



State Policies to Address Vertical Consolidation in Health Care

By Erin C. Fuse Brown*

Independent physician practices are struggling to remain financially solvent in the midst of the COVID-19 pandemic. Although \$175 billion has been allocated to health care providers in the Coronavirus Aid, Relief, and Economic Security (CARES) Act and other pandemic response legislation,¹ this funding has largely gone to larger hospital systems or to direct costs of COVID-19 testing and services, and many physician practices and independent community providers have suffered significant reductions in their patient visits and revenues during widespread stay-at-home orders.² One foreseeable consequence will be a further acceleration of physician practice acquisitions by large hospital systems and private equity firms, also known as vertical consolidation in health care.

This white paper discusses the increased financial pressure for vertical health care consolidation in the wake of the COVID-19 pandemic; the risks such vertical consolidation pose to states and consumers in the form of higher prices, increased spending, and reduced choice; and explores policies states may pursue to address the coming wave of vertical health care consolidation.

I. Rising Pressure for Vertical Health Care Consolidation and Its Risks

A. Vertical Consolidation in Health Care is Accelerating

Consolidation of independent physician practices — whether acquired by health systems or venture-backed staffing firms — has been increasing for years. Vertical acquisitions of physician groups by hospitals has increased dramatically in recent years. From 2012-2018, hospital ownership of physician practices grew 128 percent. In 2012 about 25 percent of physicians were employed by hospitals, and by 2018 that figure had grown to 44 percent.³ Over the 18-months from July 2016 to December 2018, hospitals acquired over 8,000 physician practices, employing 14,000 physicians.⁴ In 2018, for the first time, more physicians were employees than owners of their medical practice.⁵

Private equity-backed staffing firms are also gobbling up physician practices. Between 2013 and 2016, private equity firms acquired 355 physician practices, targeting an array of specialties including emergency medicine and anesthesiology (who can engage in out-of-network billing strategies because patients do not select these providers), primary care physicians (who may be

sources of lucrative referrals), and dermatology and ophthalmology (with significant income from elective procedures).⁶

Layered atop these existing trends, the COVID-19 pandemic is accelerating pressure for vertical consolidation in health care. Remaining independent physician practices are under dire financial strain due to COVID-19, and even those who previously resisted acquisition face new pressure to sell to large health care systems or private equity investors for financial stability and survival.⁷

B. Risks of Vertical Consolidation: Increased Costs, Loss of Choice, No Improvement in Quality

Evidence suggests that vertical health care consolidation leads to higher health care prices—including higher hospital prices, 14 percent higher physician prices, and 10-20 percent higher total expenditures per patient.⁸ Despite promised efficiencies, there are several ways vertical consolidation can increase health care costs. First are the addition of facility fees (described further below) that hospitals can charge for outpatient services provided by acquired physicians. Second, the consolidated entity can leverage its market power to engage in all-of-nothing bargaining and insist on anticompetitive contract terms with health insurance plans, allowing a large system to demand higher prices for all its providers. Third, acquisitions allow hospital systems to direct the referrals of captive physician practices to a greater extent than independent physicians, which increases referrals to for higher-cost (lower value) providers and services. Finally, private equity-backed staffing companies have used a strategy of going out-of-network and charging higher prices to health plans and balance bills to patients to maximize their revenues.

Increasing facility fees are an outgrowth of vertical consolidation of hospitals and physicians. The ability of a consolidated system to charge more for identical outpatient services than can be charged by independent physician practices manifests as facility fees and is a significant factor in the price increases driven by hospital-physician consolidation.⁹ When hospitals acquire physician practices, they can tack on an additional outpatient facility fee to the professional service fee that physician practice previously charged. Fees for services at physician's offices usually include both the professional and overhead costs of the service in a single charge. By contrast, hospital outpatient departments are traditionally paid more than physicians' offices for performing the same type of service because hospital outpatient settings receive a facility fee to compensate them for the expenses of maintaining standby capacity to service acute care needs that may present at any time in addition to the physician's professional service fee.¹⁰ But there is nothing to justify a facility fee that is simply the result of the hospital's acquisition of the physician's practice—nothing has changed in terms of the location, supplies, technology, staffing, duration or intensity of the care, and the patients are no sicker and do not need more services than when their physician practice was characterized as a freestanding community setting.¹¹ The higher price is merely the result of a change in corporate ownership, which allows

the hospital to charge a facility fee for the acquired physician’s services as though it were rendered in an outpatient department of the hospital. The ability to charge facility fees is one of the main financial incentives driving hospital-physician consolidation.

Increased vertical consolidation in health care reduces consumer choice by creating larger, exclusive networks and driving patients and health plans to pay higher prices. These higher costs and reductions in choice among independent providers is not offset by higher quality or efficiency from improved care coordination. Thus, states are increasingly searching for ways to curb the rising costs and loss of choices driven by vertical health care consolidation.

