Provider consolidation: The role of Medicare policy

Jeff Stensland and Kate Bloniarz

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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

Horizontal hospital consolidation

- 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

Market share of E&M visits	99214 commercial price relative to Medicare*	RVU price relative to others in the market
Not hospital owned		
<10% mkt share	100%	93%
10% to 30% share	122	104
Over 30% share	141	106
Hospital-owned practices		
<10% mkt share	123%	104%
10% to 30% share	128	112
Over 30% share	138	111

*Price is relative to the national average for Medicare in 2013.

Source: Medicare analysis of HCCI claims data and Medicare claims data for 2013

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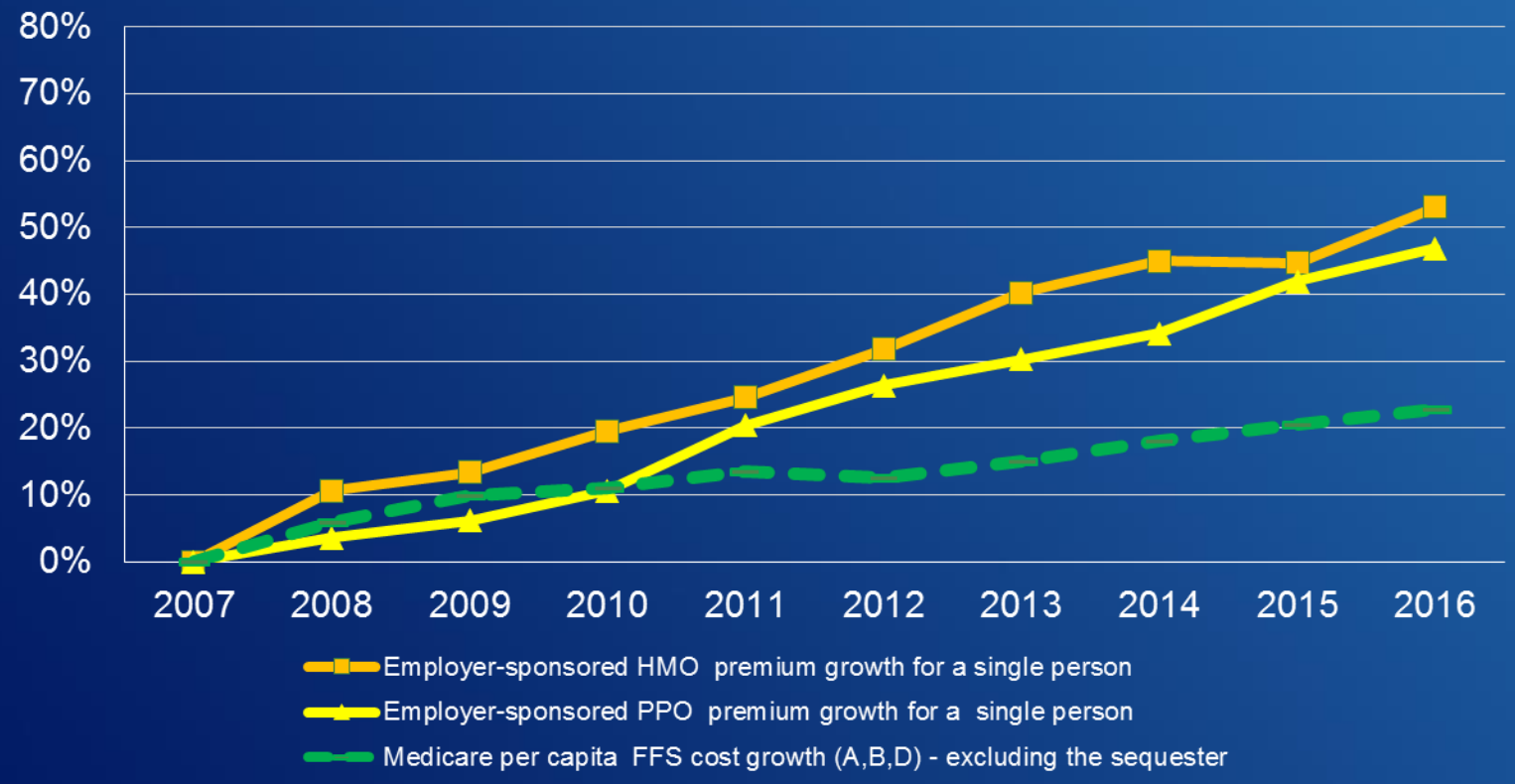
Preliminary and subject to change

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