



Hospitals in the Post-ACA Era: Impacts and Responses

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Hospitals are important civic institutions in their communities. In addition to providing medical care, they employ many people and are often a source of civic identity. They are also major sources of health care expenses and legislative influence. Their operating environment has changed significantly in the last few years, due to, among other reasons, changes in Medicare policy, lower rates of uncompensated care, greater experimentation with provider payment reforms by public and private payers, and innovations enabling the delivery of more medical care in ambulatory settings.

To better understand these trends, the changing roles of hospitals, the public policy implications, and the relevant levers available to policymakers, the Milbank Memorial Fund and the New England States Consortium Systems Organization (NESCSO) sponsored a one-day forum in October 2016 that brought together state government health policy leaders from across New England. Leaders had an opportunity to discuss the current state of hospitals in the region, the ways in which hospitals are responding to the changing health care environment, and how state governments can ensure those responses are consistent with efforts to improve population health and health care value.

A summary of the changing environment for hospitals was presented at the conference by Gary Young, JD, PhD, Director, Northeastern University Center for Health Policy and Healthcare Research Professor of Strategic Management and Healthcare Systems, D'Amore-McKim School of Business and Bouvé College of Health Sciences, Northeastern University. This resulting issue brief looks at the ways the Affordable Care Act sought to change hospitals, how hospitals are responding to these pressures, and result-

ing considerations for state policymakers. Of particular interest—and noted in this issue brief—are increased hospital-provider consolidation activity, hospital participation in value-based care arrangements, and expectations for hospitals to play an increasing role in improving community health.

We hope this summary is of use to anyone interested in helping determine appropriate roles and public policies for these important institutions in improving the health of their communities.

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Hospitals are a central component of the US health care infrastructure. The United States currently spends more than \$970 billion on hospital services, approximately one-third of the nation's total health care expenditures.¹ At the same time, hospitals continue to face many challenges in the form of increased competition for the services they provide, tighter reimbursement from purchasers, and greater demands from consumers for performance accountability. The Patient Protection and Affordable Care Act (ACA), which was signed in 2010, included provisions that amplified some of these challenges for hospitals and introduced new challenges as well. This issue brief, which was presented at a New England States Consortium Systems Organization (NESCSO) conference titled “The Future of Hospitals in New England” in October 2016, focuses on ACA provisions and their impact on hospitals. Section I presents key ACA provisions pertaining to hospitals. Section II presents a national perspective on the status of hospitals in the post-ACA era with particular attention to the impact of the ACA on hospitals' financial condition and utilization, consolidation, quality of care, and population health engagement. Section III outlines key issues for state policymakers.

I. Key ACA Provisions for Hospitals

Expanded Insurance Coverage

The ACA is intended to expand health insurance coverage generally and, consequently, has implications for hospitals' financial condition and utilization. Expanded insurance coverage was expected to generate at least modest increases in hospital utilization and potentially reduce hospitals' uncompensated care costs (i.e., combined bad debt and charity care). A central feature of the legislation is the individual insurance requirement. In addition, the ACA encouraged states to expand their Medicaid programs in terms of eligibility criteria, which 31 states have done.² Recent reports indicate the number of uninsured people has dropped by more than 30% from pre-ACA levels.³

Payment

The ACA included a set of Medicare-related payment cuts and payment reforms for hospitals. The payment reforms encompass multiple programs linking hospital reimbursement to performance metrics focusing on quality and efficiency (e.g., Hospital Value-Based Purchasing Program, Hospital Readmissions Reduction Program, Hospital-Acquired Condition Reduction Program, Medicare Shared Savings Program).⁴ Additionally, the Centers for Medicare and Medicaid Services (CMS) is planning to channel more Medicare payments to providers through alternative payment arrangements (i.e., global or bundled payments rather than fee-for-service payments).⁵ The CMS goal is to have 50% of all Medicare payments made through alternative payment arrangements by 2018. These payment cuts and reforms have the potential to affect hospitals' financial condition and quality of care (Figure 1).

