (providers, patients, payers)
- Identify next steps, follow-up tasks, and/or needed resources

## FEEDBACK

- What are key lessons or considerations for future discussions?
- What, if any, additional sub-topics or nuances would you like to explore? Population specific? Specialty specific? State specific?
- How do you want to consider or include in your work moving forward?

* * Incorporate equity into discussion and recommendations * *

COLORADO

# Housekeeping & Announcements

# Housekeeping & Announcements

- Meeting minutes – approve April meeting minutes in June
- Website updates
  - Primary Care Payment Reform Collaborative
  - HB22-1325 – Primary Care Alternative Payment Models
    - DRAFT reporting guidance posted
  - Colorado Alternative Payment Model (APM) Alignment Initiative
- Membership update
  - One-pager feedback to Tara Smith (tara.smith@state.co.us)
  - New member announcement

# New PCPRC Member – Welcome!

## Gretchen Stasica, ASA, AAA

Executive Director, Actuarial Services

Kaiser Permanente

COLORADO

# Federal & State Updates

# Federal Updates

- Final Rule – Nondiscrimination Protections, Section 1557 of ACA
  - Requires covered health care providers, insurers, grantees, others to proactively notify patients that language assistance services are available at no cost, and accessibility services are available at no cost
  - Clarifies coverage health programs/activities offered via telehealth must be accessible to individuals with limited English proficiency and/or disabilities;
  - Codifies 1557's prohibition against discrimination based on sex includes LGTBQI+ patients
  - Clarifies application of 1557 nondiscrimination requirements to health insurance plans
- Final Rule – Health Coverage for DACA Recipients
  - DACA recipients and other newly eligible individuals will qualify for special enrollment period for 60 days following rule's 11/1/24 effective date
  - If qualify to enroll in Marketplace plan, may also qualify for advance premium tax credit and cost-sharing reductions

# Federal Updates

- CMS National Quality Strategy – Quality in Motion
  - Update to CMS National Quality Strategy released with three-part call to action: 1) adopt Universal Foundation measures; 2) commit to improving safety and reducing harm; 3) advance health equity in all quality and value-based programs
- Office of Minority Health – Health Equity Data Resource
  - OMH released new resource document of health equity-related data definitions, standards, and stratification practices for 9 data elements
  - Providers, states, community organizations, researchers, and others collecting and or stratifying their health equity-related data can make use of this resource to align with CMS
- 2024 CMS Health Equity Conference – May 29-30
  - Register HERE

# State Updates

- 2024 Legislative Session – TOTAL BILLS = ~778

| Systems/Administration | Substance Use Disorder | Data | Benefits |
|---|---|---|---|
| • HB24-1149 - Prior Authorization Requirements Alternatives<br>• SB24-093 - Continuity of Health-Care Coverage Change<br>• SB24-080- Transparency in Coverage<br>• SB24-034 - Increase Access to School-Based Health Care<br>• SB24-221 - Funding for Rural Health Care<br>• HB24-1322 - Medicaid Coverage Housing & Nutrition Services<br>• SB24-142 – Oral Health Screening in Schools<br>• HB24-1416 – Create Healthy Food Incentives Program | • HB24-1045 – Treatment for Substance Use Disorders<br>• SB24-047 – Prevention of Substance Use Disorders<br>• SB24-048 – Substance Use Disorders Recovery | • SB24-205 – Consumer Protections for Artificial Intelligence<br>• HB24-1130 - Protection of Biometric Identifiers & Data<br>• HB24-1058 - Protect Privacy of Biological Data | *Maternal health*<br>• SB24-175 – Improving Perinatal Outcomes<br>• HB24-1262 - Maternal Health Midwives<br>• HB24-1459 - Birth Equity<br><br>*Health benefit plans*<br>• HB24-1392 – Insurance Coverage Pediatric Neuropsychiatric Syndrome<br>• SB24-124 – Health-Care Coverage for Biomarker Testing<br><br>*Other*<br>• HB24-1010 – Insurance Coverage for Provider-Administered Drugs |

# State Updates

- 2024 Legislative Session – Did NOT Pass:
  - HB24-1005 - Health Insurers Contract with Qualified Providers
  - SB24-059 – Children's Behavioral Health Statewide System of Care
  - HB24-1040 - Gender-affirming health care study
  - SB24-163 – Arbitration of Health Insurance Claims
  - HB24-1028 – Overdose Prevention Centers
- Upcoming topics:
  - Update on HB22-1302
  - CIVHC – Primary Care & APM Report

