



April 20, 2022

Lina M. Khan, Chair  
U.S. Federal Trade Commission

Jonathan Kanter, Assistant Attorney General  
Antitrust Division, U.S. Department of Justice

**RE: Request for Information on Merger Enforcement**

Dear Ms. Khan and Mr. Kanter:

Community Catalyst is pleased to submit these comments on how the Federal Trade Commission and Department of Justice (“the agencies”) can modernize enforcement of the antitrust laws regarding mergers and acquisitions. Community Catalyst is a leading non-profit national health advocacy organization dedicated to advancing a movement for health equity and justice. We partner with national and state/local advocates in more than 40 states to leverage and build power so all people can influence decisions that affect their health. Health systems will not be accountable to people without a fully engaged and organized community voice.

We share your goals of making the health care system work for those who are medically-underserved, especially Black, Latinx, Indigenous and Asian people, Pacific Islanders, individuals with low incomes, women, LGBTQ+ people, older adults and those with chronic conditions or disabilities, rural residents and people who are uninsured or Medicaid-insured. We commend the agencies for seeking to ensure that your guidelines and enforcement efforts are appropriate for current market conditions and take into account both the price and non-price effects of mergers, especially as they affect medically-underserved individuals, families and communities.

Decades of hospital and health system consolidation across the United States have created large regional and national health systems with the market power to raise prices. This consolidation trend has also included the downsizing or closing of hundreds of community hospitals, especially in low-income rural and urban areas, while health systems have been shifting facilities into middle-income suburban neighborhoods with commercially-insured residents. When health systems close or reduce services at hospitals, physicians associated with those facilities often transfer to other system facilities, depriving patients of their usual health providers or, in some cases, any convenient health provider at all (such as for people living in rural areas and people with disabilities who face accessibility obstacles in traveling to other facilities.) The people most affected by these trends have been those who are medically underserved. The real-life consequences for individuals, families and communities amount to a national health equity crisis that is:

**Community Catalyst** works to ensure individual interests are represented wherever important decisions about health and the health system are made: in communities, courtrooms, state houses and on Capitol Hill.

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- affecting the price of health care;
- increasing medical debt; and
- having non-price impacts on timely access to care, continuity of care and the ability of communities to hold their local hospitals accountable.

We will urge the agencies to use a health equity framework in assessing the likely impact of such consolidation. Such an approach would be responsive to President Biden’s 2021 Executive Order on Advancing Racial Equity and Support for Underserved Communities through the Federal Government,<sup>1</sup> which specifically urged federal agencies to consider “whether new policies, regulations or guidance documents may be necessary to advance equity in agency actions and programs.” In presenting a health equity analysis, our comments will respond primarily to the following questions posed by the agencies:

*1.h. How should the guidelines assess whether a lessening of competition is “substantial”? What factors should be considered in assessing the likelihood and, separately, the magnitude of harms resulting from a merger?*

*2.a. Has the guidelines’ framework been interpreted unduly narrowly as focusing primarily on the predicted price outcome of a merger? Are there non-price effects that are not adequately analyzed by analogy to price effects, and how should the guidelines address such effects? What evidence should the guidelines consider in evaluating these effects?*

*6.h. How should markets be defined when the potential harm to competition stems not from the risk of an immediate price increase, but instead from other longer-term or non-price factors such as a loss of innovation, changes to product quality or variety, or creation of new entry barriers?*

We will provide examples of how a health equity assessment could be applied to your agencies’ reviews of potentially anti-competitive health facility mergers, acquisitions and affiliations. We also suggest greater attention to mergers and acquisitions that, while too small to meet the Hart-Scott-Rodino dollar thresholds for required notification of your agencies, have an outsized impact on communities of color and people with low incomes, especially in rural areas.

### **Hospital consolidation increases prices and contributes to medical debt**

Hospital consolidation has been shown to increase the price of health care in consolidated markets, as has been documented in numerous studies and was summarized in a 2020 MedPAC report.<sup>2</sup> Moreover, hospital acquisition of physician practices adds facility fees and increases prices from 3% to 14%.<sup>3</sup> The agencies have often relied on testimony from commercial health

<sup>1</sup> <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/>

<sup>2</sup> MedPAC, “March 2020 Report to the Congress: Medicare Payment Policy,” March 13, 2020.

<sup>3</sup> Neprash HT, Chernew ME, Hicks AL, Gibson T, McWilliams JM. Association of financial integration between physicians and hospitals with commercial health care prices. *JAMA Intern Med.* 2015;175(12):1932. doi:10.1001/jamainternmed.2015.4610. And Capps C, Dranove D, Ody C. The effect of hospital acquisitions of physician practices on prices and spending. *J Health Econ.* 2018;59:139-152. doi:10.1016/j.jhealeco.2018.04.001.

insurers when challenging in court those proposed mergers and acquisitions deemed likely to increase prices. We want to underscore for the agencies the real-life impact on individuals and families when hospital and health system consolidation leads to increases in the price of health care and coverage, and encourage the agencies to consider utilizing testimony from individuals and community-based organizations about those effects.