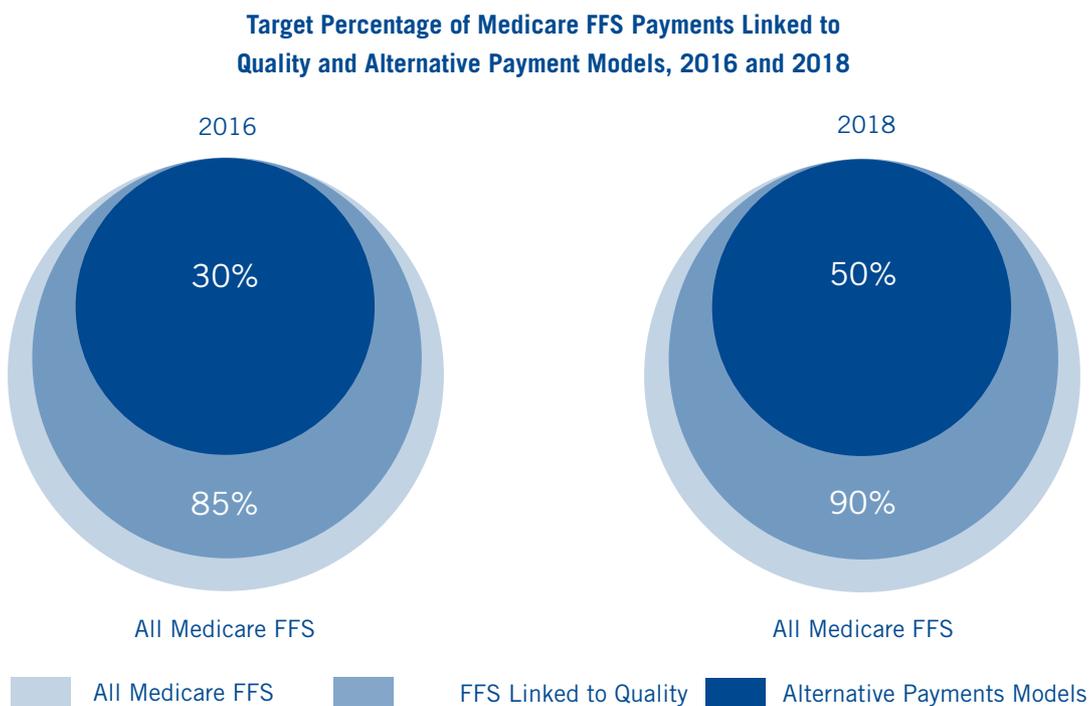


Figure 1.

Abbreviation: FFS, fee-for-service

Source: Centers for Medicare and Medicaid Services. Better care. Smarter spending. Healthier people: paying providers for value, not volume. January 2015.

Along with these payment reform initiatives, CMS has moved forward with its efforts to promote transparency for consumers regarding the performance of health care providers, including hospitals. CMS most recently implemented a five-star rating system for hospital performance whereby hospitals receive one to five stars based on their performance for more than 60 quality measures.⁶

Also, because of the ACA's potential for reducing hospitals' uncompensated care costs, policymakers included provisions in the ACA that reduce the federal government's disproportionate share hospital (DSH) payments, payments intended to offset uncompensated care costs to hospitals. The reductions in Medicaid DSH payments have been deferred until 2018.⁷

Population Health

The ACA embraced population health principles including the idea that providers need to focus more on preventing illness rather than just treating it. The Shared Savings Program aligns with this perspective because it is intended to give providers, assembled into accountable care organizations (ACOs), financial incentives to reduce care costs by keeping their assigned members healthier. Hospitals can sponsor or otherwise participate in these ACOs.