II. State Policies to Address Vertical Consolidation in Health Care

The pressure for vertical consolidation created by the COVID-19 pandemic for the survival of physician practices means that, in many cases, states will be unable to prevent this consolidation from occurring. Rather, states must explore policies to provide robust oversight over the consolidated entities to mitigate the risks posed by vertical consolidation. Moreover, state oversight is critical because these vertical mergers fly under the radar of federal antitrust agencies because they tend to be too small in size to be reported under the Hart-Scott-Rodino (HSR) Act.¹²

The following table lists a range of policy tools states can deploy to monitor and oversee vertical health care consolidation:

Policy Approach	Tools
A. Data gathering	<ul style="list-style-type: none"> • All-payer claims databases
B. Pre-transaction review and approval	<ul style="list-style-type: none"> • Notice of proposed transactions • Prior review, approval, and conditions
C. Oversight of vertically consolidated entities	<ul style="list-style-type: none"> • Attorney general enforcement against anticompetitive conduct • Independent health commission • Certificates of need authority
D. Controlling outpatient costs	<ul style="list-style-type: none"> • Restrictions on facility fees • Counteracting private equity-backed consolidation • Global budgets

A. Data: the foundation for any policy

Policymakers need information about the drivers of health care costs, utilization patterns, and transactions to guide policies and target enforcement. States with all-payer claims databases (APCDs) have a rich source of data to inform their policies. APCDs are comprehensive

databases of health care claims and data from a variety of payers, including private insurers, Medicaid, Medicare, Children’s Health Insurance Program (CHIP), state employee health plans, and others.¹³ Currently 19 states have established APCDs, and an additional four states are in the process implementation.¹⁴

All of the policies described here would be guided by data — whether studying the price, utilization, or referral effects of vertical transactions; detecting targets for enforcement; providing oversight of vertically integrated entities; planning and assessing the need for new or additional services; quantifying the amount of facility fees charged; enforcing compliance with surprise out-of-network billing rules; or implementing global budgets. In states with APCDs, the data underpinning the policies would come from the APCD. In states without an APCD, each policy described here could include a data reporting requirement to facilitate implementation, such as a data submission requirement for pre-transaction review, CON applications, facility fee reporting, or as part of the global budget process. In addition, states can use data from APCDs or work with payers (e.g., the state employee health plan) to establish consumer transparency tools to help consumers choose high-value providers and to drive a range of other health care policies to improve patient care and control costs.¹⁵

Recommendation on APCDs

- A state cannot understand or respond to what is going on in the health care market without detailed price, utilization, and ownership data, so the first step would be to establish or connect with a state APCD to determine high-impact policy priorities.
- For states without an APCD, it could require data reporting from health care entities as a component of any of the policies described below.

B. Notice, review, and approval for health care transactions

States could take a more active role monitoring or preventing vertical health care consolidation that poses risks to competition. State attorneys general (AGs), the Federal Trade Commission, and the US Department of Justice can use their parallel antitrust enforcement authority to prevent and regulate anticompetitive mergers or conduct by health care entities.

State AGs can challenge anticompetitive mergers and conduct and bring enforcement actions both independently and in conjunction with a federal action.¹⁶ Although historically reluctant to pursue enforcement against vertical mergers, the federal antitrust enforcement agencies have recently issued draft vertical merger guidelines in a signal that they are looking to develop tools to go after such mergers.¹⁷ But most physician acquisitions go unexamined by federal authorities because the dollar value of these deals is too small to be reported to federal antitrust agencies under HSR thresholds.¹⁸ Thus, state AGs can assume a larger role policing these mergers.¹⁹

1. Notice of proposed transactions

To further antitrust enforcement and state oversight over vertical health care transactions, states may pass legislation requiring hospitals, health systems, physician groups, and private investment firms to notify the state of any significant proposed merger or contractual affiliation. Specifically, states can require reporting of transactions with dollar values less than the federal HSR thresholds. Transactions should be reported to the state AG and to a state health agency, such as an independent health care commission or the state's certificate of need authority.²⁰

Although many states already require hospitals to notify state officials of proposed mergers or acquisitions, states could expand the requirement to transactions involving physicians. Existing state examples include Washington State, which passed a law in 2019 to require notification to the state AG of health care transactions, including those involving “provider organizations,” below the HSR (Hart-Scott-Rodino Antitrust Improvements Act) threshold.²¹ Connecticut requires 30-days’ notice to the AG and the head of the Office of Health Strategy (Connecticut’s CON authority) of any proposed transaction involving a physician practice of eight or more physicians.²² Massachusetts requires all provider organizations to provide the AG, the Health Policy Commission, and the Center for Health Information Analysis with 60 days’ notice of any mergers, acquisitions, or affiliations.²³

In 2020, lawmakers in California proposed legislation (S.B. 977) that would require health systems, private equity groups, and hedge funds to provide notice to, and obtain the consent of, the AG prior to an acquisition of or affiliation with a health system or health care provider.²⁴ There is an exception for transactions between health care systems and facilities or providers valued at less than \$500,000 (but not those involving private equity groups or hedge funds) or a transaction of any value involving an academic medical center, which only need to provide 30 days’ notice and need not obtain the AG’s consent.²⁵ The California bill goes beyond the notice requirements in other states by specifically including transactions involving private equity and hedge fund investors, not just other health care entities.

Recommendations on notice of health care transactions:

- To address all forms of health care consolidation, state policymakers could require state regulators be notified of a broad array of health care transactions, involving all types of providers, facilities, and private investment funds and a broad scope of transactional structures, including mergers, acquisitions, affiliations, and changes of voting control.
- To enable pre-transaction review and ongoing oversight, state policymakers could require parties to notify the multiple state officials of the transaction, including the state AG and a state health agency or independent commission.