For people with employer-sponsored insurance, the usual impact of higher hospital prices in consolidated markets is that insurers will raise premiums and increase the size of deductibles and co-pays that leave individuals and families responsible for thousands of dollars in out-of-pocket medical expenses. Between 2011 and 2021, the average cost of family health insurance rose by 47 percent, outpacing workers' earnings (up 31 percent) and inflation (up 19 percent), according to the Kaiser Family Foundation. In 2021, 85 percent of people with employer-sponsored insurance had a deductible, and the average amount of those deductibles was \$1,669, nearly double the amount from a decade earlier. People working at small employers (with fewer than 200 workers) had much higher deductibles, an average of \$2,379.<sup>4</sup> Small businesses employ 47.1 percent of U.S. workers and, in some states, significant proportions of those small business employees are Black, Latinx or other people of color.<sup>5</sup>

Medicaid enrollees face cost-sharing burdens in some states, and thus can be affected by increases in hospital prices. Medicaid coverage is reserved for people with the lowest of incomes, and yet, states can charge up to 5% of a family's income for total out-of-pocket costs. This means that for an individual who qualifies under Medicaid expansion with an income of \$13,590 or below, health care providers can charge up to \$680 in cost-sharing.<sup>6</sup> The [Kaiser Family Foundation](#) reports that “even relatively small levels of cost-sharing are associated with reduced care, including necessary services, as well as increased financial burden for families.” Reduced care can lead to poorer health outcomes, such as higher morbidity and mortality rates and a higher degree of health disparities. Research shows that health disparities are costly, as the Kaiser Family Foundation estimates that disparities produce approximately \$93 billion in excess medical costs and \$42 billion in lost productivity per year, as well as additional economic losses due to premature deaths. We applaud the Biden administration's [rejection](#) of Medicaid premiums as part of several states' proposed 1115 Medicaid waiver applications. But rising prices due to hospital consolidation may prompt some states to continue or increase cost sharing in Medicaid programs that are financially strained.

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<sup>4</sup> Kaiser Family Foundation 2021 Benchmark Health Benefits Survey, published Nov. 10, 2021, accessed at <https://www.kff.org/health-costs/press-release/average-family-premiums-rose-4-this-year-to-top-22000/>

<sup>5</sup> U.S. Small Business Administration Statistics. In New York State, for example, racial minorities made up 33.4 percent of workers at small business, according to the 2021 Small Business Profile from the U.S. Small Business Administration's Office of Advocacy, accessed at <https://cdn.advocacy.sba.gov/wp-content/uploads/2021/08/30143119/Small-Business-Economic-Profile-NY.pdf>

<sup>6</sup> Ndugga, N., and Artiga, S., Disparities in Health and Health Care: 5 Key Questions and Answers, Kaiser Family Foundation, May 11, 2011. <https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/#:~:text=Research%20further%20finds%20that%20health,losses%20due%20to%20premature%20deaths>

Uninsured and under-insured people face impossible choices of avoiding expensive medical care or facing financial ruin and in some cases, even medical bankruptcy. Analysis of Census data from the [Survey of Income and Program Participants](#) estimates that 17 percent of households had outstanding medical bills in 2019 amounting to at least \$195 billion in medical debt. Individuals who are Black, Indigenous and other people of color (BIPOC), and other historically excluded populations are disproportionately burdened by medical debt. Nearly 27 percent of Black households and just under 19 percent of Latinx families had medical debt in comparison to 16 percent of white families.<sup>7</sup>

People facing unaffordable medical bills may then be subjected to aggressive billing and collection practices that large multi-state health systems introduce at hospitals and physician practices they are acquiring. Some of the nation's largest, most prestigious and financially sound non-profit hospitals and health systems provide significantly less in community investment than they receive in tax breaks.<sup>8</sup> Some of these same health systems are among those that have taken legal action against thousands of patients with limited incomes,<sup>9</sup> who often lack legal representation to defend themselves in court.<sup>10</sup> In at least one state, it was documented that large health systems were commonly the source of medical debt for those filing for bankruptcy.<sup>11</sup> Interest added to medical debt makes the cost of health care even more unaffordable for people with low and moderate incomes. Medical bills account for 58% of collection accounts on credit reports, and it is estimated that \$88 billion in medical debt sits on people's credit reports. The reporting of medical debt in arrears has an oversized detrimental effect on people's credit scores.<sup>12</sup>

As local hospitals become part of larger health systems, these hospitals often must comply with system-wide policies, which makes it difficult for community residents to negotiate and resolve issues such as billing disputes. Analysis of data from the Consumer Financial Protection Bureau's consumer complaint database found that one large multi-state and for-profit health system was responsible for hundreds of medical debt collection complaints and that they were penalized for illegal collection actions.<sup>13</sup>

We thank the Biden-Harris Administration for taking steps to make quality health care accessible and affordable for every American. Specifically, we applaud the recent administrative actions

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<sup>7</sup> The Burden of Medical Debt in the United States, Kaiser Family Foundation, March 10, 2022, <https://www.census.gov/data/tables/2019/demo/wealth/wealth-asset-ownership.html>

<sup>8</sup> The 41 Hospitals Costing Communities \$4 Billion, The Lown Institute Hospital Index, August 5, 2021 <https://lownhospitalsindex.org/publication/the-41-hospitals-costing-communities-4-billion/>

<sup>9</sup> 'There's no way I can pay for this:' One of America's largest hospital chains has been suing thousands of patients during the pandemic, CNN, May 198, 2021 <https://www.cnn.com/2021/05/17/us/hospital-lawsuits-pandemic-invs/index.html>

<sup>10</sup> St. Dominic Knew Patients Couldn't Afford Care. It Sued Them Anyway, Mississippi Center for Investigative Reporting, August 6, 2021

<sup>11</sup> Unhealthy Debt-Medical Costs and Bankruptcies in Oregon, OSPIRG, Fall 2021 [https://ospirg.org/sites/pirg/files/reports/OSPIRG\\_Unhealthy-Debt%20FINAL%20%281%29.pdf](https://ospirg.org/sites/pirg/files/reports/OSPIRG_Unhealthy-Debt%20FINAL%20%281%29.pdf)

