Considering the ACA's Impact on Hospital and Physician Consolidation

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Regardless of public sentiment on the success or failure of the Patient Protection and Affordable Care Act ("ACA"), its impact on the health care industry is beyond dispute. The sheer scope of activities it has impacted — reimbursement, quality of care, delivery mechanisms, insurance coverage, access and affordability of care — is second only to the introduction of the Medicare and Medicaid programs in the 1960s.

Just as consequential as the areas directly addressed by the ACA are industry responses to ACA mandates. This Comment posits that hospital/health system and physician consolidation is an expected strategic response to the current business and regulatory environment, while arguing that consolidations should be measured against how well they move organizations toward achieving health care's "Triple Aim"[1] of high quality, accessible health care at a reasonable cost.

The ACA Has Encouraged Consolidation

The ACA has prompted increased consolidation throughout the health care industry, with greater involvement of larger systems in change of control transactions. While there is always an opportunistic aspect to consolidation, changes in the regulatory and financial environment are a large factor, as demonstrated by consolidation that has occurred over the last thirty years.

Managed care, for example, was introduced as an important cost containment initiative in the 1990s. Institutional leaders understood that the financial incentives inherent in managed care, and the emphasis on exclusive networks and contracting, meant that geographic reach was integral to growing enrollment. Beyond the influx of managed care, the delayed impact of Medicare's mid-1980s transition to a prospective payment system further constrained the ability of hospitals to pass on cost increases. These new payment models resulted in a surge of change of control transactions,[2] which reached a high of 139 announced transactions in 1998.[3]

Hospital transactions slowed in the early 2000s due to general economic conditions, with 50–60 occurring

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per year from 2005–2009, with an average of only 1–2 "large" transactions (i.e., revenues of involved parties exceeding $1 billion/year).[4] However, the passage of the ACA in 2010 accelerated transactions, with 76 transactions in 2010 and 93 in 2011.[5] This trend continued with 100 or more transactions in 2014–2016; in 2017 115 transactions were announced, the highest number in recent history.[6]

While the pace of consolidation is quickening, the size of the parties involved has simultaneously grown. The number of large transactions from 2010–2016 spiked significantly, with an average of 5–6 per year.[7] Eleven transactions were announced in 2017 with revenues over $1 billion — the largest number of transactions of this size ever recorded in a single year.[8] This trend continues in 2018, with the February announcement of Bon Secours Health System and Mercy Health's proposed merger, which would create a 43-hospital entity serving seven states, with combined revenue of $8 billion.[9]

In addition, physician practices have been consolidating for some time. A significant reason for this has been the push by hospitals to vertically integrate, enabling them to control health care components that impact the acute care setting and/or reimbursement.[10] This push by hospitals alongside the heightened cost of operating medical practices (as discussed below) has led to a deterioration of solo and small group practice in most specialties. For instance, from 1995–2005 the proportion of physicians in solo or two-person practices declined from 40.7% to 32%, further declining to 25% in 2012 and 17% in 2016.[11] 2016 marked the first time that physician-owned practices were not the dominant organizational structure and delivery model for physician services, with only 47.1% of physicians practicing out of corporate entities owned and controlled by physicians.[12] This trend is likely to continue unabated, as practice acquisitions saw a 78% increase from the fourth quarter of 2016 to the first quarter of 2017.[13]

Beyond hospitals increasing the size of their employed medical groups through practice acquisitions, large medical groups also have been particularly aggressive in building scale. The country's largest physician group, Permanente Medical Group, employs almost 20,000 physicians.[14] Other household names, such as the Mayo Clinic and Cleveland Clinic, bring significant size to bear.[15] In addition, certain specialties have their own consolidators. And, in one of the largest transactions of its kind, the private equity group Ares Management, L.P. invested $1.45 billion in DuPage Medical Group ("DMG"), providing DMG with significant funds to further its growth and acquisition strategies.[16]

Why has the Pace of Consolidation Quickened under the ACA?

While every consolidation possesses its own unique mission or market specific reasons for occurring, cost, uncertainty, and the need for essentiality are the key factors behind the ACA-led consolidation wave.

The first key factor is the high cost of operating a health system or physician business. The quickening pace of new technology, treatment modalities, and pharmaceuticals, coupled with an aging demographic and continually rising consumer expectations, suggests that the cost of business will continue its upward spiral. Regulatory costs, including HIPAA compliance, meaningful use requirements, compliance protocols and the like have also added significantly to the costs borne by providers.[17]

In a rising cost environment, with little ability to pass on enhanced costs due to the present reimbursement structure,[18] scale becomes a dominant management strategy.[19] Shared costs are an extremely attractive approach, as they can be effectively spread across a larger platform. Larger size also brings additional resources, such as greater access to capital, focused management, programmatic resources, and the ability to leverage the organization's strength with contracting partners and payors; in combination, these resources potentially lead to great organizational success.

