

- What are the prospects for Emanuel’s recommendation for addressing high-volume, high margin procedures and imaging through:
 - Use of shared decision-making aids with objective performance data as a requirement for getting paid for a procedure
 - Reference pricing based on objective quality metrics
- What are the prospects for Emanuel’s recommendation to reduce administrative costs via a more “automated process based on electronic health record data”?

6. Provider Consolidation

Trends in Provider Consolidation

The trend toward larger healthcare systems isn’t slowing down. 2017 was the year with the most hospital mergers since at least 2000, with a total of 115 transactions. Carnegie Mellon’s Martin Gaynor testified in February 2018 to a House panel that there have been 1,519 hospital mergers in the past 20 years, with 680 since 2010.³¹ It’s becoming common for one large, powerful health system to dominate care in a local area, such as Partners in Boston or UPMC in Pittsburgh.

Hospital mergers: One dimension of consolidation is hospital mergers. Data from the consulting firm Kaufman Hall show annual hospital mergers and acquisitions (M&A) activity averaging about 54 between 2002-2009. M&A transactions then rose steadily following the passage of the Affordable Care Act (ACA) to 115 in 2017, a 12.7% increase over 2016.

An analysis in *Health Affairs* that covered U.S. healthcare market concentration trends in the United States from 2010 to 2016 found increased concentration in both hospital and physician organization markets.³² In 2016, 90% of Metropolitan Statistical Areas (MSAs) were highly concentrated for hospitals. High levels of hospital concentration now are the norm throughout America.

Recent Examples of Hospital Mergers

National examples:

San Francisco-based Dignity Health and Englewood, Colorado-based Catholic Health Initiatives in 2017 announced a merger to create a new, not-for-profit Catholic health system that will serve customers across 28 states.³³ It will include more than 700 care sites and 139 hospitals, employing more than 25,000 physicians and other advanced practice clinicians and 159,000 other employees. The two large health systems collectively represent \$28 billion in revenues and \$39 billion in assets.

Aurora Healthcare and Advocate Healthcare Network, the largest health systems in Wisconsin and Illinois, respectively, merged to create Advocate Aurora Health.³⁴ With combined annual revenues of approximately \$11 billion, the new organization is now America’s 10th largest not-

for-profit integrated health system, representing 27 hospitals and more than 500 sites of care, employing more than 3,300 physicians and nearly 70,000 associates and caregivers.

St. Louis-based Ascension Health and Washington state-based Providence St. Joseph Health have been in talks to create the nation's largest hospital chain, with 191 hospitals in 27 states and annual revenue of \$44.8 billion. According to Modern Healthcare, the merger would surpass for-profit giant HCA, which currently has 117 hospitals and is worth nearly \$42 billion.³⁵

A state/regional example: Healthcare is well consolidated in Michigan, where Zetema member Wright L. Lassiter III, serves as president and CEO of Henry Ford Health System. Most areas have some sort of entity that has multiple hospitals and multiple ambulatory sites and physician organizations attached to it. Three national systems (Ascension, Tenet, and Trinity) have by virtue of their size and scale of strategy taken a large share of the Michigan market. Regional organizations such as Henry Ford and Beaumont and other smaller organizations have consolidated what remains of the market.

Buying up of physician practices: The other major dimension of consolidation involves hospitals buying different types of provider organizations, primarily physician practices. The *Health Affairs* analysis cited above found growing concentration in physician organization markets between 2010 and 2016. The largest increase was seen in primary care physician practices, due in part to their acquisition by hospitals and healthcare systems. In 2016, 65% of Metropolitan Statistical Areas (MSAs) were highly concentrated for specialist physicians, and 39% for primary care physicians. (57% of MSAs were highly concentrated for insurers.)

As Kaiser Health News recently reported, large hospital systems in Northern California have been buying up independent physician practices.³⁶ This is reflective of a national trend: an Avalere Health study reports an 86% increase in hospitals employing physician practices from 2012 to 2015.³⁷ According to the KHN report, the acquisitions of these practices by Sutter and Stanford Medicine are driving up costs by reducing competition.

In Massachusetts, where Zetema member Steve Strongwater, MD, works as president and CEO of Atrius Health, about 85% of physicians are now part of a large system. Independent physicians are increasingly joining larger entities either through direct contracting, such as a PHO, or employment. He says, "Primary care doctors are in high demand, and hospitals are trying to acquire them to meet a certain number of hospital beds. As a result, primary care salaries become stabilized when they join a larger system."