COLORADO

# Market Dynamics

# Opening Credits

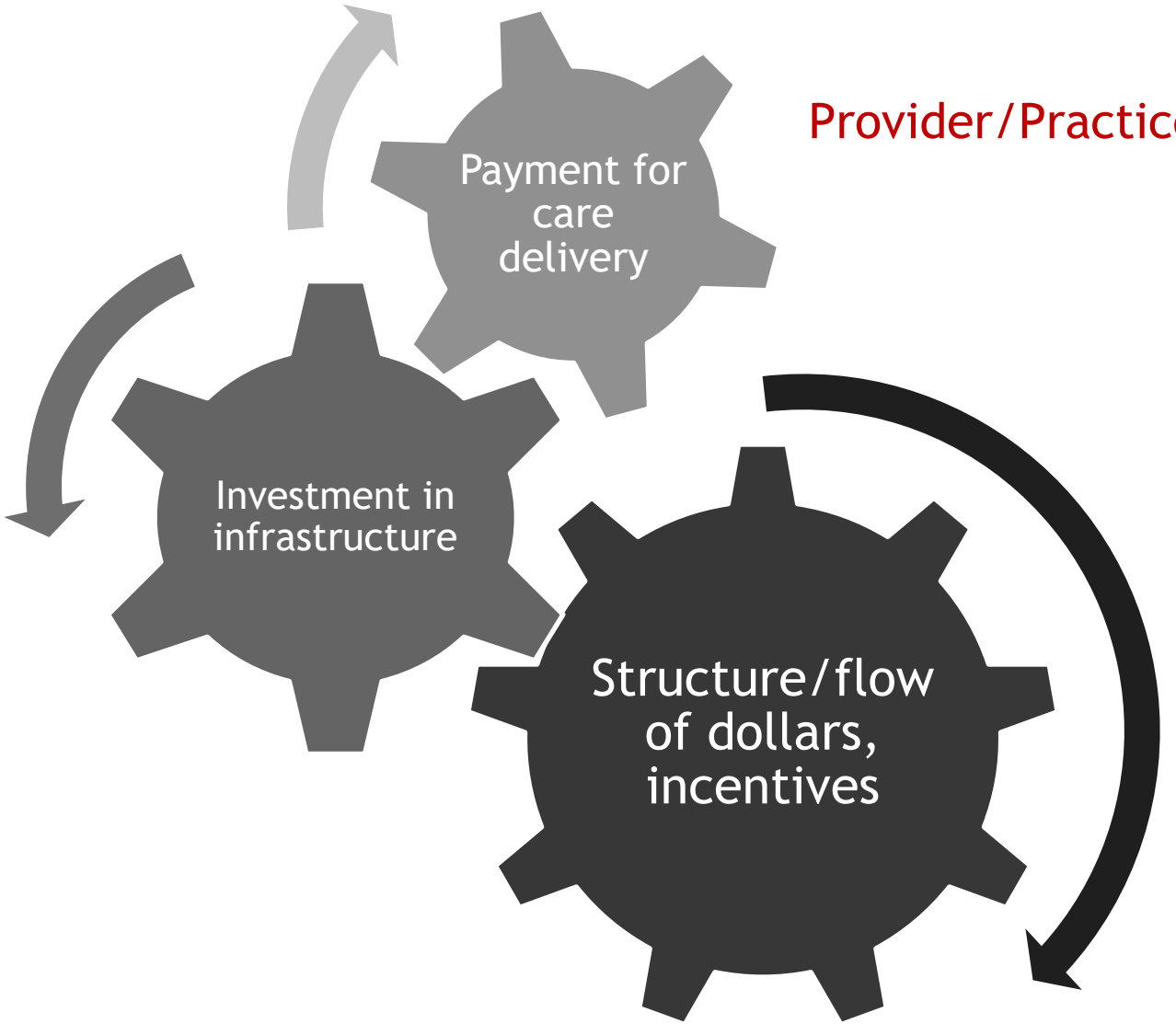

https://www.youtube.com/watch?v=9jNXh-ysnws

- Rachel M. Werner, MD, PhD, *Moderator*
- Atul Gupta, PhD
- Sabrina T. Howell, PhD
- Ryan McDevitt, PhD
- Brian Powers, MD, MBA


https://www.youtube.com/watch?v=UhxcwIS8rUQ

- Dean Ashish K. Jha, Brown University
- Professor Andy Ryan, Brown University, *Moderator*
- Chris Whaley, Associate Professor of Health Services, Policy and Practice, Brown University
- Yashaswini Singh, Assistant Professor of Health Services, Policy and Practice, Brown University
- Cory King, RI Health Insurance Commissioner
- Erin Fuse Brown, Catherine C. Henson Professor of Law; Director Center for Law, Health & Society, Georgia State University College of Law

# Flow of Health Care Dollars




Provider/Practice Reimbursement

System-level investments in workforce, broadband, interoperability

U.S. health care system
- $4.3 Trillion
- ~20% of GDP

Consolidation, venture capital, private equity

# Policy Challenges – Social and Health

- As health care spending continues to rise, what are we crowding out?
  - Trade-offs: education, social services, infrastructure
- Expensive, fragmented, and unequal health care system in U.S.
  - Invites predatory behavior from actors looking to exploit opportunities

