Policies to Protect Independent Practices

Provider Consolidation: No end in sight

For over a decade, economists, policy-makers and virtually every other stakeholder concerned with rising health care costs has warned of the pending crisis of provider consolidation. *Consolidation* is a phenomenon that exists in two forms: vertical and horizonal. Under *Vertical Consolidation*, a hospital or health system purchases independent physician group practices or ancillary providers to channel referrals into its own hospitals and/or diversify its revenue sources. Under *Horizonal Consolidation,* a hospital or health system purchases additional hospitals/health systems to create a mega health system in a single market or across multiple markets.

Although the volume of mergers seems to have plateaued slightly (90 in 2018 down from 115 in 2017), the size of these mergers continues to grow -- some large systems are gobbling up medium-sized systems to create mega-monoliths.[1] Health systems aren't just swallowing each other, they are also buying physician practices, reducing the number of providers who practice independently. The *2018 Physician Benchmark* survey from the American Medical Association finds that, for the first time since the survey launched in 2012, the proportion of providers who have an ownership stake in their practice (45.1%) was lower than the portion who are employed (47.4%).[2] This decline in the number of health systems and independent providers means that patients have fewer choices about where to seek care, giving providers increased market leverage over health care purchasers.

The impact of these mergers can be measured empirically, though imperfectly, with *the Herfindahl-Hirschman Index* (HHI), which is a tool that economists use to measure market concentration in a variety of industries.[3] Research from the Health Care Cost Institute examined 172 Metropolitan Service Areas (MSAs) in the United States, using the HHI to measure hospital concentration in the US; they found that consolidation is strong and growing. In 2016, the proportion of *highly concentrated* hospital markets with HHI scores of >2,500 rose to 72%, up from 67% in 2012.[4] The HHI does not account for health systems that exert market leverage across multiple markets.

Theoretically, provider consolidation could have an upside for patients and health care purchasers: as health systems align with each other and with the physician community, they have an opportunity for economies of scale, elimination of service redundancy, and tighter care coordination. Unfortunately, the evidence points to the contrary. A 2017 study from *The Journal of Health Economics* found that, when hospitals purchase provider practices the average price of services within those practices rose by an average of 14%.[5] Multiple studies have examined the impact of hospital mergers on pricing; while the methodologies, markets and magnitude of outcomes varied, the studies found *without exception* that prices rise following hospital consolidation.[6] Meanwhile, there is little to no evidence that consolidation has any positive effect on quality or efficiency. A 2019 study published in *Medical Care Research and Review* analyzed 29 quality measures reported to the Center for Medicare and Medicaid Services' Hospital Compare database and found that "Vertical integration has a

[1] https://mnareview.kaufmanhall.com/the-growth-of-mega-mergers?_ga=2.195083116.1177820953.1550596993-1216528080.1546983849
[2] https://www.ama-assn.org/system/files/2019-07/prp-fewer-owners-benchmark-survey-2018.pdf
[3] The Herfindahl-Hirschman Index (HHI), which has a range from 0 to 10,000, was used to create the following market concentration categories: unconcentrated (HHI<1,500), moderately concentrated (1,500 ≤ HHI < 2,500), highly concentrated (2,500 ≤ HHI < 5,000), and super concentrated (HHI ≥ 5,000).
[4] https://www.healthcostinstitute.org/research/hmi/hmi-interactive
[5] Carlin, CS, Feldman, R, Dowd, B. The impact of provider consolidation on physician prices. *Health Economics*. 2017; 26: 1789– 1806. https://doi.org/10.1002/hec.3502
[6] https://www.nihcm.org/component/content/article/11-charts/1822-hospital-consolidation-trends-impacts-outlook?

limited effect on a small subset of quality measures. Yet increased market concentration is strongly associated with reduced quality across …10 patient satisfaction measures."[7]

What can be done to protect independent practices and mitigate the cost impact of provider mergers?

The unfortunate news is that provider consolidation drives up prices, has minimal to no impact on quality, and is a continuing trend. This does not, however, mean that health care purchasers are powerless to mitigate the impact. The following sections outline strategies stakeholders within the health care ecosystem can take to soften the impact of provider consolidation and help retain provider independence where it exists. Not all the strategies discussed here are within the power of purchasers alone, but by supporting the efforts of carriers, federal and state government, and by pooling their influence with other like-minded health care purchasers, there is opportunity to shift market dynamics and lessen the impact of consolidation-driven price inflation. These are discussed in turn below.