The second key factor behind consolidation is that the ACA unleashed a wave of uncertainty within the health care industry. Larger size is always seen as a bulwark in an uncertain environment, and eight years after the ACA's passage, this uncertainty continues, strengthening the force driving consolidation.[20] Initially, uncertainty was created by the passage and implementation of the ACA by the Obama administration. The ACA portended a massive reconfiguration of the dominant fee-for-service reimbursement models, shifting toward "experimental" methodologies (e.g., bundled payment), heightened rewards and penalties for quality, and seemingly moving toward a population health, capitation-friendly payment system. It also promised a new population of patients, whose access to care had been diminished, thereby needing a greater intensity of services given their general lack of consistent medical care. Further, it encouraged private payors to develop creative, innovative models to contain cost and promote quality.

For better or worse, the ACA unleashed these things while continuing to maintain a strong foothold in the fee-for-service reimbursement world, forcing executives to simultaneously manage two very different business environments that financially rewarded different activities.[21] Managements' response to this type

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of convoluted business and regulatory environment has been to consolidate.

The second type of uncertainty prevalent today involves the political uncertainty surrounding the stability of the ACA. Massive investments have been made by the health care industry to comply with the ACA mandates and respond to its incentives and policies.[22] The Trump Administration called many of these actions into question, without providing a clear alternative.[23] If anything, this second layer of uncertainty makes the movement for size and scale much more compelling.

The third key factor behind consolidation involves the drive to achieve essentiality. Scale coupled with success leads to essentiality, the key determinant of success for any business in any industry. Essentiality is the concept that the organization has a unique characteristic or combination of factors — i.e., brand, market position, service, mission, cost structure — that is recognized and rewarded by payors, patients, physicians or other important constituencies. Essentiality does not guarantee success, but without it an organization will not survive or thrive.

Essentiality is especially important in the health care industry, and the pace of change in the industry means that the "rules" for obtaining and maintaining essentiality, and the factors causing an organization to be viewed as essential, are in flux and rapidly changing. An outgrowth of essentiality is the ability to exert leverage, particularly with payors. Thus, "needing" to be in a network for the payor to have a viable product in the market and, therefore, being able to negotiate favorable rates, is critical to success.

Consolidation is not a guarantor of essentiality, but it can help significantly. Barring some unique specialty or affiliation (e.g., a specialty hospital, linkage to a medical school), larger organizations, with wider geographic spread and patient allegiance, have an opportunity to use their size to make them network "must haves."

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Impact on the Triple Aim

The Institute for Healthcare Improvement, then led by former Department of Health and Human Services Secretary Donald Berwick, coined the phrase "Triple Aim" due to a "growing realization that the successful health and health care systems of the future will be those that can simultaneously deliver excellent quality of care, at optimized costs, while improving the health of their population."[24] This formulation and others like it provide a sound lens for examining the impact of both policy and market forces on improving health care delivery. Therefore, it is appropriate to ask whether the consolidation encouraged by the ACA is improving the health care delivery system.

It is fair to say that there is limited empirical data on this point. Studies supportive of consolidation among hospitals and health systems as advancing the Triple Aim generally conclude that economies of scale lead to decreased costs, increased access to capital, assist in standardization of clinical protocols to enhance quality of care, increase volumes further enabling heightened quality of care, expand the scope of services to better serve the covered population, and enable more efficient and comprehensive care.[25]

Conversely, the Center for Health Policy Research at the Brookings Institution, in conjunction with Carnegie Mellon University's Heinz College, found that consolidation leads to rising prices, price variation and uneven quality.[26] A 2006 study by the Robert Wood Johnson Foundation predating the ACA concluded that the available evidence on the impact of consolidation on care quality was varied and that the most reputable studies found a reduction in quality; consolidation only "modestly reduces" hospitals' cost of providing care.[27]

Studies also reflect a mixed picture for physicians. One of the very few studies, a Canadian study conducted in 2013, found that larger groups provide better patient access and comprehensiveness of care, but worse continuity of care.[28] Further, anecdotal evidence suggests that the ability to move physician practice style from a fee-for-service mentality to one premised upon integration, while promising effectiveness and heightened quality in the long run, may lead to nearer term negative impacts.[29]

Part of the difficulty in procuring a definitive assessment of consolidation is that the rationale for each

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consolidation, in each particular market with its own dynamics, can vary greatly. Further, the skill and desire of the particular management teams involved to secure "Triple Aim" enhancements also varies greatly. Admittedly, many consolidation initiatives are premised on survival, securing leverage with payors and wringing out "back office"-type savings, none of which will truly enhance the patient experience. Overall, it is very hard to create an organization that is truly transformative.

However, this does not mean that consolidation cannot further cost, quality and access improvements — it can. But, achieving these goals includes a high reliance on metrics and accountability, and close collaboration with caregivers to redesign the patient experience to ensure the right care at the right time in the right setting. Initiatives like this require a certain scale, including financial resources and a high level of executive talent, which arise more readily in larger organizations. Nevertheless, the consolidation track record is not rife with these types of mergers. This begs the question of whether consolidation strategy will transition to this.

Given continued regulatory uncertainty, heightening cost of care and tight reimbursement, system and physician leadership will continue to turn to consolidation. Thus, it is imperative that the industry demonstrate that this business strategy will pay significant dividends to the people it serves.

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Note

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