➢ Private equity a symptom, not the cause

✓ Policy levers to close loopholes/opportunities & mitigate harms to:

**System/Consolidation** | **Workforce/Providers** | **Patients/Tax payers**

# Financialization of Health

- **Corporatization**: the increasing role of large organizations that leverage market power to maximize profits
  - Consequence of horizontal and vertical integration
- **Privatization**: the ownership status of firms and describes the growing role of private-sector actors in the provision of health care resources, such as the rising prominence of private insurance companies in the Medicare program under Medicare Advantage
- **Financialization**: the growing influence of financial markets, motives, institutions, and elites in our economy and society
  - Encompasses the expanding influence of financial actors — including commercial and investment banks, private equity (PE) firms, venture capital firms, and other types of investors — and a shift in the business of non-finance related entities away from trade and commodity production toward new financial channels and maneuvers

# 3 Waves of Consolidation in Health Care

- 1995 – 2000: Hospital merger boom
  - Hospitals acquiring each other, creating mega-systems
  - Emergence of anti-competitive markets across U.S.
- Starting in ~2000: Vertical integration
  - Hospital systems acquiring physician practices and other health care providers; increase market dominance and presence
- In last 5 years: Expanding influence of financial actors
  - Private equity, venture capital, commercial and investment banks

Deregulation

"Shareholder Primacy"

Hospital investment arms

Share buy-backs

Public financing

# Private Equity 101 – Physician Practices

- PE investments totaled around $5 billion in 2000, and $100 billion in 2018
- Over last decade, totaled around $1 trillion with over 8,000 facility investments

**Acquire target "platform practice"**

- PE funds acquire capital from institutional investors ("limited partners"- university endowments, pension funds, high net worth individuals); combine with large amounts of debt (up to 60-90%), use to acquire majority, controlling stake

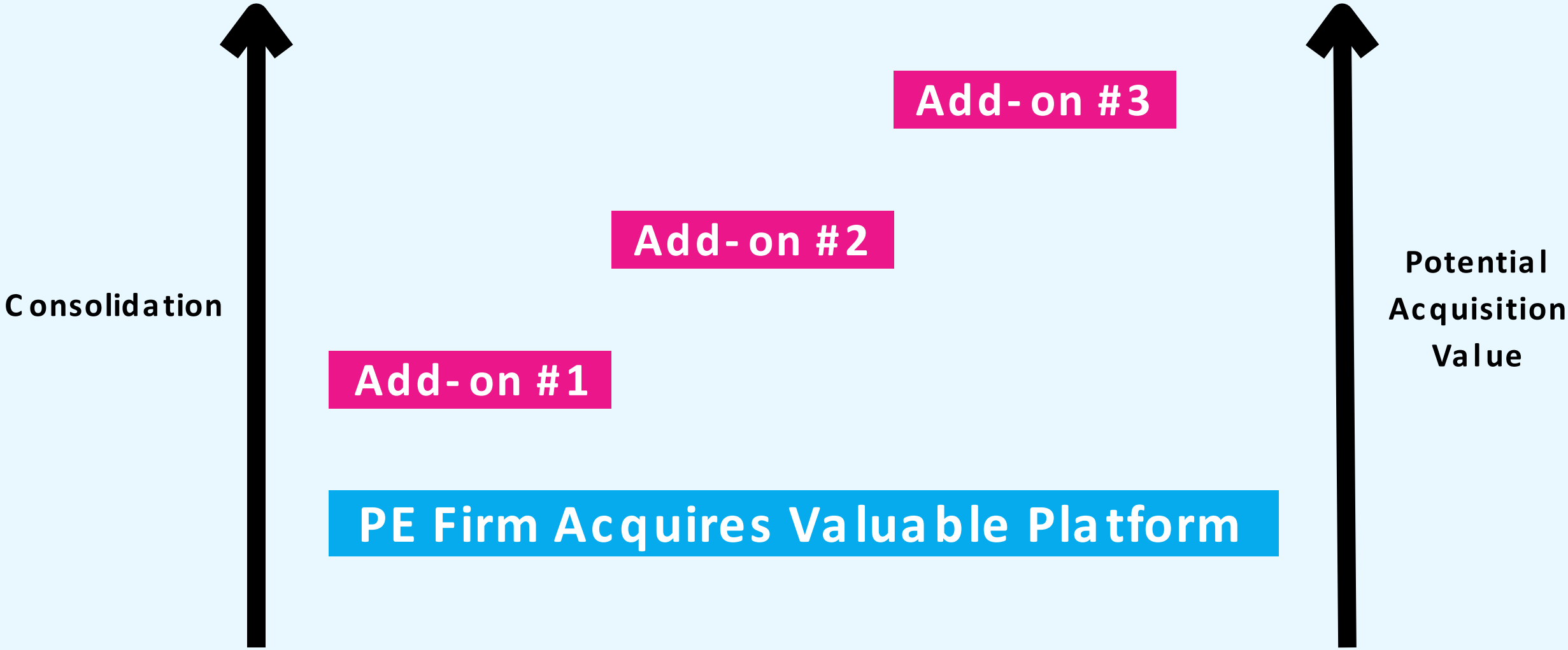
**Expand market share using "add on" strategy**