<sup>12</sup> Medical debt burden in the United States, Consumer Financial Protection Bureau, March 1, 2022

<sup>13</sup> Medical Debt Malpractice, U.S.PIRG, Spring 2017

that aim to address the burden of medical debt for millions of people. We believe that the policy strategies identified in the President’s [Executive Order](#) on Continuing to Strengthen Americans’ Access to Affordable, Quality Health Coverage—including extending coverage, fixing the family glitch and reducing cost sharing—would help people avoid going into medical debt. Additionally, we welcome the [newly released guidance](#) to alleviate the burden that medical debt plays on the lives of one in three people. Putting an end to the medical debt penalty is another good step on the way to ensuring that families are able to access affordable health care and affordable credit.

In theory, consolidations should result in lower overall supply chain spending, but research indicates that hospital supply chain costs may actually increase after acquisitions and mergers. When hospitals and health systems propose mergers or acquisitions, they often claim in filings with government regulators, such as your agencies, that such transactions will create efficiencies and reduce costs. Unfortunately, studies show that such savings may not materialize or, if realized to some extent, are not passed along in reductions to hospital prices. A study by the [National Bureau of Economic Research](#) and the Wharton School found that once hospitals merge, the actual savings are substantially less than they originally estimated when defending their potential hospital merger proposal. The study authors report that in many of the proposals, the assumed savings are predicated on supplier concentrations and related negotiation power. However, the researchers found that hospital savings in mergers are driven by a 2.6% decrease in costs for physician preference items. And, acquirers’ 6.4% savings on inexpensive commodities are more than counterbalanced by a small 1.1% increase in PPI costs post-merger. Hence, the National Bureau of Economic Research and the Wharton School found no significant evidence that savings are mediated by supplier concentration, downstream market power or standardization. Therefore, we urge that the agencies adopt a skeptical posture to claims that hospital mergers or acquisitions will lower costs, and therefore prices.

Moreover, we note that the medical supply chain is currently experiencing challenges due to the COVID-19 [pandemic](#), economic [inflation](#) and [global sanctions](#). Collectively, these factors combined with increased prices from consolidations create a syndemic impact on the medical supply chain that disproportionately affects the poor and communities of color. [For example](#), many of the supply chain shortages seen during the COVID-19 pandemic (e.g., workforce, PPE, vaccines, and pharmaceuticals) increased risks to patient care and health care personnel safety, with an outsized impact on communities of color. Given the above-mentioned inequitable distribution of strains on the supply chain, utilitarian action from policymakers should include expanding anti-trust enforcement.

***RECOMMENDATION:*** *We urge the agencies to consider a more expansive analysis of the price impacts of hospital mergers and acquisitions by examining whether transactions may contribute to medical debt. Such an analysis would recognize the compounding effects when large health systems increase prices at hospitals, physician practices and outpatient centers they acquire and then institute medical billing and collection practices that further burden financially-vulnerable patients with high interest rates and punitive lawsuits. We encourage the agencies to closely examine transactions involving those health systems that have been identified as having unfair billing and collection practices. Guidelines for review of proposed mergers and acquisitions being examined by the agencies can and should include questions about whether the*

*transactions are likely to increase medical debt among the individuals and families served by the facilities targeted by a health system acquisition or merger. Finally, we urge that the agencies closely examine, and assertively challenge, predictions that hospital mergers and acquisitions will reduce costs and produce lower prices.*

### **Hospital consolidation harms access to care and worsens health inequities**

The COVID-19 pandemic has revealed some of the most dire non-price consequences of hospital consolidation, as people in medically-underserved urban neighborhoods of color and in rural areas have faced stark inequities in obtaining timely access to hospital care. These people live in places that have been ignored or abandoned by rapidly-growing health systems that are busy acquiring facilities in largely white middle-income suburban areas and more affluent urban neighborhoods. The result has been mal-distribution of hospital capacity that is sorely needed in times of public health emergencies, such as pandemics.

For example, over a more than 20-year period, the 12 largest health systems in New York State used mergers and acquisitions to gain control of half of the acute care hospitals and 70 percent of the acute care beds across New York State, a study found.<sup>14</sup> Prime targets of these acquisitions were hospitals serving middle to upper income suburban and urban communities. Four large private health systems (Northwell, New York-Presbyterian, NYU Langone and Mount Sinai) amassed 98 percent of the total assets of those top 12 systems and considerable market power, that study found. During that same time period, however, more than 40 hospitals closed across the state, and others downsized, sometimes under pressure from systems that had acquired them or from state officials looking to reduce state subsidies to safety-net hospitals.

In New York City, the successive closures of four safety net hospitals in the borough of Queens left a financially-stressed public hospital (H+H Elmhurst) to serve the many people of color struggling to obtain COVID-19 treatment in that part of Queens when the first wave of the pandemic hit in 2020.<sup>15</sup> News reports at the time pointed out that while Elmhurst Hospital was overwhelmed, there were thousands of empty beds at other New York hospitals.<sup>16</sup> Subsequent analysis revealed that Queens had only 1.5 hospital beds per 1,000 residents, compared to 6.4 beds in Manhattan, which had a much lower rate of COVID during the first wave.<sup>17</sup> While emergency transfers of COVID patients to other New York hospitals, including in Manhattan, eventually were instituted by the Cuomo administration, the inadequacy of hospital capacity in Queens has remained unchanged by the lessons of COVID. None of the four most well-endowed private health systems has acquired or opened new hospitals in Queens. Howard Berliner, a