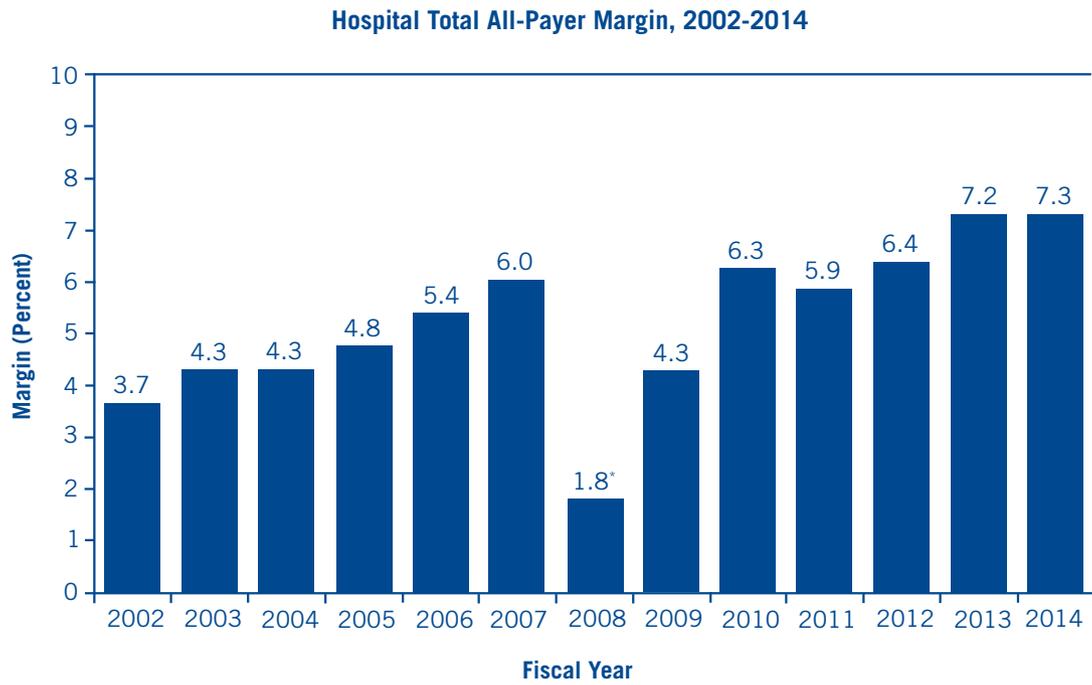
Additionally, the ACA requires that tax-exempt hospitals conduct community health needs assessments (CHNAs) and adopt an implementation strategy every three years (almost all nonprofit hospitals are tax exempt; they comprise more than 50% of all US hospitals). The CHNA mandate is the first federal provision directing tax-exempt hospitals to identify and address social and other determinants of population health within their communities. It is one of several ACA requirements for tax-exempt hospitals that stem in part from long-standing concerns among policymakers that tax-exempt hospitals deliver insufficient benefits to their community (e.g., charity care, community health improvement) relative to the value of the tax exemptions they receive.⁸ The other requirements pertain to hospital pricing and billing practices for individuals eligible for financial assistance.⁹

II. ACA Impact on Hospitals

Financial Condition and Utilization

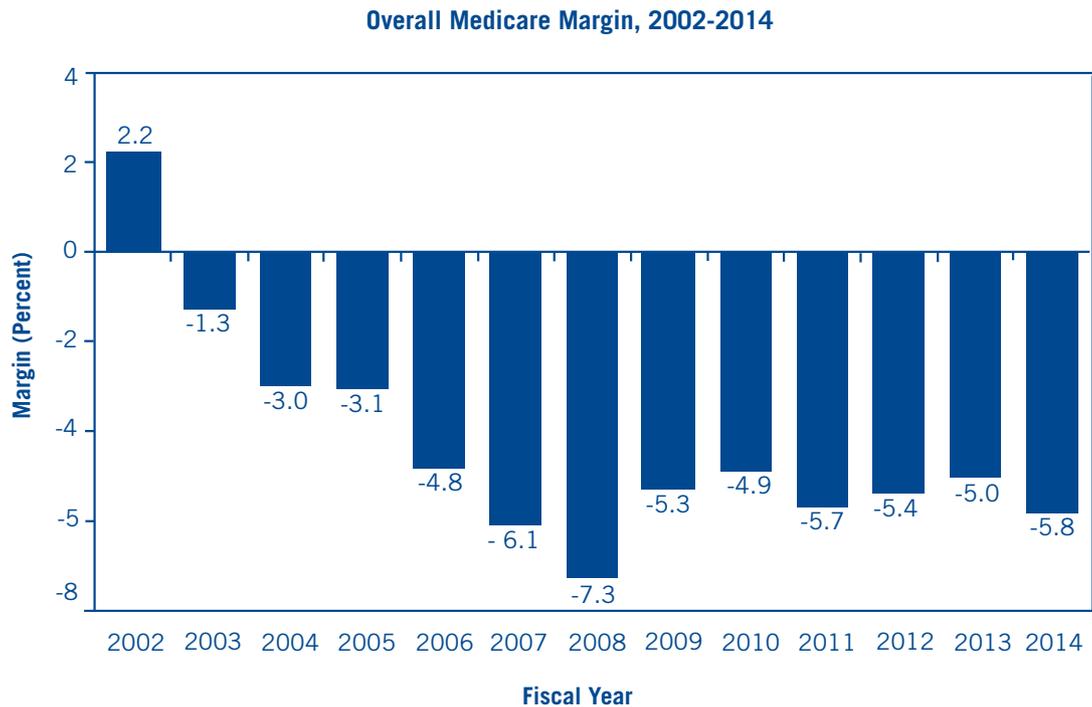
At this time, the ACA has not had a substantial impact on hospitals' financial condition or utilization. However, most data for gauging the impact are only as current as 2014 and have limited value because several relevant ACA provisions (e.g., individual insurance mandate) were just beginning to take effect. In terms of financial condition, available data present a generally positive picture. In fact, total profit margins (all payer) have been, on average, relatively strong and rising gradually (approximately 7% in 2014 versus 4.3% in 2009) even though margins for Medicare patients have been consistently in the negative range (Figure 2 and Figure 3).¹⁰

