Vertical integration and Medicare payment policy

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Medicare policies can influence health care market competition

- Site-of-service differentials in payments
- Policies aimed at coordinating care such as accountable care organizations, bundled payments
- Changes in post-acute care payment
- Start of Part D and expansion of Medicare Advantage enrollment

By 2018, about half of physicians were affiliated with health systems

	Total number, 2018	Percent growth, 2016–2018	Percent of all in category affiliated with health systems	
			2016	2018
Health systems	637	2%	n/a	n/a
Number of affiliated:				
Physicians	~508,000	9%	40%	51%
Primary care physicians	~169,000	19%	38%	49%
Hospitals	~3,400	-3%	70%	72%
Hospital beds	~611,000	2%	88%	91%

Note: n/a (not applicable). Data are preliminary and subject to change. Health systems are defined as organizations with at least one acute care hospital and one physician group providing comprehensive care that were connected through common ownership or joint management. To be included, a health system had to have at least one nonfederal general acute care hospital, 50 or more physicians, and 10 or more primary care physicians. See Agency for Healthcare Research and Quality Compendium of U.S. health systems, https://www.ahrq.gov/chsp/data-resources/compendium.html.

Source: Furukawa, M., L. Kimmey, D. Jones, et al. 2020a. "Consolidation of providers into health systems increased substantially, 2016-18," *Health Affairs* 39, no. 8 (August): 1321-1325. Furukawa, M., R. Macha, K. Barrett, et al. 2020b. "Landscape of health systems in the United States," *Medical Care Research & Review* 77 (4): 357-366.

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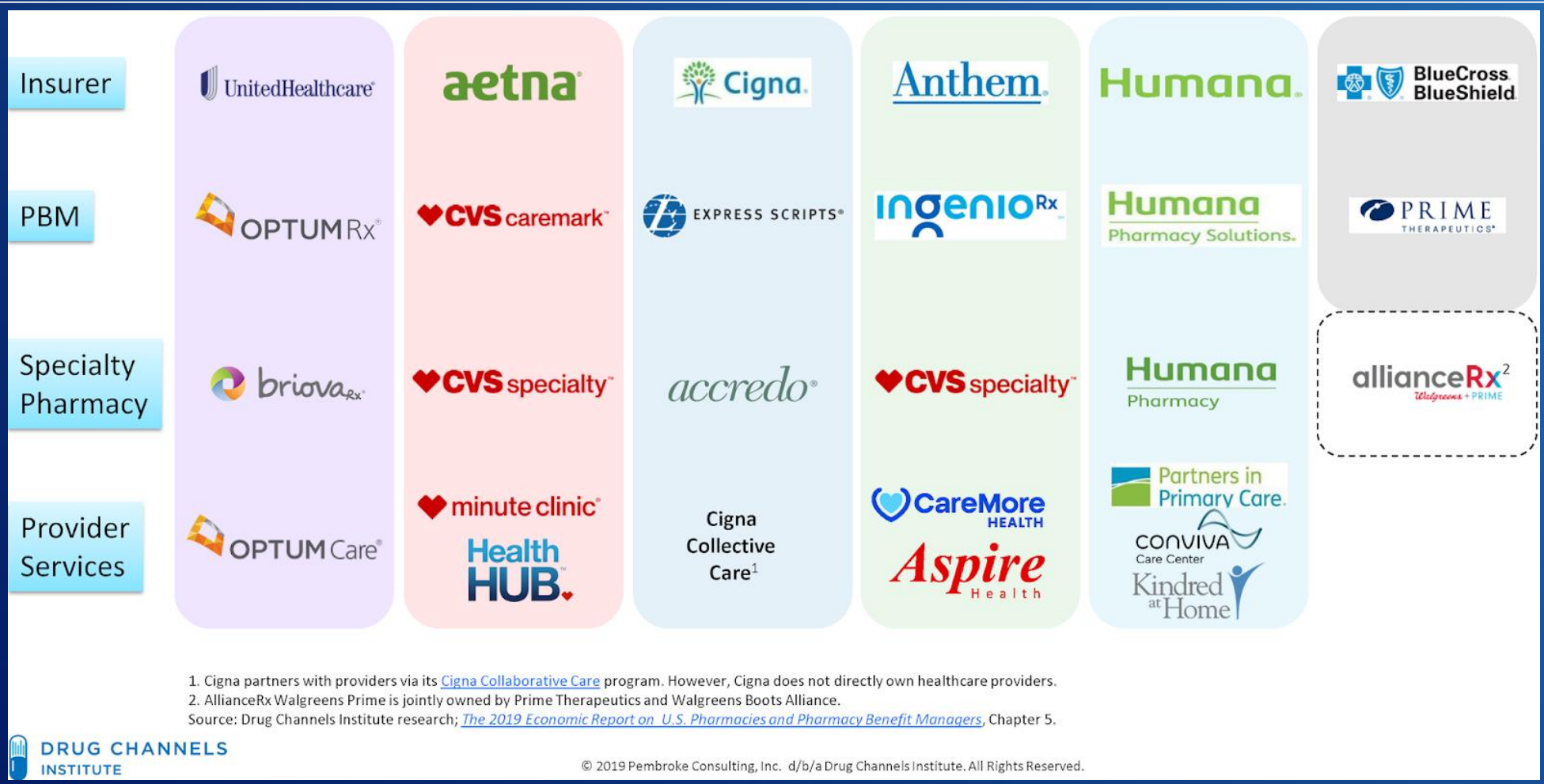
Literature on effects of hospital-physician vertical integration (March 2020 report)