2. Pre-transaction review, approval, and conditions

Although state AGs already possess the authority to challenge anticompetitive mergers under federal and state antitrust laws, state policymakers can augment the AGs' ability to address the risks of consolidation by requiring transactions to be *reviewed* and *approved* by the AG, and allow the AG to *condition* approval on the parties' competitive conduct.²⁶ Although a state AG is typically the primary official tasked with approving health care transactions, states can distribute the responsibility for conducting review to other state entities, such as a health care commission or state certificate of need authority.

Waiting periods, subpoena-power. After notice of proposed health care transactions has been given, state regulators require time and the ability to gather information to review the transaction and assess its market impact. Thus, legislation should also include mandatory waiting periods to enable pre-transaction review and the authority to subpoena and obtain economic, market, and competitive information about the proposed transaction.²⁷

Review criteria. To guide review, policymakers may specify statutory review criteria to assess health care transactions, such as the extent the transaction will (1) harm health care markets and competition; (2) increase prices; (3) reduce access to health care services; (4) violate fiduciary duty requirements, especially through self-dealing or conflicts of interest; or (5) harm the public interest.²⁸ Additional review criteria can be applied to specific types of transactions, such as those involving physicians, nonprofit hospitals, or for-profit entities.

Independent review. For transactions that raise competitive concerns, the state officials (AG or health agency) may seek independent review of the transaction either by a designated state body, such as a health care commission, or independent consultants.²⁹ Independent review can provide more in-depth analysis to aid state AGs or agencies' assessment of proposed health care transactions. State policymakers could require the parties to the transaction to pay for independent review to relieve the state of the financial burden of conducting complex market analyses.³⁰

Conditions. Legislative authority to review and approve health care transactions should also allow the AG to impose conditions of approval on the parties to the transaction. The range of conditions should respond to the criteria for approval and specific market concerns. For example, conditions could include requirements to keep critical facilities or services open, mandated community health investments, prohibitions on future acquisitions or employment of physicians, divestiture of entities or providers to preserve competition, rate controls, refraining from charging facility fees for acquired physician practices, or prohibitions on anti-competitive health plan contracting. Even without statutory authority to impose conditions of approval on transactions, state AGs can negotiate consent decrees to settle their claims challenging anticompetitive transactions. One benefit of a statutory approval authority is that, unlike consent decrees, the AG or other state official need not go to court to enforce the conditions of approval.³¹

Post-transactions monitoring. One of the conditions the AG can impose on approving a transaction is that the parties pay for an independent monitor to provide periodic post-transaction

reports to the AG and state agencies.³² The monitor tracks compliance and market effects of the transaction. If the reports identify areas of noncompliance or potential abuses of market power, the state AG can bring enforcement action and seek penalties.

Recommendations for pre-transaction review, approval, and conditions:

- **Review:** Transactions that risk significant impacts on the health care market could undergo an in-depth cost and market impact review by an independent health policy commission, the state CON authority, or independent consultants. Policymakers could establish specific criteria for review, such as the impact on healthcare markets, prices, quality, and access.
- **Approval:** Policymakers should require approval by the state AG and/or health care agency for a broad range of health care transactions, including significant transactions involving physicians or groups of physicians.
- **Conditions:** Policymakers should enable state AGs and state agencies to condition approvals on specified terms and negotiate consent decrees to mitigate potential harms to markets and the public from the transaction, and require the parties to engage an independent monitor to track compliance.

C. Oversight of consolidated entities

Although pre-transaction review is a critical tool, more than 90 percent of health care provider markets are already highly concentrated, so states require mechanisms to regulate anticompetitive behavior by entities that already possess market power.³³ Different state authorities can play a role in overseeing vertically consolidated health care entities, including the state AG, an independent health policy commission, and the state’s certificate of need (CON) authority.

1. AG enforcement against anticompetitive conduct

State AGs possess broad powers under federal and state antitrust laws to challenge anticompetitive behavior of entities with market power.³⁴ And unlike federal antitrust authorities, state AGs have authority over nonprofit entities.

Vertically consolidated health care entities may engage in a range of anticompetitive conduct, including using their market power to raise prices and exclude rivals, engaging in all-or-nothing bargaining with health plans to demand higher prices for all affiliated providers, and including anticompetitive terms in their contracts with health plans, such as anti-tiering or anti-steering, gag clauses preventing plans from sharing price information with consumers, or “most favored nation” provisions.³⁵

State AGs have successfully challenged anticompetitive conduct in North Carolina, California, and Washington. North Carolina's AG joined the DOJ in a case against Atrium Health, a dominant health system, to challenge its use of anti-steering clauses in health plan contracts, which prevented private health plans from using financial incentives for patients to choose higher-value and lower cost providers.³⁶ In its settlement of the case, Atrium agreed to stop using anti-steering clauses and preventing health plans from sharing costs with patients.³⁷

California AG, Xavier Becerra, brought a case against health care giant Sutter Health, alleging Sutter used its market power to raise prices in the region through its use of anticompetitive contract terms, including all-or-nothing and anti-steering clauses, the use of gag-clauses to prevent disclosure of price and quality information.³⁸ In late 2019, Sutter tentatively agreed to pay \$575 million to settle the case, to stop using all-or-nothing contracting, and to cap out-of-network rates. In June, however, Sutter asked the court to delay approving the settlement, citing losses from the COVID-19 pandemic, despite having received some \$200 million in federal relief funding.³⁹ Final court approval of the settlement is still pending.