- After initial acquisition, add series of smaller physician practices ("roll up" or "buy and build" strategy; creates economies of scale and increases negotiating power

**Divest asset to make profit**

- Typical exit window is 5-7 years, exit necessary for pay-off; often expect upwards of 20% annual return on investment; profits go to investors, not to practice/providers or patients

# Platform and Add-on Model



# Private Equity vs Venture Capital

- Private equity distinguished by
  - Target established practice/firm and grow to full potential
  - Use of financial engineering and highly leveraged loans to structure acquisitions, gain controlling interest
  - Short investment time period
  - Do not seek or want longer-term ties to the practices they acquire; less reputational concern
- Venture capital
  - Target new, high-risk, high-innovation ventures
  - May go after minority share rather than controlling interest
  - Longer-term time frame

# Why health care? Why now?

## DEMAND SIDE:

- Practice of medicine increasingly complex
- Simplify regulatory compliance, value-based contracting
- Provide administrative back-end functions and supports

## SUPPLY SIDE:

- Historically low interest rates; debt a cheaper vehicle to finance acquisitions
- Historically low anti-trust scrutiny of acquisitions
- Both have led to “stealth consolidation”

- Initial wave of PE started with acquisitions in hospital-based specialties (emergency medicine, anesthesiology, radiology)
- In last 5-7 years, shift to procedural specialties (dermatology, ophthalmology, GI)
- More recently shift to primary care and behavioral health

Private Equity-Acquired Physician Practices and Market Penetration Increased Substantially, 2012-21 – Health Affairs March 2024

- PE-acquired physician practice sites increased from 816 across 119 MSAs in 2012 to 5,779 across 307 MSAs in 2021
- Single PE firms had significant market share, exceeding 30 percent in 108 MSA specialty markets and exceeding 50 percent in 50 of those markets
- Among PE-acquired practice sites, 1,440 (24.9 percent) had primary care physicians (internal medicine pediatrics, or family medicine), followed by dermatologists in 827 practice sites (14.3 percent), obstetrician-gynecologists in 798 practice sites (13.8 percent), and gastroenterologists in 697 practice sites (12.1 percent

**Metropolitan Statistical Area (MSA)-level private equity (PE) market share of physician practices among 10 physician specialties, 2021**