Figure 2.



Source: MedPAC analysis of Medicare Cost Report Data from CMS.

Figure 3.

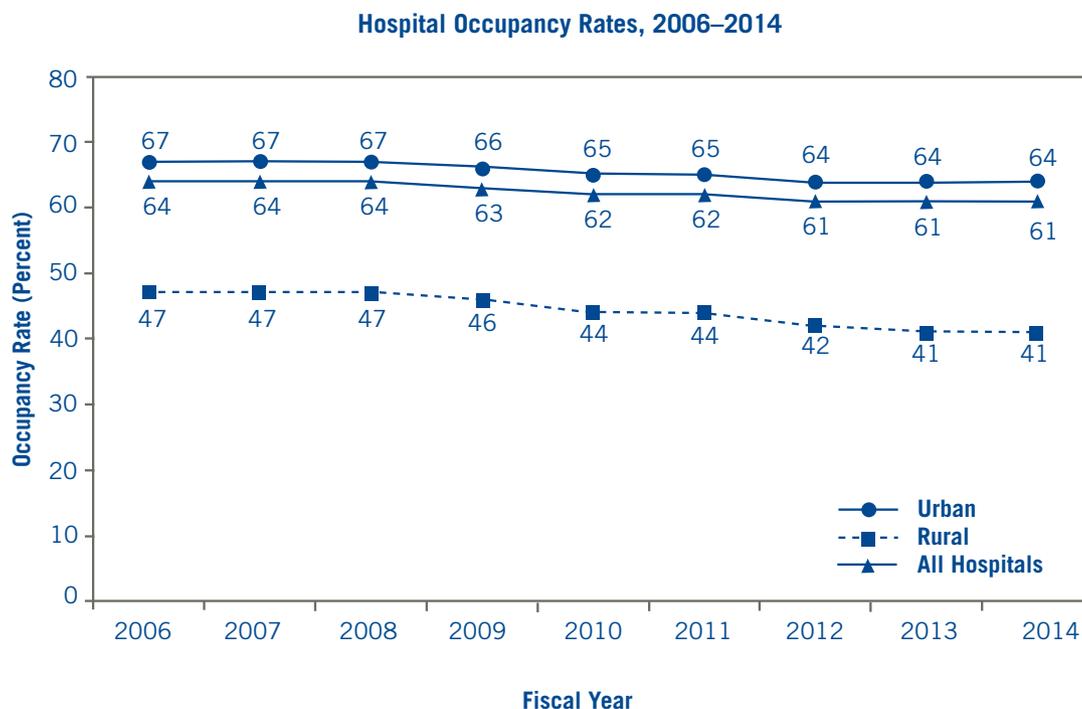


Source: MedPAC analysis of Medicare Cost Report Data from CMS.

Certainly, much variation exists in the financial condition of hospitals. More than 20% of hospitals have total margins that are negative. But this was also true before the ACA.¹¹ A recent report on the financial condition of Massachusetts' hospitals does indicate a decline in hospitals' total margins between 2014 and 2015 (4.2% to 3.7%), although most hospitals in the state had relatively healthy margins.^{12,13}

With respect to utilization, hospital occupancy rates remain pretty much at pre-ACA levels—a little above 60% (much lower for rural hospitals)—indicating at least some ongoing level of excess capacity (Figure 4).^{10,11} Some rise in occupancy rates might be expected given the ACA's focus on expanded health insurance coverage. However, as noted, hospital data for 2014 may not fully reflect the effects of key ACA provisions. Also, occupancy rates may not be increasing because hospitals are continuing to experience a shift in utilization away from inpatient care toward outpatient services, which is leading some hospitals to close or convert to ambulatory clinics.^{11,14} At the same time, hospital emergency department visits have been rising, which, according to some reports, may stem in part from difficulties patients have in securing appointments with primary care providers.^{14,15}

Figure 4.