On the heels of the AG's action against Sutter, the California legislature sought to expand the AG's authority to police anticompetitive conduct by health care entities in S.B. 977. The bill would make it unlawful for a health systems with substantial market power in any market for hospital or non-hospital services to take any action that would have a substantial tendency to cause anticompetitive effects, such as raising prices, diminishing quality, reducing choice or access with respect to hospital or nonhospital (e.g., physician services).⁴⁰ Specifically, conduct involving tying or exclusive dealing by a health system with market power would be presumptively illegal.

In a case focusing on vertical consolidation, Washington's Attorney General Bob Ferguson sued to unwind two hospital-physician transactions by CHI Franciscan health system that drove up prices on the Kitsap peninsula.⁴¹ The complaint alleged Franciscan violated Section 1 of the Sherman Act, Section 7 of the Clayton Act, and the State's Consumer Protection Act.⁴² The parties agreed to settle the case in a consent decree in which Franciscan agreed to pay \$2.5 million, divest of a surgery center, notify the state AG of future transactions, and agree to contractual changes, including a bar on using all-or-nothing bargaining with health plans.⁴³

In each case, the state AG was able to use enforcement authority to stop anticompetitive conduct by health care providers and enter settlement agreements that prevented the consolidated entities from continuing to abuse their market power. Though settlements included conduct remedies and even monetary relief, they meant the cases did not go to trial and establish legal precedent for future enforcement actions.⁴⁴ These cases are resource-intensive and politically charged, but they can challenge abuses of market power by consolidated entities and send a message of deterrence against other powerful providers. State legislatures can aid enforcement by outlawing

anticompetitive contracting practices, such as all-or-nothing bargaining, anti-tiering or anti-steering clauses, most-favored nation provisions, and gag clauses. In addition, statutes can augment State AGs' enforcement authority by declaring unlawful certain anticompetitive practices by health care entities with market power, such as tying and exclusive dealing.

Recommendations for oversight by State Attorneys General:

- State AGs can use existing authority under federal and state antitrust and consumer protection laws to challenge abuses of market power by vertically consolidated entities, such as price increases, all-or-nothing bargaining, and anticompetitive contract provisions.
- State policymakers can create additional statutory authority to enable State AGs to challenge anticompetitive conduct by health care entities with market power and make certain contracting practices *per se* unlawful.

2. Oversight by independent commission

Several states have established independent health care cost or policy commissions, insulated from political influence, to provide analysis, recommendations, and oversight of health care market consolidation. The following states have statutorily established a health care commission or board to address health care costs: Colorado, Delaware, Maryland, Massachusetts, Oregon, Pennsylvania, Vermont, and Washington.⁴⁵ Connecticut established the Office of Health Strategy to coordinate the state's health care cost containment strategy.⁴⁶ In addition, Rhode Island's Governor and heads of their health and health insurance agencies convened the Health Care Cost Trends Steering Committee through executive action with funding from a private grant.⁴⁷

Market and transaction analysis. States health care commissions provide in-depth data analysis, often using data from the state's APCD, and policy recommendations to the Governor, legislature, and executive branch agencies.⁴⁸ In addition, health care commissions can have a role in reviewing health care transactions, making recommendations to the State AG and providing post-transaction monitoring.⁴⁹ Beyond transaction-specific oversight, health care cost commissions can track health care cost and market trends more broadly across the state.

Health care cost growth benchmarks. Several states have given their health care commissions authority to set and monitor health care cost growth targets. Massachusetts pioneered the approach, which has been replicated in Delaware, Oregon, Rhode Island, Connecticut, and Washington.⁵⁰ Common features include: establishing a statewide cost growth benchmark, analyzing data and calculating spending against the benchmark, reporting on cost drivers, and using hearings, transparency, performance improvement plans to encourage providers to comply with targets.⁵¹ While some have questioned whether these health care cost commissions possess

sufficient authority to enforce compliance with health care cost growth benchmarks, the Massachusetts experience has proven fairly successful at reigning in health spending growth even with limited enforcement tools.⁵² As the model evolves, states may want to enhance the enforcement authority if soft regulatory tools prove inadequate to secure compliance with health care cost growth targets.

Recommendations for oversight by an independent commission:

- Health care cost commissions need *independence* and *information* to be effective. They should be shielded from regulatory capture by actors from the health care industry and political influence, and they should coordinate with the state APCD to obtain the necessary data to identify cost-drivers in the state.
- Health care cost commissions can serve multiple functions to combat health care consolidation: providing market analysis and recommendations for policymakers, assisting with health care transaction review, and setting and enforcing health care cost growth benchmarks, global budgets, or facility fee limits.