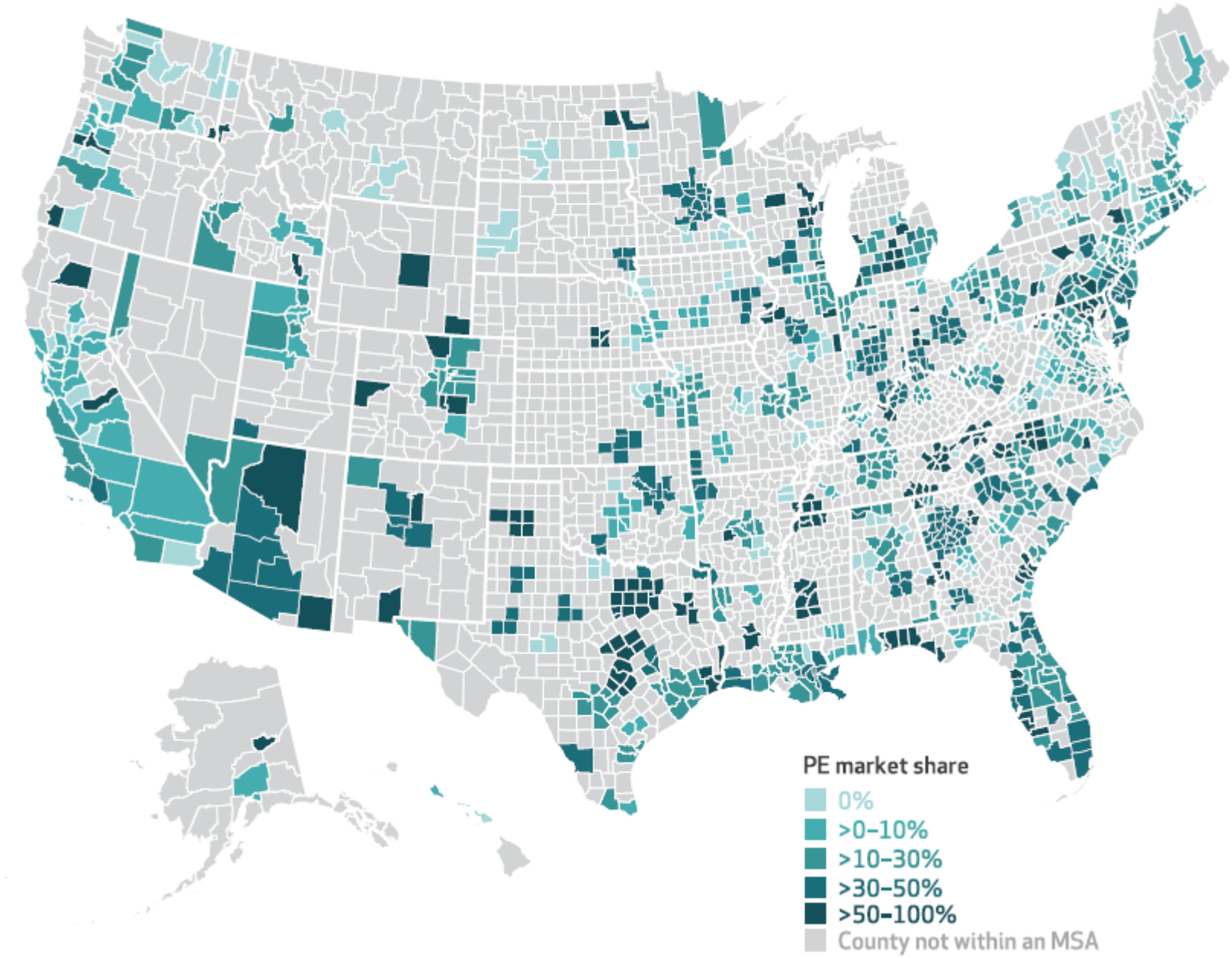
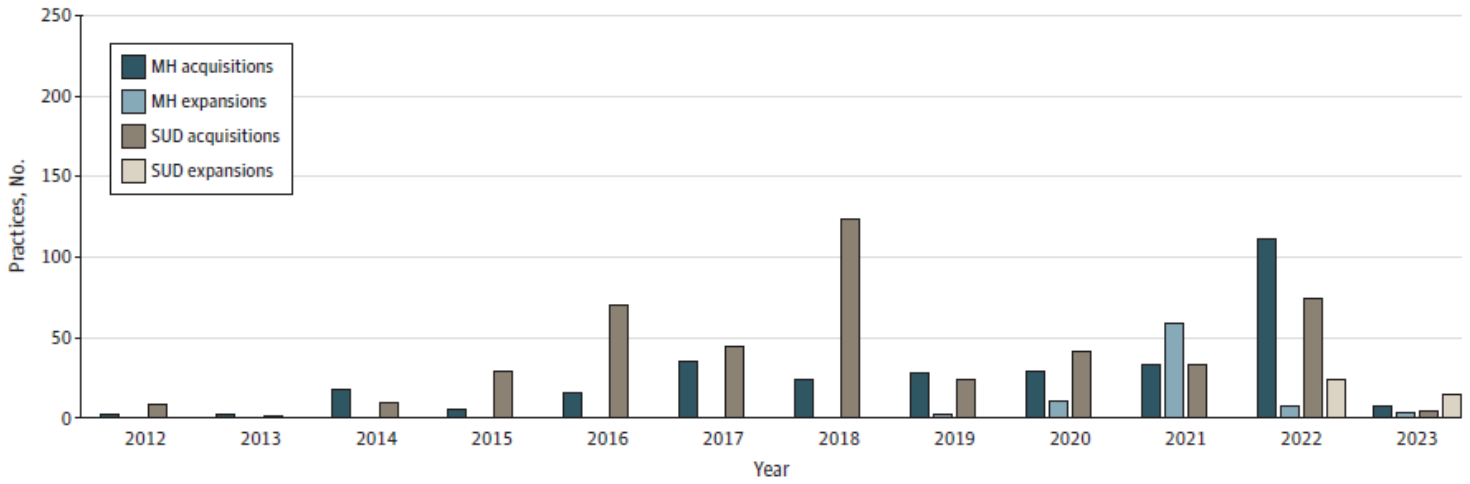