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<sup>14</sup> Uttley, L., et al “Empowering New York Consumers in an Era of Hospital Consolidation,” NYS Health Foundation and MergerWatch, 2018, accessed at: <https://nyshealthfoundation.org/wp-content/uploads/2018/05/empowering-new-york-consumers-era-of-hospital-consolidaiton-full-report.pdf>

<sup>15</sup> Dunker, A., Benjamin, E. How Structural Inequalities in New York’s Health Care System Exacerbate Health Disparities During the COVID-19 Pandemic: A Call for Equitable Reform, Community Service Society New York, June 4, 2020, accessed at <https://www.cssny.org/news/entry/structural-inequalities-in-new-yorks-health-care-system>

<sup>16</sup> Dwyer, Jim, One hospital was besieged by the virus. Nearby was “plenty of space.” New York Times, May 14, 2020.

<sup>17</sup> Dunker, A., and Benjamin, E., How Structural Inequalities in New York’s Health Care System Exacerbate Health Disparities During the COVID 19 Pandemic: A Call for Equitable Reform, Community Services Society-New York, June 2020

member of the state Public Health and Health Planning Council, which reviews proposed mergers, acquisitions and downsizing of hospitals, commented that in New York “The creation of health care oligopolies has been accompanied by the demise of small, stand-alone hospitals.”

We noted a new study by the [Lown Institute](#) which found that hospitals in 15 big cities were highly racially segregated in the patients they treat. In New York, the only hospitals scoring high on racial inclusivity were those in the public NYC Health + Hospitals System that includes the Elmhurst Queens hospital which was overwhelmed with patients of color during the first wave of COVID-19. Not a single hospital in the large private health systems in New York City scored highly on racial inclusivity. Interestingly, some of the least inclusive hospitals eventually did better on racial equity when federal pandemic relief funds made it financially-attractive to treat patients with COVID, who were disproportionately people of color. However, the Institute noted that those patients who received elective procedures were overwhelmingly white, suggesting that the end of such federal subsidies and a return to market-based incentives in hospital care could erase progress in achieving equity.

***RECOMMENDATION:*** *We urge the agencies to consider that even in metropolitan areas like New York City, where there may appear to be ample competition, market-driven hospital consolidation such as that described above can leave some neighborhoods of color (such as parts of Queens) with no local provider of hospital care, while other neighborhoods, such as the predominantly white and affluent Upper East Side of Manhattan, are over-bedded for the number and health status of local residents. The market-driven trend of health systems expanding into middle-income and affluent white communities where prices can be raised should prompt the agencies to examine the corresponding lack of competition to serve urban communities of color where people that have low incomes and either public insurance or no insurance. We encourage the agencies to consider whether approval of a merger or acquisition that expands a health system’s footprint in a middle-income largely white community might be conditioned on the health system agreeing to help address unmet needs in areas where there is no competition to serve the residents – where there is, in effect, a profound market failure needing government intervention.*

Another manifestation of inequities being worsened by market-driven hospital consolidation is the trend of health systems acquiring community hospitals and then downsizing or closing them. An example can be found in the City of Mount Vernon, which is located just north of New York City and has a population that is 65 percent Black and 16 percent Latinx. Mount Vernon, which had the third highest rate of COVID-19 in Westchester County during the initial wave, has a health facility – Mount Vernon Hospital, located in the downtown area, where many people with low incomes live. But as the pandemic hit, Mount Vernon Hospital was operating with diminished capacity, due to downsizing by the Montefiore Health System, which had acquired it in 2013 as part of the takeover of the smaller Sound Shore Health System. Despite promising that financially-struggling Mount Vernon Hospital would be saved, the Montefiore system had begun closing units of the hospital, including the ICU.

In 2019, the Montefiore System had announced plans to close Mount Vernon Hospital and replace it with a freestanding emergency department and an ambulatory center to be located not in the downtown area, but in another part of the city adjacent to a more middle-class community.

<sup>18</sup> Those facilities would be run by another Montefiore Hospital located in New Rochelle, which is 56 percent white. Mount Vernon residents and community groups organized protests, in partnership with the New York State Nurses Association (NYSNA), which represents some of the remaining hospital employees. Months later, when the pandemic hit, Mount Vernon residents were frequently transported by ambulance to Montefiore's system hub in the Bronx, instead of being admitted to Mount Vernon Hospital, where units had been closed and as many as 100 beds stood unused. A study by NYSNA reported much longer wait times for patients arriving at Mount Vernon Hospital than at White Plains Hospital, another Westchester County facility acquired by the Montefiore system. The system has also invested more dollars in its facility in White Plains, which is 60 percent white, the union charged, claiming the system is guilty of systemic racism.<sup>19</sup> The Montefiore Health System has recently paused its plans to close Mount Vernon Hospital, but the future of the facility remains unclear.

***RECOMMENDATION:*** *When the agencies are reviewing proposed acquisitions of community hospitals by large regional or national health systems, such review should consider the likely non-price effects over time on hospitals located in communities of color, especially those that have large percentages of people with low incomes. Health system executives and independent experts should be asked to project out over a period of five to 10 years whether all services currently available at hospitals being acquired will be maintained, or whether services are likely to be downsized or eliminated. Answers to such questions should be evaluated along with any potential impacts on price to arrive at a balanced picture of whether the transaction would improve or decrease access to affordable care for medically-underserved people. We also urge some type of post-transaction review by your agencies to determine whether promises made have been kept.*

Another negative impact of hospital consolidation has been on continuity of care, which has suffered as systems take over local hospitals and then close units, forcing patients to travel to other facilities within the system. This impact has been particularly acute for pregnant people traveling long distances, sometimes across state lines, to give birth after labor and delivery units are closed at their local hospitals. People with disabilities, vulnerable elderly people and immigrants whose first language is not English also face hurdles in traveling outside their home communities for care.