Physician practice consolidation: Physicians have been consolidating from smaller to larger group practices in recent years. For the June 2013–December 2015 period, one study showed a decline in the proportion of physicians in groups of nine or fewer from 40.1% to 35.3% and an increase in the proportion of physicians in groups of 100+ from 29.6% to 35.1%.³⁸ These trends were significantly more pronounced for primary care physicians than for specialists.

With payment reform and the emergence of alternative payment models such as ACOs, some have posited that physician practices would consolidate to allow providers (physicians and hospitals) to successfully bear financial risk for the full continuum of patient care. A recent study found little evidence for this, however. The study by Harvard researchers found that physicians who entered a Medicare ACO program between 2012 and 2014 showed no differential increase in integration with hospitals or rates of acquisition from the pre to the post period, compared with other physicians in the same market.³⁹ While physician groups that entered an ACO program did have significantly greater growth in size than other practices in their market, the growth was largely driven by the addition of specialists to practices that were already specialty oriented (rather than the addition of primary care physicians), suggesting that the practices did not grow in order to become ACOs.

Why Consolidation Is Occurring

Many experts conclude that providers consolidate to increase economies of scale and reduce competition. Larger health systems have more opportunities to coordinate care, more capital to invest, and more leverage to negotiate reimbursement with insurers.

Bigger is Better: “Hospitals are looking at consolidating and mergers in whatever form, saying the mantra of bigger is better,” Lassiter says. “A greater economy of scale allows you to create efficiencies on how you consolidate clinical service lines such as laboratory, radiology, and pharmacy. Focusing on market share increases and having broader geographies means larger numbers of lives to touch and join your system. The expectation is you’ll have better negotiations around contracting and rates.”

Several additional factors are driving consolidation:⁴⁰

- The shift from volume- to value-based care, including ACOs and bundled payments
- A desire to manage population health
- Greater reliance on healthcare IT, which requires substantial investment but whose benefits and costs scale well

Getting a competitive edge: Strongwater says this is a moment in time when people are trying to secure markets. “The current market is ripe for this kind of exploration because people are trying to lock down and position for some uncertainty.”

The physician factor: Strongwater offers that the Affordable Care Act “...created a fertile ground for physicians and hospitals to work more collaboratively than they have in the past.” Models such as ACOs and bundled payment programs aligned financial interests driven by measures of improved outcomes and lowering total care costs. “Physicians are joining larger systems to secure their future or they’re being acquired by hospitals because primary care is viewed as a mechanism to channel volume. In my experience, they’re getting paid better. They’re getting shielded from the real reimbursement environment because hospitals provide direct salary support,” Strongwater says.

Hospitals also benefit from buying up physician practices. Medicare and most private insurers typically reimburse at higher rates to hospitals than independent physician practices, under the assumption that hospital-based care is more expensive to provide. Hospitals also have more bargaining power than smaller practices to negotiate for higher prices. A *New York Times* article illustrated this point by describing how the price of a Medicare patient's cardiac ultrasound soared from \$189 to \$453, subsequently hiking up the patient's share of the bill after a doctor's practice was purchased by a local hospital.⁴¹

A 2014 study by researchers from the University of California, School of Public Health, Berkeley, and the Integrated Healthcare Association that compared expenditures of hospital-owned physician organizations and physician-owned organizations from 2009 to 2012 yielded the following results:

- Per patient expenditures for local hospital-owned physician organizations were more than 10% percent higher than for physician-owned organizations;
- Multihospital systems that owned physician organizations incurred expenditures that were nearly 20% higher than physician-owned organizations; and
- Per patient expenditures for the largest physician organizations were 9.2% higher than for the smallest organizations.⁴²

Views on Consolidation May Vary Among Physician Specialty Groups

Primary care providers who join larger healthcare organizations see this as a way to gain stability, support, and access to more resources. Specialists might not feel the same way. Orthopedists and other surgical specialists like ENTs or ophthalmologists, for example, might own or have an investment in an ambulatory surgery center and want to retain that ability to compete. "In an acquisition, MDs might have to divest (be bought out or sell shares) impacting long term income. They would also be trading out entrepreneurial future opportunities for employment," according to Strongwater.

However, many doctors oppose consolidation. "A lot of physicians are delivery system-agnostic. They... are not looking to be bought by larger systems and don't want an employer to control them," Lassiter says. This is especially true in Southern California, where large physician groups play themselves against the hospital systems. "Hospitals have gotten bigger, but in some cases physician groups have gotten bigger."