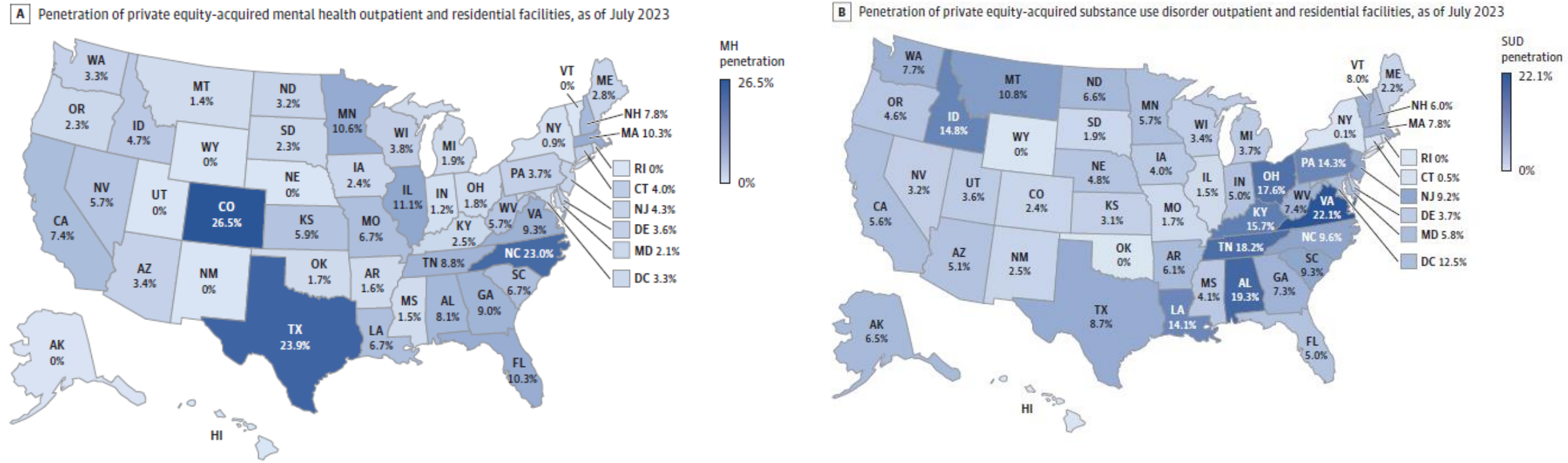
Figure 1. Counts of Private Equity–Owned Behavioral Health Practices in the US, January 2012 to July 2023




Geographic Penetration of Private Equity Ownership in Outpatient and Residential Behavioral Health – JAMA Psychiatry May 2024

- Cumulatively, PE-owned mental health practices constituted 6.2% of all mental health facilities (652 of 10324) and 7.1% of all SUD facilities (1152 of 16 174) nationally
- Private equity–owned mental health facilities were most prevalent in CO (40 of 151 [26.5%]), TX (74 of 309 [23.9%]), and NC (56 of 244 [23.0%])

