Consolidation and Competition in Healthcare Markets: How Big Do You Have to Be to Succeed?

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Sixth National ACO Congress
Hyatt Regency Century Plaza
Los Angeles, CA
November 16, 2015

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ACO Growth Nationally

- Now 775 across the U.S.
- In almost every state
- About 20 million people

Source: Leavitt, Inc.

Growth in California

- About 80+
- About one million lives
- 11 percent of California Medicare FFS beneficiaries

Source: Fulton, Pegany, Keolani et al. 2015, JHPPL, 667-688

What Evidence To Date Suggests

1. Use of Patient Centered Medical Home processes is increasing for both large (20+ doctors) and small practices (<= 19 doctors). But it is significantly higher for large practices (53.4%) than for small practices (29.1%)

Source: Casalino, Ramsay, Shortell et al. 2015, in process; Wiley, Rittenhouse, Shortell et al. Health Affairs, 2015: 78-88

2. Large multi-specialty medical groups provide higher quality care at lower cost than other provider organizations

Source: Weeks, Gottlieb and Nyweide et al. Health Affairs, 2010: 991-997

3. Also more Integrated Medical Groups

Source: Mehrotra, Epstein and Rosenthal, Annals of Internal Medicine, 2006: 826-33.

But Also Some Evidence That Smaller Practices Perform Better

1. **Can reduce costs for patients with diabetes**
Source: Kralewski, Dowd and Xu, Health Affairs, 2012: 1830-35

2. **Can contain spending and improve quality for Medicare beneficiaries**
Source: McWilliams, Chernew, Zaslavsky et al., JAMA Internal Medicine, 2013; 1447-1456

3. **Can provide better care for patients with cardiovascular disease.**
Source: Landon, Normand, and Meara et al. Medical Care Research and Review, 2008: 167-86

4. **Have lower ambulatory care sensitive admission rates**
Source: Casalino, Pesko and Ryan et al. Health Affairs, September 2014, 1680-88.

Some Interesting Findings from California

- Higher levels of pre-existing managed care are associated with higher ACO entry and enrollment growth
- Hospital concentration is associated with fewer ACOs and lower enrollment
- Concentrated physician markets have a smaller percent of individuals in commercial ACOs but a larger number of commercial ACO organizations. So the ACOs are smaller in these markets.

Source: Whaley, Frech and Scheffler, JHPPL, August 2015: 687-701.

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State Actions to Promote and Restrain Commercial ACOs

TABLE 2. PROMOTING THE RESPONSIBLE DEVELOPMENT OF COMMERCIAL ACOS

	Tools that Support and Regulate Providers						Tools that Support and Regulate Payers			
Potential State Roles	Risk Certificates	Certificates of Authority or Licensing	Antitrust Enforcement	Antitrust Exemptions	Restrict Range of Permissible Contracts	Support and Funding	Cost Caps and Benchmarks	Population-Based Contracting Targets	Primary Care Targets	Targets for Alternative Payments
Support and Encourage Integrated Care		NY		NY			RI	RI		
Support Alternative Payment Methodologies		NY				X		RI		RI
Support Strong Networks of Primary Care									RI	
Protect the Public from Anticompetitive Behavior		TX	X		MA					
Encourage Providers to Responsibly Assume Risk	MA	TX								RI
Develop and Support Comprehensive Databases						X				
Encourage Public Reporting of Cost and Quality Data		NY				X				

Source: Authors' Analysis

Notes: The state abbreviations refer to existing activities. "X" refers to activities that are possible, but have not been pursued in the context of these case studies. The state abbreviations in this table are illustrative, not exhaustive.

State Actions to Promote and Restrain Commercial ACOs

TABLE 3: CHARACTERISTICS OF CERTIFICATES OF AUTHORITY AND RISK CERTIFICATES

	Massachusetts		Texas	New York
Characteristics of Certification	ACO Certification	Risk Certificates[1]	HCC Certification[2]	ACO Certification[3]
Voluntary or Mandatory	Voluntary	Mandatory	Mandatory	Voluntary
May Create a Safe Harbor or Safety Zone	No	N/A	Yes	Yes
Provides Protections from Other Laws or Requirements	No	N/A	No	Yes[4]
Includes a Solvency Review	No	Yes	Yes	No
Requires Public Reporting of Cost and Quality Data	Yes	N/A	No	Yes
Includes a Re-Certification Requirement	Yes	Yes	Yes	No

Source: Authors' Analysis

Notes
[1]Applies to Risk Bearing Provider Organizations
[2]Applies to Health Care Collaboratives that assume downside risk
[3]Applies to Accountable Care Organizations that do not assume downside risk
[4] Other exemptions include: ban on corporate practice of medicine, fee splitting, and self-referral laws

Source: Hollingshead A et al. State Actions to Promote and Restrain Commercial ACOs. UC Berkeley Petris Center, 2015

Potential ACO Antitrust Risk Assessment Diagnostic Indicators: Sample Measures

- Percent of patients under risk-based contracts involving downside risk for losses (-)
- ACO is at risk for hospital costs (-)
- ACO meets all quality measures (-)
- ACO scores high on Patient Centered Medical Home (PCMH) index measures (-)
- High primary care physician/specialist ratio (-)
- ACO is physician led vs. hospital led (-)
- ACO does not include a hospital or has no exclusive arrangement with a hospital (-)

Source: Shortell, Colla, Lewis et al. JHPPL, August 2015: 645-666.

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Overall Assessment

- A lot of “moving parts”
- Still evolving
- Encourage ACO growth but remain vigilant!

Thank You

QUESTIONS/DISCUSSION

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