3. Oversight by certificate of need (CON) authority

The COVID-19 pandemic has highlighted the importance of health care planning to assure the state's capacity to address public health crises as well as ongoing demand for health services, particularly in rural areas where a sole provider is responsible for the provision of health care services. Although debate continues over the impact of existing CON laws on competition, price, and quality in the health care market, states with CON authorities have the administrative infrastructure to expand CON from a health facility planning function to an overseer of vertically consolidated health care entities. Over a dozen states already require a CON or require notice to CON authorities for the sale or transfer of health care facilities, including nonprofits health care entities.⁵³ Moreover, existing facilities often seek CON approval to add or remove services or seek affiliations. These CON requirements could be extended to vertical transactions involving physician groups and play a larger role in ongoing oversight of vertically consolidated providers.

Connecticut's CON authority, the Health Systems Planning (HSP) office, reviews and requires a CON for all transactions involving a broad range of health care providers, including hospitals and provider groups.⁵⁴ HSP conducts an in-depth cost and market impact review for transactions involving the sale or transfer of a hospitals in transactions of a certain size or involving a for-profit buyer and may place conditions on the approval of a CON for a hospital transaction.⁵⁵

To oversee vertical transactions, a state could extend the authority of the CON officials to require a CON for provider group transactions of a certain size, require some form of market impact

analysis, and authorize the imposition of conditions of approval for the CON. Such conditions could include refraining from charging facility fees, limiting price increases, maintaining key services, avoiding anti-competitive contracting with health plans, limiting physician employment and exclusive contracting, and satisfying quality metrics, and investing in community and population health services. Oversight over compliance with conditions must be robust, long-term, and backed by enforcement authority, including action by the state AG for violations of conditions or anticompetitive conduct.

In many states, however, CON is highly susceptible to political influence by dominant health systems and other powerful stakeholders. Thus, if CON Authorities are given a larger role in overseeing consolidated health care entities, they need to be insulated from capture by incumbent industry leaders and publicly accountable. To engage in robust oversight of health care transactions and entities' ongoing activities, CON authorities require financial, claims, and market data, whether submitted as part of the CON application process or from the state APCD, and have capacity for data analysis.

Recommendations for oversight by a CON authority:

- State policymakers could reform CON to provide oversight over a broad range of health care transactions, including vertical consolidation involving physician groups. Such authority could include requiring a CON for health care transactions involving physician groups, setting conditions upon the issuance of a CON, and enforcement authority (in conjunction with the state AG) to secure compliance with CON requirements.
- To be an effective overseer of health care consolidation for planning and cost-containment, CON should be insulated from political and provider influence, enhance transparency and accountability, and have access to data and enhanced analytic resources for market analysis.

D. Controlling rising costs driven by vertical consolidation

Another set of tools to curb rising costs when vertical consolidation has already occurred include regulations on the outpatient fees themselves. These policies target rising outpatient costs driven by additional facility fees, out-of-network billing by investor-backed physician staffing companies, and changes in referral and utilization patterns.

1. Restrictions on facility fees

The main policy tools available to states to address unwarranted facility fees are transparency and facility fee regulation.

Facility fee transparency. Like all cost-control efforts, transparency is a first step to shine a light on the practice and put patients on notice that they may receive bills for facility fees due to

corporate acquisition. However, transparency alone does not ameliorate the problem of facility fees nor does it shield a patient from incurring a facility fee. Even if they are notified of added facility fees, patients may not know what to do with the information and may be unable (or unwilling) to switch providers based on the notification about facility fees.

Examples of state laws requiring facility fee transparency come from Washington, Connecticut, Minnesota, and Texas. Washington and Minnesota's laws require that, prior to non-emergency care, provider-based clinics that charge a facility fee must notify patients that the clinic is licensed as part of the hospital and the patient may receive a separate charge or billing for the facility component, which may result in a higher out-of-pocket expense; the health care facilities must also prominently post a statement that it is part of a hospital.⁵⁶ Connecticut requires a similar notice and requires providers itemize facility fee charges on bills, disclose Medicare's applicable facility fee rate for comparison, and provide information about the patient's right to request reduction of the facility fee.⁵⁷ Texas law requires that facilities must notify patients that the site charges a facility fee, and the disclosure must include the median facility fee at the facility, the range of possible fees, and the facility fee for each level of care.⁵⁸ To enhance transparency, states may require annual reporting of facility fees charged or billed by health care providers, identified by location (e.g., the physician's office) to be published on a publicly accessible website.

Facility fee regulation. Prohibiting or limiting allowable facility fee charges by providers can eliminate price differences for the same outpatient services based on the location or "site" of service. Medicare has instituted site-neutral payment, based on the view that "if the same service can be safely provided in different settings, a prudent purchaser should not pay more for that service in one setting than another."⁵⁹

States could adopt policies that would limit or prohibit hospitals and health systems from charging facility fees. For the broadest impact, the state could (a) eliminate all facility fees at locations more than 250 yards away from a hospital's main campus (a *site-specific limit*), and (b) eliminate facility fees for outpatient services that do not require additional standby capacity, including evaluation and management (E&M) services, regardless of whether the service is provided on- or off-campus (a *service-specific limit*).⁶⁰

Connecticut prohibits hospitals from charging a facility fee for outpatient office visits at an off-campus, hospital-based facility.⁶¹ But this prohibition only applies to E&M codes used for office visits, not the full range of outpatient services. In addition, Connecticut does not limit facility fees for on-campus outpatient visits. However, states could implement broader site-specific and service-specific facility fee restriction policies that cover the full range of non-emergency outpatient services and apply both on- and off-campus. For uninsured patients, Connecticut requires providers to charge no more than the applicable Medicare rate for outpatient services

received at an off-campus, hospital-based facility, thereby incorporating any Medicare site-neutral payment changes into the amounts charged to uninsured patients.⁶²