1. State & Federal Government

Some Federal policies have a negative impact on the survival of independent physician practices, but they could also offer solutions to prevent further consolidation. In the spirit of "first do no harm," the federal government could begin by examining policies that create incentives for provider consolidation, such as CMS's policy of paying higher rates to hospital-affiliated physicians. Also, the Affordable Care Act may have inadvertently intensified consolidation incentives by encouraging the formation of Accountable Care Organizations (ACOs) and deeper coordination across the delivery system. Many hospitals and physician groups believe that they must fully integrate to succeed as an ACO.[8] It's worth noting, however, that these integrated delivery system ACOs did not achieve superior performance under the Medicare Shared Savings Program (MSSP).[9] A third federal incentive for provider consolidation is the 340b drug pricing program, which entitles qualifying hospitals to discounts on outpatient drugs and creates greater profits for hospitals when they purchase community physician practices.[10]

The Federal government also has an opportunity to staunch the flood of hospital mergers and physician practice acquisitions through heightened enforcement of anti-trust legislation. Section 7 of *The Clayton Act* prohibits mergers and acquisitions where the effect "may be substantially to lessen competition, or to tend to create a monopoly."[11] The statute itself is narrow, pertaining only to increased profitability from reduced competition. Moreover, the Federal Trade Commission (FTC) has *interpreted* this statute narrowly, requiring litigants to demonstrate reduced competition within a geographical market; this becomes problematic when hospital mergers span multiple markets, which was the case in over half of the hospital mergers occurring between 2000 and 2012.[12]

2. Health Plans

Beyond their role as a price negotiator, there is much that health plans can do to help re-balance market power and support independent practices. A *Health Affairs* study published in November 2019 found that the rise of shared savings and shared risk models has exacerbated provider consolidation, as individual practices lack the infrastructure and scale to manage risk and manage population health effectively.[13] But there are strategies and resources that health plans can offer to help smaller, independent providers participate in the alternative payment model movement. These include:

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[7] Weighing the Effects of Vertical Integration Versus Market Concentration on Hospital Quality. Marah Noel Short, Vivian Ho. February 2019. *Medical Care Research and Review*.
[8] https://pnhp.org/news/hospital-consolidation-and-the-affordable-care-act/
[9] https://www.americanprogress.org/issues/healthcare/reports/2018/12/05/461780/provider-consolidation-drives-health-care-costs/
[10] https://www.nejm.org/doi/full/10.1056/NEJMsa1706475
[11] https://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws/antitrust-laws
[12] https://www.nihcm.org/component/content/article/11-charts/1822-hospital-consolidation-trends-impacts-outlook?
[13] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2018.05415

- Population health management tools, resources and reports offered at no cost to providers who operate in shared savings/shared risk models
- Alternative payment models (APMs) designed for providers who are organized in small independent practices; these models confine the provider's risk and incentives to metrics and outcomes within the purview of independent physician groups
- Provider incentives for steering patients to a narrowed list of specialists and facilities who are low-cost and high-quality – note that this is different from a *narrow* or *high-performance network* in that the onus and incentives fall on the primary care provider (PCP) rather than the member

Health Plans can also, a priori, build provisions into their contracts that mitigate the price inflation effects of mergers, and dampen the financial incentives for vertical integration. These include provisions like a "four walls policy," which prohibit health systems from charging their higher rates for provider practices they newly acquire. A four walls policy stipulates that the rates negotiated between the health plan and the hospital system only apply within the health system's "four walls" and therefore any new physician practice acquisitions cannot be priced at the health system's rate, and would have to be negotiated separately.[14]

Case Studies on protecting independent practices and mitigating the cost impact of provider mergers

In their efforts to stem the tide of provider consolidation, states have pursued three avenues: *legislation, regulation and litigation*. Examples of each strategy are profiled below:

1. Legislation

- **Texas requires all Accountable Care Organizations (ACOs) to obtain certificate of authority from state's department of insurance.** Texas is the only state that currently requires ACOs (or Health Care Collaboratives – HCCs - as they are called in Texas) to obtain prior approval from the Department of Insurance. To obtain a Certificate of Approval, the HCC must demonstrate that it has "processes that contain costs without jeopardizing quality of patient care;" the approval process also includes an impact analysis to determine whether the HCC is "is likely to reduce competition in any market for physician, hospital, or ancillary health care service."[15]