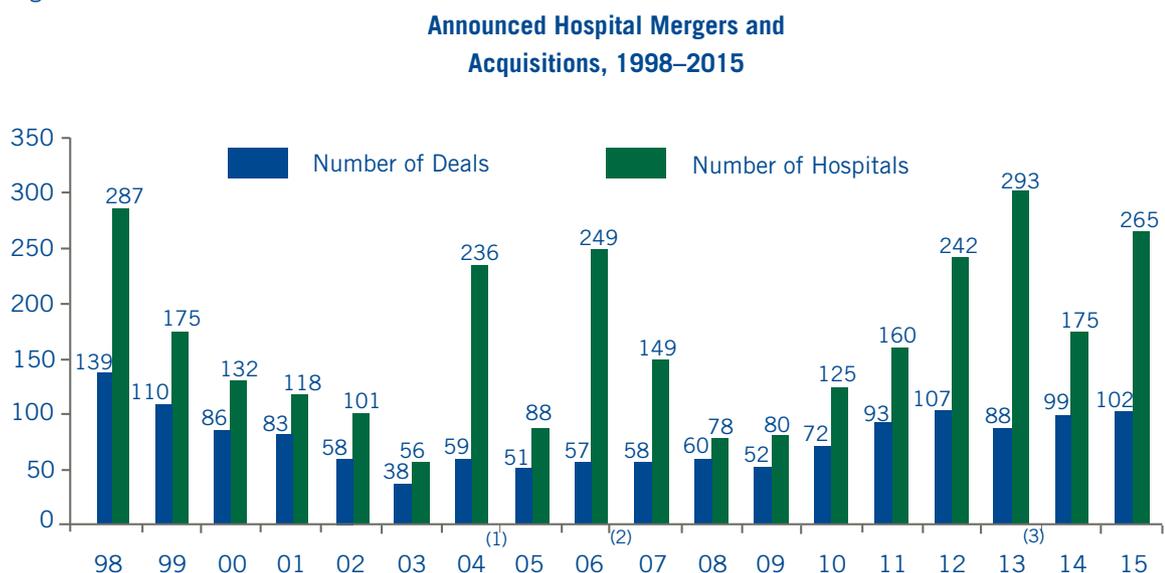
Source: MedPAC analysis of Medicare Hospital Cost Reports.

A recently published study (based on 2014 data) indicates that ACA-related Medicaid expansions had some impact on hospital finances and utilization. Hospitals in expansion states saw a relatively larger increase in their volume of Medicaid patients than did other hospitals. Additionally, hospitals in expansion states appear to be seeing a decrease in uncompensated care costs that, according to one estimate, is approximately a full percentage point below pre-expansion levels (4.1% versus 3.1% of operating costs). By comparison, hospitals not in expansion states reportedly have seen no such decline.¹⁶

Industry Consolidation

Hospitals are responding to the ACA by consolidating. Since the ACA was passed, the number of hospitals involved in mergers and acquisitions nationally has exceeded 100 per year (2010 through 2015) and was above 250 in 2013 and 2015 (Figure 5).^{10,11} This level of merger and acquisition activity has not occurred since the late 1990s.

Figure 5.



Source: Irving Levin Associates, Inc. (2016). *The Health Care Services Acquisition Report*, Twenty-Second Edition.

⁽¹⁾ In 2004, The Privatization of Select Medical Corp., an Operator of Long-Term and Acute-Care Hospitals, and Divestiture of Hospitals by Tenet Healthcare Corporation Helped to Increase the Number of Hospitals Affected.

⁽²⁾ In 2006, The Privatization of Hospital Corporation of America, Inc. Affected 176 Acute-Care Hospitals. The Acquisition was the Largest Health Care Transaction Ever Announced.

⁽³⁾ In 2013, Consolidation of Several Investor-Owned Systems Result In a Large Number of Hospitals Involved in Acquisition Activity.

Chart. 2.10 in 2009 and earlier years' Chartbooks.