Figure 2. Penetration of Private Equity–Acquired Facilities



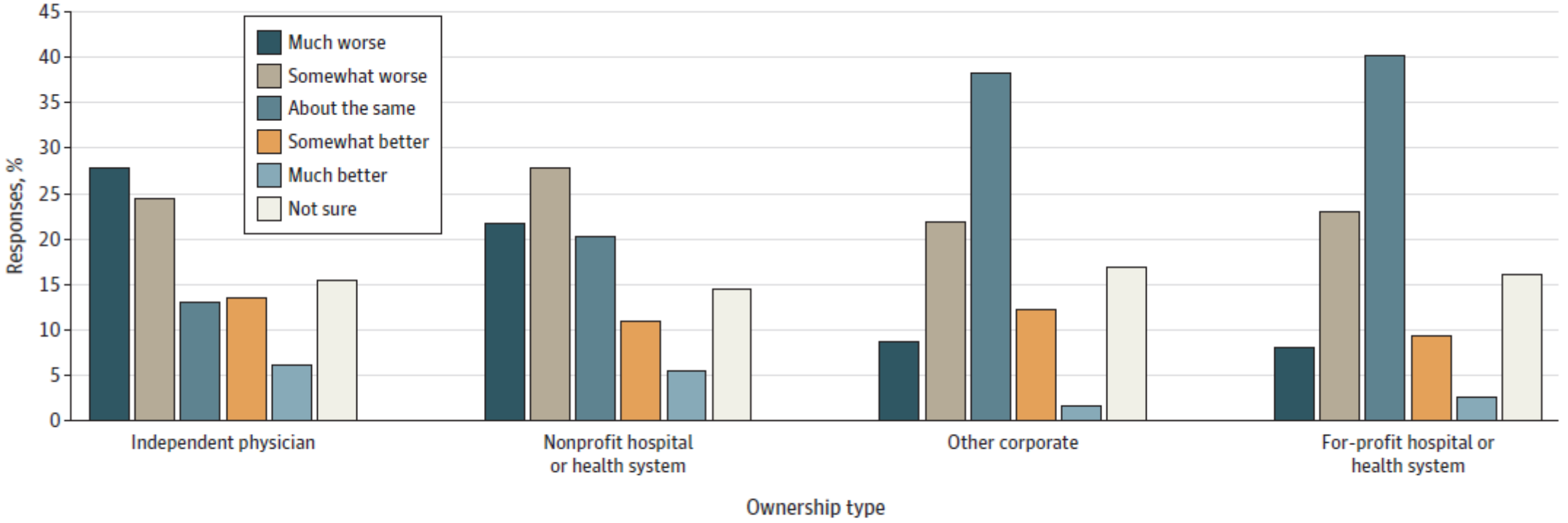
# HARMS

- Systemic
  - Financialization of health care market – “value shifting”
  - Consolidation – acceleration thought PE
  - Increased costs; utilization impacts; access
- Workforce
  - Shifting staffing patterns
  - Physician burnout – moral crisis
  - Loss of autonomy
- Patient care
  - Health outcomes
  - Costs – increased cost-sharing, premium impacts, wage stagnation

| | Impacts | | | |
|---|---|---|---|---|
| | Health outcomes | Costs to patients or payers | Costs to operator | Quality |
| Borsa and Bruch 2022[36] | Neutral | | | Neutral |
| Bos and Harrington 2017[37] | | | | Harmful |
| Bos et al 2020[38] | | | | Harmful |
| Braun et al 2021[39] | | Harmful | | |
| Braun et al 2021[60] | Harmful | Harmful | | Neutral |
| Braun et al 2020[40] | Harmful | | | Mixed |
| Broms et al 2023[61] | | | | Harmful |
| Bruch et al 2023[62] | | | | Harmful |
| Bruch et al 2022[63] | Neutral | Neutral | | |
| Bruch et al 2021[41] | | Neutral | | Harmful |
| Bruch et al 2020[42] | | Harmful | | Beneficial |
| Cerullo et al 2022[43] | | | Beneficial | Harmful |
| Cerullo et al 2022[44] | Beneficial | Neutral | | Neutral |
| Cerullo et al 2021[45] | | | | Mixed |
| Creadore et al 2021[46] | | | | Beneficial |
| Gandhi et al 2020[22] | | | | Mixed |
| Gandhi et al 2020[47] | Beneficial | | | Beneficial |
| Gupta et al 2021[48] | Harmful | Harmful | Harmful | Harmful |
| Harrington et al 2012[49] | | | | Harmful |
| Huang and Bowblis 2019[50] | | | | Mixed |
| La Forgia et al 2022[51] | | Harmful | | |
| La France et al 2021[52] | | | | Harmful |
| Liu 2021[53] | Neutral | Harmful | Beneficial | Mixed |
| Nie et al 2022[66] | | Harmful | | Harmful |
| Nie et al 2022[54] | | | | Mixed |
| Offodile et al 2021[55] | | Harmful | Beneficial | Harmful |
| Patwardhan et al 2022[64] | | | | Harmful |
| Pradhan et al 2014[56] | | | | Mixed |
| Pradhan et al 2013[57] | | | Harmful | |
| Singh et al 2022[65] | | Harmful | | |
| Stevenson and Grabowski 2008[58] | | | | Mixed |
| Winblad et al 2017[59] | | | | Mixed |