Regulatory Factors

Two regulatory issues that may promote industry consolidation are:

- Certificate of public advantage (COPA) laws that "allow healthcare providers to enter into cooperative agreements that might otherwise be subject to antitrust scrutiny" – but also may prevent the FTC from pursuing legal challenges.

- Certificate of need (CON) laws intended to facilitate coordinated planning of new services and construction – but also may be used by incumbents to prevent expansion or building of competing facilities.⁴³

Many experts say that COPAs and CONs substitute regulation for competition, and so encourage concentration and consolidation.

Advantages and Drawbacks of Consolidation

The financial impact:

An AHA-supported study concluded that hospital mergers and acquisitions reduce operating costs by achieving economies of scale and boosting clinical standardization while reducing capital costs.⁴⁴ An empirical analysis showed a 2.5 percent reduction—equating to \$5.8 million—in annual operating expenses at acquired hospitals.

But costs aren't the same as prices, and most observers believe that provider consolidation has *increased* prices. "I don't know of one case in the country where a reduction in pricing has resulted from consolidation," says Zetema member Karen Ignagni, president and CEO of EmblemHealth. The practice leads to cost shifting and monopolistic behavior, trends that unions, policy makers, and regulators are seeing more and more, she says.

The Medicare Payment Advisory Commission examined this issue at a 2016 meeting and concluded that consolidation will lead to higher commercial rates, which will subsequently lead to higher hospital costs and larger losses on Medicare admissions.⁴⁵ A 2016 study examining hospital price increases in California determined that from 2004 to 2013, hospital prices at California-based Sutter Health and Dignity Health—two of the state's largest multi-hospital systems—increased by 113%, compared with 70% at 175 other California hospitals.⁴⁶ This amounted to a nearly \$4,000 gap per patient admission. The study's authors said these healthcare giants leveraged their market power to drive up prices. Sutter Health has since been sued by California's attorney general for anticompetitive business practices.⁴⁷ A University of California, Berkeley report says the health system's consolidation practices have led to increases in healthcare prices.⁴⁸

Another study from the Healthcare Pricing Project that analyzed data on nearly 28% of individuals in the United States with employer-sponsored insurance coverage (88 million) determined that hospital consolidation was driving up prices for the privately insured.⁴⁹ Hospitals with a monopoly in a certain area had prices averaging 15% higher than areas with four or more rivals. According to the report, "monopoly hospitals also have contracts that load more risk on insurers (e.g., they have more cases with prices set as a share of their charges). In concentrated insurer markets, the opposite occurs—hospitals have lower prices and bear more financial risk."

Lassiter counters that he hasn't seen any significant pricing impact in his home state of Michigan. "Consolidation hasn't appreciably driven prices up or down and I see no data that shows that provider consolidation has had any impact on quality or outcomes. However, I'm not suggesting it's not happening elsewhere."

Impact on quality and health outcomes: There are some huge systems like Geisinger that are unique and are committed to improving care, Strongwater offers. "Generally, they impose their model of care on the systems that join and improve outcomes. This is proven care that has standardized protocols and will lower the costs of care, reduce unjustified variations, and generally improve clinical outcomes. That's why Geisinger has been able to offer warranties for total hip replacement, heart surgery, etc."