One example of this problem is the closure of labor and delivery units at hospitals in rural Connecticut and in the adjacent Hudson Valley of New York that were consolidated into the Nuvance Health System through a 2019 merger of the Western Connecticut Health Network with New York-based Health Quest. Connecticut state regulators conditioned Nuvance's acquisition of rural Sharon Hospital on maintaining maternity and obstetrics services for a period of five

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<sup>18</sup> Robinson, David, Mount Vernon Hospital Closure: What to Know about Opposition, Montefiore Money, Investments, January 16, 2020, Accessed at: <https://www.lohud.com/story/news/health/2020/01/16/why-montefiore-finances-key-mount-vernon-hospital-closure-detail/4481264002/>

<sup>19</sup> Cusaac-Smith, Tiffany, and Robinson, David, Montefiore expansion into Hudson Valley reinforced racial disparities, NY nurses claim, March 12, 2021, accessed at: <https://www.lohud.com/story/news/2021/03/12/montefiore-mount-vernon-hospital-black-community-racial-disparities/4643105001/>

years.<sup>20</sup> But, two years later, Nuvance said that wasn't possible and is applying to the state for permission to shut down maternity services.<sup>21</sup> Meanwhile, Nuvance is also shutting maternity services, at least temporarily, at another of its facilities, Putnam Hospital in New York's Hudson Valley. Both closings of maternity units have prompted protests from pregnant women who fear being forced to drive long distances to give birth. Our colleagues at the Universal Health Care Foundation of Connecticut flagged the proposed Sharon Hospital maternity unit closing and the suspension of maternity care at two other hospitals that had been acquired by systems active in that state: Windham Hospital (part of Hartford Healthcare) and Johnson and Memorial Hospital (Trinity Health).

A national study published in 2017 found that more than half of rural counties across the nation now have no local hospital labor and delivery service, as a result of waves of closures (some, but not all, of which followed mergers or acquisitions.) The study noted that counties with higher percentages of non-Hispanic Black women of reproductive age and lower median household incomes were more likely to experience the loss of obstetric services, highlighting the health equity impact when hospital systems take over rural hospitals and then close maternity services.<sup>22</sup> Study authors noted that compared to urban US women, rural women experience disparities in access and outcomes, with higher rates of postpartum hemorrhage and blood transfusions during delivery. More than half of rural women must travel more than 30 minutes to the nearest hospital obstetric services, the study reported.

Rural hospital closures also increase the distances that patients must travel for emergency care services. A [2019 study](#) found that more than half of the 222 low-margin rural hospitals were more than 20 miles away from the next-closest hospital-based emergency departments, and one-tenth were more than 35 miles away. The average distance to the next closest emergency department was 22 miles. As emergency departments are on the front lines for rural health, the disappearance of rural, low-margin hospitals greatly increase patients' travel distances for emergency and can be [life-threatening for some emergency situations](#). Additionally, research indicates that the status quo is for "patients in rural areas to travel two to three times farther to see medical and surgical specialists than those living in urban areas" and that "rural residents with heart disease, cancer, depression or needing complex cardiac procedures or cancer treatment travel the farthest."<sup>23</sup>

Our colleagues at the Pennsylvania Health Action Network have flagged the impact on Pennsylvania residents of the Tower Health system's closing of hospitals it had acquired. Tower Health closed its Jennersville and Brandywine Hospitals and the fate of four other system hospitals is unclear. A public hearing held in the fall of 2021, local residents and their representatives testified about the impact on quality and access to care. "The pandemic has

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<sup>20</sup> Golvala, Katy, In some rural CT towns, hospital cuts mean fewer options for giving birth, CT Mirror, Nov. 28, 2021.

<sup>21</sup> Fenster, J. Why Another Connecticut Hospital Wants to Close its Maternity Ward, CT Insider, Jan. 30, 2022. <https://www.ctinsider.com/news/article/Why-another-Connecticut-hospital-wants-to-close-16817036.php>

<sup>22</sup> Hung, Peiyin, et al, Access to Obstetric Services in Rural Counties is Still Declining, With 9 Percent Losing Services 2004 14, Health Affairs, September 2017.

<sup>23</sup> Chan, L. et al, Geographic access to health care for rural Medicare beneficiaries, PubMed.gov, Spring 2006, <https://pubmed.ncbi.nlm.nih.gov/16606425/#:~:text=The%20patients%20in%20rural%20areas,cancer%20treatment%20traveled%20the%20farthest>

exposed how badly people need close and affordable health care,” said Rep. Dan Williams, D-Sadsbury Township. “Closures and consolidations impact our seniors and put stress on the services provided by our municipalities,” said state Rep. Danielle Friel Otten, D-Chester.<sup>24</sup>

The closure of Jennersville Hospital at the end of 2021 was particularly concerning to elderly residents who had depended on having an emergency department close by. Jerry Dobbs, an 84-year-old who lives at a senior living community in Oxford, PA, recalled that when he fell and fractured his kneecap, an ambulance took him 10 minutes away to Jennersville Hospital. “If there was not Jennersville ER, then I would have had to ride a lot longer to wherever the ER that they would take me to,” Dobbs told a local news outlet. Since Jennersville Hospital closed the nearest emergency department is now 40 minutes away by ambulance, according to a local emergency response official.<sup>25</sup>

Urban residents have experienced interruptions in the continuity of their care due to hospital consolidation, such as what happened after the Wheaton Franciscan Health System closed St Michael’s Hospital in Milwaukee in 2006. Citizen Action of Wisconsin, one of Community Catalyst’s partners, shared the story of Lisa Jones, who lived near St. Michael’s when it was operational and at the time that it closed.