To be sure, many hospital markets were highly consolidated before the ACA. More than two-thirds of US hospitals were already members of a system, defined as a corporate entity that owns two or more hospitals.¹⁷ But hospitals also appear to see consolidation as an important means for adapting to ACA-related challenges. Consolidation offers economies of scale and financial capital for purchasing information technology. In addition, it offers hos-

pitals within the same geographic area better negotiating leverage with health plans. These advantages are particularly important for smaller hospitals and hospitals in weak financial condition, but many transactions reportedly involve independent hospitals that are relatively large and financially healthy.¹⁸

The ACA also appears to be promoting broader industry consolidation as hospitals integrate vertically into other health care sectors. Hospitals are integrating vertically presumably to be in a better position to coordinate patient care and to be positioned to control the flow of health care dollars, both considered important for success in the post-ACA world. In particular, hospitals are aggressively acquiring physician practices and employing physicians directly. A recent report indicates that hospitals own 26% of physician practices, up from 14% in 2012.¹⁹ Several factors underlie physicians' motivation to join hospitals, but a key factor is the substantial financial requirements needed to purchase information technology for managing patient care. Many physician practices lack the necessary financial capital.²⁰

This type of hospital-physician integration is not entirely new. Hospitals acquired primary physician practices in the 1990s as a response to managed care pressures, though this was followed by a period of retrenchment as many hospitals experienced significant financial losses from these acquisitions.²⁰ A distinction between the recent trend and the one in the 1990s is that hospitals are currently acquiring specialty practices (e.g., cardiology) as well as primary care practices.

Beyond physician services, some hospitals are entering the health insurance sector either organically or through acquisition of plans. According to one report, 13% of hospital-based systems offer health insurance products, covering approximately 8% of all insured lives in the United States. This type of consolidation appears to have become more frequent in the past 24 months.²¹

These consolidation trends have raised concerns among policymakers regarding the cost of health care services.²² Much evidence indicates that hospital consolidation is associated with higher prices for hospital services, attributable to the better negotiating leverage hospitals gain with health plans.²³ One study points to price increases of between 5% and 15% for commercially insured patients when markets consolidate to fewer than four hospitals.²⁴ Hospital-driven vertical integration generally raises fewer concerns about price effects, but there is evidence suggesting that hospital-physician integration is stoking higher prices.²⁵ Through this type of vertical integration, hospitals may be enhancing their market power with payers by bundling their services with those of physicians.

While these price effects raise significant concerns, some policymakers are optimistic that hospital-driven vertical integration can promote better quality through improvements in the coordination of patient care. A few studies point to better quality of care among hospitals that employ physicians, but the evidence base is pretty thin.^{26,27}

Payment Reform and Hospital Performance

The impact of ACA payment reforms and related policy initiatives on hospitals' performance is somewhat uncertain. Many quality metrics for hospitals have shown steady improvement during the past few years, even in the presence of Medicare payment cuts.¹⁰ But formal evaluations of value-based purchasing programs have produced mixed results. In a report last year, the Government Accountability Office concluded that during the early years of the Hospital Value-Based Purchasing Program (i.e., 2013–2015), there was no substantial impact from the program on the quality measures that hospitals were incentivized to improve.²⁸ Other studies also indicate that improvements for at least some quality metrics were occurring before the implementation of value-based purchasing programs, thus raising questions about the specific contributions of the programs to hospital performance.²⁹ In addition, preliminary results from a CMS evaluation of a bundled payments initiative for orthopedic surgery and cardiovascular surgery are somewhat mixed in terms of savings and quality improvement.³⁰

It is apparent that many hospitals are responding to these new payment programs in some manner that holds promise for better quality of care. For example, hospitals are responding to readmission penalties and bundled payment initiatives by developing tighter clinical arrangements with post-discharge providers, particularly nursing homes. In some cases, hospitals are acquiring these providers, but a more common response appears to be selecting such providers for inclusion in so-called preferred networks based on their willingness to collaborate on readmission issues.³¹

Payment reform initiatives appear to create disadvantages for safety-net hospitals. Because safety-net hospitals treat a relatively large proportion of socioeconomically disadvantaged patients, they are less likely to perform well under these programs, most of which include performance measures that are affected negatively when patients face financial and educational barriers to accessing care.^{32,33,34}