Eliminating facility fees for the broad range of outpatient services (including those currently enjoying higher site payments under previously consummated acquisitions) is highly contentious and politically difficult. Connecticut legislators originally planned broader facility fee regulation, but they narrowed the requirement after facing strong opposition from powerful hospital facilities and physician groups in the state.⁶³

Connecticut's law on facility fees also set forth a model for enforcement by making a provider's violations of the facility fee prohibitions an unfair trade practice under the state's Unfair and Deceptive Acts and Practices (UDAP) law.⁶⁴ It is also an unfair trade practice for a provider in Connecticut to report a patient's nonpayment of a prohibited facility fee to a credit reporting agency.⁶⁵ This provides individual patients who have been charged unlawful facility fees or who have not received mandated notices about such fees a private right of action against providers. By contrast, Medicare patients do not have a private right of action if they are improperly charged cost-sharing payments for facility fees. Similarly, states can create an administrative enforcement mechanism for the relevant state agency, such as the Department of Health, to impose administrative penalties for violations of the facility fee policy. Ideally, administrative enforcement would be in addition to private remedies.

Recommendations for restrictions on facility fees:

- For the broadest impact, state policymakers could prohibit (1) *site-specific facility fees* for services rendered at physician practices and clinics located more than 250 yards from a hospital campus; and (2) *service-specific facility fees* for identified outpatient services, such as those billed using E&M codes, even if those services are provided on a hospital campus.
- State restrictions on facility fees should be accompanied by enforcement measures, including an annual facility fee audit by the relevant state agency, a private right of action for consumers, and administrative penalties against health care providers for violations.
- If states cannot regulate facility fees, they can improve facility fee transparency by requiring notice to patients with estimates of facility fees, requiring providers to report the facility fees charged by location, and posting the information on a publicly accessible website.

2. Counteracting private equity-backed consolidation

Although vertical consolidation between hospitals and physicians tends to reduce the opportunities for out-of-network billing (because employed physicians are more likely to participate with all the plans of their parent health system), the opposite is true for consolidation

driven by private equity firms. Surprise medical billing is a key revenue strategy for private equity firms that invest in physician practices where patients are unable to choose their provider, such as emergency physicians or anesthesiologists.⁶⁶ These companies strategically go out-of-network so they can seek higher out-of-network charges from health plans and balance bills from patients, driving up premiums and out-of-pocket bills.

Thus, states can counteract the higher costs driven by private equity investment in health care by enacting comprehensive protections against surprise medical bills. As NASHP and others have tracked, a growing number of states have enacted laws against surprise out-of-network billing, which protect many of the state's consumers and payers from the excess costs from out-of-network bills.⁶⁷

Many of the tools described above — gathering data on pricing and referral trends from an APCD, pre-transaction review, and post-transaction oversight — can include particularized scrutiny for transactions involving private equity or venture-backed investors or staffing companies.⁶⁸ An additional policy idea worth exploring is to shore up states' prohibitions on the corporate practice of medicine to target private investment and control of physician practices by unlicensed corporations.

Recommendations to counteract private equity-backed consolidation:

- State policymakers could enact comprehensive surprise medical billing protections to curtail the use of out-of-network billing as a revenue model by private equity-backed physician groups.
- States should gather data in their APCDs on excess costs driven by private equity investment in health care, and subject these transactions to rigorous pre-merger review, approval, and post-transaction oversight.
- States could explore strengthening their prohibitions on the corporate practice of medicine as applied to physician practices controlled or owned by unlicensed corporations.

3. Global budgets

Three states, Maryland, Vermont, and Pennsylvania, have secured arrangements with the Centers for Medicare & Medicaid Services (CMS) and the Center for Medicare & Medicaid Innovation (CMMI) to establish global budgets for health systems within the state. Although global budgets generally target hospitals, vertical consolidation increases spending for hospitals and physicians and for inpatient and outpatient services. Thus, the global payment model could be a tool to contain rising costs posed by vertical consolidation.

Maryland's global budget model builds on its long-standing all-payer rate setting system, administered by the Health Services Cost Review Commission under a federal waiver allowing higher Medicare payments as part of the system. In 2014, the state moved to an all-payer global budget system for all the acute care hospitals in the state. The state limits per-person hospital spending to a predetermined target growth rate, with a goal on reducing total spending growth and shifting care toward lower-cost settings and primary care.⁶⁹ Although early results of the program were mixed, the effects may be limited in part because the program did not initially include physician payments in the global budgets.⁷⁰ Subsequent refinements are shifting to a total cost of care model that would extend financial incentives beyond hospitals to physicians and other care settings.⁷¹

Vermont's all-payer ACO model involves most of the state's hospitals and payers to collaborate in a statewide accountable care organization.⁷² Vermont's Green Mountain Care Board is responsible for overseeing the ACO, setting benchmarks and budgets, and evaluating performance and cost-trends among the participating providers.⁷³ The Green Mountain Care Board also oversees a hospital budget review process that establishes, publicizes, and enforces hospital budgets as a means of controlling health spending.⁷⁴