Lisa’s personal doctors were based at St. Michael’s, most notably her OB/GYN. Her daughter was born at St. Michael’s. The hospital had all kinds of doctors and specialists whose primary offices were right in the facility so people from surrounding neighborhoods could get all of their care in one place. Lisa’s mother also saw a doctor at St. Michael’s for her back and got back surgery at St. Michael’s.

When St. Michael’s Hospital closed, all of the specialist doctors scattered to clinics around the county, sometimes even outside it, especially to the suburbs and outer rim of the city and county. This left people from the neighborhood scrambling to answer the question “so where do I go now?” Lisa’s OB/GYN moved farther away, leaving Lisa to travel a longer distance to receive care. Lisa’s mother’s back doctor was the last to leave the St. Michael’s facility after the main hospital was closed. The doctor moved from the St. Michael’s facility in a residential area to Mt. Sinai hospital in a different network, located downtown. In addition to needing to travel a longer distance to see her doctor, the new location of the doctor in a downtown area with terrible parking meant that Lisa’s mom could no longer go to appointments alone. She was not physically capable of parking a long distance from the hospital and walking to the facility. Now, she had to be dropped off by a family member and would make her way up to her appointment while her family member parked the car before coming inside to wait for the appointment to be over, then going back to fetch the car.

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<sup>24</sup> PA lawmakers hear from health care workers, first responders affected hospital consolidation, MediaNews Oct. 13, 2021, accessed at: <https://www.readingeagle.com/2021/10/13/local-lawmakers-hear-from-healthcare-workers-first-responders-impacted-by-hospital-consolidation/>

<sup>25</sup> Yu, Alan, Losing Jennersville Hospital will mean longer trips to the nearest ER for southern Chesco residents. WHYY, Dec. 30, 2021, accessed at: <https://whyy.org/articles/jennersville-hospital-closure-chester-county-impact/>

Moreover, when doctors were forced to scatter, many people were not able keep seeing their preferred and trusted doctors for many reasons, including transportation challenges (like not having a car, or bus routes not reaching suburbs) and time constraints (like needing to be able to get off work for longer) that come with needing to go outside of one's neighborhood.

As St. Michael's closed, the network that owned the hospital sent a letter to all the people who used the hospital saying that the hospital was closing and referring them to the nearest hospital of the same network, St. Joseph's Hospital. Both St. Michael's and St. Joseph's are located in predominantly Black neighborhoods. The effect of this letter was to consolidate a large number of Milwaukee's Black neighborhoods and residents into using one hospital - St. Joseph's - without giving that hospital more resources (at least from the community perspective) to serve the influx of patients. Shortly after, community perception of St. Joseph's Hospital and the quality of care at the hospital began to erode.

It's worth noting that in 2018, the Ascension Wisconsin system (into which the Wheaton St. Francis system had merged in 2015) announced that it was cutting services at St. Joseph's Hospital, including eliminating the medical and surgical units.<sup>26</sup> That announcement prompted cries of concern from local residents worried about yet another disruption to their care.

In Southwest Georgia, residents have had similar experiences with interruptions of continuity of their care and delays in obtaining emergency care brought about by an anti-competitive acquisition that attracted the FTC's attention.<sup>27</sup> In 2011, Phoebe Putney Health System acquired 102-bed Palmyra Medical Center in a \$198 million deal that greatly consolidated the market for hospital services in southwest Georgia. The FTC appropriately challenged this acquisition, but was unable to force Phoebe Putney Health to divest the Palmyra Medical Center because of obstacles in the state's Certificate of Need (CON) process.

Phoebe Putney effectively closed Palmyra Medical Center as a general hospital and has only used it for overflow. Community Catalyst's partner, SOWEGA Rising, shared the following examples of the impacts of Phoebe's acquisition of Palmyra on local residents:

- Overwhelmed emergency department – Prior to the acquisition, Southwest Georgians could go to either Palmyra or Phoebe for medical emergency visits. If the wait times at Phoebe were long, people would simply go a few blocks away to Palmyra. Since Palmyra closed, Phoebe Putney's emergency rooms continue to have 8+ hour wait times, crowded waiting rooms and overworked staff.
- Lack of specialty care – Since the consolidation, many specialties, such as pediatric care, that had been provided by doctors at Palmyra are no longer available to patients now reliant on Phoebe. As a result, many residents have to leave the area and drive or be life-

<sup>26</sup> Boulton, Guy, Ascension Wisconsin cutting services at St. Joseph's Hospital, April 5, 2018. <https://www.jsonline.com/story/money/business/health-care/2018/04/05/ascension-wisconsin-reduce-services-st-joseph-hospital-part-broader-long-term-plan/488523002/>

<sup>27</sup> Evan, Melanie, FTC ends four-year fight with Phoebe Putney Health System, Modern Healthcare, April 1 2015.

flighted to other hospitals as far as Atlanta, Macon or Columbus for specialized care, check-ups, procedures or lifesaving treatments.

- Loss of physicians and restrictions on remaining physicians harms patient care -- Many of the private doctors closed their practices and left the area. Some that stayed are not able to continue to treat their patients if they don't agree to join Phoebe's network. Advocates have heard stories of many pregnant women who, if they are admitted to Phoebe for any emergencies or when they deliver, were not allowed to continue to receive OB/GYN care from their private doctors who are out of Phoebe's network.