# HARMS

**Figure 1. Favorability of Private Equity Ownership Compared With Other Types of Ownership**

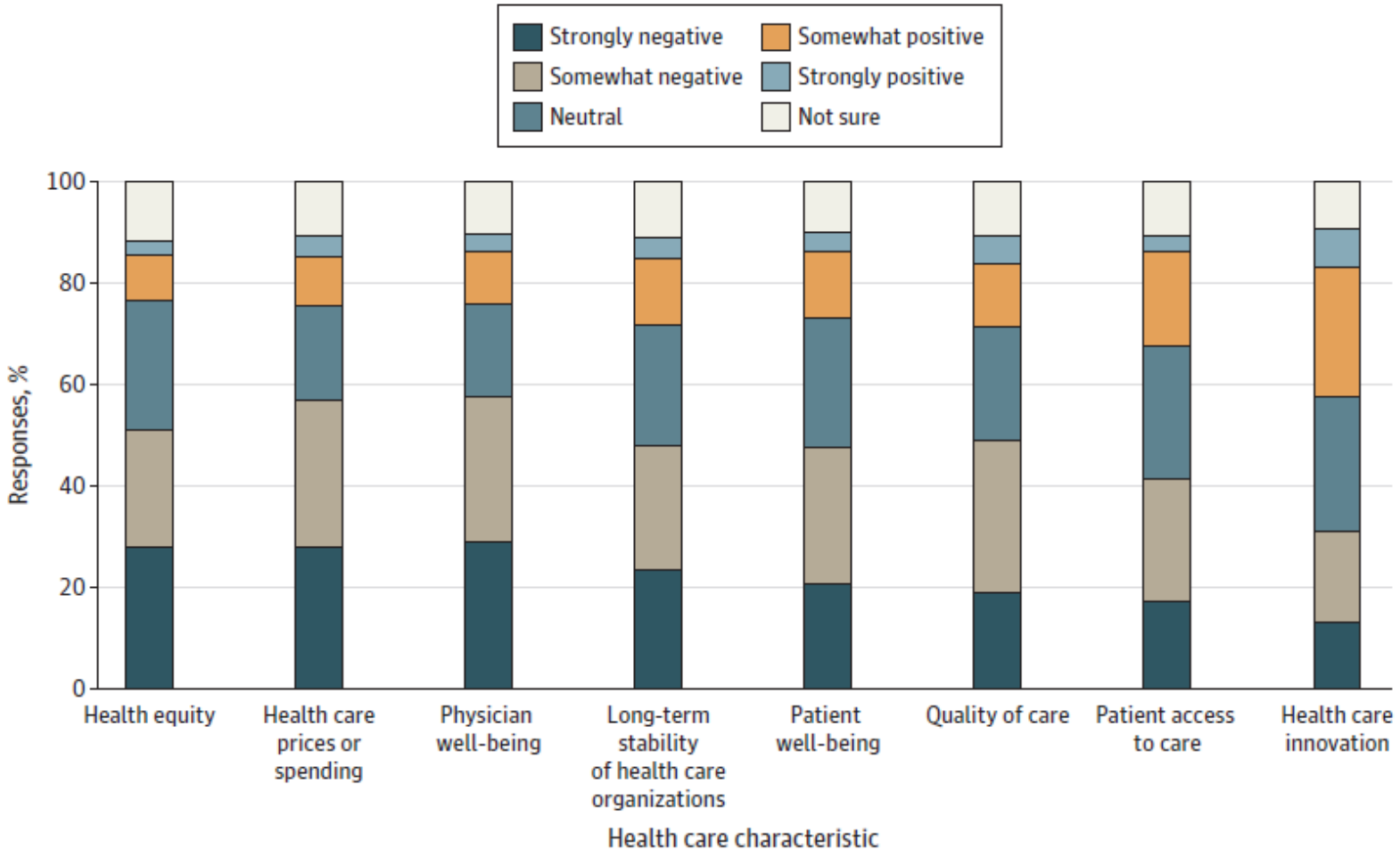



Data are from a survey of 525 actively practicing MD or DO physicians using the American College of Physicians Internal Medicine Insider Research Panel. Shown are responses to the question, "Compared to the following forms of ownership, is private equity ownership much worse, somewhat worse, about the same, somewhat better, or much better than [ownership type]."

Physician Perspectives on Private Equity Investment in Health Care – JAMA Internal Medicine May 2025

# HARMS

**Figure 2. Perspectives of Private Equity's Effects on Various Health Care Dimensions**




Data are from a survey of 525 actively practicing MD or DO physicians using the American College of Physicians Internal Medicine Insider Research Panel. Shown are responses to the question, "What is your opinion of the effect of private equity involvement in the health care sector on [aspect of health care]."

Physician Perspectives on Private Equity Investment in Health Care – JAMA Internal Medicine May 2025

# Policy Levers

## FEDERAL:

- Antitrust laws
- Fraud and abuse laws
- Payment policies – Medicare, Medicaid, VA, etc.

## STATE:

- Antitrust laws
- Fraud and abuse laws
- Ability to regulate practice of medicine
  - Corporate practice of medicine
  - Physician non-competes
- Regulatory touch points
  - Acquisition (upstream)
  - Divestment (downstream impacts)

**Federal Trade Commission v. U.S. Anesthesia Partners, Inc. et al.**

# Discussion Questions

- How have you seen financialization/private equity playing out in Colorado?
  - Impacts on your practice/community?
  - Impacts on your network(s)?
  - Impacts on patients?
- What are the key implications for primary care and the work of the Collaborative?
  - Payment or other policy levers that you would elevate?
  - Other strategies, considerations
  - Resource allocation
- Specific questions for: federal partners,  other states, payers?

# Upcoming Meetings

# Draft Schedule

**APRIL**

Equity in APMs

**MAY**

Impact of venture capital, private equity, consolidation, integration on PC

Market Dynamics

**JUNE**

Flow of primary care dollars within/outside of "systems" (e.g., ACOs, FQHCs, IDS); rural, independent providers

**JULY**

Current state of PC investment (CO, other states, national)

PC Investment

**AUG**

Investment strategies- payment (APMS), infrastructure, team-based care, care coordination (HRSN)

**SEPT**

* * Review APM Parameters * *

Measurement, scorecard, communications

**OCT**

Identify recommendations

**NOV**

CIVHC Report/ Recommendations

**DEC**

Draft Recommendations

* * * DRAFT Proposal * * *

# Public Comment

COLORADO

# Thank you!!