Pennsylvania has also launched a global budget demonstration for rural hospitals with the federal CMMI that will transition rural hospitals from fee-for-service to a global budget payment.⁷⁵ While Pennsylvania does not rely on its Health Care Cost Containment Council to administer the global budget program, the cooperating federal and state agencies established an independent body to administer the program, the Rural Health Redesign Center Authority, through legislation in 2019.⁷⁶

Global budgets work best if they unify all the payers to participate in and contribute to the budget for a region's health systems. Thus, these global budget models all involve CMS to include Medicare and Medicaid and the state's biggest payers. In addition, with spending increasingly shifting to outpatient services and driven by physician referral patterns, to effectively control costs, the global budget model must go beyond hospitals to include physicians and outpatient facilities, whether in an ACO or a total-cost-of-care approach. Despite the significant amount of coordination and administrative infrastructure required to implement global budgets, these states have shown that health system budgets may be a way forward in rural and other areas where competition is inadequate and health systems are vulnerable to financial instability.

Recommendations for global budgets:

- Global budgets require approval from CMMI at CMS to include all payers in the model and buy-in from the state’s payers and providers.
- States may wish to start in rural areas where health systems lack competition and financial stability to provide budgetary stability to these regions.
- To address vertical consolidation and control costs global budget models should extend beyond hospitals to include physicians and other outpatient settings, whether in an ACO or total-cost-of-care approach.

III. Conclusion

It is well-established that horizontal hospital consolidation and the concentration of provider market power is leading to uncontrolled increases in health care prices and spending. Yet, vertical health care consolidation between hospitals and physician groups and private equity investment in physician practices has largely gone unchecked, due to the relatively small dollar values of these transactions and pressure for health care integration. Policymakers are now starting to realize the threat posed by vertical health care consolidation, years into a wave of vertical mergers that is accelerating with the strain on independent practices from the COVID-19 pandemic.

States have a critical role in developing policy tools to address vertical health care consolidation, because these transactions escape review by federal authorities. States must consider a range of policy tools with a focus on oversight of vertically consolidated entities and broad regulatory authority over rising costs, because much consolidation has already occurred. States are at the vanguard of this policy effort to address this perennial health policy challenge: soaring health care costs driven by consolidation.

Notes

*Erin C. Fuse Brown, JD, MPH, is associate professor of law and director of the Center for Law, Health and Society at Georgia State University College of Law. This work was performed in her capacity as a consultant to National Academy for State Health Policy.

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⁸ Laurence C. Baker, M. Kate Bundorf & Daniel P. Kessler, *Vertical Integration: Hospital Ownership of Physician Practices Is Associated with Higher Prices and Spending,* 33 Health Aff. 756, 760 (2014); Cory Capps, David Dranove, Christopher Ody, *The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending,* 59 J. Health Econ. 139 (2018); James C. Robinson & Kelly Miller, *Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California,* 312 JAMA 1663 (2014); Hannah T. Neprash et al., *Association of Financial Integration Between Physicians and Hospitals With Commercial Health Care Prices,* 175 JAMA INTERNAL MED. 1932, 1937 (2015).

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¹¹ Reschovsky & White, *supra* note 9, at 4.

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¹⁷ Federal Trade Comm’n, Press Release: FTC and DOJ Announce Draft Vertical Merger Guidelines for Public Comment, Jan. 10, 2020, <https://www.ftc.gov/news-events/press-releases/2020/01/ftc-doj-announce-draft-vertical-merger-guidelines-public-comment>.

¹⁸ 15 U.S.C. § 18a (in 2019 the HSR threshold for notification was \$90 million).

¹⁹ The analyses, state examples, and recommendations in this section are drawn from an in-depth report by legal and economic researchers at the *Source for Healthcare Price & Competition* at UC Hastings College of the Law. JAIME S. KING, SAMUEL M. CHANG, ALEXANDRA D. MONTAGUE, KATHERINE L. GUDIJKSEN, AMY Y. GU, DANIEL ARNOLD, AND THOMAS L. GREANEY, PREVENTING ANTICOMPETITIVE HEALTHCARE CONSOLIDATION: LESSONS FROM FIVE STATES, THE SOURCE ON HEALTHCARE PRICE AND COMPETITION 11 (June 15, 2020), <https://sourceonhealthcare.org/profile/preventing-anticompetitive-healthcare-consolidation-lessons-from-five-states/>.

²⁰ *Id.* at 11.

²¹ Act effective as of July 28, 2019, ch. 267, 2019 Wash. Laws, <http://lawfilesexxt.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/House/1607-S.SL.pdf?q=20200124073816>.

²² Conn. Gen. Stat. § 19a-486i, http://media.sourceonhealthcare.org/Conn_Gen_Stat_19a-486i.pdf.

²³ Mass. Gen. Laws ch. 6D, § 13, <https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter6D/Section13>.

²⁴ S.B. 977, 2019-2020 Reg. Sess., § 1190.10(a) (Cal. 2020) (as amended June 19, 2020), https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB977.

²⁵ Cal. S.B. 977, § 1190.10(f).

²⁶ King et al., *supra* note 20, at 14-26.