2. Regulation

- **Massachusetts Health Policy Commission:** In 2012, Massachusetts established an independent Health Policy Commission charged with "monitoring health care spending growth in Massachusetts and providing data-driven policy recommendations regarding health care delivery and payment system reform."[16] When it comes to managing provider consolidation, the Commission reviews all "material ownership changes," and escalates mergers of concern to the Massachusetts Attorney General. In doing so, the state brings a heightened degree of scrutiny and impact analysis to all pending health care mergers and acquisitions. While it is unclear that this oversight has blocked or deterred any mergers in Massachusetts, the State's total healthcare expenditure trend has been at or below 3% since 2015.[17]

[14] https://mediproviders.anthem.com/Documents/WIWI_CAID_Newsletter_Winter2019.pdf
[15] https://www.catalyze.org/wp-content/uploads/2017/04/2014-State-Policies-on-Provider-Market-Power.pdf
[16] https://www.mass.gov/about-the-health-policy-commission-hpc
[17] https://www.mass.gov/doc/presentation-2019-cost-trends-hearing-day-one/download

- **Rhode Island Office of the Health Insurance Commissioner (OHIC):** In 2004, Rhode Island established the OHIC to hold health insurance companies accountable for managing costs and ensuring affordability. OHIC's responsibilities include rate review for insurance carriers "to determine if health insurance companies are proposing unreasonable rates," and setting affordability standards that prescribe investment from the insurance carriers into alternative payment models.[18,19]

3. Litigation

- **Idaho blocks merger between St. Luke's Health System and Saltzer Medical Group:** In 2017, the FTC and the Attorney General of Idaho successfully challenged a proposed merger between St. Luke's Health System and Saltzer Medical Group, Idaho's largest independent, multi-specialty physician practice group. The State and the FTC argued that "the combination of St. Luke's and Saltzer would give it the market power to demand higher rates for health care services provided by primary care physicians (PCPs) …ultimately leading to higher costs for health care consumers."[20]
- **Illinois blocks merger between Advocate Health Care and NorthShore University Health System:** In 2017, the FTC and the State of Illinois challenged a merger between the two of the largest health systems in Chicago. Had the merger been allowed to proceed, it would have created the largest health care system in the state, comprising 16 hospitals, with over 4,000 beds, treating over 3 million patients per year. Federal officials successfully argued that "Advocate and NorthShore's merger would likely have reduced the quality, and increased the cost, of health care for residents of the North Shore area of Chicago."[21]

Concluding Highlights

Absent a major legislative overhaul from the federal government, reversing the trend of provider consolidation and mitigating its effects is likely to remain a primary cause of health care price inflation. Re-balancing power within highly consolidated markets and preserving the independence of provider practices will remain an uphill battle; however, there are solutions that purchasers, insurance carriers, states and the federal government can pursue to stem the tide and to limit the financial incentives that drive consolidation. The good news for purchasers is that recent litigation has broken in favor of plaintiffs seeking relief from anti-competitive health system practices; while these wins are no guarantee of future success, they do indicate - perhaps - that health systems can only push the envelope so far before facing public backlash and sanction. Moreover, a closer look at the AMA's Physician Benchmark Survey shows that 54% of physicians operate out of practices that are wholly owned by physicians – meaning that although the number of employed physicians continues to rise, most of those physicians are employed by other physicians, not hospitals or health systems.[22] The backlash against anti-competitive practices and the desire of (most) physicians to remain independent of hospitals are two market trends that bode well for purchasers hoping to regain some market power balance. However, purchasers would be wise to exercise the full set of tools at their disposal: advocacy, steerage solutions and, group purchasing, to mitigate the effects of provider consolidation and to help independent providers retain independence.

[18] http://www.ohic.ri.gov/ohic-formandratereview.php
[19] http://www.ohic.ri.gov/ohic-reformandpolicy-affordability.php
[20] https://www.ftc.gov/news-events/press-releases/2013/03/ftc-idaho-attorney-general-challenge-st-lukes-health-systems
[21] https://www.healthcaredive.com/news/advocate-northshore-merger-is-off/437647/
[22] https://www.ama-assn.org/system/files/2019-07/prp-fewer-owners-benchmark-survey-2018.pdf