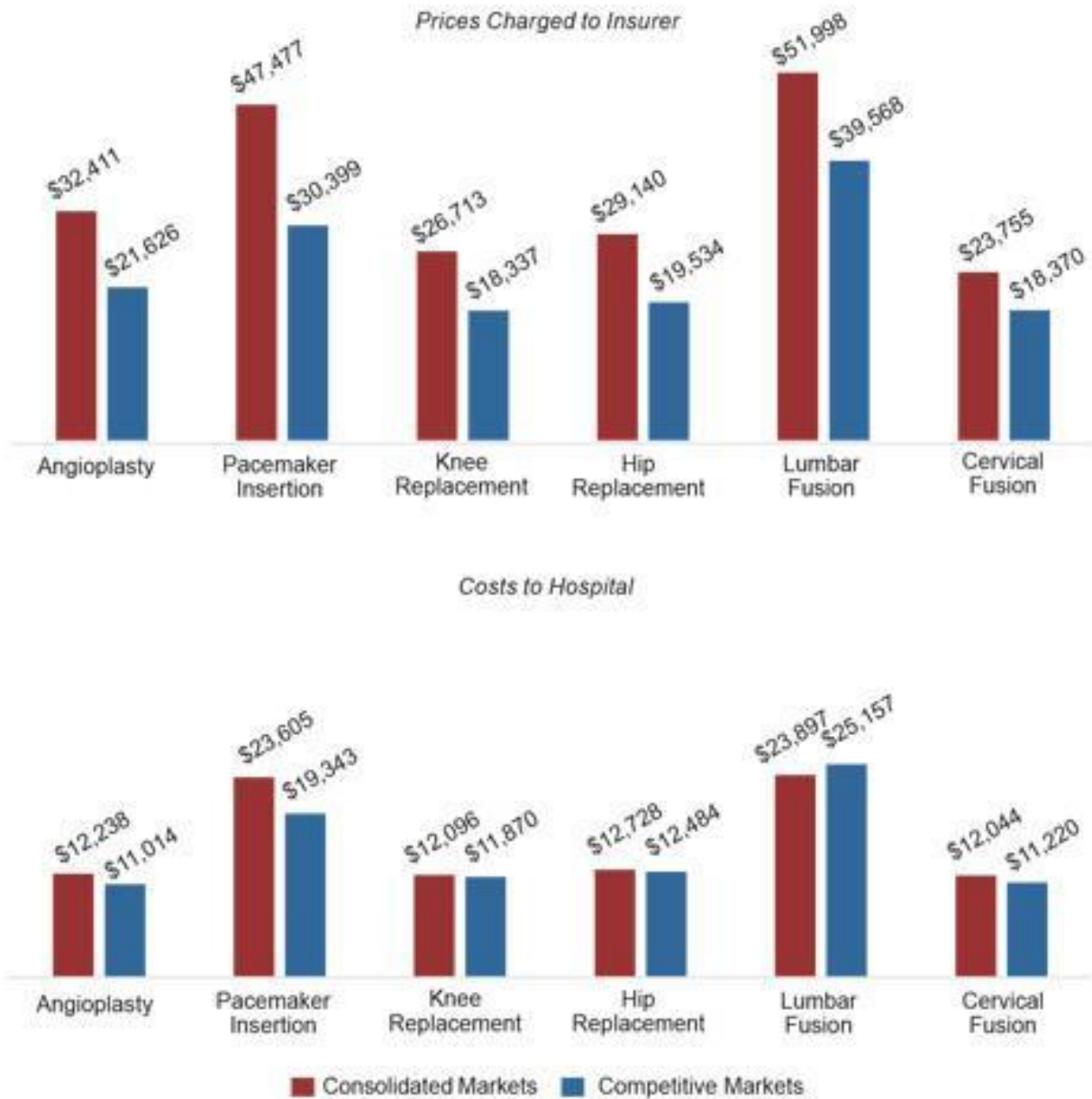
However, a 2017 Brookings white paper drove home the point that patients do worse at hospitals that don't have much competition.⁵⁰ "In particular, when prices are set by regulators, as in the Medicare program, less competition can lead to dramatically worse patient outcomes," and lower quality of care, the paper stated. The paper mentioned the following statistic: heart attack patients on Medicare had a nearly 1.5 percentage point higher chance of dying within a year if they received care from a hospital with little competition versus one that faced a great deal of competition.

The Health IT factor: Health IT is an important infrastructure for standardizing care and for creating libraries of resources and decision support tools that force clinicians to follow best practices. According to Strongwater, it's very expensive in the context of consolidation to do "rip and replace." The biggest challenge is to create common data architecture and infrastructure to share the advances in knowledge and analytics from one site to another.

A preliminary study by A. Jay Holmgren (Harvard Business School) and Julia Adler-Milstein, PhD (University of California, San Francisco) on electronic health record changes following consolidation yielded inconclusive results. In some instances, getting acquired by a hospital system did seem to influence EHR vendor choices. Using 2012 - 2015 American Hospital Association annual survey and IT supplement data, investigators identified 93 hospitals that had been acquired by or joined a hospital system. Of those, 20 were already on the most common EHR vendor used by hospitals in that system. Twenty-two switched from the non-dominant to the dominant vendor, whereas 51 did not have the same vendor, nor did they switch vendors.

Winners and Losers: One of the risks of consolidation is there will be winners and losers, and those on the outs could be at great jeopardy going forward, Strongwater offers. "That's in part due to smaller hospitals going into bigger aggregates. Most of the people I talk to think that consolidation is inevitable, that we're reaching a tipping point where there's only one or two large systems and you might not have as much diversity across the country."