- No substantial effect on hospital or physician volume of services in the aggregate
- Ambiguous or no effects on quality of care
- Higher commercial prices for physician services
  - Facility fees plus professional fees
  - Greater market power in negotiating commercial rates
- Higher commercial and Medicare payments because of:
  - Higher payment for hospital-based care
  - Referral patterns toward hospital-based facilities

Large health plans are vertically integrated



Source: Fein, A. 2019. Insurers + PBMs + specialty pharmacies + providers: Will vertical consolidation disrupt drug channels in 2020? Drug Channels blog, December 12. https://www.drugchannels.net/2019/12/insurers-pbms-specialty-pharmacies.html.

Medicare Advantage (MA) and Part D enrollees are concentrated in plans offered by large sponsors

Plan sponsor	Share of MA enrollment, 2019		Share of PDP enrollment, 2019
	Metropolitan counties	Nonmetropolitan counties	All PDP regions
UnitedHealth Group	26%	29%	20%
Humana	17%	26%	17%
CVS Health/Aetna	10%	10%	24%
Total of top 3	53%	65%	61%
Total of top 10	76%	80%	96%

Note: MA (Medicare Advantage), PDP (stand-alone prescription drug plan). Data are preliminary and subject to change. MA enrollment shares as of October 2019. Excluded are cost-reimbursed plans and Medicare–Medicaid demonstration plans. The nonmetropolitan counties include those designated as micropolitan counties and counties that are neither metropolitan nor micropolitan as defined by the Office of Management and Budget. PDP enrollment shares as of April 2019.
Source: MedPAC analysis of CMS enrollment data.

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Vertical integration between health plans and outpatient providers

- Include higher-quality, lower-cost providers in plans' networks, align incentives through risk-based payments
- Encourage enrollees to use lower-cost providers and sites of care
- May help providers acquire electronic tools for decision support and quality measurement
- Response to health system acquisitions of practices as well as competing health plans

Will vertical integration between health plans and outpatient providers benefit Medicare and beneficiaries?

- Acquired providers may or may not overlap with geographic concentration of plans' MA enrollment
- Affiliations between health plans and group practices not necessarily through employment
- Multiple payer arrangements may undermine alignment of incentives
- Harmonizing technology platforms is challenging
- Retail outlets may not lower spending

Vertical integration between health plans and pharmacy benefit managers (PBMs)

- Major PBMs own large mail and specialty pharmacies
- Acquisition may be easier than an arm's-length contract between a health plan and PBM, which can be difficult to monitor and costly to enforce
- Access to net drug price information
- Align incentives and internalize tradeoffs between medical and drug expenses
- Access to real-time prescription claims information

Will vertical integration between health plans and PBMs benefit Medicare and beneficiaries?

- Contracts between smaller plan sponsors and PBMs owned by large plan sponsors may be difficult to monitor and costly to enforce
- Whether efficiencies lead to lower plan bids depends on degree of competition among plans in MA and Part D markets
- Vertical integration will not resolve poor incentives in MA and Part D payment systems

Vertical integration between health plans and post-acute care (PAC) services

- Include higher-quality, lower-cost providers in plans' networks, align incentives through risk-based payments
- Acquired PAC management companies may help clarify decisions about which patients most likely need PAC and at which settings
- Encourage enrollees to use home-based, non-institutional PAC in recovery, shorten institutional stays when they are needed

Will vertical integration between health plans and PAC services benefit Medicare and beneficiaries?

- Acquired providers may or may not overlap with geographic concentration of plans' MA enrollment
- Multiple payer arrangements may lead to mixed incentives
- Uncertainty about whether substituting home care for institutional care will improve quality, lower spending
- Whether efficiencies lead to lower plan bids depends on degree of competition among plans in MA markets

Summary

- Medicare policies, among other factors, can influence health care market competition
- Health systems and large health plans have become more vertically integrated
- Tension between goals of care coordination and maintaining market competition
- Some vertical mergers may improve quality and efficiency, but not all mergers benefit Medicare and beneficiaries

Implications for Medicare policy

- Consider potential effects of policy changes on market competition of providers and plans
- Policies that may promote competition
  - Full implementation of site-neutral payments
  - Simplify and standardize quality measures of care outcomes
  - Encourage rivalry among MA and Part D plans

Discussion

- Questions about the material?
- Any additional elements of vertical integration you would like us to pursue?
- Have we missed implications for Medicare that you would like us to address?