Because of how overwhelmed Phoebe has been since the consolidation, there was interest in neighboring communities in attracting another hospital system to come to the area. They were met with legal challenges from Phoebe. Thanks to FTC intervention, Phoebe was barred from challenging a Certificate of Need application for five years to allow for other systems to enter the market. Lee County took advantage of the moratorium and applied for a CON, but was challenged by Phoebe, although unsuccessfully. Lee County was eventually awarded the CON, however, to date no hospital has been built. This put a negative light on Phoebe for many in the community.

Medicaid enrollees are likely to feel the harms of hospital consolidation if they are left with inadequate provider networks, particularly inadequate access to providers of specialist services, that threatens their continuity of care. Sometimes, the loss of key providers within Medicaid plan provider networks can force enrollees to travel to facilities in other nearby states. Such out-of-state care can be allowed in instances in which there is “a medical emergency, the beneficiary's health would be endangered if required to travel to the state of residence, services or resources are more readily available in another state, or it is general practice for recipients in a particular locality to use medical resources in another state.” However, providers may be less willing to serve out-of-state Medicaid beneficiaries due to lower reimbursement rates for out-of-state providers. There are additional burdens for providers to see out-of-state patients because they must enroll with the Medicaid program in enrollees' states of residence and meet federal screening requirements. As Medicaid serves people with low incomes and with [disproportionate](#) numbers of Black and Latinx/Hispanic people enrolled in Medicaid, there are further equity concerns because the federal screening requirement is unique to Medicaid providers. Hospital consolidation exacerbates these existing problems as hospitals gain pricing power and may choose to limit Medicaid patient access altogether, leading to equity concerns as people have less options to pursue care.

***RECOMMENDATION:*** *We urge the agencies to include in their review guidelines some consideration of how proposed hospital and health systems mergers and acquisitions could have long-term effects of interrupting continuity of care. Such interruptions can occur when systems eliminate services at some of the facilities they have acquired, and expect patients to travel to system “hub” hospitals, or to facilities across state lines. We suggest the agencies ask specific questions about system's long-term plans for hospitals or other systems they are acquiring, including whether any services would be consolidated or eliminated, and examine the potential impact of such changes on medically-underserved individuals and communities, including Medicaid enrollees for whom crossing state lines to obtain care can be especially burdensome. Because of the serious impacts on rural residents of mergers, acquisitions and subsequent*

*downsizing, we suggest your agencies make clear that you are interested in reviewing proposed transactions that may be too small in dollar size to require automatic notice to your agencies. We also urge some type of post-transaction review to assess the actual impact of mergers and acquisitions on continuity of care.*

An additional often-unrecognized impact of some types of hospital consolidation is the loss of key reproductive services, emergency obstetric care, gender-affirming health care and end-of-life treatment options when religiously-sponsored health systems take over community hospitals and impose non-medical policies restricting the provision of such care. Such transactions can reduce or completely eliminate community access to these services, causing patients to experience delays in obtaining needed services, increased costs from traveling to obtain care elsewhere and stigma from being refused care.

Community Catalyst has tracked the growth of large Catholic health systems that use religious directives to prohibit or restrict the provision of contraception, abortion, sterilization and infertility services, as well as gender-affirming care and certain end-of-life options. Our [2020 report](#) noted that Catholic systems have been growing larger and larger – primarily through mergers and acquisitions that include takeovers of historically non-Catholic facilities. The 10 largest Catholic health systems control more than 1,000 hospitals and hundreds of physician practices, ambulatory surgery centers and urgent care centers. In five states (Alaska, Iowa, South Dakota, Washington and Wisconsin), more than 40 percent of the acute care hospital beds are subject to religious health restrictions due to ownership by Catholic systems. In 52 regions across the country, people have no choice other than a Catholic-sponsored sole community provider hospital.

***RECOMMENDATION:*** *Communities can experience a complete loss of access to certain health services when non-medical restrictions on provision of care are introduced through mergers of religious and non-religious facilities, causing denials of care and forcing patients to travel elsewhere for care. We are concerned that the consequences of such mergers and acquisitions may escape the notice of agency regulators. We recommend that the potential harm from these transactions should be a subject of agency review, even though those services do not represent a pre-merger horizontal competitive overlap.*

### **Hospital consolidation decreases accountability to local communities**

Communities are less able to hold their local hospitals accountable as decision-making power shifts from local hospital executives to CEOs at large health systems headquartered out of state. This loss of local accountability can cause broad system priorities, practices and policies to override community concerns. For example, the board and executives of Hoag Hospital in Orange County, CA, had high hopes for improved responsiveness to community needs when they merged with the St. Joseph's Health System, a chain of Catholic hospitals in Orange County, in 2013. But in 2016, the St. Joseph's system merged with the Providence Health System, reducing Hoag Hospital to a small player in what is now one of the nation's largest multi-state hospital systems. Ethical differences, stemming from the Providence system's interpretation and application of Catholic health directives that prohibit certain services, worsened followed the merger. Hoag Hospital's board and executives became so unhappy with

the long-distance, but heavy handed, oversight of the Providence system that in 2020 they took the unusual step of seeking a divorce from their parent system, which was finally executed in January of 2022.<sup>28</sup>

Also dramatically affecting local control of hospitals is the wave of private equity acquisitions that have sometimes loaded up the hospitals with debt, caused layoffs and service reductions and ultimately deprived communities of functioning hospitals. By taking these actions, the private equity firms have reaped large payouts. Leonard Green & Partners was a majority owner of Prospect Medical Holdings, a multi-state chain of safety net hospitals. In June of 2021, Rhode Island Attorney General Peter Neronha, issued a [report](#) asserting that Leonard Green and other owners raided the hospital chain of over half a billion dollars while the hospitals suffered poor quality ratings, operational challenges and declining financial health. Previously, in a May 2020 [report](#), it was reported the Leonard Green collected \$658 million in dividends and fees from Prospect Medical Holdings despite a commitment they had made to regulators in states where they acquired hospitals, such as Rhode Island.