Population Health Engagement

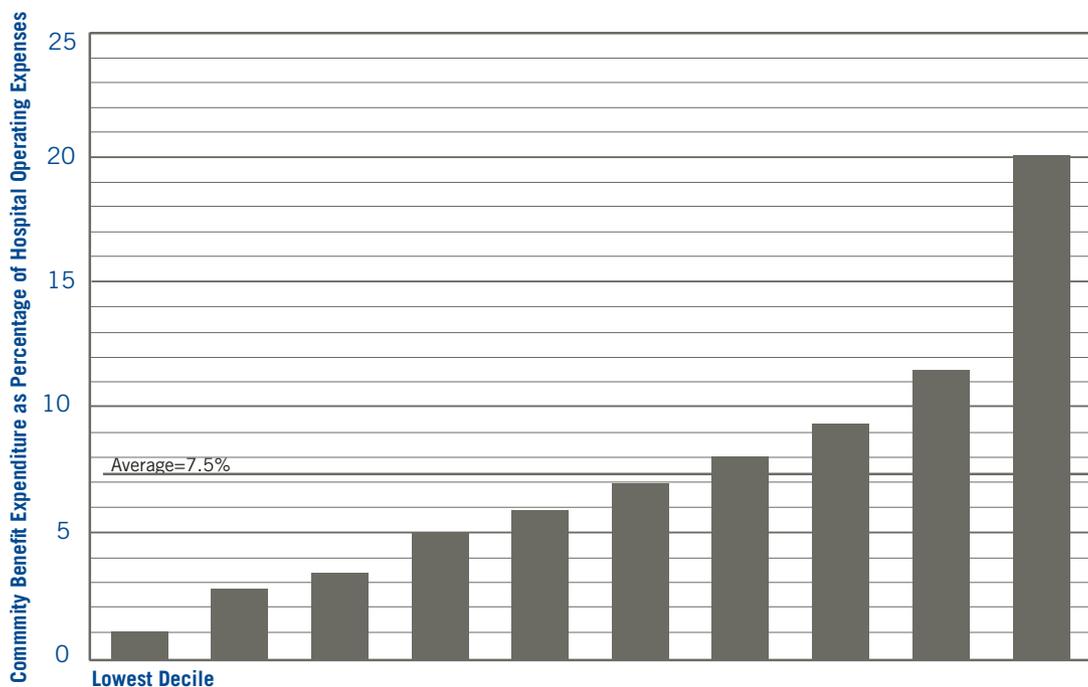
For most hospitals, population health initiatives constitute a major departure from their traditional mission and functions. So far, hospitals have shown interest in the Shared Savings Program. There are more than 400 hospital participants nationwide, including at least 45 in New England.³⁵ Some research suggests that the Shared Savings Program is reducing patient care costs, though no evidence exists yet that these cost reductions have been achieved by keeping patients healthier.³⁶

At the same time, preliminary evidence indicates that hospitals are not making much progress in other forms of population health engagement. First, analyses of 2013 hospital reports to the Internal Revenue Service (IRS) suggest that many hospitals still have far to go in meeting federal CHNA requirements, particularly in terms of adopting an implementation strategy for addressing identified needs.³⁷

Second, analyses of these same IRS filings for 2014 indicate little change in hospital spending on community-level health improvement initiatives.³⁸ Policymakers have been hopeful that hospitals will begin increasing their investment in the health status of their local communities, particularly if expanded health insurance frees up dollars that hospitals would have otherwise allocated to charity care. One national study shows that hospitals devoted approximately 7.5% of their operating budgets to community benefits (i.e., those recognized by the IRS) in the pre-ACA era, but just a fraction of this—less than 1% of operating budgets—went to community-level health improvement initiatives (Figure 6 and Figure 7).³⁹ Based on 2014 IRS data, hospitals have not increased their community-benefit spending in this area.

