Provider consolidation: The role of Medicare policy

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Overview

- Effects of provider consolidation
  - Medicare: physician prices increase due to facility fees
  - Commercial: physician and hospital prices increase due to market power
- Policy responses
  - Site-neutral prices for facility fees
  - Restrain Medicare hospital and physician prices

- Insurer-provider consolidation
  - Effects on quality, cost
  - Policy response?
Four types of consolidation

- Horizontal hospital consolidation
- Horizontal physician consolidation
- Vertical consolidation: hospitals employ physicians
- Vertical consolidation of provider functions and insurance risk
  - Providers take on insurance risk
  - Insurers purchase provider groups
Most markets are highly consolidated, market power is part of our environment.

Consolidation can lead to higher hospital prices, without clear evidence of quality improvement.

Prices commercial insurers pay hospitals can vary by a factor of five for the same service.

On average, commercial prices are about 50 percent above costs, well above Medicare.
Growth in large physician practices

- Share of physicians in practices with over 50 doctors increased from 16 percent in 2009 to 22 percent in 2014
- Practices are merging into common ownership, often without physically merging practices
- Solo practices still had 20 percent share of Medicare business in 2014
Vertical physician-hospital consolidation

- Hospitals buy physician practices
- Bill physician services as hospital outpatient (HOPD) services
- Medicare: Facility fees result in higher Medicare spending
- Commercial: Higher negotiated prices
Vertical consolidation leads to higher Medicare payments for physician services

- Medicare pays facility fees for on-campus outpatient services and grandfathered hospital-owned off-campus clinics

- Facility fee example:
  - Medicare paid hospitals $1.6 billion more for E&M visits than if hospitals were paid physician office rates in 2015
  - Beneficiary cost sharing was $400 million higher
Horizontal and vertical consolidation is associated with higher E&M prices

<table>
<thead>
<tr>
<th>Market share of E&amp;M visits</th>
<th>99214 commercial price relative to Medicare*</th>
<th>RVU price relative to others in the market</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not hospital owned</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;10% mkt share</td>
<td>100%</td>
<td>93%</td>
</tr>
<tr>
<td>10% to 30% share</td>
<td>122</td>
<td>104</td>
</tr>
<tr>
<td>Over 30% share</td>
<td>141</td>
<td>106</td>
</tr>
<tr>
<td>Hospital-owned practices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;10% mkt share</td>
<td>123%</td>
<td>104%</td>
</tr>
<tr>
<td>10% to 30% share</td>
<td>128</td>
<td>112</td>
</tr>
<tr>
<td>Over 30% share</td>
<td>138</td>
<td>111</td>
</tr>
</tbody>
</table>

*Price is relative to the national average for Medicare in 2013.
Source: Medicare analysis of HCCI claims data and Medicare claims data for 2013
Preliminary and subject to change
Higher cost growth for commercial insurance illustrates the importance of Medicare restraining prices

Sources: Employer sponsored premiums are from Kaiser Family Foundation surveys, 2007-2016
Medicare spending is A/B program spending from the CMS actuaries
Part D spending is from MedPAC analysis of claims and reinsurance data from 2007 to 2015, 2016 part D spending is a projection
Possible policy responses to consolidation

- Horizontal consolidation response: Do not follow commercial prices
  - Has worked in recent years
  - In the long-run, commercial rate growth may cause access concerns
- Vertical consolidation response: Site-neutral pricing
  - Prevents higher costs for taxpayers
  - Prevents higher costs for beneficiaries
Integrating provider functions and insurance risk

- MA plans
  - Some MA plans integrate providers via a group model or a staff model
  - Some plans contract with providers at close to Medicare FFS rates

- ACOs
  - Integrating provider functions and some insurance risk
  - Destination: two-sided models
MA plan insurer-provider consolidation

- MA plans have mixed performance relative to FFS
  - Better scores on some process measures than FFS
  - Patient experience equal to FFS
  - Lower service use than FFS, but still cost taxpayers about 4 percent more than FFS
- MA plan insurer/provider consolidation may have quality benefits, but has not been shown to lower MA premiums or assure financial viability
- ACOs
  - Improving quality
  - About break-even for the taxpayer
- Greater MA and ACO success in high-use markets
Variation in performance of MA plans relative to FFS

- 78 markets where all three models existed in 2013
  - Traditional FFS was the low-cost model in 28 markets
  - ACO was the low-cost model in 31 markets
  - MA was the low-cost model in 19 markets

Note: MA plans exclude special needs plans and employer-based plans. Relative costs refer to 2012-2013 for ACOs and 2015 bid data for MA plans. Differences between FFS and ACOs are generally small. See June 2015 MedPAC report.
Source: MedPAC analysis of ACO data and MA plan bid data.
Two possible policy responses

- Financial neutrality: Pay FFS and all types of MA plans equal base rates
  - Higher quality could receive higher payments
- Favor one type of model
  - Pay more for certain structure or process
  - Concerns
    - May not correctly identify best model for all markets
    - May discourage delivery system innovation
- Financial neutrality will shift market share to most efficient model in each market
Discussion: MA / ACO / FFS payment policy

- FFS
  - Traditional
  - ACO
- MA
  - MA integrated with providers
  - MA plans that only contract with providers
- Financial neutrality: Pay based on patient needs and outcomes
- Favoring one model: Paying more for certain legal or organizational structure