In the case of LifePoint Health, a rural hospital chain owned by Apollo Global Management, they have benefited from various government programs. It is reported that LifePoint derived 55.2% of its revenue from Medicare and Medicaid in 2019. They also received [\\$1.6 billion](#) in COVID-19 relief funds. During the pandemic, rather than improve quality and invest in improving operations at existing facilities, [LifePoint](#) sought to acquire another healthcare company, Kindred Healthcare. Kindred was a long-term, acute care hospital and rehabilitation company. In December of 2021, a new health care system, Scion Health, was established after the [acquisition](#). [ScionHealth](#) owns and operates both acute and post-acute care hospitals in 25 states.

### **Proposal for Use of Health Equity Assessments**

Our recommendations provided above for strengthening the agencies' guidelines for review of hospital and health system consolidation respond to several of the questions asked by the RFI. We want to suggest possible ways of incorporating a health equity assessment into the agencies' reviews of proposed hospital and health system consolidation in order to better address the negative impacts of consolidation on medically-underserved people. Two states (Oregon and New York) have new laws instituting such health equity assessments in processes for reviewing proposal health facility transactions.

New York's Health Equity Assessment Act (S1451A) amends the state's Certificate of Need process to require an independent assessment of how a proposed transaction might affect medically-underserved people, including people of color, people with low-incomes, immigrants, women, LGBTQ+ people, people with disabilities, vulnerable older adults and rural residents. The assessment must include meaningful engagement of the affected community and must include consideration of these components, including:

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<sup>28</sup> Hiltzik, M. Hoag Hospital finally extricates itself from the heavy hand of Catholic health care, Los Angeles Times, Jan. 11, 2022. <https://www.latimes.com/business/story/2022-01-11/hoag-extricates-itself-from-the-heavy-hand-of-catholic-healthcare>

- Demonstration of whether (and if so, how) a proposed transaction will:
  - Improve access to hospital services and health care, and
  - Improve health equity and reduction of health disparities with particular reference to medically underserved groups in the service area.
- Data showing what proportion of the people in the service area who are currently using the facility or its services are from medically-underserved groups and predictions of how would that change (increase or decrease?) if the transaction proceeds.
- Details about access by private or public transportation to the hospital if the transaction is implemented.
- Whether applicant's performance in meeting its obligations in providing uncompensated care, community services, etc., will be improved or reduced by the transaction.
- How (and to what extent) applicant will provide hospital and health-related services to members of medically underserved groups if the transaction is completed.
- The amount of indigent care that will be provided by the applicant if the transaction is approved.
- The planned means of ensuring effective communication between applicant's hospital staff and people of limited English-speaking ability and those with speech, hearing, or visual impairments if project is implemented

Results of the health equity assessment will be utilized in state Certificate of Need review of proposed transactions. While a poor health equity review would not automatically lead to rejection of a merger application, the assessment process will provide incentives for CON applications to achieve positive health equity assessments. The assessment could also suggest conditions that state regulators might attach to approval of a transaction.

The new Oregon law (HB 2362), which went into effect March 1, gives the Oregon Health Authority jurisdiction to review and either approve, disapprove or conditionally approve large-size health care transactions. Review will encompass four domains – cost, access, equity and quality – thus tracking both the price impacts that have historically been your agencies' focus, as well as the non-price impacts we would recommend you consider more fully. The law specifically requires review of whether access to a list of essential services might be significantly reduced by a transaction. Implementing regulations adopted earlier this month, lay out these benchmarks for assessing whether a reduction in services would be significant:

- One-third increase in travel time or distance for existing patients to alternative providers; *or*
- One-third or more decrease in trained culturally competent providers; *or*
- One-third or more decrease in health care interpreters or clinicians taking new patients or serving uninsured individuals; *or*
- One-third or more decrease in any essential service as a result of restrictions being placed on clinicians' ability to provide, discuss, or refer for such services.

We want to urge your agencies to consider how you might adapt these models for use in revising your guidelines for review of mergers and acquisitions in the health industry. We noted with

approval the announcement by CMS on April 18, 2022,<sup>29</sup> that it is proposing three health equity-focused measures for adoption in the Hospital Inpatient Quality Reporting (IQR) Program, which would give your agencies access to metrics that can inform your consideration of how a proposed merger or acquisition might affect medically-undeserved people and communities.

Thank you for the opportunity to submit these above recommendations. Please do not hesitate to contact Lois Uttley, Senior Advisor for the Hospital Equity and Accountability Project at [luttley@communitycatalyst.org](mailto:luttley@communitycatalyst.org) if you have any questions or if you would like additional information.

Respectfully submitted,

DocuSigned by:  
  
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Dr. Brandon G. Wilson, DrPH, MHA  
Director of the Center for Consumer Engagement in Health Innovation

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<sup>29</sup> CMS Proposes Policies to Advance Health Equity and Maternal Health, Support Hospitals, CMS press release, April 18, 2022.