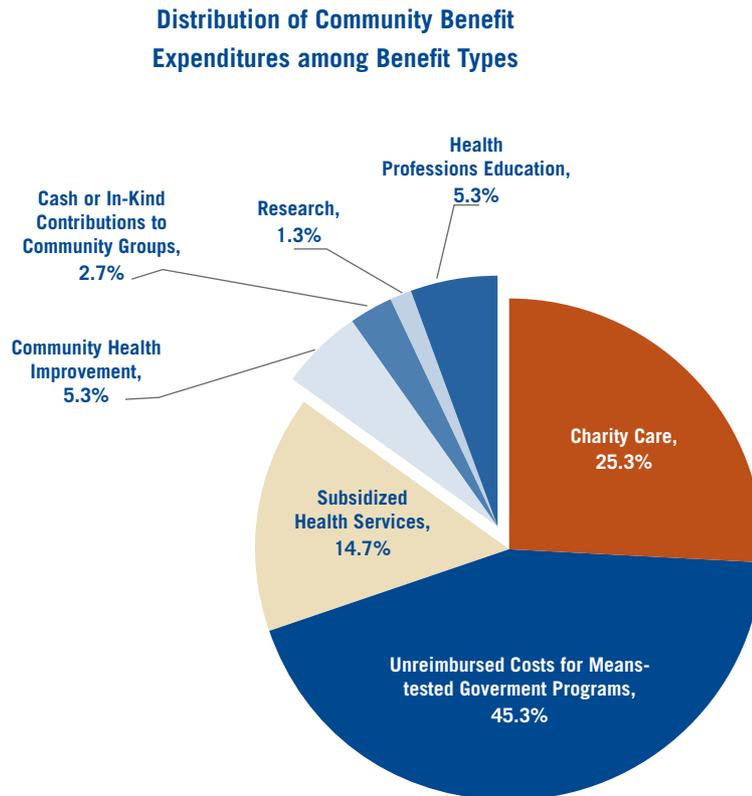
Figure 6.

Distribution of Hospital Community Benefit Expenditures¹



Source: Young GJ, Chou CH, Alexander J, Lee SY, Raver E. Provision of community benefits by tax-exempt US hospitals. *N Engl J Med.* 2013;368(16):1519-1527.

Figure 7.



Source: Young GJ, Chou CH, Alexander J, Lee SY, Raver E. Provision of community benefits by tax-exempt US hospitals. *N Engl J Med.* 2013;368(16):1519-1527.

Also, as noted, the ACA included additional requirements for tax-exempt hospitals regarding billing and pricing practices for patients who might qualify for financial assistance. One study based on 2012 IRS filings indicates mixed compliance by hospitals with these requirements.⁴⁰ A recent IRS report of hospital audits also points to compliance issues with ACA requirements, including CHNA.⁴¹

III. Key Issues for State Policymakers

The following are key issues and considerations for state policymakers moving forward.

- **Continuing industry consolidation presents serious risks for future health care cost inflation.**

Consolidation trends and negative margins on Medicare patients create a scenario in which hospitals will aggressively seek higher prices from health plans and employers.

State policymakers need to decide whether and how to intervene in the consolidation efforts of hospitals (e.g., regulatory controls, antitrust enforcement, certificate of need, cy pres proceedings).

Decision tools are needed to distinguish between consolidations that are likely to improve hospital quality and efficiency and those that are more likely to lead to higher hospital prices.

Limited provider networks offer opportunities for controlling health care costs but are controversial and require provider markets that are competitive.

- **A key consideration is whether states should follow the federal government's lead in the adoption of value-based purchasing initiatives, particularly alternative payment models (APMs).**

Diffusion of APMs in the commercial health insurance sector has been limited. Massachusetts, a bellwether state in this regard, has seen its own diffusion of APMs level off.

The effectiveness of these payment reform models is not yet clear. What other options exist for payment models that can control spending and create strong incentives for quality of care?

- **Population health is the new frontier for health policy, and hospitals need to be central players—but little progress will likely occur without strong commitment from state policymakers.**

Hospitals face significant challenges in transitioning to a population health orientation. In particular, hospitals continue to rely on fee-for-service revenue, so filling beds and performing clinical procedures remain priorities. Also, many hospitals lack the intellectual and material infrastructure for population health engagement.

What policy levers might be available for motivating hospitals to move faster in transitioning to a population health orientation, such as community benefit regulations or property tax exemptions? How can state policymakers help hospitals make this transition, such as with financial resources, training, or other supports?

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About the Milbank Memorial Fund

The Milbank Memorial Fund is an endowed operating foundation that works to improve the health of populations by connecting leaders and decision makers with the best available evidence and experience. Founded in 1905, the Fund engages in nonpartisan analysis, collaboration, and communication on significant issues in health policy. It does this work by publishing high-quality, evidence-based reports, books, and *The Milbank Quarterly*, a peer-reviewed journal of population health and health policy; convening state health policy decision makers on issues they identify as important to population health; and building communities of health policymakers to enhance their effectiveness.

About the New England States Consortium Systems Organization

The New England States Consortium Systems Organization (NESCSO) is a non-profit corporation organized by the New England Health and Human Services agencies and the University of Massachusetts Medical School. NESCSO'S Board is comprised of five New England States Health and Human Services Commissioners and/or their delegates.