²⁷ King et al., *supra* note 20, at 20. (“Substantive transaction reviews, such as a CMIR or HCIS, may require access to trade secrets or other proprietary information. To ensure the state has access to all information necessary to conduct a thorough review, state legislatures should grant the AG and other state entities the authority to compel information during the review process and for subsequent investigations following the review.”). The report by King et al. details state examples from California, Connecticut, Rhode Island, and Massachusetts, authorizing state officials to compel the parties to produce information to assist in review. *Id.* at Appendix F.

²⁸ King, et al., *supra* note 20, at 16. As an alternative to legislative review criteria, at least one state (Pennsylvania) has created a sub-regulatory process and criteria for the AG to review health care transactions involving nonprofit entities. See Review Protocol for Fundamental Change Transactions Affecting Health Care Nonprofits, Office of the Attorney General, Commonwealth of Pennsylvania, <https://www.attorneygeneral.gov/protect-yourself/charitable-giving/review-protocol-for-fundamental-change-transactions-affecting-health-care-nonprofits/>.

²⁹ See, e.g., MASS. GEN. LAWS ch. 6D § 13,

<https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter6D/Section13> (requiring the Health Policy Commission to conduct a cost and market impact review of proposed transactions that will have a significant impact on the state’s ability to meet its cost-growth benchmark or on the competitive market); CONN. GEN. STAT. § 19a-639f, https://www.cga.ct.gov/current/pub/chap_368z.htm#sec_19a-639f (requiring the Health Systems Planning

Unit of the Office of Health Strategy—the state’s CON authority—to conduct a cost and market impact review of proposed transactions requiring a CON including the retainer of independent consultants to conduct the economic analysis).

³⁰ King et al., *supra* note 20, at 18-20.

³¹ King et al., *supra* note 20, at 23-26.

³² King et al., *supra* note 19, at 26-28.

³³ Brent D. Fulton, *Health Care Market Concentration Trends in the United States: Evidence and Policy Responses*, 36 HEALTH AFF. 1530–38 (2017).

³⁴ BERENSON ET AL., *supra* note 15, at 33-34.

³⁵ *Id.* At 34-35 (describing these anticompetitive contract terms in more detail and providing examples).

³⁶ United States v. Charlotte-Mecklenburg Hosp. Auth., 248 F. Supp. 3d 720 (W.D.N.C. 2017).

³⁷ Final Judgement, United States of America and the state of North Carolina v. the Charlotte-Mecklenburg Hospital Authority d/b/a Carolinas Healthcare System, No. 3:16-cv-00311-RJC-DCK (W.D. NC Apr. 24, 2019).
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⁴² Complaint, State of Washington v. Franciscan Health System, No. 3:17-cv-05690 (W.D. WA Aug. 31, 2017).

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⁴⁴ BERENSON ET AL., *supra* note 15, at 37-39 (discussing the tradeoffs between litigation and legislative approaches to combat anticompetitive practices by health care entities).

⁴⁵ BERENSON ET AL., *supra* note 15, at 49-53. In 2020, Washington passed H.B. 2457, creating the Health Care Transparency Board and authorizing it to establish a health care cost growth benchmark,
[http://lawfilesexternal.wa.gov/biennium/2019-20/Pdf/Bills/Session percent20Laws/House/2457-S2.SL.pdf#page=1](http://lawfilesexternal.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/House/2457-S2.SL.pdf#page=1).

⁴⁶ Conn. Gen. Stat. § 19a-754a.

⁴⁷ Office of the Rhode Island Health Insurance Commissioner, RI Health Care Cost Trends Project,
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<https://dhss.delaware.gov/dhcc/about.html>; “What is the Pennsylvania Health Care Cost Containment Council?”
<http://www.phc4.org/council/mission.htm>.

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⁵³ NASHP staff internal analysis suggests that the following states require CON review of certain health care transactions: Arkansas (only for specified facilities), Connecticut (CON required for transfer of a facility of a large practice group), Delaware (CON for acquisition of a non-profit healthcare facility), Hawaii (administrative review only), Illinois (exemption required), Kentucky, Maine, Massachusetts, Michigan (CON required for acquisition of an existing facility), Mississippi (CON required for change in ownership of existing health care facilities, major medical equipment, or a health service), Missouri (CON required for change of owner, operator to an existing CON approved project not yet complete), New Jersey (for general hospitals only), New York (CON required for change in ownership, consolidations, or creation of parent entities), Oklahoma (only long-term care, psychiatric, and chemical dependency treatment facilities), Washington (sale, lease, or purchase of an existing hospital).

⁵⁴ CONN. GEN. STAT. § 19a-638 (“A certificate of need issued by the unit shall be required for [. . .] [a] transfer of ownership of a health care facility [or] [. . .] [a] transfer of ownership of a large group practice to any entity” except as specified”).

⁵⁵ CONN. GEN. STAT. § 19a-639.

⁵⁶ Wash. Rev. Code § 70.01.040, http://media.sourceonhealthcare.org/WA_70.01.040.pdf. Minn. Stat Ann. §62J.824 (2018) <https://www.revisor.mn.gov/statutes/cite/62J.824>

⁵⁷ Conn. Gen. Stat. §19a-508c, http://media.sourceonhealthcare.org/Conn_Gen_Stat_19a-508c.pdf.

⁵⁸ Acts 2019, 86th Leg., R.S., Ch. 1062 (H.B. 1112)

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