U.S. Health-Care Costs vs. Prices and Hospital-Industry Concentration



Source: James Robinson, "Hospital Market Concentration, Pricing, and Profitability in Orthopedic Surgery and Interventional Cardiology."

Source: Yevgeniy Feyman & Jonathan Hartley. "[The Perils of Hospital Consolidation](#)," *National Affairs*, Summer 2016.

Examples:

Community hospitals: Depending on the situation, consolidation can be a win-lose for these entities. In small communities with limited competition, community hospitals may join a larger system to ensure their future by having greater access to capital and system resources. Example: Lewistown General Hospital (LGH) joining Geisinger. Geisinger secures the future of LGH and also provides access to many specialists not available in the community. Smaller hospitals in more competitive areas may also join a larger system over fears that the larger system will acquire a larger market share over time.

“Large systems with owned or contracted physician networks can threaten the viability of independent practitioners, especially when there are narrow network insurance products which channel patients to network MDs,” according to Strongwater. In cases where large healthcare systems decide to close hospitals, smaller community hospitals vulnerable to such closures may “lose” whereas hospitals within the network may “win” by becoming more efficient.

Physicians: With doctors, it’s a tradeoff. They’re going to trade independence for financial stability and access to more tools and resources to better manage care. “If, or some might say when, value-based care reimbursement predominates, it may not be feasible for physicians to remain independent (particularly primary care) because of needed capital—for infrastructure renewal, investments in IT, data, data processing tools, and access to advanced analytics,” Strongwater said.

Potential Policy Solutions

Experts have proposed various responses to provider consolidation:

- **Antitrust:** Block or slow future mergers. Zetema member Avik Roy and others have proposed substantially increasing funding for the Federal Trade Commission (FTC) to provide staffing that can assess and regulate proposed consolidation. However, since the vast majority of areas already have high levels of hospital concentration, this approach wouldn’t have much impact unless the FTC went so far as to break up existing systems – a much more complex, disruptive, and politically challenging task.
- **Price caps:** Regulate prices by capping provider reimbursement at or somewhat above Medicare rates. This would allow health systems to reap the benefits of investment capital, population health management, and care coordination without permitting them to charge monopolistic rates. The approach would engender market competition (likely on issues other than price) on a level playing field for providers of all sizes.
- **Site-neutral pricing:** Reduce the degree or impact of hospital purchase of physician practices by paying equivalent rates for specific services regardless of where they’re provided (e.g., hospital inpatient or physician office).
- **Research and monitoring:** Fund enforcement-focused research on healthcare consolidation, and establish public databases that provide information about ownership and financial links

among healthcare providers, including net commercial prices for their services. This likely would be informative, but it's unclear whether such efforts would affect prices or quality.

In Massachusetts, a special commission recommended the regulation of hospital prices to keep costs in line.⁵¹ “Market forces solutions aim to correct distortions and inefficiencies in the marketplace by increasing competition, so that differences in prices reflect so-called warranted reasons for price variation. It is important to foster competition among healthcare providers and insurers in light of increasing consolidation in healthcare markets, both in Massachusetts and nationally,” their report says.

6.1 Provider Consolidation: Discussion Questions

- Do hospital mergers typically raise prices?
- Does hospital-physician consolidation typically raise prices?
- Does provider consolidation make it more difficult for payers to create narrow networks?
- Are the arguments valid that consolidation and scale are necessary for hospitals to survive in an era of accountable care, population health management, and high IT investment?
- What has been the impact of the Massachusetts Health Policy Commission on consolidation and costs?
- Should the size of the FTC be increased substantially to deal with provider consolidations?
- Should regulators not only restrict potential mergers but actively break up existing ones?
- What would be the impact of site-neutral pricing on consolidation? On healthcare costs?
- Does the employment base of hospitals restrain state government antitrust action?
- Should the government use the Essential Hospital label to reduce monopolistic power?
- Could California's case against Sutter Health be a game-changer?

7. Provider Regulation as A Cost Driver

Overview

- Estimated that up to 20% of total healthcare costs are due to regulations
- Too many regulations contribute to physician burnout and take resources away from patient time
- Many regulations are outdated and do not reflect the current reality of the healthcare landscape
- Other regulations do not contribute to quality improvement
- The Trump administration has signaled interest in reducing regulatory burden for healthcare providers

Scope of Practice

- There is wide variation in scope-of-practice (SOP) regulations across states. In 22 states, nurse practitioners (NPs) are permitted to provide care independently.⁵² Other states do not permit NPs to practice without collaborating with, or being supervised by, a