Health. Virtually. Everywhere.

May 31, 2024

The Honorable Merrick Garland
Attorney General
Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Lina Khan
Chair
Federal Trade Commission
600 Pennsylvania Ave, NW
Washington, DC 20580

Re: ATA Action Comments on Request for Information on Consolidation in Health Care Markets (Docket No. ATR 102)

Submitted electronically on regulations.gov

Dear Attorney General Garland, Secretary Becerra, and Chair Khan:

On behalf of the American Telemedicine Association, the only organization focused on advancing telehealth, and ATA Action, the ATA's affiliated advocacy arm, we appreciate the opportunity to provide feedback on the request for information (RFI) on Consolidation in Health Care Markets from the Department of Justice (DOJ), the Department of Health and Human Services (HHS), and the Federal Trade Commission (FTC), or "the agencies".

The ATA and ATA Action represent a diverse array of health care stakeholders, all committed to advancing access to health care through innovation and virtual modalities of care. The care models our members use focus on high quality care and often do result in lower health care costs and better working conditions for health care providers. We strongly agree with the goals of promoting lower health care costs and improving working conditions, while fostering high-quality patient care and driving innovation across the health care systems. However, we disagree with the premise that health care consolidation and investment in health care are inherently counter to these shared goals. Instead, we offer these two principles to help guide the discussion on health consolidation.

1) **Investment in health care is necessary and can drive innovation that improves care and reduces costs**. While innovation can often be the driver of more efficiency and ultimately improve access and lower the cost of care, driving and implementing innovation requires an initial investment. Whether it's a hospital system investing in a new technology platform or a telehealth company developing an AI-enabled tool to deliver better outcomes, investment is required to get that innovation off the ground. Today, virtual care providers are able to reach patients that were historically underserved due lack of reliable or accessible in-person care – whether in rural areas, specialty deserts, or where transportation or childcare is unobtainable for an in-person visit. This has been particularly poignant and widely recognized in reaching people

to treat mental health and substance use disorders.[1] This type of expansion in access to care is preventative and can reduce the need for more costly treatment down the line, but does require investment by health care providers to use technology and change their workflows. In this way, investment in health care leads to more patient choice and more competition, not less.

Additionally, transactions between health care entities are not by definition nefarious. In some cases, transactions are necessary to prevent an entity from closing its doors. In others, consolidation can lead to efficiencies or expanded service offerings.

Lastly, we would offer that operating high quality health care systems is a costly venture. Health care is necessarily a highly regulated industry, and there are many state and federal laws administered by a number of agencies that must be followed to ensure patient safety. In order to encourage innovative entrants to the health care market, investment in health care must be allowed. If not, we rely on a stagnant health care system without new competition and without incentive to innovate and improve.

2) **We must preserve clinical professionals' autonomy and decision-making.** Some policies that have been considered in an attempt to intervene in transactions in health care have interfered with a clinician's ability to make their own decisions about their practice mode and arrangements. We agree with the American Medical Association that "physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans and other entities as permitted by law and in accordance with the ethical principles of the medical profession."[2]

With those principles in mind, we offer the following recommendations in response to the RFI.

- **The agencies should more narrowly target and focus its areas of concern**. Assuming that all investment in health care and health care transactions are problematic is a troublesome premise to start from and could stifle innovation and ultimately better access to care for patients. Without a clear definition of where the agencies are concerned, it is difficult to respond and rectify any issues.

- **The agencies should focus areas of concern on negative results, not source of funding**. Where a transaction or an investment result in higher health care costs, worse patient outcomes, and/or worse working conditions, that should be addressed. However, painting with a broad brush that because there were some examples of negative outcomes under a certain type of financing arrangement, that all of those arrangements must be stopped ignores the positive outcomes that could result from that arrangement. The financing mechanism is not necessarily what drives the outcome, but the commitment of the entities involved to patient safety and quality of care.

- **Lastly, the agencies should consider positive scenarios that have resulted from health care investment or consolidation.** The RFI seeks only negative examples and thus the responses will show a one-sided view. If you only ask for negative examples, you will be led to believe the premise that all transactions and investment are bad. However, there are countless examples of investment in health care, described broadly above and in one specific case below, that have led to better patient and provider outcomes and reduced costs.

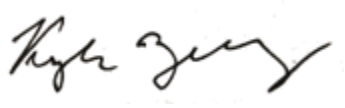
Example: In rural Kittitas County, Washington, a 25-bed critical access hospital was faced with staffing and other challenges in its attempt to provide obstetric care. The hospital went through a community

[1] https://store.samhsa.gov/sites/default/files/pep21-06-02-001.pdf
[2] Follow principles in 6 key areas to protect employed physicians | American Medical Association (ama-assn.org)

needs assessment process and chose to innovate to address its challenges. It ultimately decided to engage OB Hospitalist Group, a private equity backed provider group, in order to effectively provide care. Now, Kittitas Valley Healthcare is optimistic that its new model will be fully staffed with ob-gyn providers.[3]

Again, thank you for the opportunity to provide input on this RFI. We welcome the opportunity to provide you additional information to DOJ, HHS, and FTC as you review comments and determine a path forward. If you have any questions, please reach out to Kyle Zebley (kzebley@ataaction.org).

Kind regards,



Kyle Zebley
Executive Director
ATA Action

[3] https://www.aha.org/case-studies/2024-04-22-kittitas-valley-healthcare